



STATE FISCAL YEAR 2015  
EXTERNAL QUALITY REVIEW  
TECHNICAL REPORT

July 1, 2014–June 30, 2015

May 2016

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## Introduction

The Ohio Department of Medicaid (ODM) is the single Executive-level state Medicaid agency that administers the Medicaid Managed Care Program in Ohio. As of June 2015, ODM contracted with five managed care plans (MCPs) to deliver services to over 1.7 million low-income children and adults, pregnant women, and children and adults with disabilities throughout the State of Ohio. Contracted MCPs included Buckeye Community Health Plan (Buckeye), CareSource, Molina Healthcare of Ohio, Inc. (Molina), Paramount *Advantage* (Paramount), and UnitedHealthcare Community Plan of Ohio, Inc. (UnitedHealthcare).

Title XIX of the Social Security Act (SSA), Section 1932(c)(2)(A) requires states that operate Medicaid managed care programs to “provide for an annual (as appropriate) external independent review conducted by a qualified independent entity of the quality outcome and timeliness of, and access to the items and services for which the organization is responsible under the contract.” Federal external quality review (EQR) requirements have been further specified in 42 Code of Federal Regulations (CFR) §438.358 and §438.364 regarding the EQR activities and the technical report.

ODM contracted with Health Services Advisory Group, Inc. (HSAG), to conduct various EQR activities and produce this technical report, which covers review activities completed during the period of July 1, 2014, through June 30, 2015. This report also describes ODM monitoring activities and the manner in which HSAG aggregated and analyzed data from the EQR activities, in accordance with CFR and ODM requirements. HSAG used the Centers for Medicare & Medicaid Services’ (CMS’) November 9, 2012, update of its External Quality Review Toolkit for States when preparing this report.<sup>1-1</sup>

The State Fiscal Year (SFY) 2015 EQR Technical Report was developed to comply with the EQR reporting requirements mandated by the SSA, codified in the CFR, and further defined by CMS. The report provides an assessment of the quality, accessibility, and timeliness of services MCPs provided to Medicaid consumers during SFY 2015.

## Overview of Findings

### ***Validation of Managed Care Provider Network Submissions***

The MCPs are required to submit detailed provider panel information to ODM monthly in the Managed Care Provider Network (MCPN) files. This information is provided to Automated Health Systems (AHS), which provides enrollment services to managed care consumers, including access to

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<sup>1-1</sup> The Centers for Medicare & Medicaid Services. External Quality Review Toolkit, November 2012. Available at: <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Downloads/EQR-Toolkit.pdf>. Accessed on: Sept 24, 2013.

provider panel information. Complete, accurate, and up-to-date MCPN files are necessary to ensure Medicaid consumers have appropriate access to information regarding health care providers.

As a continuation of SFY 2014 activities, HSAG reviewed information contained within the MCPN files specific to primary care providers (PCPs) serving consumers in the Medicaid program, and conducted a phone survey of the PCP offices in the Ohio Medicaid Managed Care West Region during the first calendar quarter of SFY 2015 to validate the MCPN information. All five MCPs were included in this telephone survey: Buckeye Community Health Plan (Buckeye), CareSource, Molina Healthcare of Ohio, Inc. (Molina), *Paramount Advantage* (Paramount), and UnitedHealthcare Community Plan (UnitedHealthcare).

The SFY 2015 contract year added a “secret shopper” approach as a new data collection method for this activity.

While access results showed that a majority of providers with accurate telephone numbers and MCP affiliation information were able to provide appointments for routine care to a new patient within 30 calendar days, many inconsistencies in provider information were identified between the MCPN data and information obtained by the secret shoppers.

Providers’ names and county information were generally accurate when compared to the MCPN data. More than 97 percent of cases matched MCPN data for providers’ names, and more than 92 percent of cases matched county information in each quarter. ODM provided the results to the MCPs, requiring them to reconcile the information and to submit feedback to ODM within a specific time frame. MCPs are expected to perform ongoing verification and reconciliation of provider panel information.

### **Addenda Audit**

MCPs submit documentation to ODM demonstrating adequate provider panel capacity to provide preventive, primary care, and specialty services adequate for the anticipated number of consumers in the service area, while maintaining a provider panel that is sufficient in number, mix, and geographic distribution to meet the needs of consumers in the service area.

The addenda audit was completed in SFY 2015 to validate the Model Medicaid Addenda signed by providers against the provider panel requirements established by ODM and the data contained within the MCPN files. Overall, among Medicaid-only providers, 81 percent of the required elements were documented and included in the addendum reviewed by HSAG. Individual MCP performance showed considerable variation, with overall MCP results ranging from 54.6 percent to 89.0 percent.

### **Call Centers Review**

ODM requires MCPs to provide consumers with access to a member services call center and to a nurse advice line 24 hours a day, seven days a week. ODM also requires MCPs to meet the URAC<sup>1-2</sup>

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<sup>1-2</sup> URAC is an independent nonprofit organization known as a leader in promoting health care quality through its accreditation, education, and measurement programs. Formerly known as the Utilization Review Accreditation Commission, the organization is now simply referred to as URAC.

standards which are applicable to call centers and nurse advice lines: abandonment rate, blockage rate, and average speed of answer. Overall findings indicated that the MCPs provided consumers with appropriate and timely access to call centers.

## **Consumer Complaints**

Ohio Medicaid monitors complaints to assess consumers' overall satisfaction with the Ohio Medicaid Managed Care Program; this includes consumers' satisfaction with access to health care services. Calls to the consumer hotline, as well as those submitted directly to contract administrators, are entered directly into the HealthTrack system when a complaint is identified about an MCP. AHS call center employees input identifying information and summarize the caller's problem. The MCPs follow a specified process to ensure that a resolution is reached. Overall, nearly 90 percent of consumer complaints were related to non-access issues.

## **Grievances**

ODM requires that each MCP submit appeal and grievance activity at least monthly in an electronic data file format pursuant to the *ODM Appeal File and Submission Specifications* and *ODM Grievance File and Submission Specifications*. Overall, approximately 28 percent of the grievances filed in SFY 2015 were related to consumers' access to health care services. All MCPs exhibited a high level of compliance with the timeliness standards for processing grievances regardless of grievance type. Nearly 100 percent of all grievances were resolved within the required time frames.

## **Performance Measurement**

ODM established quality measures and minimum standards of performance for MCPs in key program areas (i.e., access, clinical quality, and consumer satisfaction) which aligned with specific focus areas of the Medicaid Quality Strategy. When MCPs do not meet performance standards, ODM holds them accountable and can issue a noncompliance finding to the MCP. This report presents statewide performance based on MCP self-reported, audited Healthcare Effectiveness Data and Information Set (HEDIS<sup>1-3</sup>) rates for the calendar year (CY) 2013 measurement period (i.e., January 1, 2013–December 31, 2013).

Access-related, CY 2013 statewide HEDIS measure results demonstrated that the rate for *Adults' Access to Preventive/Ambulatory Health Services* remained the same from CY 2012 to CY 2013, and exceeded the National Committee for Quality Assurance (NCQA) national Medicaid HEDIS 50th percentile. The rate for *Children and Adolescents' Access to Primary Care Practitioners* remained stable for the 12–24 months age group, but declined for those consumers who were ages 25 months through 19 years. All child access measures fell below the HEDIS 50th percentiles.

Clinical quality measures focused on asthma, behavioral health, cardiovascular disease, diabetes, high-risk pregnancy/premature births, and upper respiratory infections (URIs).

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<sup>1-3</sup> HEDIS® refers to the Healthcare Effectiveness Data and Information Set and is a registered trademark of the National Committee for Quality Assurance (NCQA).

Notable rate increases (more than 5 percentage points) from CY 2012 to CY 2013 include Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up and Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase. A notable rate decrease was seen for Well-Child Visits in the First 15 Months of Life—Six or More Well-Child Visits.

In addition, two non-HEDIS (Children's Health Insurance Program Reauthorization Act [CHIPRA]) measures were calculated. The CY 2013 statewide average for the annual number of patients with asthma with at least one asthma-related emergency room visit was 12.4 percent. MCP-specific results ranged from 11.6 to 13.6 percent. The percentage of live births weighing less than 2,500 grams showed a statewide average of 9.3 percent.

ODM used the CY 2013 Consumer Assessment of Healthcare Providers and Systems (CAHPS<sup>1-4</sup>) survey *Rating of Health Plan* measure for both children and adults to further assess MCP performance. This measure evaluates consumer satisfaction with MCP services and operations. HSAG calculated a three-point mean for the *Rating of Health Plan* measure for each MCP. For the adult population, all MCPs' *Rating of Health Plan* results were at or above the NCQA national Medicaid 50th percentile. For the general child population, three of the five MCPs scored at or above the 50th percentile, down from four of the five MCPs in CY 2012.

In addition to access, clinical performance, and consumer satisfaction monitoring, ODM selected a specific subset (six) of the clinical performance HEDIS measures as the basis for its Pay-for-Performance (P4P) Incentive System. Focus areas, which also aligned with the Medicaid Quality Strategy, included behavioral health, high-risk pregnancy/premature births, asthma, upper respiratory infections, diabetes care, and cardiovascular disease. All MCPs earned a portion of the available incentive award, ranging from 10 percent to 45 percent, for a total of 22 percent potential incentive dollars. This represents a significant decrease from incentive dollars awarded for CY 2012 performance, when the MCPs earned 40 percent of potential incentive awards.

### **Performance Improvement Projects**

In SFY 2015, the PIP process was redesigned to support real and sustained improvement in study indicators. In July 2014, ODM and HSAG began to develop a new PIP framework based on a modified version of the Model for Improvement developed by the Associates in Process Improvement and used extensively by the Institute for Healthcare Improvement. The key concepts of the new framework include forming a PIP team; setting aims; establishing measures; determining interventions; conducting incremental, rapid-cycle testing; and thoughtful spreading of successful changes. The core component of this new process involves testing change on a small scale, using a series of Plan-Do-Study-Act (PDSA) cycles and applying the results of the rapid-cycle learning process over the course of the project. CMS approved this new PIP approach for the State of Ohio in October 2014.

Formal initiation of the PIP began in 2015 when ODM selected a new topic, *Progesterone Initiation*, which aligns with the Medicaid Quality Strategy by targeting the related goals of reducing preterm

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<sup>1-4</sup> CAHPS® refers to the Consumer Assessment of Healthcare Providers and Systems and is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

birth and infant mortality. A key component of the PIP initiation phase was the partnership of ODM and its contracted MCPs with the Ohio Perinatal Quality Collaborative (OPQC). OPQC is a statewide partnership consisting of providers, policymakers, and governmental entities that began efforts to increase progesterone use at 23 OB practices in 2007. This partnership allows interventions to be tested simultaneously at the micro (practice-level), mezzo (managed care level), and macro (statewide level) to determine best practices for sustained improvement.

### **Consumer Satisfaction**

ODM required each MCP to administer the CAHPS survey for both adults and children in SFY 2014. CAHPS is a standardized survey assessing consumer, parent, or caregiver perspectives on health care and services. Survey results provide valuable feedback on MCP performance based on consumers' experiences with the health plan and health care providers.

When compared to NCQA national Medicaid percentile distributions, statewide MCP results demonstrated that adult consumers and parents or caregivers of children in Medicaid managed care were highly satisfied with their MCPs' customer service and how well their doctors communicated. Adult consumers were highly satisfied with their health plan and moderately satisfied with their overall health care, getting care quickly, and the level of shared decision-making with their provider.

In addition, parents or caregivers of children were highly satisfied with their ability to get the care their children needed and get that care quickly, their overall health care, their personal doctor, and specialist seen most often. They were moderately satisfied with the level of shared decision making with their provider and their children's health plan. Compared to adult consumers, parents or caregivers provided higher ratings for more measures when compared to national Medicaid percentiles.

### **Quality of Life Survey**

HSAG administered a QoL survey from June to September 2014 to children in the Aged, Blind, or Disabled (ABD) and Covered Families and Children (CFC) populations of all five MCPs. The goal of the survey was to evaluate health-related QoL experiences of children with chronic or disabling conditions to better understand their health care needs and identify potential areas to target quality improvement activities.

Measures assessed included global health, global behavioral health, role/social limitations (emotional and physical) bodily pain/discomfort composite, general behavior composite, mental health composite, parental impact (emotional and time), family cohesion item, physical summary measure, and psychosocial summary measure.

Overall, the statewide ABD population scored significantly lower than the CFC population on all measures evaluated. This could be expected, as the ABD child population is limited to children with chronic or disabling conditions. For both populations, measures assessing physical health received the highest scores, while measures evaluating behavioral issues received the lowest scores.

## **High Risk Care Management**

### **HRCM Consumer Survey**

ODM conducted a Care Management survey to evaluate both adult and child consumers' experiences with MCP high risk care management (HRCM) programs between January and March 2015. The survey instrument included 37 questions across five domains: care management participation, care manager, care plan, satisfaction with care management, and about you.

Overall, 62.0 percent of consumers were satisfied with care management services. The majority of respondents indicated knowledge of the care management program (86.7 percent) and experienced a positive relationship with their care manager (85.1 percent). Almost all respondents were familiar with their care plan (92.5 percent), but only 66.6 percent felt the care management program helped them. Approximately 86 percent of respondents reported having at least one face-to-face visit with their care manager, with 71 percent of these respondents rating the visit as very helpful.

### **Patient Engagement**

ODM identified opportunities to improve health care engagement for consumers in HRCM during case reviews completed during SFY 2014. As a result, ODM contracted with HSAG to implement a patient engagement study for the MCPs' HRCM population during SFY 2015.

ODM and HSAG selected the Patient Activation Measure (PAM). The survey instrument measures three key health-related domains: knowledge, skills, and confidence. It ranks respondents in one of four levels of activation, one being the least activated and four being the most activated. Higher activation levels are associated with an increased likelihood that a consumer will be compliant with health care recommendations and will use health care services appropriately.

Nearly 6,000 baseline PAM surveys were administered to HRCM consumers between July 15 and October 15, 2014. The baseline aggregate PAM mean score was 59.0 (on a scale of 1 to 100), with individual MCP mean scores ranging from 56.8 to 63.2. Distribution among the four activation levels was consistent with what was expected for a Medicaid population.

Based on the baseline PAM score and activation level, MCP staff members implemented tailored goals, supports, and interventions over a six-month period to improve patient activation. After the intervention period, the PAM survey was readministered to assess changes in the level of patient activation.

## **Overall Conclusions and Recommendations**

HSAG used findings across both mandatory and optional EQR activities and ODM monitoring activities conducted during the review period of July 1, 2014–June 30, 2015, to evaluate the performance of Medicaid MCPs on providing quality, timeliness of, and access to health care services to Ohio Medicaid managed care consumers.

Findings from HEDIS performance measures, CAHPS surveys, and other EQR and ODM monitoring activities identified both strengths and opportunities for improvement across the three CMS domains: quality, access, and timeliness. Overall, MCPs demonstrated that they had organizational structures, policies, and procedures to ensure the quality and timeliness of, and access to, Medicaid-covered health care services.

The following subsections present highlights of the conclusions drawn from the findings with respect to quality, access, and timeliness as they relate to health care, as well as HSAG's recommendations for the Ohio managed care program. For a more detailed discussion of conclusions and recommendations, please refer to Section 10 of this report.

## Quality

In the quality of care domain, performance was varied. The majority of quality-related MCP performance measure rates were relatively unchanged from CY 2012; results showed that four of 13 rates (four measures) with national benchmarks available for performance ranking were above the national Medicaid 50th percentiles. Nine rates (six measures) were below the national Medicaid 50th percentiles, with three rates (two measures) below the 25th percentiles. However, *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up* and *Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase* improved notably from CY 2012 to CY 2013.

The P4P incentive program was underutilized by the MCPs; awarded dollars for CY 2013 represented only 22.13 percent of the eligible dollars and a decrease from 40.39 percent in the year prior.

HSAG noted that ODM's selection of and the MCPs' participation in the *Progesterone Initiation* PIP during the review year demonstrated good alignment between quality improvement efforts, with one of ODM's priority areas to reduce infant mortality. In conjunction with the *Progesterone Initiation* PIP, which was selected by ODM, all MCPs developed methodologically sound projects to measure and monitor outcomes.

Consumer satisfaction surveys demonstrated that adult consumers and parents or caregivers of children were satisfied with their health plan, how well their doctors communicated, MCPs' customer services, and the ability to get care quickly. Efforts were also made to assess the health-related experiences of specialized populations in SFY 2015.

The QoL survey was administered to CFC and ABD child populations. Results from the QoL survey administered to children with chronic and disabling health conditions for the CFC and ABD populations showed that the CFC population scored slightly higher than the ABD population on most measures; however, the scores were very similar. This suggests that the MCPs have done fairly well with integrating the ABD child population into Medicaid managed care. The QoL results also demonstrated high scores for assessing physical health but lower scores for measures evaluating behavioral issues for both child populations. These results suggest that efforts to move toward a patient-centered approach that holistically evaluates and manages each consumer is an opportunity for improvement.

Results from the HRCM survey indicate that overall consumer experiences with HRCM were positive. The majority of consumers indicated knowledge of the care management program and their care plans, and satisfaction with their care manager. Opportunities for improvement exist in making the care management program helpful to more consumers.

Results from the PAM study showed promising potential as aggregate MCP results showed statistically significant improvement in the activation level of consumers.

The results of the readministered PAM survey suggest that tailored care planning and consumer-specific interventions were effective in improving patient activation among HRCM consumers.

## Access

In the access domain, MCP performance was mixed. The MCPN validation results showed that a majority of providers were able to provide appointments for routine care to new patients within 30 calendar days. However, some inconsistencies were identified in MCPN data during the first calendar quarter audit, and secret shopper survey results from the third and fourth calendar quarters showed that more than 25 percent of PCP locations could not be reached by callers. In addition, some providers accepting new patients imposed clinical restrictions or practice requirements (e.g., requiring a review of prospective patients' medical records) prior to scheduling an appointment.

Overall, the MCPs met contract requirements for access to MCP call centers and 24-Hour Nurse Advice Line call centers and received high rates of satisfaction among both adult and child populations with MCPs' customer service. Approximately 10 percent of consumer complaints received through ODM's consumer hotline and approximately 28 percent of all grievances filed by the MCPs during SFY 2015 were access-related.

Child and adolescent consumer access to primary care remained stable for children 12 to 24 months old, but declined in CY 2013 for children ages 25 months to 19 years. Rates for all child access measures fell below the 50th percentiles. Statewide performance on adult access to primary care did not show any major change from the year prior and continued to exceed the Medicaid national 50th percentile. One HEDIS clinical quality measure rate, *Well-Child Visits in the First 15 Months of Life—Six or More Well-Child Visits*, declined notably in CY 2013.

## Timeliness

In the timeliness of care domain, the MCPs had favorable performance. MCP statewide performance for four of the five rates (four measures) ranked above the Medicaid 50th percentiles. These rates include two pregnancy-related measures (Prenatal and Postpartum Care—Timeliness of Prenatal Care and Frequency of Ongoing Prenatal Care— $\geq 81$  Percent of Expected Visits) and two behavioral health-related measures (Follow-Up After Hospitalization for Mental Illness—7 Day Follow-Up and Follow-up Care for Children Prescribed ADHD Medication—Initiation Phase).

Adult consumers in Ohio's Medicaid managed care program generally reported moderate levels of satisfaction compared to national Medicaid results—at or between the 25th and 49th percentile and at or between the national Medicaid 50th and 74th percentile—in the areas of Getting Needed Care

and Getting Care Quickly, respectively. The parents or caregivers of children in Ohio's Medicaid managed care program generally reported high levels of satisfaction compared to national Medicaid results.

### **Recommendations**

Based on the review of the MCPs' performance on both mandatory and optional activities, HSAG provides specific recommendations for the program as a whole in the Conclusions and Recommendations section of this report, and provides the following overarching recommendations:

- ◆ MCPs should integrate access-related complaints and grievances data analyses into their overarching quality improvement program.
- ◆ MCPs should use rapid-cycle PIP methodology to address performance measures that fell below the 25th percentile, such as those related to high blood pressure and comprehensive diabetes care.
- ◆ MCPs should investigate the causes of declining and low performance on measures that fell below the 50th percentile, such as those related to well-child visits and appropriate medication for people with asthma.
- ◆ MCPs should improve performance related to low birth weights by focusing on improving women's general health over their life cycle in addition to identifying and engaging pregnant women who previously had poor birth outcomes.
- ◆ MCPs should include within their HRCM program an emphasis on developing strategies and interventions to improve the health-related QoL of children with emotional, behavioral, attention, and/or learning difficulties.

## 2. Ohio Medicaid Managed Care Plans

### Overview

ODM is the Executive-level State agency responsible for the implementation and administration of Ohio’s combined Medical Assistance program authorized under Title XIX of the Social Security Act (also referred to as Medicaid) and Title XXI of the Social Security Act (also referred to as the State Children’s Health Insurance Program [CHIP]), implemented in Ohio as a Medicaid expansion program.<sup>2-1</sup>

Ohio Medicaid has incorporated the use of managed care to provide primary and acute care services to Medicaid consumers since 1978. The managed care model was implemented as a means to improve the access, quality, and continuity of care; enhance provider accountability; and achieve greater cost predictability in the State Medicaid program. Participating MCPs must be licensed as health insuring corporations through the Ohio Department of Insurance.

The risk-based, comprehensive Medicaid managed care program was introduced in 2005 and is mandatory for most low-income children and families and certain Medicaid beneficiaries with disabilities. In 2013, changes to the Medicaid managed care program made all MCPs available statewide.

### MCP Comparison

During SFY 2015, Ohio Medicaid contracted with five qualified MCPs—Buckeye Community Health Plan, CareSource, Molina Healthcare of Ohio, Inc., Paramount *Advantage*, and UnitedHealthcare Community Plan of Ohio, Inc. These MCPs are responsible for the statewide provision of services to managed care consumers. Table 2-1 provides a profile for each MCP.

| Table 2-1—Managed Care Plan Profiles as of June 2015 |                                                 |                                                                                                                                                     |                               |
|------------------------------------------------------|-------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------|
| MCP                                                  | Year Operations Began in Ohio as a Medicaid MCP | Profile Description                                                                                                                                 | Product Lines in Ohio         |
| Buckeye Community Health Plan (Buckeye)              | 2004                                            | Subsidiary of the Centene Corporation, a publicly owned multistate managed health care company, founded in 1984 and headquartered in St. Louis, MO. | Medicaid, Medicare, Exchange* |

<sup>2-1</sup> The Centers for Medicare & Medicaid Services, Medicaid.gov. CHIP State Program Information. Available at: <http://www.medicaid.gov/chip/state-program-information/chip-state-program-information.html>. Accessed on: Sept 1, 2015

**Table 2-1—Managed Care Plan Profiles as of June 2015**

| MCP                                                              | Year Operations Began in Ohio as a Medicaid MCP | Profile Description                                                                                                                    | Product Lines in Ohio                     |
|------------------------------------------------------------------|-------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------|
| CareSource                                                       | 1989                                            | A nonprofit public sector managed health care company founded in 1989 and headquartered in Dayton, OH.                                 | Medicaid, Medicare, Exchange*             |
| Molina Healthcare of Ohio, Inc. (Molina)                         | 2005                                            | A publicly owned multistate managed health care company founded in 1980 and headquartered in Long Beach, CA.                           | Medicaid, Medicare, Exchange*             |
| Paramount <i>Advantage</i> (Paramount)                           | 1993                                            | A nonprofit regional subsidiary of Promedica, a multiline health care company founded in 1988 and headquartered in Toledo, OH.         | Medicaid, Medicare, Commercial, Exchange* |
| UnitedHealthcare Community Plan of Ohio, Inc. (UnitedHealthcare) | 2006                                            | A division of UnitedHealth Group, a publicly owned multistate health care company founded in 1974 and headquartered in Minnetonka, MN. | Medicaid, Medicare, Commercial, Exchange* |

\*The U.S. Department of Health and Human Services operates the exchange in the State of Ohio.

## Enrollment

As of June 2015, over 1.7 million Ohio consumers were enrolled in the Medicaid managed care program. Table 2-2 provides the total number of consumers by MCP.

Figure 2-1 presents the percentage of consumers enrolled in each of the five MCPs.

**Table 2-2—Ohio’s Medicaid Managed Care Enrollment by MCP  
June 2015**

| MCP                                                              | Total            |
|------------------------------------------------------------------|------------------|
| Buckeye Community Health Plan (Buckeye)                          | 191,495          |
| CareSource                                                       | 988,166          |
| Molina Healthcare of Ohio, Inc. (Molina)                         | 245,828          |
| Paramount <i>Advantage</i> (Paramount)                           | 155,091          |
| UnitedHealthcare Community Plan of Ohio, Inc. (UnitedHealthcare) | 181,626          |
| <b>Grand Total</b>                                               | <b>1,762,206</b> |

Figure 2-1—Percentage of Consumers by MCP

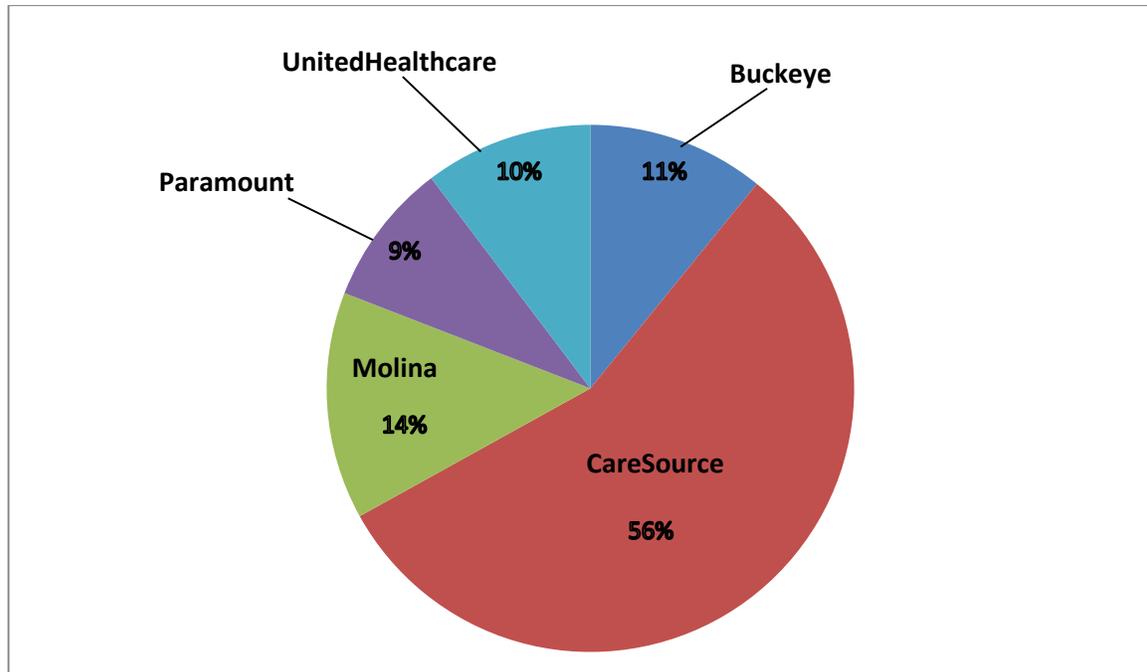
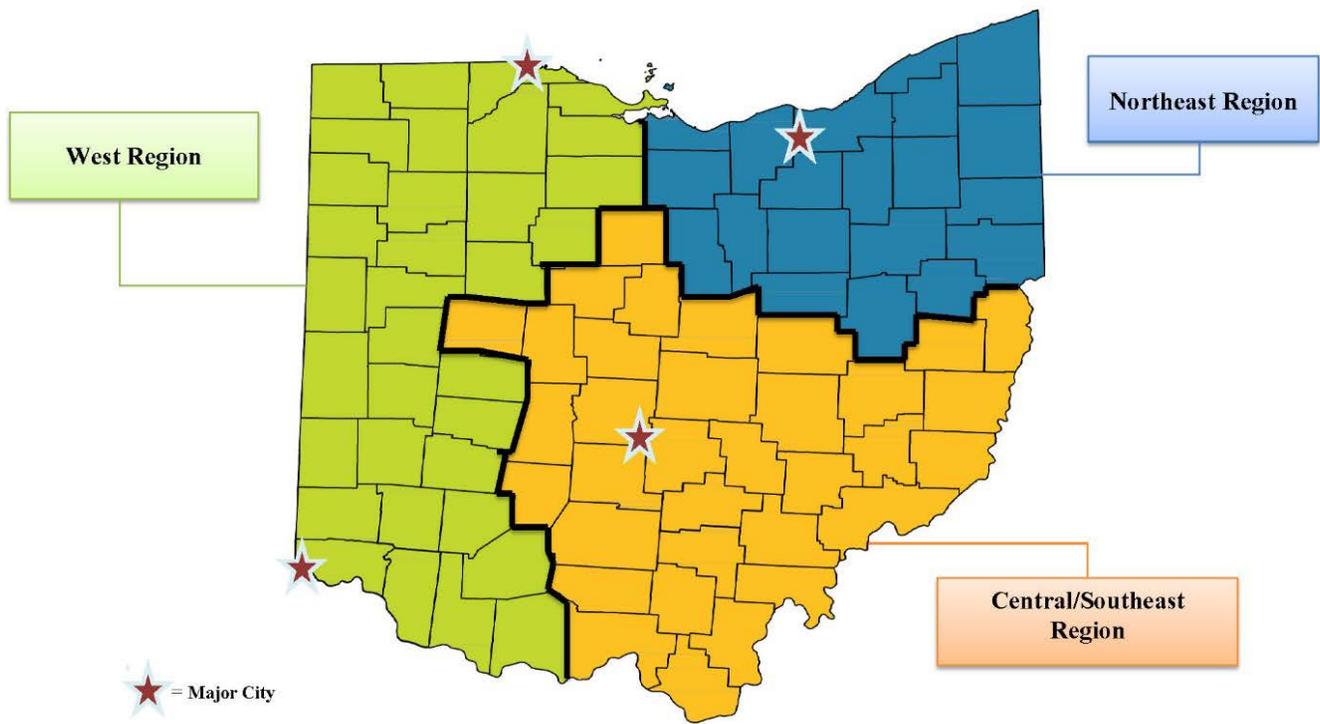


Figure 2-2—Ohio Medicaid Managed Care Regions



## Quality Strategy Goals

ODM's Medicaid Quality Strategy provides the framework for providing effective oversight of the MCPs and for improving the delivery of health care services for Medicaid consumers. The Quality Strategy is built on three aims:<sup>3-1</sup>

- ◆ **Better Care:** Improve the overall quality of care by making health care more patient-centered, reliable, accessible, and safe.
- ◆ **Healthy People/Healthy Communities:** Improve the health of Ohioans by supporting proven interventions to address behavioral, social, and environmental determinants of health.
- ◆ **Practice Best Evidence Medicine:** Facilitate the implementation of best clinical practices to Medicaid providers through collaboration and improvement science approaches.

Under these three aims, five priorities and related goals are defined as follows:

1. **Make Care Safer**—Eliminate preventable, health-care acquired conditions and errors.
2. **Improve Care Coordination**—Clear communication, accessible care, and optimized care.
3. **Promote Evidence-Based Prevention and Treatment Practices**—Improve priority populations including the following clinical focus areas: high-risk pregnancy/premature births, behavioral health, cardiovascular disease, diabetes, asthma, upper respiratory infections, and musculoskeletal health.
4. **Support Person- and Family-Centered Care**—Listen to patient/family and integrate their preferences into care.
5. **Ensure Effective and Efficient Administration**—Sustain a quality-focused, data-informed, and continuous learning organization.

Strategic initiatives for each goal define how ODM will achieve intended outcomes. Objectives are quantifiable and performance-driven, include measurable performance targets, and are based on national industry standards when possible. An extensive set of initiatives supports the goals, many of which directly relate to MCP performance.

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<sup>3-1</sup> Ohio Department of Medicaid. Quality Strategy. Available at: <http://medicaid.ohio.gov/Portals/0/Medicaid%20101/QualityStrategy/QualityStrategy.pdf>. Accessed on: Aug 4, 2015.

## Accomplishing Quality Strategy Goals

All MCPs are expected to participate in the State's efforts to meet the requirements associated with the Quality Strategy, achieve the outcomes established in the Quality Strategy, and improve the health and quality of care for the Ohio Medicaid population. ODM has created a robust accountability system to ensure that MCPs are working within the framework of the Quality Strategy to assess and improve the quality of care provided to consumers.

### *Make Care Safer*

**Ohio Neonatal Abstinence Syndrome (NAS) Project:** This initiative was funded by ODM and designed and piloted by the Ohio Perinatal Quality Collaborative (OPQC), a statewide, multi-stakeholder network dedicated to improving perinatal health. The project aims to decrease the length of opiate treatment for newborn hospital stay and reduce the length of stay (LOS) across participating sites.

In the first phase (from January 2014–June 2015), OPQC site teams participated in improving the care for babies born with NAS while reducing the length of stay by standardizing their approach to both pharmacologic and non-pharmacologic care. Since the project launch, the length of opiate treatment has decreased from 16.3 days to 14 days for participating hospitals, and the LOS for newborns has decreased from 20.6 days to 18.5 days.

In the second phase of the project (2015–2016), participating sites will be using the Orchestrated Testing/Quality Improvement method designed to learn from the accepted variation in practices across centers in order to determine the specific combination of factors (or practices) that will yield the greatest improvements in outcome.

### *Ensure Effective and Efficient Administration*

**MCP Payment Reform:** The MCP Payment Reform was initiated on January 9, 2013, as part of a comprehensive strategy to prioritize and coordinate multi-payer health care payment innovation activities in Ohio. This initiative seeks to improve the delivery of health care, including its quality, efficiency, safety, patient-centeredness, coordination, and outcomes, by significantly modifying existing payment structures and methodologies, as well as the environment in which payments are made, to incentivize patient-centered care, coordination between the public and private sectors, and cost-effective administrative processes.

MCPs are expected to achieve progress in the following areas:

- ◆ **Value-Oriented Payment:** MCPs shall design and implement payment methodologies within their networks that are designed either to cut waste or reflect value.
- ◆ **Market Competition and Consumerism:** MCPs shall design contracting methodologies and payment options and administer the benefit package to members in a manner that enhances competition among providers and reduces unwarranted price and quality variation.

- ◆ Transparency: MCPs shall participate in ODM initiatives to design and implement member-accessible comparisons of provider information including quality, cost, and patient experience, among providers in the plan's network.

### ***Improve Coordination of Care***

**Enhanced Maternal Care for MCPs:** MCPs were required to have an enhanced maternal care program, which included maternal and postpartum care; promotion of family planning services and preventive health strategies; and interfacing with community partners. MCPs received information monthly from Vital Statistics regarding mothers and infants with delineation of risk levels based on poor outcomes. MCPs used this information for early identification of mothers who needed expedited outreach and more intensive services. The MCPs identified women with high-risk pregnancies, prior pre-term births, poor birth outcomes, or high-risk medical conditions, and they implemented evidence-based interventions such as tobacco cessation programs and progesterone therapies. MCPs also identified women of childbearing age who were at risk of a poor pregnancy or poor birth outcome and provided them with evidence-based inter-conception care. MCPs were measured on timeliness of prenatal care, frequency of prenatal care, timeliness of postpartum care, and well-child care in the first 15 months of life.

### ***Promote Evidence-Based Prevention and Treatment Practices***

**SIM Payment Episodes:** Ohio applied and received a State Innovation Model (SIM) design grant from the Center for Medicare & Medicaid Innovation to develop a State Health Innovative Plan. Ohio committed to reforming the health care delivery system by designing payment models that increase access to patient-centered medical homes, support episode-based payments for acute medical events, and increase expectations for improved health care delivery. Involvement of the MCPs was important to the success of these models to ensure members achieve better health, better care, and better cost savings through improvement. MCPs were required to design and implement payment methodologies with network providers, with the goals to reduce unnecessary payment and unnecessary care and/or to tie payments to provider performance.

### ***Support Person- and Family-Centered Care***

**Care Management Redesign:** In 2015, planning occurred to transform the Medicaid care management strategy. This transformation began in January 2016 and will continue to roll out over the next two years. The new care management strategy is designed to move toward a population health management approach that focuses on four established population streams: maternal and child health, behavioral health, chronic conditions, and healthy adults. Responsibility for population health will be shifted from MCPs to capable providers in alignment with the Governor's Office of Health Transformation's value-based purchasing effort to increase access to patient-centered medical homes.

The new framework will effectively position the Medicaid managed care program for service and population expansion (e.g., behavioral health redesign and carve-in, high-risk pregnant women, children in foster care). By 2018, all Medicaid managed care consumers will be in a consumer-chosen care management arrangement with an MCP or provider that is positioned to connect with consumers and help them achieve consumer- and provider-determined health goals.

## Overview

In addition to ODM's internal monitoring, ODM contracts with HSAG to conduct routine monitoring activities. This section includes the methodologies and findings for the access activities conducted during SFY 2015.

## Methodology and Findings

### *Addenda Audit*

Federally defined access standards, as specified at 42 CFR §438.207, require MCPs to submit documentation to ODM demonstrating adequate provider panel capacity to provide preventive, primary care, and specialty services adequate for the anticipated number of consumers in the service area, while maintaining a provider panel that is sufficient in number, mix, and geographic distribution to meet the needs of consumers in the service area.

MCPs are required to enter into fully executed subcontracts with their providers. These subcontracts must include a baseline contractual agreement, as well as the appropriate Model Medicaid Addendum. The Model Medicaid Addenda incorporate all applicable Ohio Administrative Code (OAC) rule requirements specific to provider subcontracting and, therefore, cannot be modified except to add personalizing information such as the MCP's name. ODM required that the MCPs correct older addenda by the end of SFY 2016. The addenda audit was completed in SFY 2015 to validate the Model Medicaid Addenda signed by providers against the provider panel requirements established by ODM and the data contained within the MCPN files. The Medicaid addenda audit tool was developed in collaboration with ODM and represented the Medicaid addendum fields for review and numbers based on placement in the addendum.

HSAG selected a random sample of 100 providers for the Medicaid addenda data sample from the October 2014 MCPN file extract. The Medicaid addenda were provided by each MCP and were audited based on 13 indicators. For a more comprehensive list of MCPs, a total data sample size, and a description of the indicators, see Appendix A.

During an initial review, HSAG identified both missing and partially documented addenda. Based on these findings, HSAG developed and provided ODM with a "Documentation Not Submitted" list. ODM reviewed and approved the list for distribution, and the MCPs were given the opportunity to review the list and provide any additional addenda for review. For this review, HSAG considered outstanding provider addenda as incomplete, resulting in a compliance rating of *No* for all appropriate indicators.

HSAG also noted that multiple versions of the Model Medicaid Addenda were provided by each of the MCPs. The variation ranged from three to five versions of the addenda being used by each MCP and submitted for review. The variation in addenda versions used by providers and agencies created a disparity between the audit tool and the addendum being reviewed. Because of the limited correlation between the addendum and the audit tool, and based on ODM feedback, reviewers identified the information that was required for the identified provider and documented the findings in the correlated area of the audit tool.

HSAG's findings from the SFY 2015 addenda audit were determined by a desk review of the Model Medicaid Addenda and scored based on *Yes* and *No* criteria. *Yes* indicated that all documentation reviewed was consistent with the required indicators. *No* indicated that documentation was not present for the required indicator or the required provider addendum was not provided by the MCP.

Overall, among Medicaid-only providers, 81 percent of the required elements were documented and included in the addendum reviewed by HSAG. Individual MCP performance showed considerable variation, with overall MCP results ranging from 54.6 percent to 89.0 percent. Moreover, no consistent result patterns were observed in performance on individual addenda elements. On average, differences between the lowest and highest performers across all elements ranged more than 50 percentage points.

### ***Validation of Managed Care Provider Network Submissions***

MCPs must regularly submit information on additions, deletions, and significant changes for contracted providers to ODM to maintain the Managed Care Provider Network (MCPN) database. Automated Health Systems, Inc. (AHS), which provides enrollment services for managed care consumers, uses the MCPN database to provide information about panel providers to consumers.

### **Methodology**

During the first calendar quarter of SFY 2015, HSAG reviewed information contained within the MCPN files specific to PCPs serving consumers in the Medicaid program and conducted a phone survey of the PCP offices in the Ohio Medicaid Managed Care West Region to validate the MCPN information. Following the audit of the MCPN files, HSAG conducted a secret shopper survey to assess consumers' access to providers at ODM's request. This subsequent survey was conducted over two consecutive quarters beginning in the third calendar quarter of SFY 2015. A secret shopper is a person employed to pose as a shopper, client, or patient in order to evaluate the quality of customer service or the validity of information (e.g., accurate prices or location information). The secret shopper telephone survey allows for objective data collection from health care providers without potential biases introduced by knowing the identity of the surveyor. All five MCPs were included in these telephone surveys.

Based on the eligible population, HSAG used the most recently available MCPN data file to generate a random sample of PCPs for each MCP contracted with Ohio Medicaid in the selected region. Out-of-state PCPs were assigned to the nearest MCP region. HSAG randomly selected one location if the PCP had multiple locations. Results generated from the sample were within  $\pm 5$  percent of the population results at a 95 percent confidence level for each MCP in each selected region.

To conduct the audit of the MCPN files during the first calendar quarter of SFY 2015, phone calls were made to the sampled provider offices to validate information in the MCPN files. Information contained in the MCPN files for the provider’s name, address, county, telephone number, and accepting new patients were reviewed and compared to the information received from the PCP’s office during the telephone survey. HSAG analyzed the percentage of PCP locations that could be contacted, as well as the accuracy rate of each data field, statewide and by MCP.

To conduct the secret shopper survey during the third and fourth calendar quarters of SFY 2015, HSAG reviewed information contained within the MCPN files specific to PCPs and conducted phone surveys of the PCP offices to validate the MCPN information. Quarterly surveys were geographically limited to increase statistical power, and one Ohio Medicaid Managed Care region was selected to be surveyed each quarter.

Phone calls were made to the provider offices and an electronic data collection tool was used to record responses to the following indicators:

- ◆ Plan and program type affiliation
- ◆ Acceptance of new patients and limitations regarding acceptance of new patients
- ◆ Wait time for routine care visits
- ◆ Provider’s PCP status
- ◆ Provider’s name and location information

Providers’ responses for each element were compared to the MCPN files, and percentages of providers with matching information were calculated statewide, as well as by MCP and program type.

## Findings

During the audit of the MCPN files in the first calendar quarter of SFY 2015, phone calls were made to sampled provider offices to validate information in the MCPN files for each of the five MCPs. Information contained in the MCPN files for the provider’s name, address, county, telephone number, and accepting new patients were reviewed and compared to information received from the PCP’s office during the telephone survey. Table 4-1 below summarizes the percentage of PCP locations that could be contacted, as well as the accuracy rate of each data field for all PCP offices in the sample for the quarter audited during SFY 2015.

| Table 4-1—SFY 2015 MCPN Validation Surveys—MCP Accuracy Rate for Participating PCP Locations |             |         |
|----------------------------------------------------------------------------------------------|-------------|---------|
| Data Field                                                                                   | West Region |         |
|                                                                                              | Number      | Percent |
| <b>Overall Survey Results</b>                                                                |             |         |
| Sampled PCP Locations                                                                        | 1,422       | –       |
| PCP Contacted and with the MCP                                                               | 1,038       | 73.0%   |

| Table 4-1—SFY 2015 MCPN Validation Surveys—MCP Accuracy Rate for Participating PCP Locations |             |         |
|----------------------------------------------------------------------------------------------|-------------|---------|
| Data Field                                                                                   | West Region |         |
|                                                                                              | Number      | Percent |
| <b>Accuracy Rate by Element</b>                                                              |             |         |
| Name                                                                                         | 1,023       | 98.6%   |
| Address                                                                                      | 850         | 81.9%   |
| County                                                                                       | 990         | 96.8%   |
| Telephone Number                                                                             | 969         | 93.4%   |
| Accepting New Patients?                                                                      | 801         | 77.2%   |
| All elements reviewed                                                                        | 609         | 58.7%   |

Inconsistencies were identified between the MCPN file data and information obtained through telephone surveys of PCP offices. Additionally, variations in the accuracy of information were found across MCPs. Reviewers determined that 73 percent of sampled PCP locations could be contacted and the sampled provider accepted Medicaid. The provider name and county elements had a high level of accuracy when compared to the providers’ MCPN information (greater than 95 percent accuracy). Telephone number and provider address elements demonstrated lower accuracy, and the accepting new patient element had the lowest accuracy rate among the individual elements. Overall, accuracy of all elements in the complete provider record scored relatively low at 58.7 percent.

During the secret shopper survey in the third and fourth calendar quarters of SFY 2015, phone calls were made to sampled provider offices to validate information in the MCPN files for each plan contracted to provide Medicaid services in the selected MCP region. The quarter 3 study was limited to providers in the Northeast region, and the quarter 4 study was limited to providers in the Central/Southeast region.

Information contained in the MCPN files for the provider’s telephone number, MCP, program type, accepting new patients, and demographic information were reviewed and compared to information received from the PCP’s office during the telephone survey. Due to the conversational nature of the secret shopper survey, a call could be successfully completed without validating each of the study indicators. For example, if a provider’s office indicated that the provider was not accepting new patients, the conversation and survey would end without further responses pertaining to the provider’s demographic information.

Table 4-2 summarizes the percentage of PCP locations that could be contacted, as well as the accuracy rate of each data field for PCP offices sampled for the MCPs, for the third and fourth calendar quarters audited during SFY 2015.

**Table 4-2—SFY 2015 MCPN Validation Surveys—MCP Accuracy Rate for Participating PCP Locations**

| Study Indicator                                       | Quarter 3<br>Northeast Region <sup>1</sup> |         |             | Quarter 4<br>Central/Southeast Region <sup>1</sup> |         |             |
|-------------------------------------------------------|--------------------------------------------|---------|-------------|----------------------------------------------------|---------|-------------|
|                                                       | Denom.                                     | Percent | Range       | Denom.                                             | Percent | Range       |
| Sampled PCP Locations                                 | 1,455                                      |         |             | 1,446                                              |         |             |
| <b>Survey Results—Provider Access</b>                 |                                            |         |             |                                                    |         |             |
| PCP Not Reached                                       | 1,455                                      | 27.7%   | 20.4%–38.0% | 1,446                                              | 28.9%   | 17.9%–42.1% |
| PCP Contacted and with the MCP                        | 1,455                                      | 66.8%   | 55.1%–76.4% | 1,446                                              | 60.6%   | 51.4%–67.4% |
| Accepting New Patients <sup>2</sup>                   | 908                                        |         |             | 734                                                |         |             |
| Without Limitations                                   |                                            | 29.4%   | 22.7%–37.0% |                                                    | 18.8%   | 14.5%–26.5% |
| With Limitations                                      |                                            | 39.3%   | 22.0%–47.4% |                                                    | 44.7%   | 40.2%–50.0% |
| Appointment Wait Time ≤ 30 Calendar Days <sup>3</sup> | 675                                        | 80.6%   | 72.3%–89.9% | 427                                                | 64.2%   | 56.6%–69.5% |
| <b>Survey Results—MCPN Accuracy</b>                   |                                            |         |             |                                                    |         |             |
| Accepting Listed Program Type <sup>4</sup>            | 972                                        | 93.4%   | 87.1%–100%  | 876                                                | 91.6%   | 86.9%–99.0% |
| Accepting New Patients <sup>5</sup>                   | 908                                        | 68.2%   | 58.3%–73.7% | 734                                                | 68.5%   | 63.3%–71.1% |
| Provider is a PCP <sup>6</sup>                        | 624                                        | 96.8%   | 88.5%–98.1% | 534                                                | 87.3%   | 81.5%–93.3% |
| Name <sup>7</sup>                                     | 582                                        | 99.5%   | 98.0%–100%  | 455                                                | 97.8%   | 95.4%–100%  |
| Address <sup>8</sup>                                  | 179                                        | 65.8%   | 6.7%–94.8%  | 348                                                | 74.8%   | 67.5%–82.2% |
| County <sup>9</sup>                                   | 252                                        | 94.4%   | 64.0%–100%  | 383                                                | 92.7%   | 90.5%–93.8% |
| Telephone Number                                      | 962                                        | 66.1%   | 54.6%–74.8% | 926                                                | 64.0%   | 48.3%–78.8% |

<sup>1</sup> Five plans serving MCP consumers were surveyed in the Northeast and Central/Southeast regions.

<sup>2</sup> The denominator for this indicator is the number of providers reached who still contract with the MCP listed in the MCPN file and accept the listed program type.

<sup>3</sup> The denominator for this indicator is the number of providers who responded to the survey’s wait time question.

<sup>4</sup> The denominator for this indicator is the number of providers reached who still contract with the MCP listed in the MCPN file.

<sup>5</sup> The denominator for this indicator is the number of providers who responded to this survey question: “Are you accepting new patients?”

<sup>6</sup> The denominator for this indicator is the number of providers who responded to this survey question: “Are you a PCP?”

<sup>7</sup> The denominator includes only the provider locations where the provider name was verified.

<sup>8</sup> The denominator includes only the provider locations where the address elements were verified.

<sup>9</sup> The denominator includes only the provider locations in an Ohio county.

While results showed that a majority of providers with accurate telephone numbers and MCP affiliation information were able to provide appointments for routine care to a new patient within 30 calendar days, many inconsistencies in provider information were identified between the MCPN data and information obtained by the secret shoppers. Across the third and fourth calendar quarters, reviewers determined that more than 25 percent of PCP locations could not be reached by callers, and UnitedHealthcare had the highest percentage of cases that could not be reached in each quarter (38.0 percent and 42.1 percent, respectively). CareSource had the lowest percentage of cases that could not

be reached in each quarter (20.4 percent and 17.9 percent, respectively). Similarly, CareSource had the highest percentage of cases that could be contacted and were contracted with the MCP in each quarter.

Approximately two-thirds of provider offices surveyed during the third and fourth calendar quarters were found to be accepting new patients, with many providers qualifying acceptance based on clinical conditions or practices. Restrictions based on clinical conditions or practices included the following:

- ◆ The provider could not prescribe narcotics or would not treat patients with chronic pain
- ◆ The provider could not provide childhood immunizations
- ◆ The provider only accepted new patients after an interview, or following a review of prospective patients' medical records

Providers' name and county information was generally accurate when compared to the MCPN data. More than 97 percent of cases matched MCPN data for providers' names, and more than 92 percent of cases matched county information in each quarter. However, the accuracy of providers' address information varied by region, from 65.8 percent accurate among providers in the Northeast region, to 74.8 percent accurate among providers in the Central/Southeast region.

In follow-up to the MCPN file review findings, ODM provided the results to the MCPs, requiring them to reconcile the information and to submit feedback to ODM within a specific time frame. MCPs are expected to perform ongoing verification and reconciliation of provider panel information.

## **Call Centers**

ODM requires the MCPs to provide consumers with access to two types of calls centers: a centralized nurse advice line 24 hours a day, seven days a week, available nationwide, pursuant to OAC rule 5160-26-03.1 (A)(6); and a toll-free member services system pursuant to OAC rule 5160-26-08.2(A)(1).

The nurse advice lines must be staffed by appropriately trained medical personnel, physicians, physician assistants, licensed practical nurses (LPNs) and/or registered nurses (RNs). These clinicians are responsible for surveying the caller's condition and providing guidance on seeking medical attention from the appropriate level of care.

Member services staff members must be available nationwide Monday through Friday during the hours of 7:00 a.m. to 7:00 p.m. Eastern Time except during major holidays. MCPs are required to meet current URAC standards for call center lines for abandonment rate, blockage rate, and average speed of answer for both lines.

The abandonment rate represents the rate at which callers hang up before reaching a staff member. The blockage rate represents the rate at which callers receive busy signals and calls do not go through. A call center's proficiency is also measured by the average speed of answer. URAC standards for call center lines are as follows:

- ◆ Average speed of answer—A maximum of 30 seconds

- ◆ Abandonment rate—A maximum of 5 percent
- ◆ Blockage rate—A maximum of 5 percent

MCPs were required to report prior-month call center data to ODM by the 10th of each month. ODM reviews the data and assesses penalties for failure to comply with established call center standards. HSAG reviewed performance data provided by ODM for the period of July 1, 2014, through June 30, 2015 and identified the aggregate unweighted average for call center performance over a 12-month period. The findings reflect a total of 60 months monitored for five MCPs over a year.

In its review of the nurse advice line data, HSAG identified the following:

- ◆ The overall average speed of answer was 13 seconds. Three of the five MCPs met the contract standard maximum of 30 seconds for the year, one MCP met the contract standard maximum 11 out of 12 months, and one MCP met the contract standard 10 out of 12 months.
- ◆ The overall abandonment rate for the five MCPs was 1.93 percent. All five MCPs met the contract standard maximum of 5 percent for the year.
- ◆ The overall blockage rate for the five MCPs was 0.44 percent. All five MCPs met the contract standard maximum of 5 percent for the year.

In its review of the member services call center data, HSAG identified the following:

- ◆ The overall average speed of answer was 18 seconds. Three of the five MCPs met the contract standard maximum of 30 seconds for the year, one MCP met the contract standard maximum 11 out of 12 months, and one MCP met the contract standard maximum eight out of 12 months.
- ◆ The overall abandonment rate for the five MCPs was 1.65 percent. Four of the five MCPs met the contract standard maximum of 5 percent, and one MCP met the contract standard maximum 11 out of 12 months.
- ◆ The overall blockage rate for the five MCPs was 0.15 percent. All five MCPs met the contract standard maximum of 5 percent for the year.

### Consumer Complaints

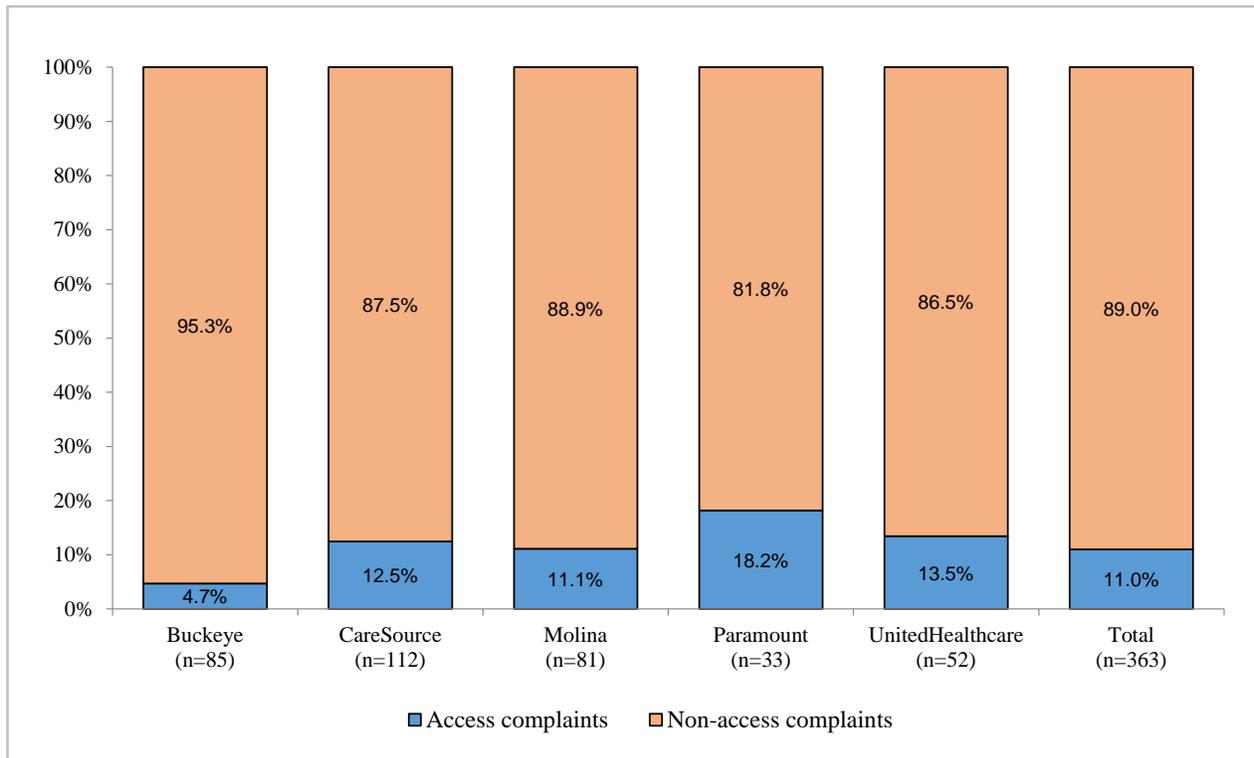
Ohio Medicaid monitors complaints to assess consumers’ overall satisfaction with the Ohio Medicaid Managed Care Program; this includes consumers’ satisfaction with access to health care services. Calls to the Ohio Medicaid consumer hotline managed by AHS, as well as those submitted directly to contract administrators, are entered directly into the HealthTrack system when a complaint is identified about an MCP. AHS call center employees input identifying information and summarize the caller’s problem. Once the complaint is entered and categorized by AHS, a system email is generated and routed to ODM as notification that a complaint has been registered. ODM reviews the complaint to verify it has been categorized correctly. Once confirmed, a due date is assigned to the complaint based on the assigned category (i.e., two days for access-related issues and five days for all others). The complaint is then submitted to the MCPs for a response. Upon receiving the notification email, the MCP addresses the complaint and enters a resolution into the system, which is returned to ODM for review. ODM reviews the response to ensure the resolution is adequate, and either closes or returns the complaint to the MCP for additional information, as necessary.

ODM uses the categories in Table 4-3 to summarize the consumer complaints it receives. For the purpose of this report, consumer complaints are further aggregated into two primary groups: access complaints and non-access complaints.

| Table 4-3—Consumer Complaint Categories by Reporting Group                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
|-----------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Access Categories                                                                                               | Non-Access Categories                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
| <ul style="list-style-type: none"> <li>◆ Panel access</li> <li>◆ Dental access</li> <li>◆ PCP access</li> </ul> | <ul style="list-style-type: none"> <li>◆ Non-panel access</li> <li>◆ Billing</li> <li>◆ Communication issues</li> <li>◆ Contracting issues</li> <li>◆ Coverage/service denials</li> <li>◆ Credentialing issues</li> <li>◆ Dissatisfaction with provider</li> <li>◆ Eligibility issue</li> <li>◆ Enrollment verification issue</li> <li>◆ ID card</li> <li>◆ MCP administrative</li> <li>◆ Medical treatment</li> <li>◆ Pharmacy</li> <li>◆ Prior authorization</li> <li>◆ Web complaint form</li> </ul> |

Figure 4-1 shows the number and percent of access versus non-access consumer complaints submitted in SFY 2015 stratified by MCP. The grouping of consumer complaint categories into access versus non-access groups is based on Table 4-3.

**Figure 4-1—Percent of Access and Non-Access Consumer Complaints by MCP SFY 2015**



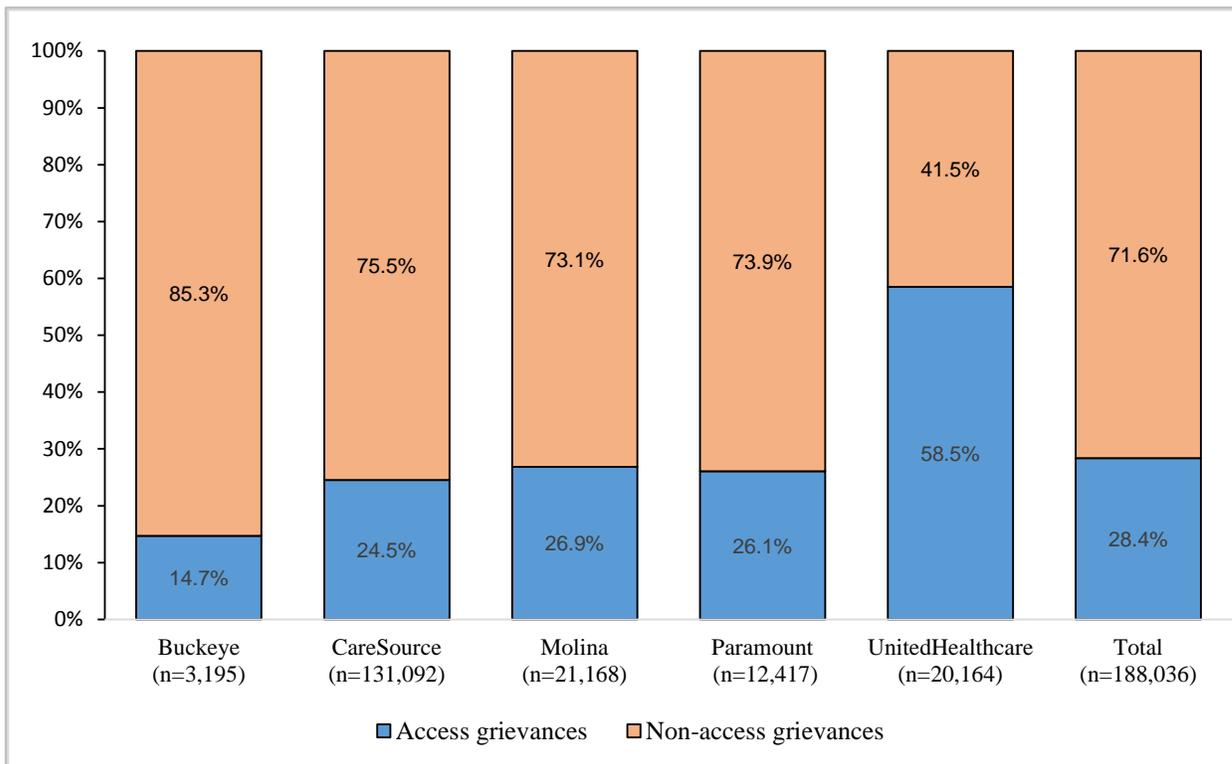
Overall, nearly 90 percent of consumer complaints were related to non-access issues, with the percentage of rates ranging from 81.8 percent (Paramount) to 95.3 percent (Buckeye). The percentage of access-related consumer complaints for one MCP (Buckeye) was below 5 percent, while the percentage for the remaining four MCPs (i.e., CareSource, Molina, Paramount, and UnitedHealthcare) exceeded 10 percent. Consumers from Paramount reported the highest percentage (18.2 percent) of access-related complaints, while Buckeye reported the lowest percentage at 4.7 percent.

## Grievance System

Pursuant to OAC rule 5160-26-08.4, MCPs are required to submit appeal and grievance activity to ODM as directed. ODM requires that each MCP submit appeal and grievance activity at least monthly in an electronic data file format pursuant to the *ODM Appeal File and Submission Specifications* and *ODM Grievance File and Submission Specifications*. A grievance is an expression of dissatisfaction with any aspect of an MCP’s or provider’s operation, provision of health care services, activities, or behaviors not related to an MCP service decision.

Figure 4-2 shows the number and percentage of access versus non-access consumer grievances filed in SFY 2015 by MCP. Access grievances are any grievances associated with dissatisfaction with accessing panel providers, whereas non-access grievances are those associated with dissatisfaction with MCP administrative services or providers services, or the inability to access non-panel providers.

**Figure 4-2—Percent of Access and Non-Access Grievances by MCP SFY 2015**



Overall, approximately 28 percent of the grievances filed in SFY 2015 were related to consumers’ access to health care services with three MCPs’ rates being consistent with the overall rate. UnitedHealthcare (58.5 percent) reported the highest percentage of access-related grievances, followed by Molina (26.9 percent), Paramount (26.1 percent), and CareSource (24.5 percent). The lowest percentage of access-related grievances was associated with Buckeye, with only 14.7 percent of total grievances related to access issues.

The access-related grievances recorded per 1,000 member months (MM) for each MCP from July 1, 2014, through June 30, 2015, are as follows: Buckeye, 0.15; CareSource, 2.27; Molina, 1.48;

Paramount, 1.27; and UnitedHealthcare, 3.85. The statewide total of all access-related grievances received across all consumers and MCPs per 1,000 MM was 2.00.

### Grievance Monitoring Process

ODM Bureau of Managed Care (BMC) staff members conduct a sample review of the MCPs' grievances by verifying that all fields, including the narrative field describing the resolution, are complete. Requirements for timely resolution of grievances filed in SFY 2015 varied, depending on the grievance type. Access grievances require resolution within two working days, while non-access grievances must be resolved within 30 calendar days for non-claims-related grievances or 60 calendar days for claims-related grievances.

All MCPs exhibited a high level of compliance with the timeliness standards for processing grievances regardless of grievance type. Across the five MCPs, nearly 100 percent of all grievances were resolved within the required time frames, with individual MCP rates ranging from 98.90 percent (i.e., Paramount/access grievances) to 100 percent (i.e., Molina/non-claims-related grievances).

### Appeals

An “appeal” is defined as a consumer’s request for a review by the MCP regarding the MCP’s denial, reduction, suspension, or termination of services; payment denials; prior authorizations; or lack of timely service. It is important to note that a consumer can file an appeal either verbally or in writing. For appeals, BMC staff members review 100 percent of appeals for timeliness and service type, and they verify that all fields describing the resolution are complete.

When an action has occurred, or will occur, MCPs are required to provide consumers with a written notice. MCPs must provide consumers with information on the appeals process and inform them of their right to appeal if they do not agree with the decision/action identified in the notification. MCPs must review and resolve each appeal as expeditiously as the consumer's health condition requires, but the resolution time frame must not exceed 15 calendar days for a standard appeal and three working days for an expedited appeal from the receipt of the appeal unless the resolution time frame is extended.

Of the four types of appeals—i.e., standard appeals, standard extended appeals, expedited appeals, and extended expedited appeals—only standard and expedited appeals were filed in SFY 2014. Timeliness standards for resolving appeals are as follows:

- ◆ Standard appeals = within 15 calendar days of appeal receipt
- ◆ Standard extended appeals = within 29 calendar days of appeal receipt
- ◆ Expedited appeals = within three working days of appeal receipt
- ◆ Extended expedited appeals = within 17 working days of appeal receipt (i.e., three days [expedited] + 14 additional calendar days)

All MCPs exhibited a high level of compliance with timeliness standards for processing appeals. Individual MCP rates for standard appeals ranged from 99.70 percent (CareSource) to 91.39 percent (Buckeye). Three MCPs (CareSource, Molina, and Paramount) resolved 100 percent of expedited appeals within three days, while the rates for the other two MCPs, Buckeye and UnitedHealthcare, were 93.33 percent and 93.55 percent, respectively.

## Overview

Federal requirements from the BBA, as specified at 42 CFR §438.358, require that states ensure their MCPs collect and report performance measures annually. ODM establishes quality measures and standards to evaluate MCP performance in key program areas (e.g., access, clinical quality, consumer satisfaction). ODM developed the measure set by selecting measures from national measurement sets such as NCQA's HEDIS measures, CAHPS, and the Core Set of Children's Health Care Quality Measures for Medicaid and CHIP (Child Core Set). ODM then aligned the selected measures with specific priorities, goals, and focus areas of the Medicaid Quality Strategy.

For HEDIS measures, federal requirements allow states, agents that are not managed care organizations, or an EQRO to conduct the performance measure validation to ascertain the validity of the reported rates. Beginning SFY 2013, ODM required MCPs to self-report performance measure results for HEDIS measures selected for required reporting and to undergo an independent NCQA HEDIS Compliance Audit by a licensed organization (LO).<sup>5-1</sup> The LO documented findings associated with the MCPs' compliance with NCQA's Information System standards and the audit results associated with each measure.<sup>5-2</sup> As Ohio's EQRO, HSAG received the HEDIS measure results and the final audit reports, and conducted verification to determine that the LO's audit process was consistent with NCQA's audit methodology. After the verification, HSAG used the HEDIS measure results to calculate the statewide results and conduct MCP comparisons. HSAG also used NCQA's national benchmarks to assess MCPs' performance.

In addition to the HEDIS measures, this section presents two measures related to asthma and low birth weight. HSAG calculated these performance measures, referred to as Children's Health Insurance Program Reauthorization Act (CHIPRA) measures, by following the Child Core Set technical specifications. The CY 2013 statewide and MCP-specific performance rates are presented in this section. Due to a lack of national benchmark data, MCP performance ranking was not performed for these measures.

ODM also assessed MCP performance using a minimum performance standard for the HEDIS/CAHPS *Rating of Health Plan* survey measure. Three-point mean results were calculated for CY 2012 using CAHPS 2013 data, and for CY 2013 using CAHPS 2014 data. NCQA's *Volume 3: Specifications for Survey Measures* were used to calculate the three-point means.<sup>5-3</sup>

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<sup>5-1</sup> NCQA HEDIS Compliance Audit™ is a trademark of the NCQA.

<sup>5-2</sup> There are four possible audit results for each measure: *Reportable* (R), indicating the MCP followed the specifications and produced a reportable rate or result for the measure; *Not Applicable* (NA), indicating that the MCP followed the specifications but the denominator was too small (<30) to report a valid rate; *Benefit Not Offered* (NB), indicating that the MCP did not offer the health benefit required by the measure; and *Not Reportable* (NR), indicating that the calculated rate was materially biased, the MCP chose not to report the measure, or the MCP was not required to report the measure.

<sup>5-3</sup> National Committee for Quality Assurance. HEDIS 2014, *Volume 3: Specifications for Survey Measures*. Washington, DC: NCQA Publication, 2013.

## MCP Performance Measures

This section presents statewide performance based on MCP self-reported, audited HEDIS rates and CHIPRA measure rates calculated by HSAG for the CY 2013 measurement period (i.e., January 1, 2013–December 31, 2013). MCPs were required to calculate and submit HEDIS rates for 17 measures. Sixteen of the 17 HEDIS measures are aligned with either the Access or the Clinical Quality focus area within the Medicaid Quality Strategy. These clinical focus areas included asthma, behavioral health, cardiovascular disease, diabetes, high-risk pregnancy/premature births, and upper respiratory infections. Each of these 16 measures has corresponding minimum performance standards. MCPs failing to meet a minimum performance standard would receive a noncompliance penalty. HSAG calculated the statewide rates for HEDIS measures, and statewide and MCP-specific rates for non-HEDIS measures, which are presented below based on their clinical quality focus areas.

Overall, seven rates (for seven measures) ranked at or above the national HEDIS 50th percentiles for 2013. These rates were:

- ◆ *Adults' Access to Preventive/Ambulatory Health Services—Total.*
- ◆ *Follow-Up after Hospitalization for Mental Illness—7-Day Follow-Up.*
- ◆ *Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase.*
- ◆ *Persistence of Beta-Blocker Treatment after a Heart Attack.*
- ◆ *Comprehensive Diabetes Care—Eye Exam.*
- ◆ *Prenatal and Postpartum Care—Timeliness of Prenatal Care.*
- ◆ *Frequency of Ongoing Prenatal Care—≥ 81 Percent of Expected Visits.*

Seventeen rates (for 11 measures) ranked below the national HEDIS 50th percentiles for 2013. These rates were:

- ◆ *Children and Adolescents' Access to Primary Care Practitioners—12–24 Months, 25 Months–6 Years, 7–11 Years, and 12–19 Years.*
- ◆ *Use of Appropriate Medications for People with Asthma.*
- ◆ *Adolescent Well-Care Visits.*
- ◆ *Initiation and Engagement of Alcohol and Other Drug Dependence Treatment—Engagement of AOD Treatment, Total.*
- ◆ *Cholesterol Management for Patients with Cardiovascular Conditions—LDL-C Control and LDL-C Screening.*
- ◆ *Controlling High Blood Pressure.*
- ◆ *Comprehensive Diabetes Care—HbA1c Adequate Control (HbA1c < 8%), LDL-C Screening, and Blood Pressure Control (<140/90 mm Hg).*
- ◆ *Prenatal and Postpartum Care—Postpartum Care.*
- ◆ *Appropriate Treatment for Children with Upper Respiratory Infection.*
- ◆ *Well-Child Visits in the First 15 Months of Life—Six or More Well-Child Visits.*
- ◆ *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life.*

In the section below, statewide performance for each measure under its respective focus area is presented in a graph. For the 16 HEDIS measures, the current year’s statewide rates are compared to the prior year’s rates. The statewide performance ranking relative to a national Medicaid benchmark is also presented if one is available.

For the two CHIPRA measures (*Annual Number of Asthma Patients with at Least One Asthma-Related Emergency Room Visit* and *Percentage of Live Births Weighing Less than 2,500 Grams*), results are presented for CY 2013 at the statewide and MCP-levels. No benchmarks are available for these measures.

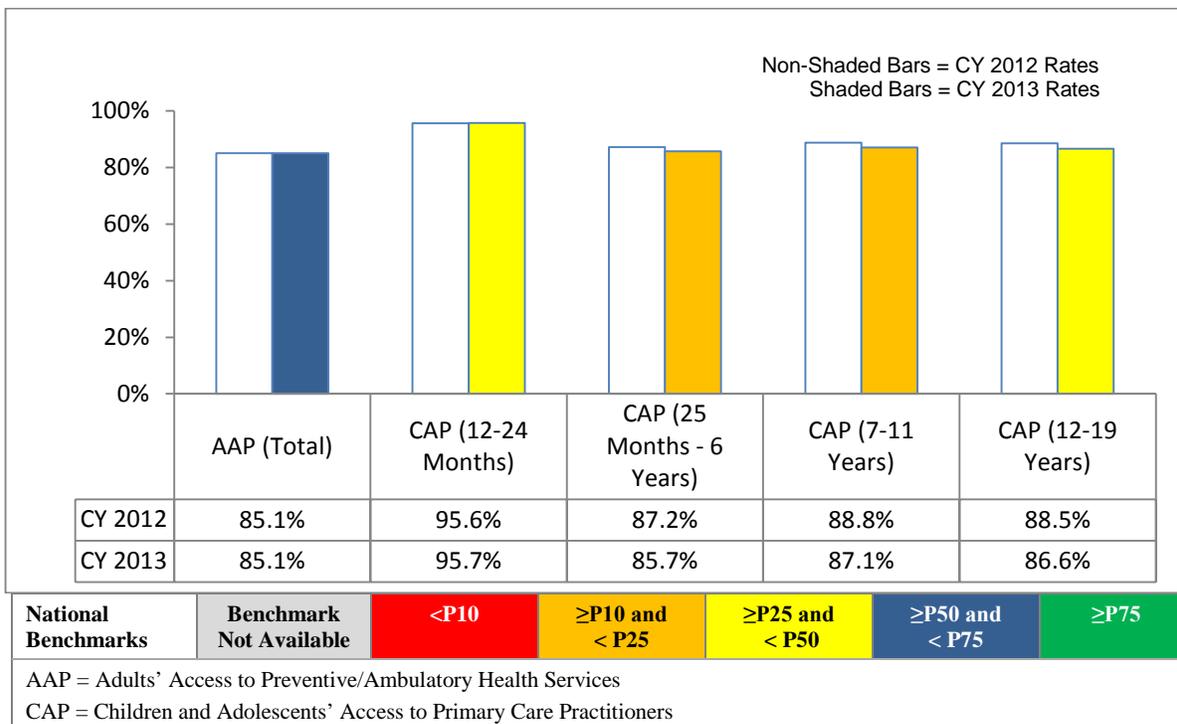
**Access**

Two HEDIS measures (a total of five rates) were categorized within the Access focus area:

- ◆ *Adults’ Access to Preventive/Ambulatory Health Services—Total (AAP)*
- ◆ *Children and Adolescents’ Access to Primary Care Practitioners—12–24 Months, 25 Months–6 Years, 7–11 Years, and 12–19 Years (CAP)*

Figure 5-1 compares the statewide results between CY 2012 and CY 2013 for these measures. The white vertical bars represent 2012 statewide rates. The different colors assigned to the CY 2013 vertical bars denote the statewide performance level as compared to 2013 NCQA national Medicaid HEDIS percentiles.

**Figure 5-1—Statewide CY 2012 and CY 2013 Access Measure Rates**



CY 2013 statewide results on the Access focus area showed very stable performance from CY 2012. The *Adults’ Access to Preventive/Ambulatory Health Services—Total* rate exceeded the national

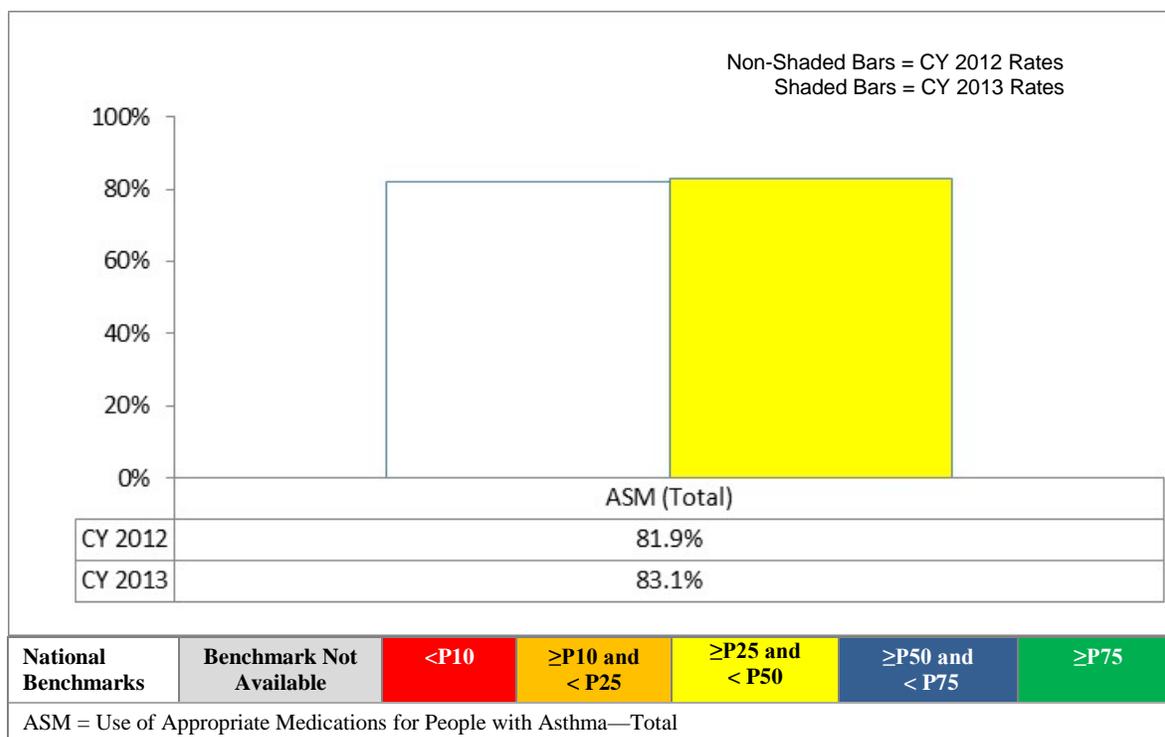
Medicaid 50th percentile. For *Children and Adolescents' Access to Primary Care Practitioners*, the youngest and the oldest age groups performed below the national Medicaid 50th percentiles, while the rates for the *25 Months to 6 Years* and *7 to 11 Years* age groups were below the national Medicaid 25th percentiles.

## Clinical Quality

### Asthma Measures

One HEDIS measure (*Use of Appropriate Medication for People with Asthma—Total [ASM]*) and one CHIPRA measure (*Annual Number of Asthma Patients with at Least One Asthma-Related Emergency Room Visit*) were categorized within the Asthma Clinical Quality focus area. Figure 5-2 compares the statewide results between CY 2012 and CY 2013 for the *Use of Appropriate Medication for People with Asthma—Total* measure. The white vertical bar represents the 2012 statewide rate. The yellow vertical bar denotes the CY 2013 statewide performance level as compared to the 2013 NCQA national Medicaid HEDIS percentile.

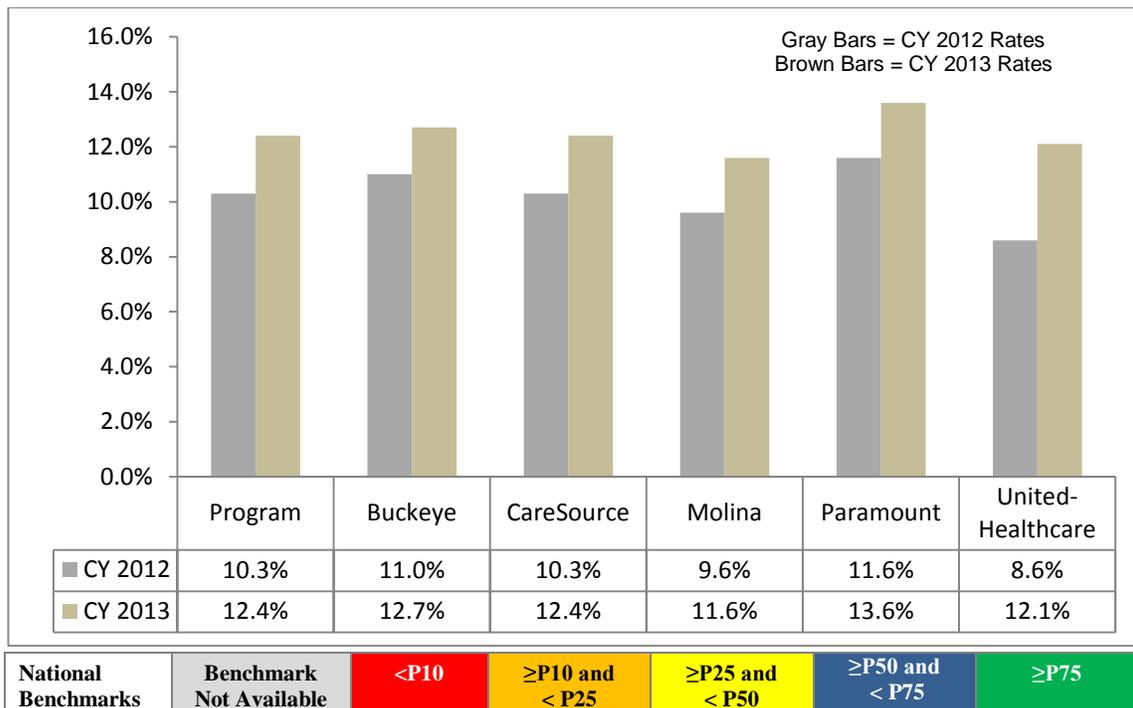
**Figure 5-2—Statewide CY 2012 and CY 2013 Use of Appropriate Medications for People with Asthma—Total Measure Rate**



The Asthma rate increased slightly in CY 2013. When compared to the national Medicaid benchmark, the CY 2013 rate ranked below the national Medicaid 50th percentile but at or above the national Medicaid 25th percentile.

Figure 5-3 displays the statewide and each MCP’s performance rates for the *Annual Number of Asthma Patients with at Least One Asthma-Related Emergency Room Visit* measure for CY 2012 and CY 2013.

**Figure 5-3—CY 2012 and CY 2013 Annual Number of Asthma Patients with at Least One Asthma-Related Emergency Room Visit**



The statewide performance rate for this measure was 12.4 percent for CY 2013. In CY 2013, Paramount had the highest percentage of patients with at least one asthma-related emergency room visit, while Molina had the lowest percentage of patients. Compared to CY 2012 rates, the CY 2013 rates for this measure increased for the statewide average and for all MCPs. UnitedHealthcare had the largest increase in the percentage of patients with at least one asthma-related emergency room visit.

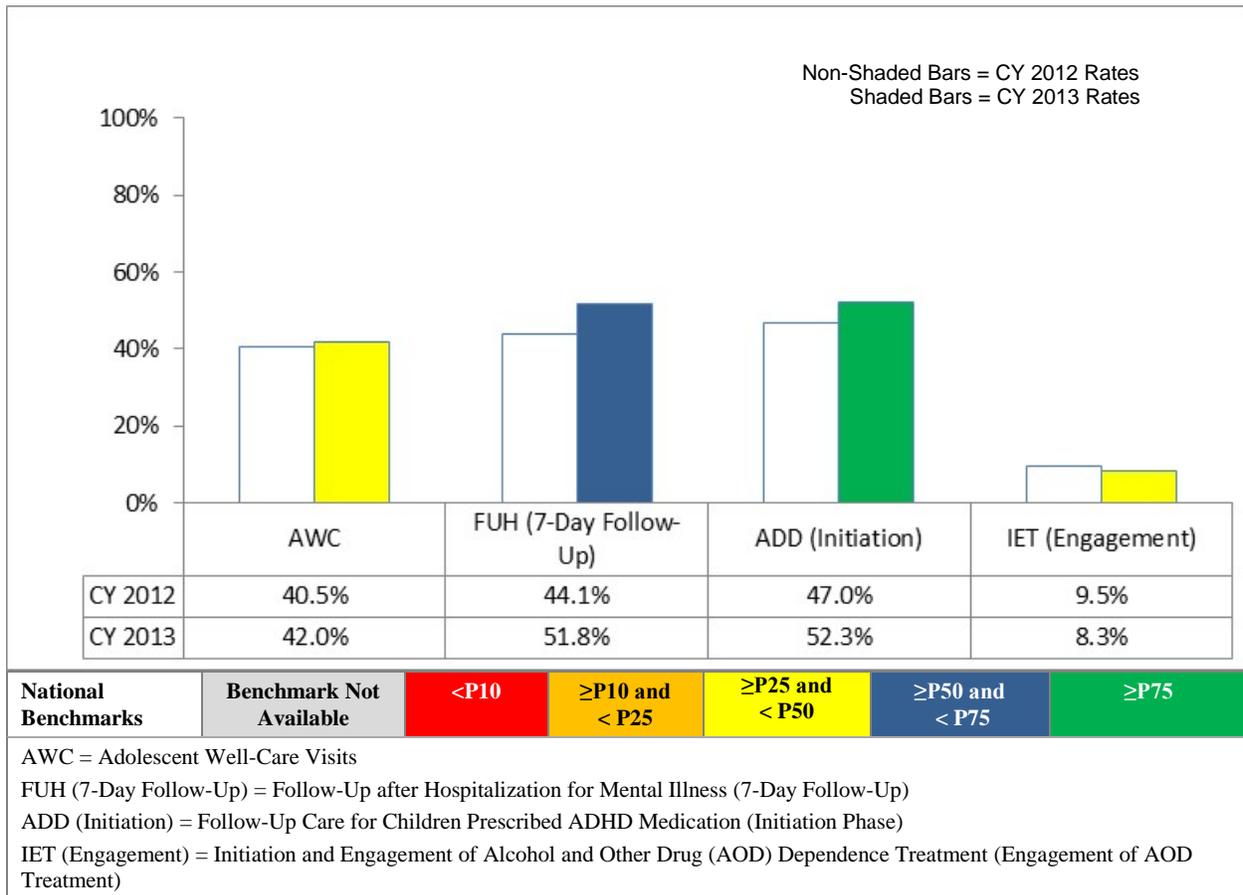
### Behavioral Health Measures

Four HEDIS measures (a total of four rates) were categorized within the Behavioral Health Clinical Quality focus area:

- ◆ *Adolescent Well-Care Visits (AWC)*
- ◆ *Follow-Up after Hospitalization for Mental Illness—7-Day Follow-Up (FUH-7)*
- ◆ *Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase (ADD-Initiation)*
- ◆ *Initiation and Engagement of Alcohol and Other Drug Dependence Treatment—Engagement of AOD Treatment, Total (IET-Engagement)*

Figure 5-4 compares the statewide results between CY 2012 and CY 2013 for these measures. The white vertical bars represent 2012 statewide rates. The different colors assigned to the CY 2013 vertical bars denote the statewide performance level as compared to 2013 NCQA national Medicaid HEDIS percentiles.

**Figure 5-4—Statewide CY 2012 and CY 2013 Behavioral Health Measure Rates**



Three of the four Behavioral Health measure rates increased. More specifically, the *Follow-Up after Hospitalization for Mental Illness—7-Day Follow-Up (FUH-7)* and *Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase (ADD-Initiation)* rates increased more than 5 percentage points from CY 2012. These two measures also exceeded the national Medicaid 50th percentiles.

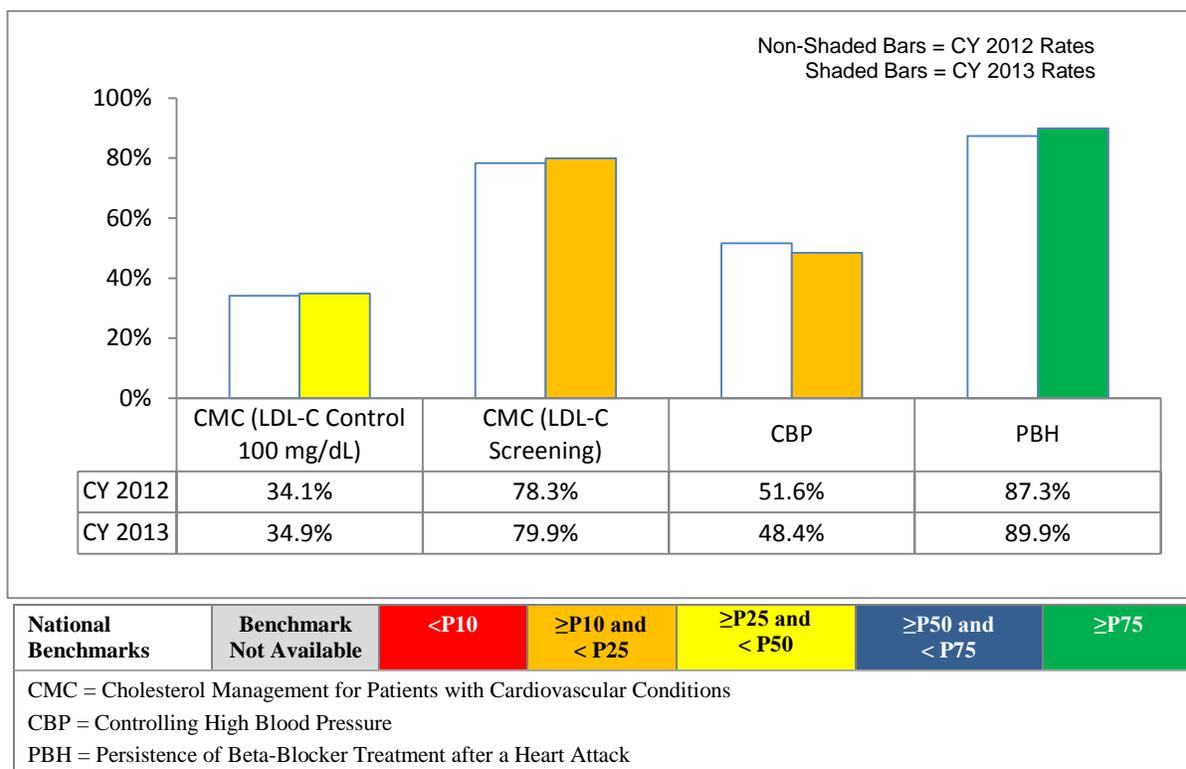
### Cardiovascular Measures

Three HEDIS measures (a total of four rates) were categorized within the Cardiovascular Clinical Quality focus area:

- ◆ *Cholesterol Management for Patients with Cardiovascular Conditions (CMC)—LDL-C Control and LDL-C Screening*
- ◆ *Controlling High Blood Pressure (CBP)*
- ◆ *Persistence of Beta-Blocker Treatment after a Heart Attack (PBH)*

Figure 5-5 compares the statewide results between CY 2012 and CY 2013 for these measures. The white vertical bars represent 2012 statewide rates. The different colors assigned to the CY 2013 vertical bars denote the statewide performance level as compared to 2013 NCQA national Medicaid HEDIS percentiles.

**Figure 5-5—Statewide CY 2012 and CY 2013 Cardiovascular Measure Rates**



Three of the four statewide Cardiovascular measure rates increased slightly in CY 2013. Statewide performance on the *Persistence of Beta-Blocker Treatment after a Heart Attack (PBH)* measure exceeded the national Medicaid 75th percentile. HSAG noted opportunities for improvement for the *Controlling High Blood Pressure* measure as the statewide 2013 rate declined by 3.2 percentage points and was ranked the lowest among the other Cardiovascular measures (between the 10th and 25th percentiles).

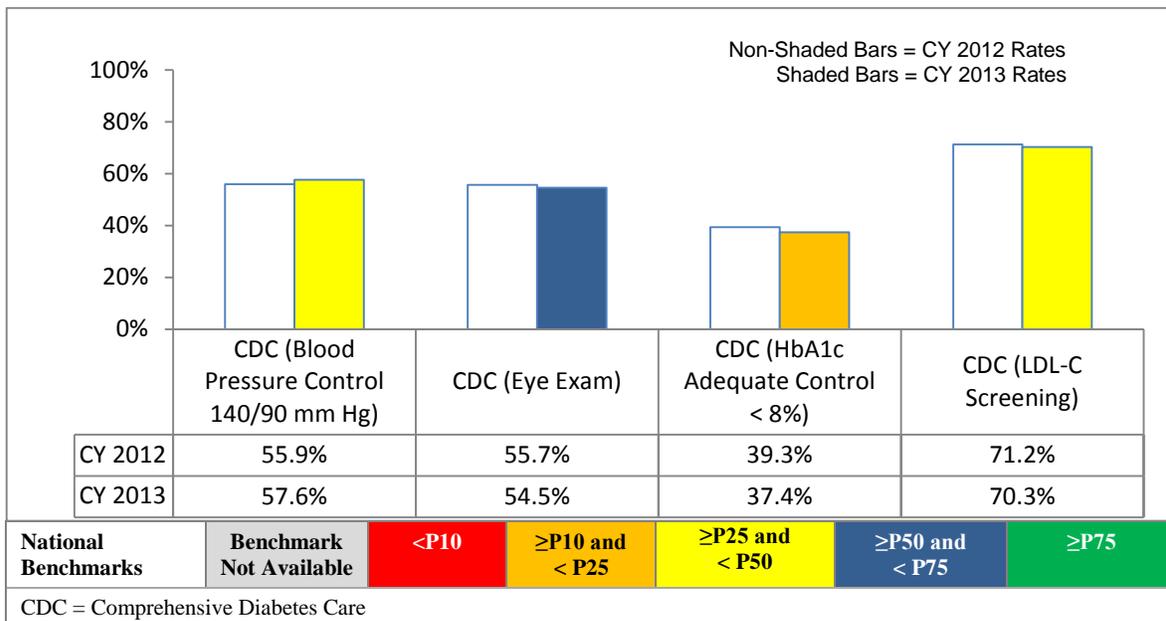
**Diabetes Measures**

Four rates (all included in the HEDIS *Comprehensive Diabetes Care* measure) were categorized within the Diabetes Clinical Quality focus area:

- ◆ *Blood Pressure Control (<140/90 mm Hg)*
- ◆ *Eye Exam (Retinal) Performed*
- ◆ *HbA1c Adequate Control (HbA1c < 8%)*
- ◆ *LDL-C Screening*

Figure 5-6 compares the statewide results between CY 2012 and CY 2013 for these measures. The white vertical bars represent 2012 statewide rates. The different colors assigned to the CY 2013 vertical bars denote the statewide performance level as compared to 2013 NCQA national Medicaid HEDIS percentiles.

**Figure 5-6—Statewide CY 2012 and CY 2013 Diabetes Measure Rates**



Of the four statewide Diabetes rates, only one (*Blood Pressure Control <140/90 mm Hg*) increased slightly in CY 2013. Despite a slight rate decline, the *Eye Exam (Retinal) Performed* rate ranked above the national Medicaid 50th percentile. HSAG noted opportunities for improvement for the other three Diabetes measures, as their performance levels were below the national Medicaid 50th percentiles. Two measures in particular (*HbA1c Adequate Control < 8%* and *LDL-C Screening*) ranked between the 10th and 25th percentiles.

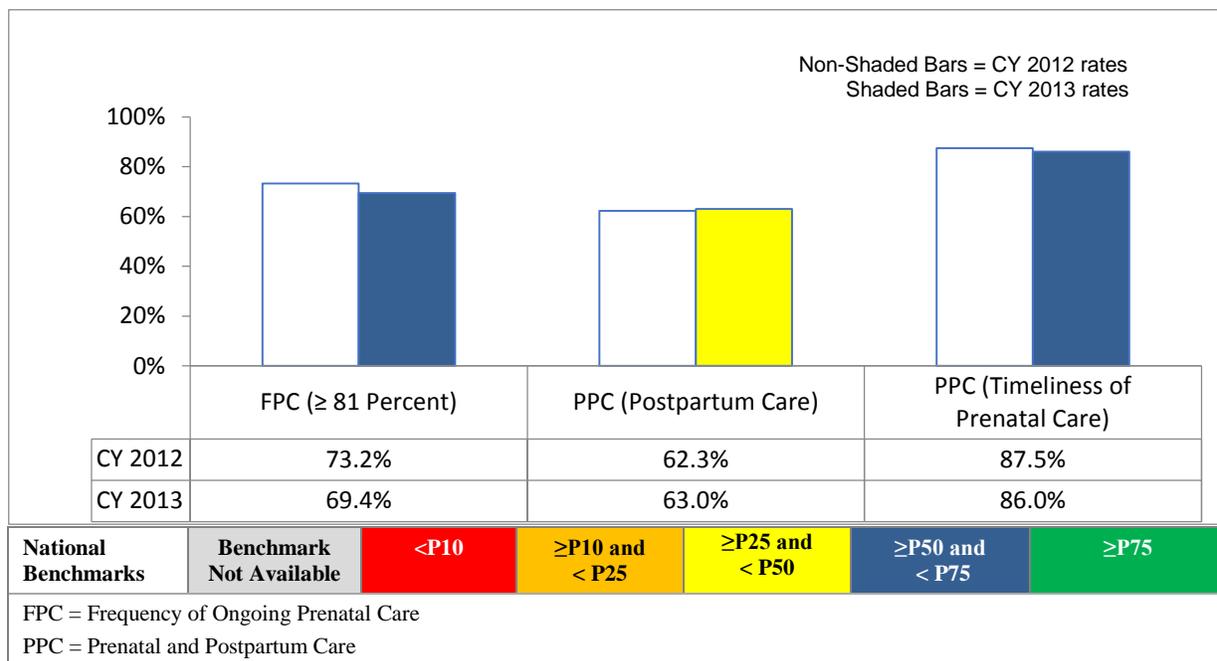
### High-Risk Pregnancy/Premature Births Measures

Two HEDIS measures and one CHIPRA measure (a total of four rates) were categorized within the High-Risk Pregnancy/Premature Births Clinical Quality focus area:

- ◆ *Frequency of Ongoing Prenatal Care— ≥ 81 Percent of Expected Visits (FPC)*
- ◆ *Prenatal and Postpartum Care—Postpartum Care and Timeliness of Prenatal Care (PPC)*
- ◆ *Percentage of Live Births Weighing Less than 2,500 Grams (LBW)*

Figure 5-7 compares the statewide results between CY 2012 and CY 2013 for the two HEDIS measures (*Frequency of Ongoing Prenatal Care* and *Prenatal and Postpartum Care*). The white vertical bars represent 2012 statewide rates. The different colors assigned to the CY 2013 vertical bars denote the statewide performance level as compared to 2013 NCQA national Medicaid HEDIS percentiles.

**Figure 5-7—Statewide CY 2012 and CY 2013 High-Risk Pregnancy/Premature Births HEDIS Measure Rates**



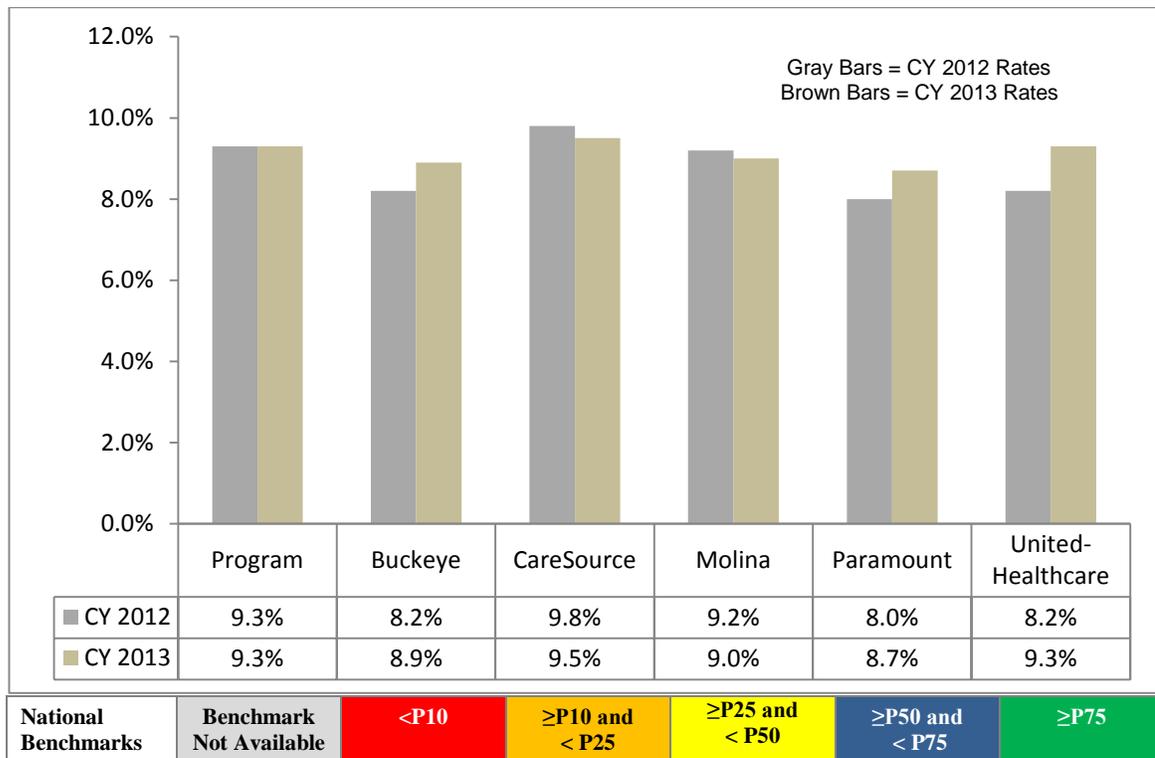
Statewide CY 2013 performance did not show major rate changes. Although both prenatal care rates (*Frequency of Ongoing Prenatal Care— ≥ 81 Percent of Expected Visits* and *Prenatal and Postpartum Care—Timeliness of Prenatal Care*) declined from CY 2012, the decline was less than 5 percentage points and their performance levels continued to exceed the national Medicaid 50th percentiles. The statewide *Postpartum Care* rate increased slightly (less than 1 percentage point), but its performance level was still below the national Medicaid 50th percentile and presented opportunities for improvement.

The *Percentage of Live Births Weighing Less than 2,500 Grams* methodology required that claims data be used to identify births, and that vital statistics data be used to determine the birth weight of

each baby. For CY 2013 results, ODM and HSAG collaborated to develop a robust methodology for linking claims data to vital statistics data using the statistical programming software SAS.<sup>5-4</sup>

Figure 5-8 displays the statewide and each MCP’s performance rates for the *Percentage of Live Births Weighing Less than 2,500 Grams* measure for CY 2012 and CY 2013.

**Figure 5-8—CY 2012 and CY 2013 Percentage of Live Births Weighing Less than 2,500 Grams**



The statewide performance rate for this measure was 9.3 percent for CY 2013. In CY 2013, CareSource had the highest percentage of live births weighing less than 2,500 grams, while Paramount had the lowest percentage. The statewide performance measure rate for this measure did not change from CY 2012 to CY 2013. However, CareSource and Molina improved their performance measure rates from CY 2012 to CY 2013.

<sup>5-4</sup> SAS and all other SAS Institute Inc. product or service names are registered trademarks or trademarks of SAS Institute Inc. in the USA and other countries. ® indicates USA registration.

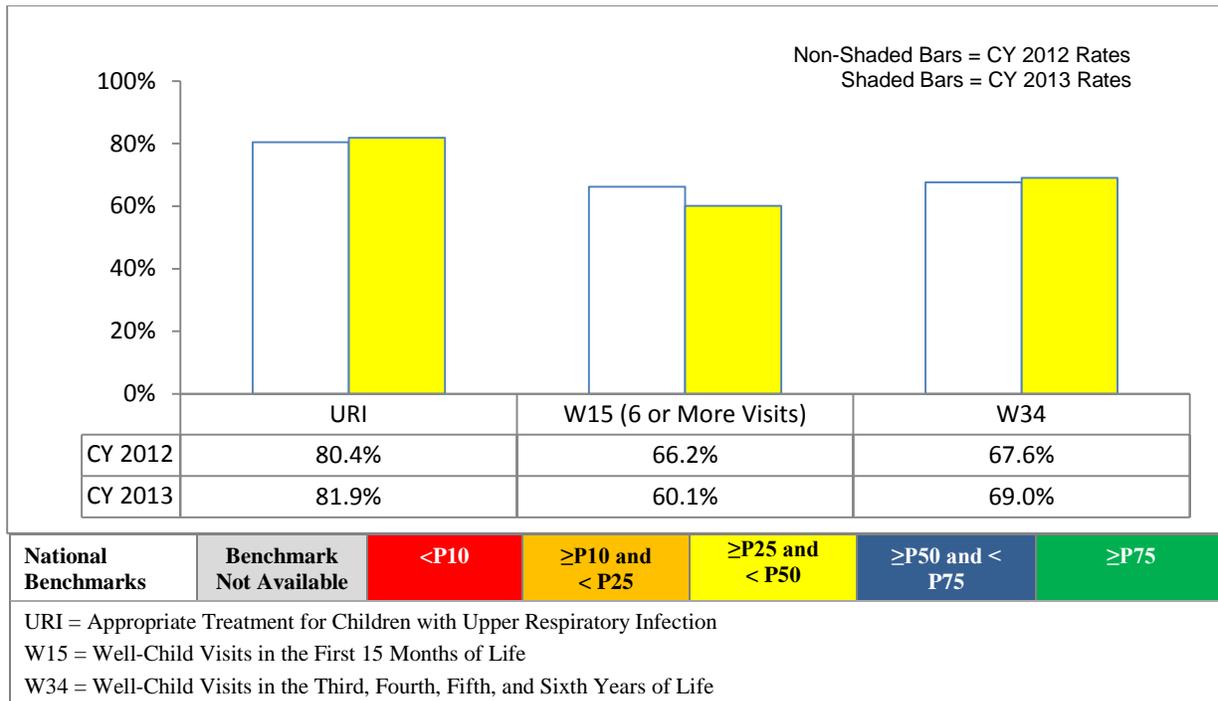
### Upper Respiratory Infections Measures

Three HEDIS measures (a total of three rates) were categorized within the Upper Respiratory Infections Clinical Quality focus area:

- ◆ *Appropriate Treatment for Children with Upper Respiratory Infection (URI)*
- ◆ *Well-Child Visits in the First 15 Months of Life—Six or More Well-Child Visits (W15)*
- ◆ *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life (W34)*

Figure 5-9 compares the statewide results between CY 2012 and CY 2013 for these measures. The white vertical bars represent 2012 statewide rates. The different colors assigned to the CY 2013 vertical bars denote the statewide performance level as compared to 2013 NCQA national Medicaid HEDIS percentiles.

**Figure 5-9—Statewide CY 2012 and CY 2013 Upper Respiratory Infections Measure Rates**



Slight rate increases were noted for two of the three measures in this area (*Appropriate Treatment for Children with Upper Respiratory Infection* and *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*). However, the *Well-Child Visits in the First 15 Months of Life—Six or More Well-Child Visits* rate declined more than 5 percentage points. All measures were below the national Medicaid 50th percentiles, suggesting opportunities for improvement.

## CAHPS Results

ODM assesses MCP performance by using a minimum performance standard for the HEDIS/CAHPS *Rating of Health Plan* survey measure. HSAG calculated three-point mean results for CY 2012 using CAHPS 2013 data and for CY 2013 using CAHPS 2014 data. HSAG followed NCQA’s Volume 3: Specifications for Survey Measures to calculate the three-point means.

In addition to assessing MCP performance compared with national benchmarks, MCP performance relative to established contract standards for the *CAHPS Rating of Health Plan* measure was evaluated. Performance was assessed separately for the general child and adult survey populations. An overall average score was calculated for each population and for each MCP by population on a 3.0 scale. For the SFY 2014 review period, Ohio Medicaid’s adult and general child minimum performance standards for the *CAHPS Rating of Health Plan* measure were  $\geq 2.31$  and  $\geq 2.51$ , respectively.

Table 5-1 provides a crosswalk of the adult population national HEDIS 2014 Medicaid three-point mean benchmarks for the *Rating of Health Plan* measure and the associated rankings.<sup>5-5</sup> NCQA does not provide 10th percentile data for the *Rating of Health Plan* measure; therefore, the 10th percentile was estimated based on the distribution of the percentile data that were provided by NCQA (i.e., the 25th, 50th, 75th, and 90th percentiles).

| Table 5-1—Adult National HEDIS 2014 Medicaid Benchmarks Crosswalk |            |                                                                                            |
|-------------------------------------------------------------------|------------|--------------------------------------------------------------------------------------------|
| Three-Point Mean Range                                            | Ranking    | Description                                                                                |
| 0–2.25                                                            | <P10       | Below the national HEDIS 2014 Medicaid 10th percentile                                     |
| 2.26–2.31                                                         | P10–P25    | At or above the national HEDIS 2014 Medicaid 10th percentile and below the 25th percentile |
| 2.32–2.39                                                         | P25–P50    | At or above the national HEDIS 2014 Medicaid 25th percentile and below the 50th percentile |
| 2.40–2.45                                                         | P50–P75    | At or above the national HEDIS 2014 Medicaid 50th percentile and below the 75th percentile |
| 2.46–2.53                                                         | P75–P90    | At or above the national HEDIS 2014 Medicaid 75th percentile and below the 90th percentile |
| $\geq 2.54$                                                       | $\geq P90$ | At or above the national HEDIS 2014 Medicaid 90th percentile                               |

Table 5-2 displays each MCP’s and the statewide average adult population’s three-point means for the *Rating of Health Plan* measure, as well as the ranking compared to national Medicaid benchmarks.

<sup>5-5</sup> National Committee for Quality Assurance. *HEDIS® Benchmarks and Thresholds for Accreditation 2014*. Washington, DC: NCQA; July 25, 2014.

| Table 5-2—CAHPS Adult Rating of Health Plan Overall Medicaid Measurement Period—CY 2013 |                  |                |
|-----------------------------------------------------------------------------------------|------------------|----------------|
| MCP                                                                                     | Three-Point Mean | Ranking        |
| Buckeye                                                                                 | 2.48             | P75–P90        |
| CareSource                                                                              | 2.55             | ≥P90           |
| Molina                                                                                  | 2.43             | P50–P75        |
| Paramount                                                                               | 2.52             | P75–P90        |
| UnitedHealthcare                                                                        | 2.46             | P75–P90        |
| <b>Statewide Average</b>                                                                | <b>2.49</b>      | <b>P75–P90</b> |

CareSource’s three-point mean was at or above the national Medicaid 90th percentile. The three-point means for the statewide average, Buckeye, Paramount, and UnitedHealthcare were at or above the national Medicaid 75th percentile and below the 90th percentile. Molina’s three-point mean was at or above the national Medicaid 50th percentile and below the 75th percentile. Figure 5-10 provides a comparison of the CY 2012 and CY 2013 *Rating of Health Plan* measure three-point means for the adult population, and a comparison of Ohio’s means to national benchmarks (Adult Medicaid percentile distribution) for CY 2013. The grey vertical bars represent CY 2012 three-point means. The different colors assigned to the CY 2013 vertical bars denote the performance level as compared to 2013 NCQA national Medicaid benchmarks.

**Figure 5-10—CAHPS Adult Rating of Health Plan—Overall Medicaid Three-Point Means**

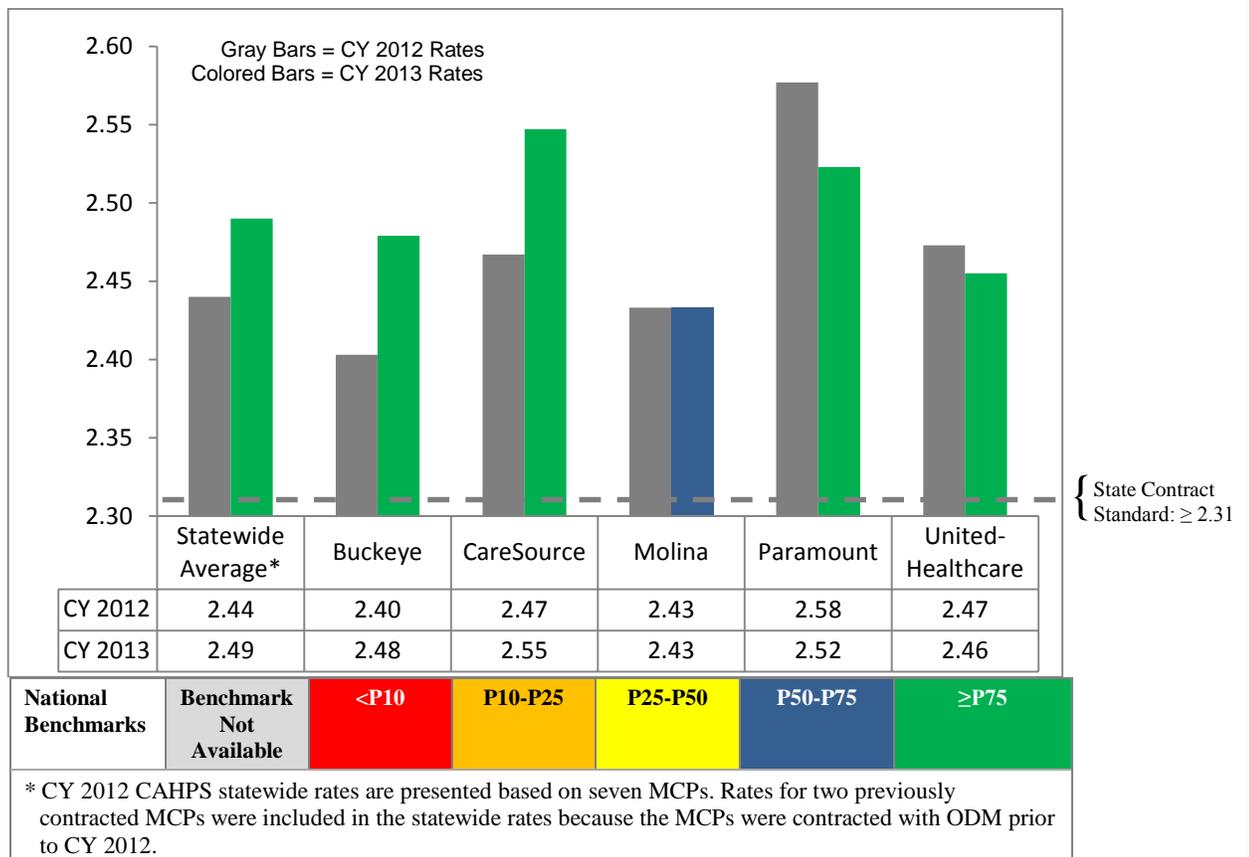


Table 5-3 provides a crosswalk of the general child population national HEDIS 2014 Medicaid three-point mean benchmarks for the *Rating of Health Plan* measure and the associated rankings. NCQA does not provide 10th percentile data for the *Rating of Health Plan* measure; therefore, the 10th percentile was estimated based on the distribution of the percentile data that were provided by NCQA (i.e., the 25th, 50th, 75th, and 90th percentiles). All MCPs met the Rating of Health Plan measure contract standard for the adult population.

| Table 5-3—Child National HEDIS 2014 Medicaid Benchmarks Crosswalk |         |                                                                                            |
|-------------------------------------------------------------------|---------|--------------------------------------------------------------------------------------------|
| Three-Point Mean Range                                            | Ranking | Description                                                                                |
| 0–2.46                                                            | <P10    | Below the national HEDIS 2014 Medicaid 10th percentile                                     |
| 2.47–2.50                                                         | P10–P25 | At or above the national HEDIS 2014 Medicaid 10th percentile and below the 25th percentile |
| 2.51–2.56                                                         | P25–P50 | At or above the national HEDIS 2014 Medicaid 25th percentile and below the 50th percentile |
| 2.57–2.61                                                         | P50–P75 | At or above the national HEDIS 2014 Medicaid 50th percentile and below the 75th percentile |
| 2.62–2.66                                                         | P75–P90 | At or above the national HEDIS 2014 Medicaid 75th percentile and below the 90th percentile |
| ≥2.67                                                             | ≥P90    | On or above the national HEDIS 2014 Medicaid 90th percentile                               |

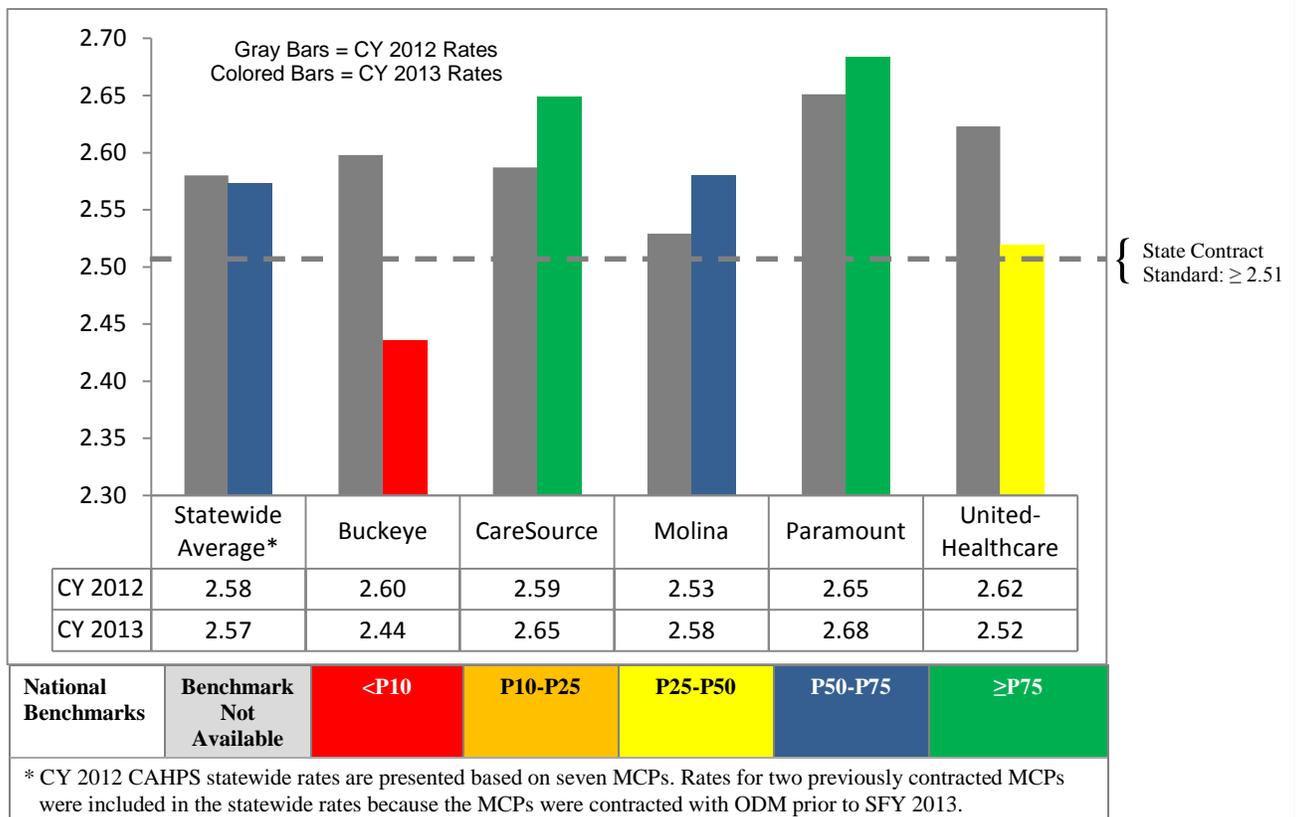
Table 5-4 displays the MCP’s and statewide average general child population three-point means for the *Rating of Health Plan* measure, as well as the ranking compared to national Medicaid benchmarks.

| Table 5-4—CAHPS General Child Rating of Health Plan<br>Overall Medicaid Measurement Period—CY 2013 |                  |                |
|----------------------------------------------------------------------------------------------------|------------------|----------------|
| MCP                                                                                                | Three-Point Mean | Ranking        |
| Buckeye                                                                                            | 2.44             | <P10           |
| CareSource                                                                                         | 2.65             | P75–P90        |
| Molina                                                                                             | 2.58             | P50–P75        |
| Paramount                                                                                          | 2.68             | ≥P90           |
| UnitedHealthcare                                                                                   | 2.52             | P25–P50        |
| <b>Statewide Average</b>                                                                           | <b>2.57</b>      | <b>P50–P75</b> |

Paramount’s three-point mean was at or above the national Medicaid 90th percentile. The three-point mean for CareSource was at or above the national Medicaid 75th percentile and below the 90th percentile. The three-point means for both the statewide average and Molina were at or above the national Medicaid 50th percentile and below the 75th percentile. UnitedHealthcare’s three-point mean was at or above the 25th percentile and below the 50th percentile, and the three-point mean for Buckeye was below the 10th percentile.

Figure 5-11 provides a comparison of the CY 2012 and CY 2013 *Rating of Health Plan* measure three-point means for the general child population, and a comparison of Ohio’s means to national benchmarks (Child Medicaid percentile distribution) for CY 2013. The grey vertical bars represent CY 2012 three-point means. The different colors assigned to the CY 2013 vertical bars denote the performance level as compared to 2013 NCQA national Medicaid benchmarks.

**Figure 5-11—CAHPS General Child Rating of Health Plan—Overall Medicaid Three-Point Means**



Buckeye was the only MCP that did not meet the *Rating of Health Plan* measure contract standard for the child population.

## Pay for Performance (P4P)

ODM utilizes P4P financial incentives to reward MCPs for high levels of performance and to encourage performance improvement in program priority areas. The P4P Incentive System is aligned with specific priorities, goals, and areas of clinical focus identified in the Ohio Medicaid Quality Strategy. One incentive determination is made annually, per MCP, using six HEDIS measures. Results for each measure are calculated per MCP and include all regions in which the MCP has membership. Incentive payments made to the MCPs are funded through the State’s managed care program performance payment fund and represent a bonus payment above and beyond the contracted, capitation rates.

For SFY 2014, ODM calculated an amount equal to 1 percent of the MCP's total premium and delivery payments for services delivered during CY 2013 to determine each MCP's potential bonus payment. ODM then allocated one-sixth of the amount to each of the six measures used in the P4P Incentive System. Each MCP was awarded a percentage (from 0 percent up to 100 percent) of the amount allocated to each measure. A separate percentage was determined for each measure, based on the MCP's performance result for the measure. The higher or better the result, the higher the percentage awarded. The MCP's total SFY 2014 P4P performance bonus payment is the sum of the amount awarded for each of the six measures. For SFY 2014, each MCP could earn up to 100 percent of the potential bonus payment.

For SFY 2014, six HEDIS measures were selected as P4P measures:

- ◆ *Follow-Up after Hospitalization for Mental Illness—within 7 Days of Discharge*
- ◆ *Timeliness of Prenatal Care*
- ◆ *Use of Appropriate Medications for People with Asthma—Total*
- ◆ *Appropriate Treatment for Children with Upper Respiratory Infections*
- ◆ *Comprehensive Diabetes Care: LDL-C Screening*
- ◆ *Controlling High Blood Pressure*

Figure 5-12 displays the SFY 2014 performance rates, the corresponding P4P performance levels, and the bonus amount for Buckeye.

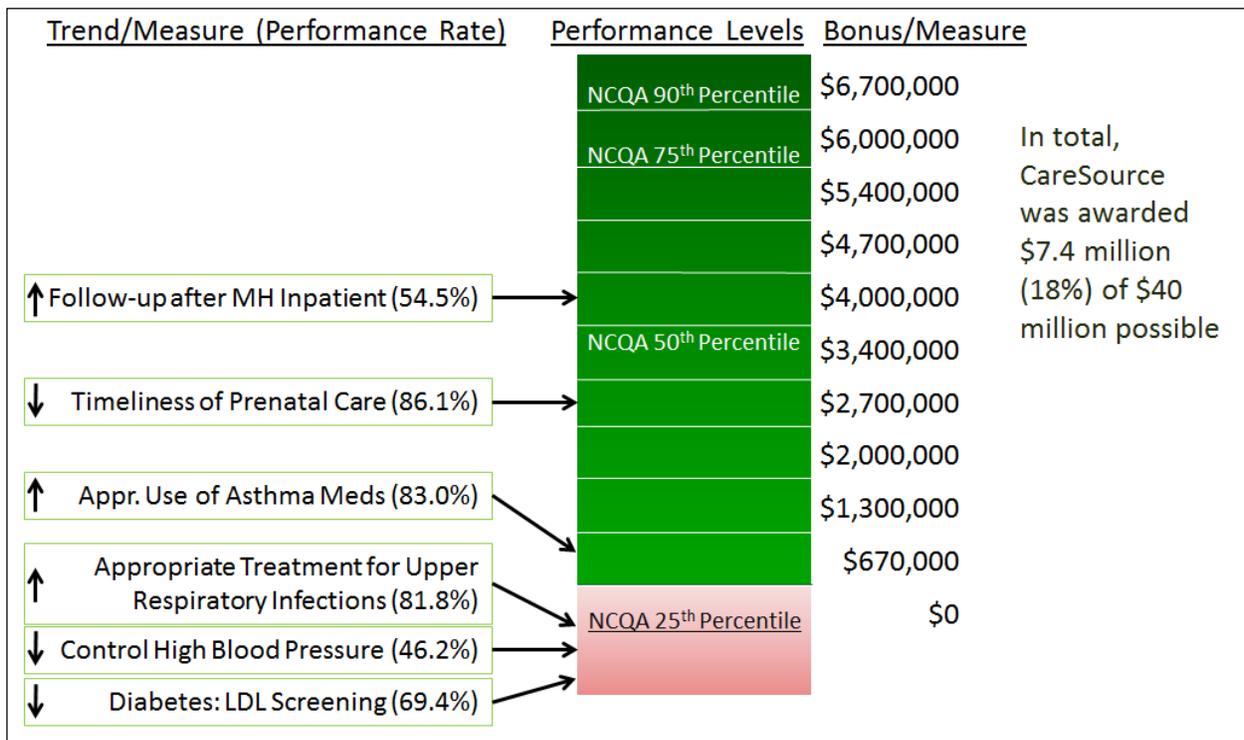
**Figure 5-12—SFY 2014 P4P Rates, Performance Levels, and Bonus Amount for Buckeye**

| <u>Trend/Measure (Performance Rate)</u>                            | <u>Performance Levels</u>        | <u>Bonus/Measure</u> |                                                                                            |
|--------------------------------------------------------------------|----------------------------------|----------------------|--------------------------------------------------------------------------------------------|
|                                                                    | NCQA 90 <sup>th</sup> Percentile | \$1,300,000          |                                                                                            |
|                                                                    |                                  | \$1,200,000          |                                                                                            |
|                                                                    | NCQA 75 <sup>th</sup> Percentile | \$1,000,000          |                                                                                            |
| ↑ Apr. Use of Asthma Meds (86.5%) →                                |                                  | \$910,000            | In total,<br>Buckeye was<br>awarded<br>\$1.6 million<br>(22%) of \$7.6<br>million possible |
|                                                                    |                                  | \$780,000            |                                                                                            |
| ↓ Follow-up after MH Inpatient (52.2%) →                           | NCQA 50 <sup>th</sup> Percentile | \$650,000            |                                                                                            |
|                                                                    |                                  | \$520,000            |                                                                                            |
|                                                                    |                                  | \$390,000            |                                                                                            |
| ↓ Timeliness of Prenatal Care (82.5%) →                            |                                  | \$260,000            |                                                                                            |
| ↓ Control High Blood Pressure (39.4%) →                            |                                  | \$130,000            |                                                                                            |
| ↑ Appropriate Treatment for Upper Respiratory Infections (84.1%) → | NCQA 25 <sup>th</sup> Percentile | \$0                  |                                                                                            |
| ↓ Diabetes: LDL Screening (69.9%) →                                |                                  |                      |                                                                                            |

Performance rates for three of Buckeye’s six P4P measures fell within the P4P performance levels. Two of these three measures were at or above the national Medicaid 50th percentiles. Overall, Buckeye was awarded approximately \$1.6 million for its P4P performance, amounting to 22 percent of the \$7.6 million award possible.

Figure 5-13 displays the SFY 2014 performance rates, the corresponding P4P performance levels, and the bonus amount for CareSource.

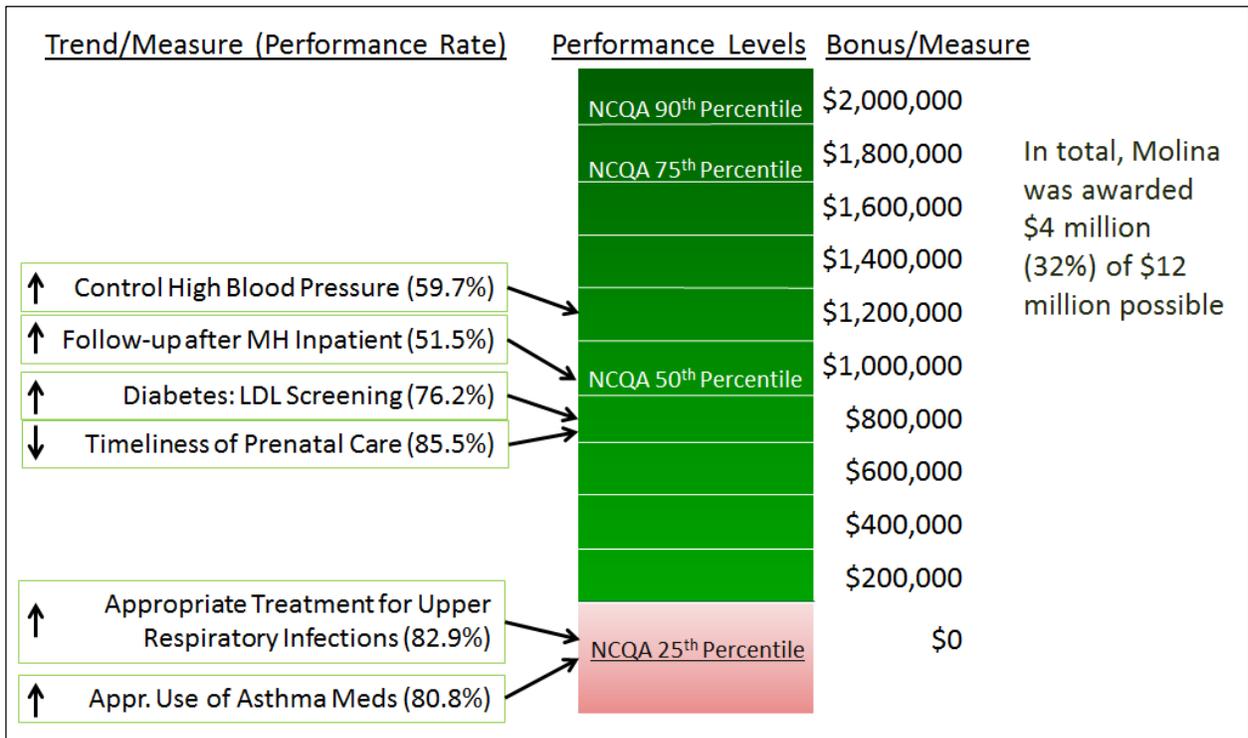
**Figure 5-13—SFY 2014 P4P Rates, Performance Levels, and Bonus Amount for CareSource**



Performance rates for three of CareSource’s six P4P measures fell within the P4P performance levels. One measure was at or above the national Medicaid 50th percentile. Overall, CareSource was awarded approximately \$7.4 million for its P4P performance, amounting to 18 percent of the \$40 million award possible.

Figure 5-14 displays the SFY 2014 performance rates, the corresponding P4P performance levels, and the bonus amount for Molina.

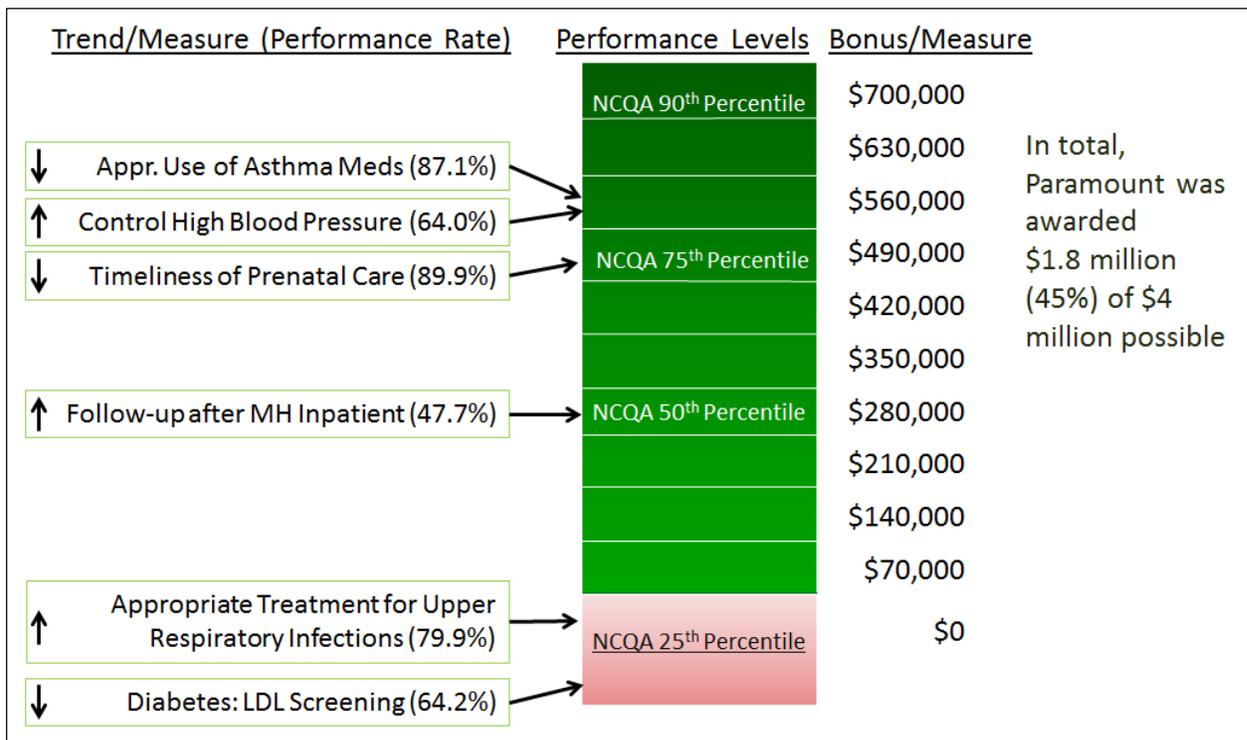
**Figure 5-14—SFY 2014 P4P Rates, Performance Levels, and Bonus Amount for Molina**



Performance rates for four of Molina’s six P4P measures fell within the P4P performance levels. Two measures were at or above the national Medicaid 50th percentiles. Overall, Molina was awarded approximately \$4 million for its P4P performance, amounting to 32 percent of the \$12 million award possible.

Figure 5-15 displays the SFY 2014 performance rates, the corresponding P4P performance levels, and the bonus amount for Paramount.

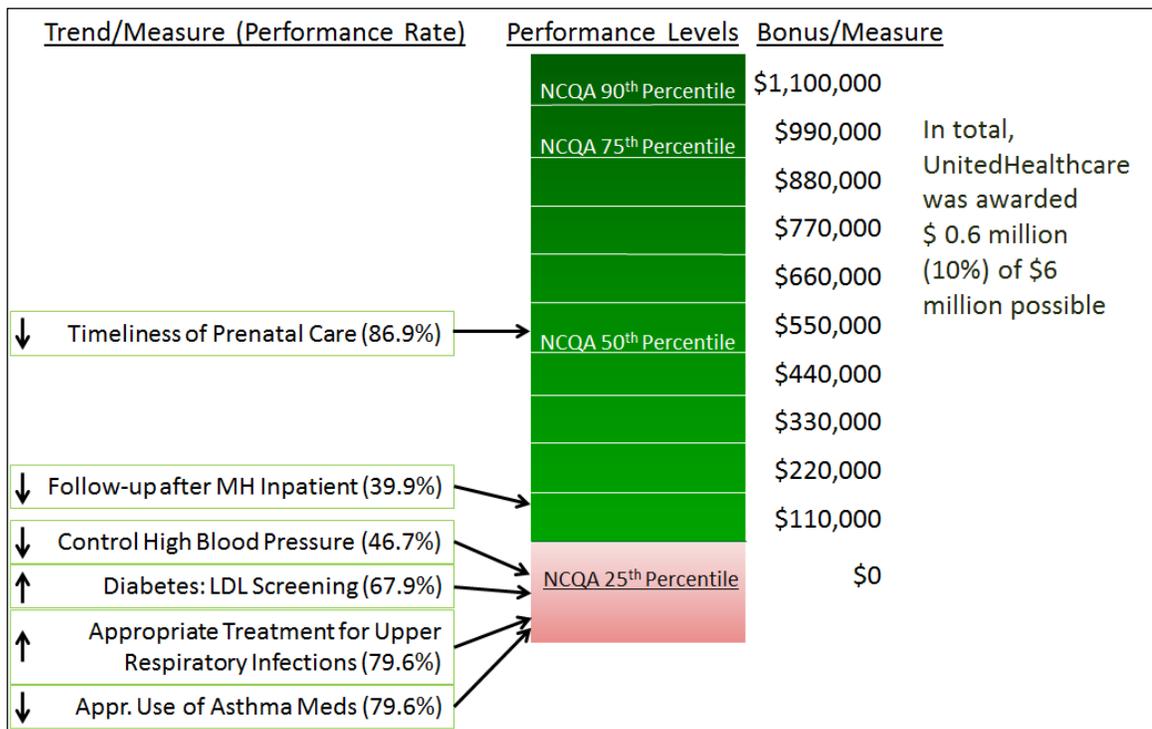
**Figure 5-15—SFY 2014 P4P Rates, Performance Levels, and Bonus Amount for Paramount**



Performance rates for four of Paramount’s six P4P measures fell within the P4P performance levels. These four measures were also at or above the national Medicaid 50th percentiles, three of which attained the 75th percentiles. Overall, Paramount was awarded approximately \$1.8 million for its P4P performance, amounting to 45 percent of the \$4 million award possible.

Figure 5-16 displays the SFY 2014 performance rates, the corresponding P4P performance levels, and the bonus amount for UnitedHealthcare.

**Figure 5-16—SFY 2014 P4P Rates, Performance Levels, and Bonus Amount for UnitedHealthcare**



Performance rates for two of UnitedHealthcare’s six P4P measures fell within the P4P performance levels. One measure was at or above the national Medicaid 50th percentile. Overall, UnitedHealthcare was awarded approximately \$0.6 million for its P4P performance, amounting to 10 percent of the \$6 million award possible.

## 6. Performance Improvement Projects

### Overview

ODM was responsible for administering the Ohio Medicaid managed care program and overseeing quality improvement activities that comply with state and federal regulations. ODM required its contracted MCPs to conduct PIPs as set forth in 42 CFR §438.240. The project aimed to improve the quality of care for a targeted clinical or nonclinical service. ODM contracted with HSAG, as the EQRO for the Ohio Medicaid Managed Care Program, to conduct the annual validation of PIPs.

### SFY 2015 *Progesterone Initiation* Performance Improvement Project

In SFY 2015, ODM selected *Progesterone Initiation* as its new PIP topic. The PIP, initiated across all MCPs in January 2015, focuses on reducing preterm births and infant mortality through increased utilization of progesterone among at-risk women. It addresses CMS' requirements related to quality outcomes—specifically, timeliness of, and access to care and services—and is aligned with Ohio's quality strategy by promoting evidence-based prevention and treatment practices, and improving the health of priority populations (e.g., clinical focus areas such as high-risk pregnancy and premature births). For this PIP, ODM and the MCPs collaborated with clinics participating in the Ohio Perinatal Quality Collaborative (OPQC) to increase access to progesterone in an effort to reduce premature birth and associated infant mortality.

ODM has the Global Aim of reducing the rate of pre-term birth and associated infant mortality. For this PIP ODM chose to focus its efforts on progesterone use, an evidence-based, cost-effective method for preventing preterm birth. The SMART Aim for the PIP focuses on improving the initiation of progesterone therapy between 16–24 weeks gestational age for the high-risk maternity Medicaid population seen by OPQC-affiliated practices from 15 percent to 30 percent by December 31, 2016. This initiation allows women to begin a treatment that will last the duration of their pregnancy. Currently, the SMART Aim measure for the project is operationalized as follows:

- ◆ Numerator—Total number of progesterone candidates who received an initial dose of progesterone treatment between 16–24 weeks gestation.
- ◆ Denominator—Total number of identified progesterone-eligible candidates.
- ◆ Data Collection Intervals—Data were collected and reported weekly.

Details about the framework and methodology for this PIP project are available in Appendix D.

Due to the timing of the PIP, the initial SFY 2015 validation of the *Progesterone Initiation* focused on MCP submissions of Module 1, “PIP Initiation.” Although there were no outcome data to report for this PIP validation cycle, each MCP made significant progress in establishing its clinical partnerships and identifying existing internal processes to examine for improvement. The following are the key findings for each MCP.

## Findings

Although PIP validation is an annual requirement, the true focus for each MCP is to improve processes and health care outcomes using continuous improvement concepts and tools. Module 1 of the redesigned PIP focuses on building internal quality improvement teams and external, collaborative partnerships as well as depicting the team’s agreed-upon theory of improvement for initial testing using a key driver diagram. The collaboratively built key driver diagram ensures that the team is in agreement with regard to what it is trying to accomplish (the SMART Aim) and what changes the team thinks can be made that will result in improvement (the interventions); these are two of the central questions in the Model for Improvement, which is the framework for the redesigned PIP.

Upon validation of each of the five Ohio MCP’s submissions of Module 1, “PIP Initiation,” HSAG identified areas of the module that needed revision to document MCP progress according to established validation criteria. These revisions were necessary to ensure that lessons learned regarding partnerships and the initial theory of change would be available for future improvement efforts. The main areas for revision—team member roles and responsibilities and inclusion of multi-levels of intervention—were due largely to the organic, continually evolving nature of quality improvement and the use of tools such as team rosters and key driver diagrams to record this evolution. The concerted and coordinated nature of PIP activities across managed care plans also made the inclusion of state-level interventions necessary so that the multi-level approach to improvement could be recorded. During this same period, ODM also worked with the MCPs to help them understand the application of quality science tools for health outcome improvement. For the SFY 2015 validation of the MCPs’ *Progesterone Initiation* PIP, each MCP completed and submitted Module 1.

### ***Buckeye Community Health Plan***

Upon initial review, HSAG identified that Buckeye’s documentation required revisions to reflect the MCP’s initial OPQC team partners and the initial assigning of roles and responsibilities. The key driver diagram also needed to be updated to add state-level (macro-level) drivers and MCP-level (mezzo-level) drivers to more holistically depict the agreed-upon theory of change. After revision based on assistance from HSAG and ODM, Buckeye’s resubmitted Module 1 received *Achieved* scores for all documentation requirements.

### ***CareSource***

Upon initial review, HSAG identified that CareSource’s documentation needed revision to include the initial roles and responsibilities for both internal and external team members. The key driver diagram also needed to reflect the PIP focus (SMART Aim) and the interventions and to include both the MCP and state-level drivers. After revision based on assistance from HSAG and ODM, CareSource revised Module 1 and resubmitted for final validation. For the final validation, CareSource’s resubmitted Module 1 received *Achieved* scores for all documentation requirements.

### ***Molina Healthcare of Ohio, Inc.***

Upon initial review, HSAG identified that Molina’s documentation required revisions to the PIP focus, its initial partnerships with external partners, and the roles of its internal team members. The key driver diagram was also updated to include the state-level (macro) key drivers. After incorporating feedback from HSAG and ODM and resubmitting Module 1, Molina received *Achieved* scores for all documentation requirements.

### ***Paramount Advantage***

Upon initial review, HSAG identified that Paramount’s documentation needed to be revised to better reflect the external partners actively participating in the project. Additionally, the PIP focus and SMART Aim needed to reflect those of the overall project and the MCP- and state-level drivers on the key driver diagram. Also, potential interventions needed to be updated to reflect the overall project’s theory of change and answer the questions of the Model for Improvement. Paramount incorporated HSAG’s and ODM’s recommendations, and the revised Module 1 received *Achieved* scores for all documentation requirements.

### ***UnitedHealthcare Community Plan of Ohio, Inc.***

Upon initial review, HSAG identified that UnitedHealthcare’s documentation needed revisions to the SMART Aim to include the targeted focus of the project. In addition, the key driver diagram needed to include the MCP- and state-level drivers, and potential interventions needed to be updated to reflect the overall project’s theory of change and answer the questions of the Model for Improvement. UnitedHealthcare incorporated HSAG’s and ODM’s recommendations, and the revised Module 1 received *Achieved* scores for all documentation requirements.

## Overview

ODM uses a comprehensive strategy to evaluate consumer satisfaction, including analyses of consumer satisfaction survey data and QoL survey data. Satisfaction surveys are used to assess the experiences of Medicaid managed care consumers with regard to their ability to access quality health care services in a timely manner.

ODM required each MCP to administer CAHPS surveys in 2014 to the MCP’s Ohio Medicaid consumers. The CAHPS surveys are standardized surveys that assess consumer, parent, or caregiver perspectives on care and services. The MCPs administered the CAHPS 5.0H Adult Medicaid Health Plan Survey and the CAHPS 5.0H Child Medicaid Health Plan Survey—including the chronic conditions measurement set. HSAG aggregated and analyzed the survey data to measure Ohio Medicaid consumers’ experiences with regard to accessing needed care in a timely manner, accessing health plan information, how well their physicians communicated with them, and how well their MCP communicated with them. Survey data were also used to measure consumers’ perceptions of the quality of care received and satisfaction with their physicians and their MCP.

## National Benchmarks

HSAG calculated MCP-specific averages and an overall program average for four global ratings and five composite measures for the general child and adult populations. HSAG compared each result to the NCQA national Medicaid percentile distributions.<sup>7-1</sup> Based on this comparison, ratings of one (★) to five (★★★★★) stars were assigned to each MCP’s results for the four global ratings and five composite measures, with one star being the lowest possible rating (i.e., *Poor*) and five stars being the highest possible rating (i.e., *Excellent*). Star ratings were assigned to each MCP’s results for the four global ratings and five composite measures using the National Medicaid percentile distributions in Table 7-1.

| Stars | National Medicaid Percentiles   |
|-------|---------------------------------|
| ★★★★★ | ≥ 90th percentile               |
| ★★★★  | 75th percentile–89th percentile |
| ★★★   | 50th percentile–74th percentile |
| ★★    | 25th percentile–49th percentile |
| ★     | < 25th percentile               |

<sup>7-1</sup> The star assignments are based on NCQA’s HEDIS 2014 Accreditation Benchmarks and Thresholds, except for the Shared Decision Making composite. NCQA does not publish accreditation benchmarks and thresholds for the Shared Decision Making composite; therefore, the Shared Decision Making star assignments are based on NCQA’s 2014 national adult and child Medicaid data.

## CAHPS Results Findings

Table 7-2 displays the 2014 CAHPS Adult Comparisons to National Benchmarks for each measure for the Ohio Medicaid Program and each MCP.

| Table 7-2—2014 CAHPS Adult Comparisons to National Benchmarks |                       |                           |                           |                                      |                     |                      |                              |                  |                        |
|---------------------------------------------------------------|-----------------------|---------------------------|---------------------------|--------------------------------------|---------------------|----------------------|------------------------------|------------------|------------------------|
|                                                               | Rating of Health Plan | Rating of All Health Care | Rating of Personal Doctor | Rating of Specialist Seen Most Often | Getting Needed Care | Getting Care Quickly | How Well Doctors Communicate | Customer Service | Shared Decision Making |
| <b>Ohio Medicaid Program</b>                                  | ★★★★                  | ★★★★                      | ★★                        | ★                                    | ★★                  | ★★★★                 | ★★★★★★                       | ★★★★             | ★★★★                   |
| <b>Buckeye</b>                                                | ★★★★                  | ★★★★                      | ★★                        | ★★★★                                 | ★★                  | ★★★★                 | ★★★★★★                       | ★★               | ★★★★                   |
| <b>CareSource</b>                                             | ★★★★★★                | ★★★★★★                    | ★★                        | ★★                                   | ★★★★                | ★★★★                 | ★★★★                         | ★★★★★★           | ★★★★                   |
| <b>Molina</b>                                                 | ★★★★                  | ★★                        | ★★★★                      | ★★★★                                 | ★★                  | ★★★★                 | ★★★★★★                       | ★★★★★★           | ★★                     |
| <b>Paramount</b>                                              | ★★★★                  | ★★★★                      | ★★★★                      | ★                                    | ★★                  | ★★★★                 | ★★★★★★                       | ★★★★★★           | ★★★★                   |
| <b>UnitedHealthcare</b>                                       | ★★★★                  | ★★★★                      | ★★                        | ★                                    | ★★                  | ★★★★                 | ★★★★★★                       | ★★★★★★           | ★★★★                   |

For each measure, a minimum number of 100 responses are required in order to be reported as a CAHPS survey result. Measure results that do not meet the minimum number of responses are denoted as Not Applicable (NA).

Adult consumers in Ohio’s Medicaid Managed Care Program demonstrated moderate satisfaction scores as compared to the national Medicaid 50th percentile for most measures. The Managed Care Program generally performed best in the areas of How Well Doctors Communicate, Rating of Health Plan, and Customer Service. The Managed Care Program generally performed moderately—at or between the national Medicaid 50th and 74th percentiles—in the areas of Rating of All Health Care, Getting Care Quickly, and Shared Decision Making.

CareSource outperformed all other MCPs, achieving or exceeding the national Medicaid 75th percentile for five of the nine measures, and meeting the national Medicaid 50th percentile for two measures (Getting Needed Care and Getting Care Quickly). Paramount and UnitedHealthcare showed the greatest opportunity for improvement, with one reportable measure (Rating of Specialist Seen Most Often) below the national Medicaid 25th percentile.

Table 7-3 displays the 2014 CAHPS General Child Comparisons to National Benchmarks for each measure for the Ohio Medicaid Program and each MCP. CareSource’s 2014 results were derived from the MCP’s independent administration of the CAHPS 5.0 Child Medicaid Health Plan Survey.

| Table 7-3—2014 CAHPS General Child Comparisons to National Benchmarks |                       |                           |                           |                                      |                     |                      |                              |                  |                        |
|-----------------------------------------------------------------------|-----------------------|---------------------------|---------------------------|--------------------------------------|---------------------|----------------------|------------------------------|------------------|------------------------|
|                                                                       | Rating of Health Plan | Rating of All Health Care | Rating of Personal Doctor | Rating of Specialist Seen Most Often | Getting Needed Care | Getting Care Quickly | How Well Doctors Communicate | Customer Service | Shared Decision Making |
| <b>Ohio Medicaid Program</b>                                          | ☆☆☆                   | ★★★★★                     | ★★★★★                     | ★★★★★                                | ★★★★★               | ★★★★★                | ★★★★★                        | ★★★★★            | ☆☆☆                    |
| <b>Buckeye</b>                                                        | ★                     | ☆☆☆                       | ★★                        | NA                                   | ☆☆☆                 | ☆☆☆                  | ★★★★★                        | ★★★★★            | ★★★★★                  |
| <b>CareSource</b>                                                     | ★★★★★                 | ★★★★★                     | ★★★★★                     | ☆☆☆                                  | ★★★★★               | ★★★★★                | ★★★★★                        | ★★★★★            | ☆☆☆                    |
| <b>Molina</b>                                                         | ☆☆☆                   | ★★★★★                     | ☆☆☆                       | ☆☆☆                                  | ☆☆☆                 | ★★★★★                | ★★★★★                        | ★★★★★            | ★★                     |
| <b>Paramount</b>                                                      | ★★★★★                 | ★★★★★                     | ★★★★★                     | NA                                   | ★★★★★               | ★★★★★                | ★★★★★                        | ★★★★★            | NA                     |
| <b>UnitedHealthcare</b>                                               | ★★                    | ★★★★★                     | ☆☆☆                       | ★★★★★                                | ★★★★★               | ★★★★★                | ★★★★★                        | ☆☆☆              | ★★★★★                  |

For each measure, a minimum number of 100 responses are required in order to be reported as a CAHPS survey result. Measure results that do not meet the minimum number of responses are denoted as NA.

The parents or caregivers of children in Ohio’s Medicaid Managed Care Program generally reported moderate to high levels of satisfaction compared to national Medicaid results for all nine measures. The Managed Care Program achieved or exceeded the national Medicaid 75th percentiles for the Rating of All Health Care, Rating of Personal Doctor, and Rating of Specialist Seen Most Often global measures, and the Getting Needed Care, Getting Care Quickly, How Well Doctors Communicate, and Customer Service composite measures. Additionally, the program achieved the national Medicaid 50th percentile in the areas of Rating of Health Plan and Shared Decision Making.

CareSource and Paramount outperformed all other MCPs by achieving or exceeding the national Medicaid 75th percentile for seven of nine reportable measures. Buckeye showed the greatest opportunity for improvement, with two of nine measures below the national Medicaid 50th percentile (Rating of Health Plan and Rating of Personal Doctor).

## Overview

ODM administered a Quality of Life (QoL) survey from June to September 2014 to the ABD and CFC child populations for all MCPs in Ohio's Medicaid Managed Care Program.<sup>8-1</sup> The goal of the QoL survey was to evaluate the health-related QoL experiences of children with chronic or disabling health conditions who were enrolled in the Ohio Medicaid Managed Care Program in an effort to better understand this population's health care needs and to identify potential areas to target quality improvement activities. Data were collected by population—ABD child members and CFC child members. ABD child members were surveyed at the MCP level to provide detailed data for a baseline assessment, while CFC child members were surveyed at the program level to allow for a comparative analysis of the two populations.

The QoL survey instrument chosen by ODM was the Child Health Questionnaire—Parent Form 50 (CHQ-PF50), which was developed by HealthActCHQ, Inc. This survey measures 14 unique physical (PHY) and psychosocial (PSY) domains, which comprise the PHY and PSY summary scores.<sup>8-2</sup> The following domains are captured within the CHQ-PF50:

- ◆ General Health
- ◆ Behavior
- ◆ Physical Functioning
- ◆ Role/Social Limitations—Physical
- ◆ Role/Social Limitations—Emotional
- ◆ Role/Social Limitations—Behavioral
- ◆ Bodily Pain/Discomfort
- ◆ Parental Impact—Time
- ◆ Parental Impact—Emotional
- ◆ Self-Esteem
- ◆ Mental Health
- ◆ Family Activities
- ◆ Change in Health
- ◆ Family Cohesion

ODM also added supplemental questions to the survey instrument that addressed disease prevalence, and child and respondent demographics.<sup>8-3</sup> The survey instrument consisted of 74 questions (50 CHQ-

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<sup>8-1</sup> The CFC and ABD populations were limited to child members receiving SSI.

<sup>8-2</sup> ©2014 HealthActCHQ, Inc., Boston, MA USA. All rights reserved.

<sup>8-3</sup> HSAG received permission from the developers to add supplemental questions to the CHQ-PF50 survey instrument.

PF50 questions and 24 supplemental questions). A total of 3,287 completed surveys were returned for the 2014 QoL study.

## Findings

### *MCP-Level Findings (ABD Only)*

Key ABD MCP-level findings include:

- ◆ Approximately 70 percent of child members were male.
- ◆ Approximately 70 percent of child members were between the ages of 11 and 18.
- ◆ Approximately 21 percent of child members had zero chronic conditions, while approximately 54 percent had three or more (among 14 chronic conditions assessed by the survey).
- ◆ The most prevalent chronic conditions were attention deficit disorder/attention deficit hyperactivity disorder (61.1 percent); allergies (47.2 percent); and depression, anxiety, or other emotional problems (46.7 percent).
- ◆ Buckeye scored significantly higher than the ABD population on three composite measures: (1) Role/Social Limitations—Emotional/Behavioral, (2) Self-Esteem, and (3) Parental Impact—Emotional. Buckeye also scored significantly higher than the ABD population on the PSY summary score.
- ◆ CareSource scored significantly lower than the ABD population on the Parental Impact—Emotional composite measure.
- ◆ Paramount scored significantly lower than the ABD population on three composite measures: (1) Role/Social Limitations—Physical, (2) General Health Perceptions, and (3) Parental Impact—Time.

### *Program-Level Findings (ABD and CFC)*

Key ABD and CFC program-level findings include:

- ◆ For all of the measures (i.e., global ratings, composite measures, and individual items), the ABD population mean score was slightly less than the CFC population mean score. In addition, the ABD population mean score was statistically lower than the CFC population mean score for 10 measures.
- ◆ The ABD population mean score was statistically lower than the CFC population mean score for the PHY and PSY summary scores.
- ◆ Approximately 21 percent of ABD and 18 percent of CFC child members had zero chronic conditions, while approximately 54 percent of ABD and 55 percent of CFC child members had three or more chronic conditions (among 14 chronic conditions assessed by the survey).
- ◆ The top three chronic medical conditions were the same for the ABD and CFC populations: (1) attention deficit disorder/attention deficit hyperactivity disorder; (2) allergies; and (3) depression, anxiety, or other emotional problems. However, the top condition for the ABD population was 6.1 percent lower in the CFC population.

### Comparative Analysis Results

HSAG performed two comparative analyses to evaluate the different populations of the QoL survey: (1) ABD MCP-level comparative analysis, and (2) ABD and CFC Ohio Medicaid Managed Care Program-level comparative analysis. For both analyses, an overall mean was calculated for each global rating, composite measure, individual item, and PHY and PSY summary measures in accordance with the instructions and algorithms provided in the CHQ Scoring and Interpretation Manual.<sup>8-4</sup>

#### ABD MCP-Level Comparative Analysis

The MCP-level mean adjusted scores were compared to the program-level average score to determine whether there were statistically significant differences between the mean adjusted scores for each MCP and the program-level average for the ABD population. An MCP’s mean was case-mix-adjusted to the other MCPs’ means. The ABD program-level average was calculated using each MCP’s adjusted score. Table 8-1 presents a summary of the ABD MCP-level comparative analysis displaying specific MCP measure results that were statistically higher or lower than the Ohio ABD population average. (Note: Measures not presented in the table did not have any statistically significant differences when compared to the ABD population average.)

**Table 8-1—MCP Comparison Highlights**

| Measures                                                                                                                | Buckeye | CareSource | Molina | Paramount | United-Healthcare |
|-------------------------------------------------------------------------------------------------------------------------|---------|------------|--------|-----------|-------------------|
| Role/Social Limitations—Emotional/Behavioral Composite                                                                  | ↑       | —          | —      | —         | —                 |
| Role/Social Limitations—Physical Composite                                                                              | —       | —          | —      | ↓         | —                 |
| Self-Esteem Composite                                                                                                   | ↑       | —          | —      | —         | —                 |
| General Health Perceptions Composite                                                                                    | —       | —          | —      | ↓         | —                 |
| Parental Impact—Emotional Composite                                                                                     | ↑       | ↓          | —      | —         | —                 |
| Parental Impact—Time Composite                                                                                          | —       | —          | —      | ↓         | —                 |
| Psychosocial Summary Measure                                                                                            | ↑       | —          | —      | —         | —                 |
| ↑ Statistically higher than the Ohio ABD population result<br>↓ Statistically lower than the Ohio ABD population result |         |            |        |           |                   |

<sup>8-4</sup> HealthActCHQ. The CHQ Scoring and Interpretation Manual. Boston, MA: HealthActCHQ, 2013.

### ABD and CFC Ohio Medicaid Managed Care Program-Level Comparative Analysis

The ABD program-level mean case-mix-adjusted scores were compared to CFC program-level mean case-mix-adjusted scores to determine whether there were statistically significant differences between the scores. The ABD program-level mean was case-mix-adjusted to the CFC population. Table 8-2 provides specific population measure results that were statistically higher or lower than the other population (i.e., ABD child population or CFC child population). (Note: Measures not presented in the table did not have any statistically significant differences when comparing the populations.)

| Table 8-2—Population Comparison Highlights                                                          |                |                |
|-----------------------------------------------------------------------------------------------------|----------------|----------------|
| Measures                                                                                            | ABD Population | CFC Population |
| Global Health Item                                                                                  | ↓              | ↑              |
| Global Behavior Item                                                                                | ↓              | ↑              |
| Role/Social Limitations—Emotional/Behavioral Composite                                              | ↓              | ↑              |
| Role/Social Limitations—Physical Composite                                                          | ↓              | ↑              |
| Bodily Pain/Discomfort Composite                                                                    | ↓              | ↑              |
| General Behavior Composite                                                                          | ↓              | ↑              |
| Mental Health Composite                                                                             | ↓              | ↑              |
| Parental Impact—Emotional Composite                                                                 | ↓              | ↑              |
| Parental Impact—Time Composite                                                                      | ↓              | ↑              |
| Family Cohesion Item                                                                                | ↓              | ↑              |
| Physical Summary Measure                                                                            | ↓              | ↑              |
| Psychosocial Summary Measure                                                                        | ↓              | ↑              |
| ↑ Statistically higher than the other population<br>↓ Statistically lower than the other population |                |                |

## Overview

Care management is a significant component of the Ohio Medicaid Managed Care Program. The use of care management allows ODM to better ensure managed care consumers are receiving high quality health care in a cost-effective manner. MCPs are required to focus on helping the most vulnerable, high risk consumers through provision of a more hands-on, coordinated approach to care. The SFY 2015 Managed Care Provider Agreement included specific requirements for identifying consumers appropriate for high risk care management (HRCM), assessing the consumer, care planning, care management, interacting with the consumer, and evaluating the care management program.

ODM contracted with HSAG to administer a Care Management Survey in SFY 2015 to consumers enrolled in all five of the MCPs' care management programs. The purpose of the study was to evaluate consumers' experience and satisfaction with HRCM, to provide ODM with a better understanding of HRCM operations and service delivery, and to inform efforts to further enhance or improve these services.

In addition, ODM contracted with HSAG to implement a patient engagement activity with the HRCM population using the Patient Activation Measure survey. The goal of the activity was to improve patient engagement through evaluation of baseline patient activation and the implementation of targeted, consumer-centered interventions.

## HRCM Survey

ODM conducted a Care Management Survey to evaluate consumers' experiences with HRCM. Consumers from the MCPs completed the surveys from January to March 2015. The survey instrument was developed by HSAG in collaboration with ODM. The survey instrument contained 37 questions across five domains: care management participation, care manager, care plan, satisfaction with care management, and about you. Adult and child HRCM consumers from all five MCPs were included in the survey. A total of 3,141 completed surveys were returned for the five MCPs. Of these, 2,886 were included in the analytic population, given that the respondents confirmed that they or their child had been enrolled in a care management program.

## Findings

Key demographic, program-level findings include:

- ◆ Approximately 68 percent of adult respondents reported their health as *Fair* or *Poor*, while approximately 26 percent of parents and/or caretakers reported their child's health as *Fair* or *Poor*. Only approximately 11 percent of adult respondents reported their health as *Excellent* or *Very Good*, whereas almost 40 percent of parents and/or caretakers reported their child's health as *Excellent* or *Very Good*.

- ◆ Behavioral health disorders (45.3 percent), diabetes and endocrine disorders (26.8 percent), and pulmonary disease (24.0 percent) were the most prevalent categories of conditions care-managed in the survey population.

Key HRCM-related, program-level findings include:

- ◆ Approximately 85 percent of respondents reported they received contact information for their care manager, and that their care manager communicated effectively with them all of the time.
- ◆ Approximately 60 percent of respondents reported that their care manager helped them receive the care they needed all of the time.
- ◆ Approximately 93 percent of respondents reported that a care plan was developed for them. Of those, 94 percent reported participating in the development of their care plan, roughly 92 percent reported knowing the goals of their care plan, and almost 97 percent of respondents understood their care plan. Furthermore, approximately 78 percent of respondents reported receiving a copy of their care plan.
- ◆ Approximately 51 percent of respondents reported being contacted by their care manager monthly.
- ◆ About 46 percent of respondents reported that their care manager was available all of the time.
- ◆ Approximately 86 percent of respondents reported having at least one face-to-face visit with their care manager, and 71 percent of respondents reported their most recent face-to-face visit with their care manager as very helpful.
- ◆ Respondents reported that their home was the primary location where their care manager conducted face-to-face visits with them.
- ◆ Respondents reported that their care manager assisted them primarily with self-management of health conditions; getting services such as therapy visits, medications, and medical supplies; and understanding health conditions/symptoms.
- ◆ Approximately 83 percent of respondents reported that they were satisfied with the care management services they received all or most of the time, and 86 percent of respondents would recommend the care management services they received.
- ◆ About 39 percent of respondents definitely thought the care management program helped to improve their general health status compared to six months ago.
- ◆ About 66 percent of respondents reported they were helped by the care management program.

HSAG compared MCP-specific results to the program results for a global rating and four composite measures to determine if the MCP-specific results were significantly different than the program results. Table 9-1 displays the results of the comparative analysis for these measures for each MCP.

**Table 9-1—Comparative Analysis Summary Results**

|                                                                                                                                                                                                                                           | Buckeye | CareSource | Molina | Paramount | United-Healthcare |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------|------------|--------|-----------|-------------------|
| <b>Global Rating</b>                                                                                                                                                                                                                      |         |            |        |           |                   |
| Overall Rating of Care Management Services                                                                                                                                                                                                | —       | —          | —      | —         | —                 |
| <b>Composite Measures</b>                                                                                                                                                                                                                 |         |            |        |           |                   |
| Knowledge of Care Management Program                                                                                                                                                                                                      | ↑       | —          | —      | ↓         | —                 |
| Relationship with Care Manager                                                                                                                                                                                                            | —       | —          | —      | —         | ↑                 |
| Care Plan                                                                                                                                                                                                                                 | ↑       | —          | ↓      | —         | —                 |
| Helped by Care Management Program                                                                                                                                                                                                         | ↑       | —          | —      | ↓         | —                 |
| ↑ indicates the score is significantly higher than the program average.<br>↓ indicates the score is significantly lower than the program average.<br>— indicates the score is not significantly higher or lower than the program average. |         |            |        |           |                   |

Responses to the survey questions were classified into response categories. For the global rating, responses were classified into the following categories: 0 to 6, 7 to 8, and 9 to 10. For the composite measures, responses were classified into one of the following categories: (1) “No” and “Yes,” or (2) “None/Some of the time,” “Most of the time,” and “All of the time,” or (3) “Definitely no/Somewhat no,” “Neither yes nor no/Somewhat yes,” and “Definitely yes.” HSAG evaluated the percentage of respondents in each of the response categories for each MCP and the program. Table 9-2 displays the top (i.e., positive/favorable) consumer satisfaction ratings (i.e., “Yes,” “Definitely yes,” “All of the time”) for the global rating and composite measures.

**Table 9-2—Care Management Survey Consumer Satisfaction Ratings**

| Measure Name                                                                                                                                      | Overall Program | Buckeye | CareSource | Molina  | Paramount | United-Healthcare |
|---------------------------------------------------------------------------------------------------------------------------------------------------|-----------------|---------|------------|---------|-----------|-------------------|
| <b>Global Rating</b>                                                                                                                              |                 |         |            |         |           |                   |
| Overall Rating of Care Management Services                                                                                                        | 62.0%           | 60.6%   | 63.7%      | 64.4%   | 57.9%     | 61.6%             |
| <b>Composite Measures</b>                                                                                                                         |                 |         |            |         |           |                   |
| Knowledge of Care Management Program                                                                                                              | 86.7%           | 90.3% ↑ | 87.5%      | 85.0%   | 79.6% ↓   | 87.6%             |
| Relationship with Care Manager                                                                                                                    | 85.1%           | 85.5%   | 85.3%      | 82.7%   | 84.4%     | 87.0% ↑           |
| Care Plan                                                                                                                                         | 92.5%           | 93.9% ↑ | 92.7%      | 90.4% ↓ | 92.5%     | 92.4%             |
| Helped by Care Management Program                                                                                                                 | 66.6%           | 72.2% ↑ | 65.8%      | 65.0%   | 61.4% ↓   | 66.1%             |
| ↑ indicates the score is significantly higher than the program average.<br>↓ indicates the score is significantly lower than the program average. |                 |         |            |         |           |                   |

In addition, HSAG performed a key drivers analysis to identify which survey questions were most closely associated with the Understanding Your Health, Managing Your Health, Improving General

Health Status, and the Overall Rating of Care Management Services survey questions. Survey items that were highly correlated with these questions were identified as key drivers. Table 9-3 displays a summary of the key drivers analysis for each MCP. Check marks indicate that the item was highly correlated with the question.

| Table 9-3—Key Drivers Analysis Summary Table           |                 |         |            |        |           |                   |
|--------------------------------------------------------|-----------------|---------|------------|--------|-----------|-------------------|
| Key Drivers                                            | Overall Program | Buckeye | CareSource | Molina | Paramount | United-Healthcare |
| <b>Understanding Your Health</b>                       |                 |         |            |        |           |                   |
| Care Manager Helped Receive Care Needed                |                 |         | ✓          | ✓      | ✓         |                   |
| <b>Managing Your Health</b>                            |                 |         |            |        |           |                   |
| Care Manager Helped Receive Care Needed                |                 |         |            |        | ✓         |                   |
| <b>Improving Your General Health Status</b>            |                 |         |            |        |           |                   |
| How Helpful Face-to-Face Visit with Care Manager       |                 | ✓       |            | ✓      | ✓         |                   |
| Care Manager Helped Receive Care Needed                | ✓               | ✓       | ✓          | ✓      | ✓         | ✓                 |
| <b>Overall Rating of Care Management Services</b>      |                 |         |            |        |           |                   |
| How Often Care Manager Available When Tried to Contact |                 |         |            | ✓      |           |                   |
| How Helpful Face-to-Face Visit with Care Manager       | ✓               | ✓       | ✓          | ✓      | ✓         | ✓                 |
| Care Manager Helped Receive Care Needed                | ✓               | ✓       | ✓          | ✓      | ✓         | ✓                 |

## Patient Engagement

### Introduction

The opportunity to improve health care engagement for consumers in HRCM was identified in administrative reviews that were conducted in 2014. As a result, ODM contracted with HSAG to implement a patient engagement study for the MCPs’ HRCM population, the 13-item Patient Activation Measure (PAM) survey.

Patient activation is defined as the ability and willingness to take on the role of managing one’s own health care. The PAM is a survey instrument which measures three key patient domains of this role: (1) knowledge, (2) skills, and (3) confidence. Each respondent is scored on a 100-point scale and is assigned to one of four activation levels:

- ◆ Level 1: Disengaged and overwhelmed
- ◆ Level 2: Becoming aware, but still struggling

- ◆ Level 3: Taking action
- ◆ Level 4: Maintaining behaviors and pushing further

The higher the activation level, the more likely the consumer is compliant with health care recommendations and that health care service utilization is appropriate.

### Methodology

ODM and HSAG introduced the PAM survey to the MCPs in May 2014. Baseline PAM surveys were administered to HRCM consumers between July 15 and October 15, 2014. Based on the PAM score and activation level, the MCPs' HRCM staff implemented tailored goals, supports, and interventions with the goal of improving activation levels. Six months after the baseline survey was administered, the MCPs re-administered the PAM survey to assess if activation had improved as a result of targeted interventions.

### Baseline Results

A total of 5,898 PAM surveys were administered to consumers enrolled in HRCM, representing an overall completion rate of 53.2 percent of the eligible population. Completion rates varied by MCP, ranging from 39.8 percent to 65.1 percent. Baseline PAM mean scores are presented in Table 9-4.

| MCP              | Mean        |
|------------------|-------------|
| Buckeye          | 58.2        |
| CareSource       | 59.3        |
| Molina           | 56.8        |
| Paramount        | 63.2        |
| UnitedHealthcare | 59.9        |
| <b>Total</b>     | <b>59.0</b> |

The baseline aggregate PAM mean score was 59.0 (on a scale of 1 to 100). Mean scores varied by MCP, ranging from 56.8 to 63.2.

The expected baseline activation level distribution was provided by Insignia Health and is presented in Table 9-5.

| Level | Expected Percent of Population |
|-------|--------------------------------|
| 1     | 10%–20%                        |
| 2     | 20%–35%                        |
| 3     | 20%–30%                        |
| 4     | 20%–30%                        |

Buckeye, CareSource, and Molina showed baseline PAM level of activation distribution patterns that were similar to the aggregate MCP results. UnitedHealthcare results showed the percentage of respondents in Level 1 and Level 3 slightly higher than expected. Paramount deviated most from expected percentages, with a significantly higher percentage of respondents falling into Level 3 and Level 4, and a much lower-than-expected percentage of respondents falling into Level 1 and Level 2. However, Paramount had the fewest consumers in the survey population by a wide margin (only 3.7 percent of total respondents).

### Interventions

Between June and October 2014, all MCPs integrated PAM survey administration into their HRCM process and implemented a process of consumer-specific goal setting and intervention development aimed at improving consumers’ patient activation level. Approaches to intervention development varied by MCP. Each MCP initiated techniques, tools, and goals within its care management process to improve patient engagement and education.

### Remeasurement Results

Resurveys after the six-month intervention period totaled 3,519, or 78.4 percent of the eligible population who had completed a baseline survey. Resurvey completion rates varied by MCP, ranging from 24.0 percent to 84.1 percent.

The change in PAM mean scores by MCP and in aggregate is displayed in Table 9-6.

| MCP              | Mean        |               |              |
|------------------|-------------|---------------|--------------|
|                  | Baseline*   | Remeasurement | Difference   |
| Buckeye          | 56.4        | 57.8          | 1.4**        |
| CareSource       | 57.3        | 57.8          | 0.5          |
| Molina           | 55.4        | 57.2          | 1.8**        |
| Paramount        | 63.3        | 65.5          | 2.2          |
| UnitedHealthcare | 56.9        | 58.4          | 1.5**        |
| <b>Total</b>     | <b>56.9</b> | <b>57.9</b>   | <b>1.0**</b> |

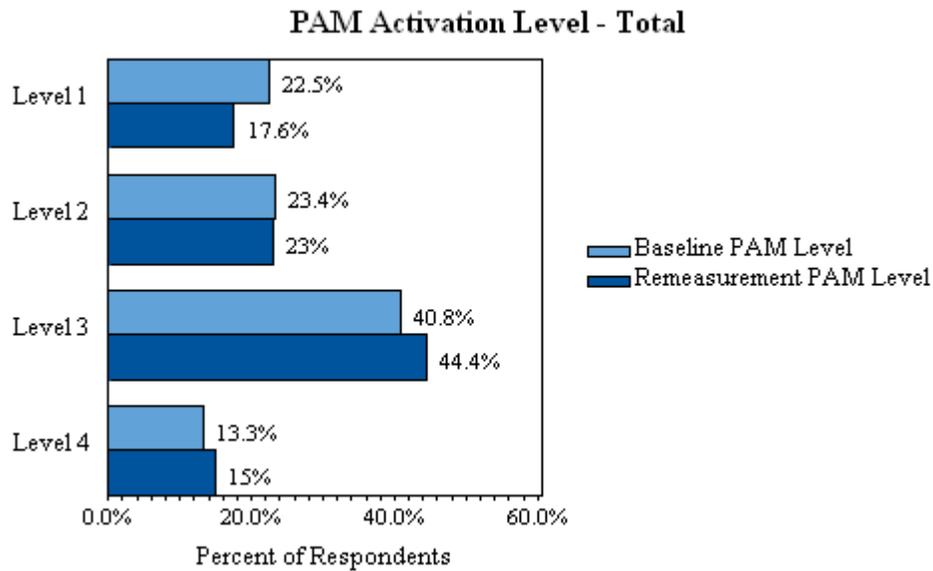
\* Baseline means in Table 9-6 reflect only the baseline scores of consumers who also completed a resurvey.

\*\* Indicates the remeasurement PAM mean score is statistically higher than the baseline PAM mean score.

A statistically significant increase in PAM mean score was seen for three of the MCPs and also for the MCPs in aggregate. While Paramount showed the largest change in PAM mean score, it was not statistically significant, due to small sample size.

The change in PAM activation level distribution for the MCPs in aggregate is displayed in Figure 9-1.

**Figure 9-1—PAM Activation Level (Total)**



The increase in PAM mean score and the shift toward the higher levels of activation (Level 3 and Level 4) suggest that tailored care planning and consumer-specific interventions based on PAM results led to an improvement in patient activation over the six-month period.

## 10. Conclusions and Recommendations

HSAG used findings across both mandatory and optional EQR activities and ODM monitoring activities conducted during the review period of July 1, 2014–June 30, 2015, to evaluate the performance of Medicaid MCPs on providing quality, timeliness of, and access to health care services to Ohio Medicaid managed care consumers.

To draw conclusions and make recommendations about the quality and timeliness of, and access to, care provided by the MCPs, HSAG assigned each of the activities reviewed to one or more of these three domains: quality, accessibility, and/or timeliness of care and services. Table 10-1 displays the objective of each activity and the applicable domains.

**Table 10-1—EQR and ODM Activities and Domains**

| Activity                                                         | Objective                                                                                                                                                                                        | Quality | Access | Timeliness |
|------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------|--------|------------|
| Addenda Audit                                                    | Assess the sufficiency of provider panel care and service capacity as well as number, mix, and geographic distribution in relation to the needs of consumers in the service area.                |         | ✓      |            |
| Validation of Managed Care Provider Network (MCPN) Submissions   | Assess the completeness and accuracy of network provider demographic data in the MCPN files to facilitate consumer access to valid provider information.                                         |         | ✓      |            |
| 24-Hour Nurse Advice/Member Services Call Centers Review         | Assess the accessibility and timeliness of services provided by the MCPs' 24-Hour Nurse Advice Lines and Member Services.                                                                        |         | ✓      | ✓          |
| Consumer Complaints Review                                       | Assess consumers' overall satisfaction with the Ohio Medicaid managed care program including consumers' satisfaction with access to health care services.                                        |         | ✓      |            |
| Grievance System Review                                          | Assess the effectiveness and timeliness of the resolution of grievances and appeals.                                                                                                             |         | ✓      | ✓          |
| Performance Measure Validation (PMV), Calculation, and Reporting | Assess the validity of performance measure rates reported by the MCPs designed to evaluate various aspects of quality, accessibility, and timeliness of care and services provided to consumers. | ✓       | ✓      | ✓          |
| Performance Improvement Project (PIP) Validation                 | Assess and improve the quality of care for a targeted clinical topic.                                                                                                                            | ✓       |        |            |
| Consumer Satisfaction                                            | Assess the experiences of consumers with regard to their ability to access quality health care and health plan services in a timely manner.                                                      | ✓       | ✓      | ✓          |

| Table 10-1—EQR and ODM Activities and Domains |                                                                                                                                        |         |        |            |
|-----------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------|---------|--------|------------|
| Activity                                      | Objective                                                                                                                              | Quality | Access | Timeliness |
| Quality of Life (QoL) Survey                  | Assess the quality of life measures for children with chronic and disabling conditions and identify opportunities for improvement.     | ✓       |        |            |
| High Risk Care Management (HRCM)              | Assess the effectiveness of MCP HRCM programs in ensuring consumers are receiving high quality health care in a cost-effective manner. | ✓       |        |            |

## Quality

The SFY 2015 ODM and EQR monitoring activities identified areas of strength as well as opportunities for improvement across the measures assessing quality of care and services as shown in Table 10-2.

| Table 10-2—Measures Assessing Quality                                                                                                                               |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>MCP Performance Measures</b>                                                                                                                                     |
| <i>Use of Appropriate Medications for People with Asthma—Total</i>                                                                                                  |
| <i>Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up</i>                                                                                           |
| <i>Follow-up Care for Children Prescribed ADHD Medication—Initiation Phase</i>                                                                                      |
| <i>Initiation and Engagement of Alcohol and Other Drug Dependence Treatment—Engagement of AOD Treatment (Total)</i>                                                 |
| <i>Cholesterol Management for Patients with Cardiovascular Conditions—LDL-C Screening and LDL-C Control &lt;100mg/dL</i>                                            |
| <i>Controlling High Blood Pressure</i>                                                                                                                              |
| <i>Persistence of Beta-Blocker Treatment after a Heart Attack</i>                                                                                                   |
| <i>Comprehensive Diabetes Care—Blood Pressure Control (&lt;140/90 mm Hg), Eye Exam (Retinal) Performed, HbA1c Adequate Control (HbA1c &lt; 8%), LDL-C Screening</i> |
| <i>Appropriate Treatment for Children with Upper Respiratory Infection</i>                                                                                          |
| <i>Annual Number of Asthma Patients with at Least One Asthma-Related Emergency Room Visit</i>                                                                       |
| <i>Percentage of Live Births Weighing Less than 2,500 Grams</i>                                                                                                     |
| <b>Performance Improvement Project (PIP) Validation</b>                                                                                                             |
| <b>CAHPS Results for the Ohio Medicaid Program</b>                                                                                                                  |
| <i>Getting Needed Care</i>                                                                                                                                          |
| <i>Getting Care Quickly</i>                                                                                                                                         |
| <i>How Well Doctors Communicate</i>                                                                                                                                 |
| <i>Customer Service</i>                                                                                                                                             |
| <i>Shared Decision Making</i>                                                                                                                                       |
| <i>Rating of Personal Doctor</i>                                                                                                                                    |
| <i>Rating of Specialist Seen Most Often</i>                                                                                                                         |

| Table 10-2—Measures Assessing Quality              |
|----------------------------------------------------|
| <i>Rating of All Health Care</i>                   |
| <i>Rating of Health Plan</i>                       |
| <b>Quality of Life (QoL) Survey</b>                |
| <b>High Risk Care Management (HRCM) Evaluation</b> |

## Conclusions

To assess the quality domain of care, HSAG used the MCPs’ performance measure rates, PIP validation results and outcomes, CAHPS results, and QoL and HRCM survey results. The performance of the Ohio managed care program in this domain was varied, with several areas of strength and other areas where opportunities for improvement were identified.

Evaluation of the Ohio managed care program on the 11 MCP measures in the quality domain showed areas of strength while also revealing opportunities for improvement. These 11 measures contained 15 rates, 13 of which had national benchmarks available for performance ranking. The Ohio managed care program excelled in two measures for which rates ranked above the 75th percentiles: *Follow-up Care for Children Prescribed ADHD Medication—Initiation Phase* and *Persistence of Beta-Blocker Treatment after a Heart Attack*. Two additional Ohio managed care program rates (*Follow-up After Hospitalization for Mental Illness—7 Day Follow-Up* and *Comprehensive Diabetes Care—Eye Exam [Retinal] Performed*) ranked between the 50th and 75th percentiles. In terms of performance improvement, two rates (*Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up* and *Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase*) improved notably from CY 2012 to CY 2013.

However, the Ohio managed care program scored below the national Medicaid 50th percentiles on nine quality performance rates (six measures). None of these rates were below the 10th percentiles, but three rates (two measures) were below the 25th percentiles, demonstrating opportunities for improvement. These measures include *Controlling High Blood Pressure* and *Comprehensive Diabetes Care (HbA1c Adequate Control <8% and LDL-C Screening)*. The statewide rate for the *Annual Number of Asthma Patients with at Least One Asthma-related Emergency Room Visit* CHIPRA measure declined by 2.1 percentage points from CY 2012 to CY 2013, indicating another area for improvement. The statewide performance rate for the *Use of Appropriate Medications for People with Asthma—Total* measure was 12.4 percent for CY 2013, which was a slight increase from the previous year. These findings indicate that MCPs may not be providing appropriate management of chronic illnesses. Improvement in medication management may reduce hospitalizations.

For all MCPs, rates for at least two of the six SFY 2014 P4P measures fell within the P4P performance levels. Of the \$69.6 million possible P4P award dollars, approximately \$15.4 million (22.13 percent) were awarded to the MCPs. The award percentages ranged from 10 percent to 45 percent. Consistently across all MCPs, performance rates for the *Timeliness of Prenatal Care* and *Follow-Up after Hospitalization for Mental Illness* P4P measures qualified for P4P award dollars.

MCPs' P4P award dollars for CY 2013 results represented 22.13 percent of the eligible dollars compared to 40.39 percent of eligible dollars awarded for CY 2012 performance, indicating that opportunities exist for MCPs to improve performance in this area.

ODM's selection of and the MCPs' participation in the *Progesterone Initiation* PIP during the review year demonstrates good alignment between quality improvement efforts with one of ODM's priority areas to reduce infant mortality. All MCPs developed methodologically sound projects that were designed to measure and monitor outcomes. Too often, results of the MCPs' performance improvement efforts are not realized until after a year or more, making the timeline for achieving performance goals undesirable. The redesign of the PIP process is more targeted, using a model that integrates quality improvement sciences, focuses on achieving health outcomes, and accelerates change.

Consumers' satisfaction with care measured through the CAHPS surveys revealed that, similar to the prior year, adult consumers and the parents or caregivers of children in Ohio's Medicaid managed care program were highly satisfied with their MCPs' customer service and how well their doctors communicated with them. Furthermore, parents or caregivers of children were highly satisfied with their child's ability to get the care they need and to get that care quickly, overall health care, their personal doctor, and their specialist seen most often. In addition, adult consumers were highly satisfied with their health plan. All MCPs met the ODM contract standard for *Rating of Health Plan* for the adult population, and four of the five met the contract standards for the child population. For the general child population, results for CareSource, Molina, and Paramount were at or above the national Medicaid 50th percentile; however, the results for Buckeye and UnitedHealthcare fell below the national Medicaid 50th percentile for CY 2013.

The Quality of Life (QoL) survey administered to children with chronic and disabling health conditions for the CFC and ABD populations showed that the CFC population scored slightly higher than the ABD population on most measures; however, the scores were very similar. The results demonstrated high scores for assessing physical health but lower scores for measures evaluating behavioral issues. These results suggest that efforts to move toward a patient-centered approach that holistically evaluates and manages each consumer represent an opportunity for improvement. In addition, these results confirm the importance of monitoring QoL in the consumer population experiencing significant morbidity due to both physical and mental health conditions. Areas of poor performance suggest an opportunity to improve the health-related QoL for this child population.

Overall, consumer experiences with certain aspects of HRCM were positive, although consumers' overall rating of the care management services they received was less positive, with a satisfaction rating of 62 percent. The majority of consumers indicated knowledge of the care management program and their care plans, and satisfaction with their care manager. Approximately 66 percent of respondents reported that the care management program helped them. Approximately 86 percent of respondents reported having at least one face-to-face visit with their care manager, with approximately 71 percent of these respondents rating the visit as very helpful.

However, opportunities for improvement exist in making the care management program helpful to more consumers. Also, with the ODM requirement that the care manager must conduct a face-to-face

visit every 90 days, there is opportunity to improve the rate of completed face-to-face visits, particularly considering that the majority of respondents felt these visits were very helpful.

Results from the PAM study, which studied patient engagement for the MCPs’ HRCM population, showed that three of the five MCPs had statistically significant improvement in patient activation from the baseline to the remeasurement period and statistically significant improvement in aggregate for all MCPs. These results suggest the possibility that the tailored care planning and interventions based on PAM results led to an increase in patient activation level for HRCM consumers and may be a useful tool for improving activation and promoting self-management skills.

## Access

The SFY 2015 ODM and EQR monitoring activities identified areas of strength as well as opportunities for improvement across the measures assessing access to care and services shown in Table 10-3.

| <b>Table 10-3—Measures Assessing Access</b>                                                                                        |
|------------------------------------------------------------------------------------------------------------------------------------|
| <b>Addenda Audit</b>                                                                                                               |
| <b>Validation of Managed Care Provider Network (MCPN) Submissions</b>                                                              |
| <b>24-Hour Nurse Advice/Member Services Call Centers Review</b>                                                                    |
| <b>Consumer Complaints Review</b>                                                                                                  |
| <b>Grievance System Review</b>                                                                                                     |
| <b>MCP Performance Measures</b>                                                                                                    |
| <i>Adults’ Access to Preventive/Ambulatory Health Services—Total</i>                                                               |
| <i>Children and Adolescents’ Access to Primary Care Practitioners—12–24 Months, 25 Months–6 Years, 7–11 Years, and 12–19 Years</i> |
| <i>Adolescent Well-Care Visits</i>                                                                                                 |
| <i>Well-Child Visits in the First 15 Months of Life—Six or More Visits</i>                                                         |
| <i>Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life</i>                                                      |
| <b>CAHPS Results for the Ohio Medicaid Program</b>                                                                                 |
| <i>Getting Needed Care</i>                                                                                                         |

## Conclusions

HSAG used the results from the addenda audit, validation of MCPN network submissions, call center statistics for the 24-Hour Nurse Advice Line call centers and MCP member services call centers, access-related complaints and grievances, access-related performance measures, and access-related CAHPS results to assess the access domain of care. Similar to the quality domain, overall performance of the Ohio managed care program in the access domain was mixed.

The addenda audit showed that among Medicaid-only providers, 81 percent of the required elements were documented and included in the addenda reviewed by HSAG. HSAG noted that multiple

versions of the addenda were utilized by the MCPs, which likely contributed to the variation of MCP performance across addenda elements.

MCPN data were validated using telephone surveys, which included an audit of MCPN provider files and a secret shopper survey. These surveys assessed Medicaid managed care consumers' access to primary care services and were used to validate provider information contained within the MCPN. The results from the audit of the MCPN provider files showed some discrepancies between the MCPN file data and information obtained through telephone surveys of PCP offices. Additionally, variations in the accuracy of information were found across MCPs. The results from secret shopper surveys showed that a majority of providers that could be contacted and were affiliated with the MCP were able to provide appointments for routine care to a new patient within 30 calendar days; however, many inconsistencies in provider information were identified between the MCPN data and information obtained by the secret shoppers. Results showed that more than 25 percent of PCP locations could not be reached by callers, which could present barriers to consumers accessing care. In addition, approximately one-third of providers that could be contacted and were affiliated with the MCP were not accepting new patients and of those that were, many providers only accepted new patients meeting certain criteria, with restrictions or requirements related to clinical conditions or practices, patients' age, or patients' PCP assignment. Inaccurate or irrelevant MCPN data can pose a barrier to consumers seeking care.

A review of consumer complaints received through ODM's consumer hotline showed that approximately 10 percent of complaints received were access-related. Approximately 28 percent of all grievances filed by the MCPs during SFY 2015 were access-related. These findings indicate opportunities to determine if patterns exist and if future complaints and grievances can be reduced.

Overall, the MCPs met contract requirements for access to MCP call centers and 24-Hour Nurse Advice Line call centers. This is further supported by the high satisfaction rates reported among both adult and child populations with MCP customer service. All MCPs met standards for the abandonment rate and overall blockage rate.

The Ohio managed care program performance on MCP performance measures showed some relative strengths as well as several opportunities for improvement. MCPs were required to report five measures (eight rates) addressing the access domain, although the Ohio managed care program did not exceed the national Medicaid HEDIS 75th percentiles in any of the five access performance measures (eight rates), one measure (*Adults' Access to Preventive/Ambulatory Health Services—Total*) ranked between the 50th and 75th percentiles.

Nonetheless, the remaining seven of eight rates (four measures) all related to children and adolescent access to care ranked below the national 50th percentiles. Two of the *Children and Adolescents' Access to Primary Care Practitioners* rates (*25 Months to 6 Years* and *7 Years to 11 Years*) ranked below the 25th percentiles. Additionally, the *Well-Child Visits in the First 15 Months of Life—Six or More Visits* rate declined by more than 5 percentage points in CY 2013. There are statewide opportunities to increase early detection of childhood illnesses by providing and improving access to care for children.

Child and adolescent consumer access to primary care remained stable for children 12 to 24 months old, but declined in CY 2013 for children ages 25 months to 19 years. All child access measures fell below the 50th percentiles, demonstrating opportunities for improvement. Statewide performance on adult access to primary care did not show any major change from the year prior and continued to exceed the Medicaid national 50th percentile. Reduced access to care for consumers may result in potential barriers to those consumers when seeking needed care.

However, CAHPS results for the Ohio managed care program in the area of *Getting Needed Care* ranked at or above the national Medicaid 75th percentile, indicating that parents or caregivers of children were satisfied with their child’s ability to access needed care.

## Timeliness

The SFY 2015 ODM and EQR monitoring activities identified areas of strength as well as opportunities for improvement across the measures assessing timeliness of care and services shown in Table 10-4.

| <b>Table 10-4—Measures Assessing Timeliness</b>                                     |
|-------------------------------------------------------------------------------------|
| <b>24-Hour Nurse Advice/Member Services Call Centers Review</b>                     |
| <b>Grievance System Review</b>                                                      |
| <b>MCP Performance Measures</b>                                                     |
| <i>Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up</i>           |
| <i>Follow-up Care for Children Prescribed ADHD Medication—Initiation Phase</i>      |
| <i>Frequency of Ongoing Prenatal Care—≥ 81 Percent of Expected Visits</i>           |
| <i>Prenatal and Postpartum Care—Postpartum Care and Timeliness of Prenatal Care</i> |
| <b>CAHPS Results for the Ohio Medicaid Program</b>                                  |
| <i>Getting Care Quickly</i>                                                         |
| <i>Getting Needed Care</i>                                                          |

## Conclusions

HSAG assessed the call center review, grievance system review, performance measure results, and CAHPS results to assess the timeliness domain of care. Overall, the Ohio managed care program demonstrated strong performance in this domain.

Of the five timeliness performance rates (four measures), four ranked above the national 50th percentiles, with one (*Follow-up Care for Children Prescribed ADHD Medication—Initiation Phase*) ranking above the 75th percentile. None of the performance rates in this domain ranked below the 25th percentiles.

Nonetheless, pregnancy-related care remained an area for improvement. The *Postpartum Care* rate ranked below the 50th percentile. Slightly more than 30 percent of deliveries received less than 80

percent of expected prenatal visits, and approximately 14 percent did not receive timely prenatal care. These rates may be a factor contributing to the high statewide rate of live births with low birth weight (9.3 percent). Timely identification and engagement of women who are pregnant and who previously had poor birth outcomes can result in reduced hospitalizations, reduced costs, and lower frequency of health complications.

Review of the MCP call centers and 24-Hour Nurse Advice Line call centers showed the Ohio managed care program generally achieved the URAC standards for timeliness in answering calls from consumers. The overall average speed of answer was 13 seconds, which met the 30-second contract standard maximum, although some MCPs did not meet the 30-second requirement every month of the year.

All MCPs showed high performance in timeliness standards related to grievance resolution; nearly 100 percent of all grievances were resolved within the required time frames, and all MCPs resolved over 90 percent of appeals within the required time frames.

Compared to adult consumers, the parents or caregivers of children in Ohio's Medicaid managed care program provided higher ratings for more measures when compared to national Medicaid results. Adult consumers in Ohio's Medicaid managed care program generally reported moderate levels of satisfaction compared to national Medicaid results—at or between the 25th and 49th percentile and at or between the national Medicaid 50th and 74th percentile—in the areas of *Getting Needed Care* and *Getting Care Quickly*, respectively. The parents or caregivers of children in Ohio's Medicaid managed care program generally reported high levels of satisfaction compared to national Medicaid results, achieving or exceeding the national Medicaid 75th percentile for *Getting Needed Care* and *Getting Care Quickly* composite measures.

Parents or caregivers of children reported that they were highly satisfied with their child's ability to get the care they need and get it quickly as well as their child's overall health care, personal doctor, and specialist seen most often. Parents or caretakers were moderately satisfied with their child's health plan and health providers' use of a shared decision making model. Adult consumers in Ohio's Medicaid Managed Care Program were highly satisfied with their health plan, and moderately satisfied with overall health care, getting care quickly, and their MCPs' implementation of a shared decision making model.

## Recommendations

Based on HSAG's overall assessment of MCPs' performance on providing quality, timeliness of, and access to health care services to Ohio Medicaid managed care consumers, the following recommendations are offered to ODM.

MCPs must pay closer attention to the accuracy of their MCPN submissions to ensure that consumers have up-to-date network information. Inaccuracies in MCPN data make it difficult for consumers to access care. MCPs should perform a weekly reconciliation of data between their online provider directories and the MCPN data file. MCPs should integrate their access-related complaints and grievances data analyses into their overarching quality program.

Regarding performance measures, five rates were below the 25th percentiles:

- ◆ *Controlling High blood Pressure*
- ◆ *Comprehensive Diabetes Care—HbA1c Adequate Control (<8.0%) and LDL-C Screening*
- ◆ *Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years and 7 Years to 11 Years*

Controlling high blood pressure and comprehensive diabetes care as well as adolescents' access to care are important issues on which the MCPs should focus. It is recommended that the current rapid-cycle PIP methodology, developed based on IHI principles, be the framework for addressing these measures.

One performance measure not only fell below the 50th percentile but also had a significant decline from the previous year: *Well-Child Visits in the First 15 Months of Life—Six or More Well-Child Visits*. Low performance on this measure may indicate that MCPs may be missing opportunities to detect and manage childhood illnesses earlier. HSAG recommends that MCPs should:

- ◆ Continue to assess completeness of data used for measure reporting.
- ◆ Increase the use of supplemental data to ensure that all service data with potential impact on performance rates are included.
- ◆ Perform a root cause analysis to identify potential targeted areas of poor performance and develop performance improvement plans to address these areas.

To improve performance on the *Use of Appropriate Medication for People with Asthma—Total* measure, the MCPs should ensure that consumers get the care and education they need to self-manage their disease effectively. Improvement on these measures may reduce hospitalizations and emergency department visits for consumers whose medication is not being effectively managed. The MCPs should also maintain a routine follow-up schedule for consumers with asthma to monitor their progress.

The statewide *Prenatal and Postpartum Care—Timeliness of Prenatal Care* measure rate was above the national Medicaid 50th percentile, and the statewide performance rate for the *Percent of Live Births Weighing Less than 2,500 Grams* measure was 9.3 percent for CY 2013. This performance indicates that the MCPs may have opportunities to reduce hospitalizations, costs, and adverse health outcomes by improvement in this area. MCPs should seek to provide timely identification of women of reproductive age who are pregnant or who are at risk for a poor birth outcome/pregnancy because of prior poor outcomes, chronic conditions, or social/behavioral risk factors. MCPs should provide family planning strategies to women to decrease the incidence of high-risk pregnancies by reducing closely spaced births and births to teenage mothers. In addition, the MCPs can stress the importance of proper prenatal care and tobacco cessation by providing educational materials, offering support services to pregnant women (e.g., transportation services and interactive training sessions), and providing referrals to community partners for additional services and support.

Consumer satisfaction and patient engagement are important themes for MCPs to continually assess and establish initiatives. To improve consumers' satisfaction with their health plans, particularly for

adult consumers, MCPs should prioritize the factors that are most likely contributing to poor performance.

The results of the QoL survey confirm the importance of monitoring QoL in this population of consumers experiencing significant morbidity due to both physical and behavioral health conditions. The MCPs should include within their HRCM program an emphasis on developing strategies and interventions to improve the health-related QoL of children with emotional, behavioral, attention, and/or learning difficulties. HSAG recommends:

- ◆ **Coordination of Behavioral Health Services**—MCPs should develop a structured approach to coordinating care for children with chronic conditions who also need behavioral health services. MCPs should consider implementing processes and training for care managers to assist consumers and their families with referrals and linkage to behavioral health services and community resources. MCPs should consider strategies to train care managers to encourage coordination between primary care and behavioral health providers.
- ◆ **Patient- and Family-Centered Care**—MCPs should focus on patient- and family-centered care strategies, including parent and family support groups. Care managers may incorporate a “teach-back” technique, which allows patients to repeat back their understanding of their conditions and subsequent actions, to enhance communication and understanding between care managers and consumers. Support groups can help consumers self-manage their health conditions by using educational materials, workshops, or home monitoring devices. Integrated and coordinated care requires collaboration and coordination among patients, families, physicians, and care management teams in order to plan, deliver, and evaluate the care of children with chronic conditions.

Results from the PAM study indicated that the interventions may have led to an increase in patient activation level for HRCM consumers. HSAG recommends this study be continued over a longer intervention period in order to assess if improved activation levels lead to more appropriate service utilization.

## Overview

Federal requirements outlined in the CFR at 42 CFR §434.6 and 42 CFR §438.6, and State of Ohio requirements outlined in the OAC rules 5160-26-05 and 5160-58-01.1, establish regulations regarding MCPs and MCOPs subcontracting and delegation. Provider panel specifications in Appendix H of the ODM) and MCP/MCOP Provider Agreements (PAs) outline the requirements concerning the mandatory use of the ODM-approved Model Medicaid Addenda and provider panel requirements. Federally defined access standards at 42 CFR 438.207 require MCPs and MCOPs to submit documentation to ODM demonstrating adequate provider panel capacity to provide preventive, primary care and specialty services adequate for the anticipated number of consumers in the service area, while maintaining a provider panel that is sufficient in number, mix, and geographic distribution to meet the needs of consumers in the service area.

## Objective and Scope of the Review

ODM contracted with HSAG to validate the Model Medicaid Addenda signed by providers and submitted by the MCPs and MCOPs against the provider panel requirements established by ODM and the data contained within the MCPN files. Although data were submitted and evaluated for both MCPs and MCOPs, only MCP results were included in this EQR report.

The following MCPs and MCOPs were included in the SFY 2015 audit:

- ◆ Aetna Better Health of Ohio (MCOP)
- ◆ Buckeye Community Health Plan (MCP/MCOP)
- ◆ CareSource (MCP/MCOP)
- ◆ Molina Healthcare of Ohio, Inc. (MCP/MCOP)
- ◆ Paramount *Advantage* (MCP)
- ◆ UnitedHealthcare Community Plan of Ohio, Inc. (MCP/MCOP)

## Methodology for Conducting the Addenda Audit

### *Indicators*

HSAG collaborated with ODM to identify the Medicaid addendum fields for review during the SFY 2015 addenda audit for all provider types:

- ◆ Indicator 1: Provider Information
- ◆ Indicator 2: MCP/MCOP Name (verified each time it is required)

- ◆ Indicator 3a: MCP/MCOP Signature (verified each time it is required)
- ◆ Indicator 3b: MCP/MCOP Printed Name (verified each time it is required)
- ◆ Indicator 4: MCP/MCOP Title (verified each time it is required)
- ◆ Indicator 5: MCP/MCOP Signature Date (verified each time it is required)
- ◆ Indicator 6: Provider Name (verified each time it is required)
- ◆ Indicator 7a: Provider Signature (verified each time it is required)
- ◆ Indicator 7b: Provider Printed Name (verified each time it is required)
- ◆ Indicator 8: Provider Title (verified each time it is required)
- ◆ Indicator 9: Provider Signature Date (verified each time it is required)

Provider by type:

- ◆ Indicator 10: Attachment A—Primary Care Provider Attestation (if required)
  - Section 1: Practice Site Information
    - Site information
    - Providers contracted to provide Medicaid services listed
    - Maximum capacity: By Provider
    - Multiple site location information: Title Attachment A and number sequentially
  - Section 2: Signature Block (verified each time it is required)
    - MCP/MCOP Signature Block (Name, Signature, Printed Name, Title, Date)
    - Provider Signature Block (Name, Signature, Printed Name, Title, Date)
    - Attached documents have required signatures
- ◆ Indicator 11: Attachment B—Non-Primary Care Providers (if required)
  - Section 1: Practice Site Information
    - Site information
    - Providers contracted to provide Medicaid services listed
    - Maximum capacity
    - Multiple site location information
  - Section 2: Signature Block (verified each time it is required)
    - MCP/MCOP Signature Block (Name, Signature, Printed Name, Title, Date)
    - Provider Signature Block (Name, Signature, Printed Name, Title, Date)
    - Attached documents have required signatures
- ◆ Indicator 12: Attachment D—Services Provided
  - Section 1: Services Provided by Provider
  - Section 2: Community Behavioral Health Services (only in the MyCare Ohio benefit package)
  - Section 3: Home and Community Based Services (only in the MyCare Ohio benefit package)
  - Section 4: Services Provided for MCP/MCOP

- Section 5: Signature Block (verified each time it is required)
  - MCP/MCOP Signature Block (Name, Signature, Printed Name, Title, Date)
  - Provider Signature Block (Name, Signature, Printed Name, Title, Date)
- ◆ Indicator 13: Addendum Provisions (if required)
  - Section 1: Delegation Subcontract Services Provided
  - Section 2: Signature Block (verified each time it is required)
    - MCP/MCOP Signature Block (Name, Signature, Printed Name, Title, Date; verified each time it is required)
    - Provider Signature Block (Name, Signature, Printed Name, Title, Date; verified each time it is required)

### Planning Review Activities

HSAG performed a series of planning review activities in preparation for the evaluation phase of the Model Medicaid Addenda. In collaboration with ODM, HSAG developed a Medicaid Combined Services Addenda review tool designed to identify the indicators under review, document HSAG's findings, and assign a compliance rating of *Yes* or *No* for each requirement.

### Description of Data Sources

HSAG identified the potential Medicaid addenda data sample from MCPN data files provided by ODM. The eligible population consisted of all Ohio Medicaid managed care and MyCare Ohio providers active as of the most recent MCPN file extract and contracted to provide services to Medicaid managed care and MyCare Ohio consumers. To identify unique providers, HSAG removed duplication from the MCPN file by *Plan ID* and *Medicaid Provider Number/Provider Reporting Number (MPN/PRN)*.

Based on the eligible provider population, HSAG selected a random sample of 100 providers from each of the participating MCPs/MCOPs stratified by PCP, non-primary care provider (non-PCP—i.e., medical specialists and dentists), and waiver providers, generating a maximum potential sample size of 600 cases. HSAG selected providers based on the following sampling strategy:

1. HSAG randomly sampled PCP and non-PCP providers based on the population(s) served, as follows:
  - ◆ Medicaid only providers
  - ◆ MyCare only providers
  - ◆ Medicaid and MyCare providers

For non-PCP providers HSAG further stratified providers by medical and dental specialty. HSAG selected dentists based on the following codes:

- ◆ 04 Dentist
- ◆ 045 General Dentistry

2. HSAG randomly sampled waiver providers, with a focus on the following waiver categories:

- ◆ Chore services
- ◆ Community transitions
- ◆ Emergency response
- ◆ Home care attendant—nursing
- ◆ Home medical equipment and supplies
- ◆ Home modifications
- ◆ Homemaker
- ◆ Independent living assistance
- ◆ Meals home-delivered
- ◆ Nutritional counseling
- ◆ Out-of-home respite
- ◆ Social work counseling
- ◆ Waiver transportation
- ◆ Waiver nursing agency
- ◆ Personal care—agency
- ◆ Assisted living
- ◆ Adult daycare

### **Communication with the MCPs/MCOPs**

HSAG developed and provided time frames for MCPs’/MCOPs’ submission of the requested Medicaid Addenda. At the conclusion of the defined procurement period, HSAG generated a “Documentation Not Submitted” list identifying all outstanding addenda and provided the list to ODM.

HSAG worked with ODM to determine a deadline for notifying each MCP/MCOP of the documentation not received by HSAG and a deadline for the MCP/MCOP to provide any documentation identified on the “Documentation Not Submitted” list. A final “Documentation Not Submitted” list was posted to each MCP’s/MCOP’s folder located on HSAG’s secure file transfer protocol (FTP) site, along with an attestation form confirming the MCP’s/MCOP’s agreement with the accuracy of the final list of documentation not received. The attestation form was required to be received by the MCP’s/MCOP’s contract administrator at ODM by a predetermined deadline.

### **Document Submission**

HSAG requested that the MCPs/MCOPs upload the Medicaid Addenda to HSAG’s FTP site two weeks after receiving the sample list.

## Evaluation Phase

During the addenda review phase, HSAG staff completed an individual Medicaid Combined Services Addenda review tool for each of the providers in the sampled population and aggregate the results across all addenda indicators to determine MCP/MCOP compliance. For this review HSAG considered outstanding provider addenda as incomplete, resulting in a compliance rating of *No* for all indicators on the Medicaid Combined Services Addenda review tool.

ODM also requested HSAG to review each MCP addendum for the following language: “Member means a Medicaid Consumer as specified in OAC rule 5101:3-26-02(B) who has selected MCP membership or has been assigned to an MCP for the purpose of receiving health care services and is subsequently enrolled in the MCP.”

## Scoring Methodology

HSAG scored the indicators based on *Yes* and *No* criteria. These scores indicated the MCPs’/MCOPs’ degree of compliance with the required indicators.

*Yes* indicates full compliance defined as:

1. All documentation reviewed was consistent with the required indicators.

*No* indicates noncompliance defined as either of the following:

1. Documentation was not present for the required indicator.
2. The required provider addendum was not provided by the MCP/MCOP.

## Data Aggregation and Analysis of Findings

From the scores assigned for each of the requirements, HSAG calculated an overall percentage-of-compliance score for the Model Medicaid Addenda reviewed. HSAG provided an appendix for each MCP/MCOP to include:

1. The MCP’s/MCOP’s completeness score.
2. The final “Documentation Not Submitted” list.
3. The MCP’s/MCOP’s Medicaid Addendum Indicator Completion Rate.

## Deliverables

HSAG produced an aggregate report as well as MCP/MCOP-specific reports and flat files with results of each addenda audit.

## Appendix B. Performance Measurement

This appendix contains multiple tables with MCP-specific results for the different types of performance measures. Table B-1 displays MCP-specific, self-reported, audited rates for HEDIS 2014 using CY 2013 data. These results are organized by ODM's Quality Strategy Focus Areas. Although the rates are reported to two decimal places in the MCP's Interactive Data Submission System (IDSS) file, they are displayed in this appendix to one decimal place for brevity. Rows displaying rates for the Pay-for-Performance (P4P) measures are highlighted in red.

The star ratings presented in the Performance Level columns reflect MCP-specific performance (rates as reported in the IDSS files) when compared to the national NCQA Medicaid HEDIS 2013 Audit Means, Percentiles, and Ratios, which reflect CY 2012 performance. The following star rating categories are used:

- ★★★★ = Meets or exceeds the HEDIS 75th percentile
- ★★★★ = Between HEDIS 50th percentile and 74th percentile
- ★★★ = Between HEDIS 25th percentile and 49th percentile
- ★★ = Between HEDIS 10th percentile and 24th percentile
- ★ = Below HEDIS 10th percentile

For some measures, no star ratings are applied due to one of the following reasons provided by the MCP's licensed organization in the IDSS for the NCQA HEDIS Compliance Audit.

- ◆ NA = *Not Applicable*. The MCP followed the specifications for producing a reportable denominator, but the denominator was too small (<30) to report a valid rate, resulting in an NA audit designation.
- ◆ NR = *Not Reportable*. The MCP calculated the measure, but the rate was materially biased, or the MCP chose not to report the measure or was not required to report the measure.

| Table B-1—2014 Self-Reported, Audited HEDIS Rates                                                                  |           |                   |            |                   |           |                   |           |                   |                  |                   |
|--------------------------------------------------------------------------------------------------------------------|-----------|-------------------|------------|-------------------|-----------|-------------------|-----------|-------------------|------------------|-------------------|
| Measures                                                                                                           | Buckeye   |                   | CareSource |                   | Molina    |                   | Paramount |                   | UnitedHealthcare |                   |
|                                                                                                                    | 2014 Rate | Performance Level | 2014 Rate  | Performance Level | 2014 Rate | Performance Level | 2014 Rate | Performance Level | 2014 Rate        | Performance Level |
| <b>Access</b>                                                                                                      |           |                   |            |                   |           |                   |           |                   |                  |                   |
| <i>Adults' Access to Preventive/ Ambulatory Health Services—Total</i>                                              | 82.5%     | ★★★               | 85.9%      | ★★★★              | 84.2%     | ★★★               | 84.4%     | ★★★★              | 85.3%            | ★★★★              |
| <i>Children and Adolescents' Access to Primary Care Practitioners—12 Months–24 Months</i>                          | 95.3%     | ★★                | 96.3%      | ★★★               | 93.6%     | ★★                | 96.3%     | ★★★               | 95.6%            | ★★★               |
| <i>Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years</i>                            | 85.5%     | ★★                | 86.2%      | ★★                | 83.5%     | ★★                | 85.4%     | ★★                | 87.5%            | ★★★               |
| <i>Children and Adolescents' Access to Primary Care Practitioners—7–11 Years</i>                                   | 85.8%     | ★★                | 88.0%      | ★★★               | 83.9%     | ★★                | 85.6%     | ★★                | 88.2%            | ★★★               |
| <i>Children and Adolescents' Access to Primary Care Practitioners—12–19 Years</i>                                  | 86.4%     | ★★★               | 87.3%      | ★★★               | 82.7%     | ★★                | 84.8%     | ★★                | 88.5%            | ★★★               |
| <b>Clinical Quality: Asthma</b>                                                                                    |           |                   |            |                   |           |                   |           |                   |                  |                   |
| <i>Use of Appropriate Medications for People with Asthma—Total</i>                                                 | 86.5%     | ★★★★              | 83.0%      | ★★★               | 80.8%     | ★★★               | 87.1%     | ★★★★              | 79.6%            | ★★                |
| <b>Clinical Quality: Behavioral Health</b>                                                                         |           |                   |            |                   |           |                   |           |                   |                  |                   |
| <i>Adolescent Well-Care Visits</i>                                                                                 | 45.6%     | ★★★               | 41.1%      | ★★                | 40.2%     | ★★                | 51.2%     | ★★★★              | 40.1%            | ★★                |
| <i>Follow-Up after Hospitalization for Mental Illness—7-Day Follow-Up</i>                                          | 52.2%     | ★★★★              | 54.5%      | ★★★★              | 51.5%     | ★★★★              | 47.7%     | ★★★★              | 39.9%            | ★★★               |
| <i>Follow-up Care for Children Prescribed ADHD Medication, Initiation Phase</i>                                    | 42.8%     | ★★★★              | 56.2%      | ★★★★★             | 47.9%     | ★★★★★             | 51.5%     | ★★★★★             | 41.4%            | ★★★★              |
| <i>Initiation and Engagement of Alcohol and Other Drug Dependence Treatment-Engagement of AOD Treatment, Total</i> | 10.6%     | ★★★★              | 6.6%       | ★★★               | 9.3%      | ★★★               | 13.5%     | ★★★★              | 10.6%            | ★★★★              |
| <b>Clinical Quality: Cardiovascular Disease</b>                                                                    |           |                   |            |                   |           |                   |           |                   |                  |                   |
| <i>Cholesterol Management for Patients with Cardiovascular Conditions—LDL-C Screening</i>                          | 80.6%     | ★★★               | 80.5%      | ★★★               | 80.7%     | ★★★               | 65.4%     | ★                 | 75.2%            | ★★                |
| <i>Cholesterol Management for Patients with Cardiovascular Conditions—LDL-C Control &lt; 100 mg/dL</i>             | 30.6%     | ★★                | 32.6%      | ★★                | 46.9%     | ★★★★              | 41.0%     | ★★★               | 28.5%            | ★★                |
| <i>Controlling High Blood Pressure</i>                                                                             | 39.4%     | ★                 | 46.2%*     | ★★                | 59.7%     | ★★★★              | 64.0%     | ★★★★★             | 46.7%            | ★★                |
| <i>Persistence of Beta-Blocker Treatment after a Heart Attack</i>                                                  | 90.1%     | ★★★★★             | 93.8%      | ★★★★★             | 86.3%     | ★★★★              | NA        | NA                | 83.8%            | ★★★★              |

Table B-1—2014 Self-Reported, Audited HEDIS Rates

| Measures                                                                                                                                                                                                                            | Buckeye   |                   | CareSource |                   | Molina    |                   | Paramount |                   | UnitedHealthcare |                   |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------|-------------------|------------|-------------------|-----------|-------------------|-----------|-------------------|------------------|-------------------|
|                                                                                                                                                                                                                                     | 2014 Rate | Performance Level | 2014 Rate  | Performance Level | 2014 Rate | Performance Level | 2014 Rate | Performance Level | 2014 Rate        | Performance Level |
| <b>Clinical Quality: Diabetes</b>                                                                                                                                                                                                   |           |                   |            |                   |           |                   |           |                   |                  |                   |
| <i>Comprehensive Diabetes Care—Blood Pressure Control (&lt;140/90 mmHg)</i>                                                                                                                                                         | 52.8%     | ★★                | 56.4%      | ★★★★              | 60.3%     | ★★★               | 74.9%     | ★★★★★★            | 59.9%            | ★★★               |
| <i>Comprehensive Diabetes Care—Eye Exam (Retinal) Performed</i>                                                                                                                                                                     | 52.3%     | ★★★               | 52.5%      | ★★★★              | 65.8%     | ★★★★★★            | 58.3%     | ★★★★              | 46.5%            | ★★★               |
| <i>Comprehensive Diabetes Care—HbA1c Adequate Control (&lt; 8.0%)</i>                                                                                                                                                               | 33.2%     | ★                 | 34.7%      | ★★                | 49.4%     | ★★★★              | 49.3%     | ★★★★              | 32.6%            | ★                 |
| <i>Comprehensive Diabetes Care—LDL-C Screening</i>                                                                                                                                                                                  | 69.9%     | ★★                | 69.4%      | ★★                | 76.2%     | ★★★               | 64.2%     | ★                 | 67.9%            | ★★                |
| <b>Clinical Quality: High-Risk Pregnancy/Premature Births</b>                                                                                                                                                                       |           |                   |            |                   |           |                   |           |                   |                  |                   |
| <i>Frequency of Ongoing Prenatal Care—≥81 Percent</i>                                                                                                                                                                               | 67.4%     | ★★★★              | 68.0%*     | ★★★★              | 72.5%     | ★★★★              | 78.7%*    | ★★★★★★            | 68.8%            | ★★★★              |
| <i>Prenatal and Postpartum Care—Postpartum Care</i>                                                                                                                                                                                 | 63.6%     | ★★★               | 64.0%*     | ★★★★              | 56.6%     | ★★                | 71.6%*    | ★★★★★★            | 59.0%            | ★★★               |
| <i>Prenatal and Postpartum Care—Timeliness of Prenatal Care</i>                                                                                                                                                                     | 82.5%     | ★★★               | 86.1%      | ★★★★              | 85.5%     | ★★★               | 89.9%*    | ★★★★★★            | 86.9%            | ★★★★              |
| <b>Clinical Quality: Upper Respiratory Infections</b>                                                                                                                                                                               |           |                   |            |                   |           |                   |           |                   |                  |                   |
| <i>Appropriate Treatment for Children with Upper Respiratory Infection</i>                                                                                                                                                          | 84.1%     | ★★★               | 81.8%      | ★★★               | 82.9%     | ★★★               | 79.9%     | ★★                | 79.6%            | ★★                |
| <i>Well-Child Visits in the First 15 Months of Life—Six or More Visits</i>                                                                                                                                                          | 57.2%     | ★★★               | 60.3%      | ★★★               | 55.0%     | ★★                | 69.0%     | ★★★★★★            | 65.0%            | ★★★               |
| <i>Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life</i>                                                                                                                                                       | 66.2%     | ★★                | 71.5%      | ★★★               | 64.1%     | ★★                | 67.8%     | ★★★               | 63.6%            | ★★                |
| * The MCP chose to submit rotated results for this measure to NCQA for HEDIS 2014 reporting. However, the rate reported above is the non-rotated HEDIS 2014 result. ODM uses non-rotated HEDIS results to evaluate MCP performance. |           |                   |            |                   |           |                   |           |                   |                  |                   |

Table B-2 displays the MCP-specific CY 2013 rates for two non-HEDIS measures. There are no benchmarks available for the non-HEDIS measures.

| Table B-2—CY 2013 Non-HEDIS Rates                                                             |           |                   |            |                   |           |                   |           |                   |                  |                   |
|-----------------------------------------------------------------------------------------------|-----------|-------------------|------------|-------------------|-----------|-------------------|-----------|-------------------|------------------|-------------------|
| Measures                                                                                      | Buckeye   |                   | CareSource |                   | Molina    |                   | Paramount |                   | UnitedHealthcare |                   |
|                                                                                               | 2013 Rate | Performance Level | 2013 Rate  | Performance Level | 2013 Rate | Performance Level | 2013 Rate | Performance Level | 2013 Rate        | Performance Level |
| <i>Annual Number of Asthma Patients with at Least One Asthma-Related Emergency Room Visit</i> | 12.7%     | —                 | 12.4%      | —                 | 11.6%     | —                 | 13.6%     | —                 | 12.1%            | —                 |
| <i>Percentage of Live Births Weighing Less than 2,500 grams</i>                               | 8.9%      | —                 | 9.5%       | —                 | 9.0%      | —                 | 8.7%      | —                 | 9.3%             | —                 |

Table B-3 displays the adult and general child population three-point means using 2014 CAHPS data for the *Rating of Health Plan* measures. The following ranking categories were used for the *Rating of Health Plan* measures:

| Ranking | Description                                                                            |
|---------|----------------------------------------------------------------------------------------|
| <P10    | Below the national HEDIS 2014 Medicaid 10th percentile                                 |
| P10–P25 | At or above the national HEDIS 2014 Medicaid 10th percentile and below 25th percentile |
| P25–P50 | At or above the national HEDIS 2014 Medicaid 25th percentile and below 50th percentile |
| P50–P75 | At or above the national HEDIS 2014 Medicaid 50th percentile and below 75th percentile |
| P75–P90 | At or above the national HEDIS 2014 Medicaid 75th percentile and below 90th percentile |
| ≥P90    | At or above the national HEDIS 2014 Medicaid 90th percentile                           |

| Table B-3—CAHPS 2012 Performance Measure Rates** |           |                   |            |                   |           |                   |           |                   |                  |                   |
|--------------------------------------------------|-----------|-------------------|------------|-------------------|-----------|-------------------|-----------|-------------------|------------------|-------------------|
| Measures                                         | Buckeye   |                   | CareSource |                   | Molina    |                   | Paramount |                   | UnitedHealthcare |                   |
|                                                  | 3-pt Mean | Performance Level | 3-pt Mean  | Performance Level | 3-pt Mean | Performance Level | 3-pt Mean | Performance Level | 3-pt Mean        | Performance Level |
| <i>Adult Rating of Health Plan</i>               | 2.48      | P75–P90           | 2.55       | ≥P90              | 2.43      | P50–P75           | 2.52      | P75–P90           | 2.46             | P75–P90           |
| <i>General Child Rating of Health Plan</i>       | 2.44      | <P10              | 2.65       | P75–P90           | 2.58      | P50–P75           | 2.68      | ≥P90              | 2.52             | P25–P50           |

\*\* The three-point mean results were calculated using CAHPS 2014 data.

## Appendix C. PIP Framework Crosswalk

| CMS Protocol Step                                                            | I           | II             | III              | IV                 | V        | VI              | VII           | VIII          | IX               | X                     |
|------------------------------------------------------------------------------|-------------|----------------|------------------|--------------------|----------|-----------------|---------------|---------------|------------------|-----------------------|
|                                                                              | Study Topic | Study Question | Study Population | Study Indicator(s) | Sampling | Data Collection | Data Analysis | Interventions | Real Improvement | Sustained Improvement |
| <b>PIP Initiation</b>                                                        |             |                |                  |                    |          |                 |               |               |                  |                       |
| Current knowledge                                                            | X           |                |                  |                    |          |                 |               |               |                  |                       |
| Topic selection                                                              | X           |                |                  |                    |          | X               |               |               |                  |                       |
| Team formation w/roles                                                       | X           |                |                  |                    |          |                 |               |               |                  |                       |
| Global/SMART Aim(s)                                                          | X           | X              | X                | X                  |          |                 |               |               |                  |                       |
| <b>SMART Aim and Baseline Data Collection</b>                                |             |                |                  |                    |          |                 |               |               |                  |                       |
| Collection of baseline data                                                  |             |                |                  |                    | X        | X               |               |               |                  |                       |
| Data collection for SMART Aim(s)                                             |             |                |                  |                    |          | X               |               |               |                  |                       |
| <b>Process Mapping, Intervention Determination, and Intervention Testing</b> |             |                |                  |                    |          |                 |               |               |                  |                       |
| Process mapping: Failure Mode and Effects Analysis (FMEA)                    |             |                |                  |                    |          |                 | X             | X             |                  |                       |
| Update Key Driver Diagram (KDD)                                              |             | X              | X                | X                  |          |                 |               | X             |                  |                       |
| Develop interventions                                                        |             |                |                  |                    |          | X               | X             | X             |                  |                       |
| Conduct PDSA cycle for each implemented intervention                         |             |                |                  |                    |          | X               | X             | X             |                  |                       |
| Analyze PDSA results                                                         |             |                |                  |                    |          |                 | X             | X             |                  |                       |
| Revise FMEA, KDD, and interventions, as needed                               |             |                |                  |                    |          |                 | X             | X             |                  |                       |
| <b>Intervention Expansion (Spread) and Abandonment</b>                       |             |                |                  |                    |          |                 |               |               |                  |                       |
| Spread of successful interventions (based on data that support expansion)    |             |                |                  |                    |          |                 |               | X             |                  |                       |
| Develop and execute sustainability plan                                      |             |                |                  |                    |          |                 |               | X             |                  |                       |
| <b>PIP Conclusions</b>                                                       |             |                |                  |                    |          |                 |               |               |                  |                       |
| Interpretation of results                                                    |             |                |                  |                    |          |                 | X             |               | X*               | X*                    |
| Evidence that SMART Aim(s) was achieved                                      |             |                |                  |                    |          |                 | X             |               | X*               |                       |
| Evidence of meaningful improvement                                           |             |                |                  |                    |          |                 | X             |               | X*               | X*                    |
| Improvement achieved was sustained                                           |             |                |                  |                    |          |                 | X             |               | X*               | X*                    |
| Lessons learned                                                              |             |                |                  |                    |          |                 | X             |               |                  |                       |

\*Real improvement may not be measured by a statistically significant change using the rapid-cycle approach.

## PIP Components and Process

In July 2014, HSAG, in collaboration with ODM, developed a new PIP framework based on a modified version of the Model for Improvement developed by Associates in Process Improvement and modified by the Institute for Healthcare Improvement (IHI). The redesigned PIP methodology is intended to improve processes and outcomes of health care by way of continuous improvement focused on small tests of change in order to determine what truly works. Because PIPs must meet CMS' requirements, HSAG then completed a crosswalk of this new framework against CMS' publication, *EQR Protocol 3: Validating Performance Improvement Projects (PIPs): A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012.<sup>D-1</sup> HSAG presented the crosswalk and new PIP framework components to CMS to demonstrate how the new PIP framework aligned with the CMS validation protocols. CMS agreed that with the pace of quality improvement science development and the prolific use of PDSA cycles in modern PIPs within health care settings, a new approach was needed. CMS provided approval to HSAG and ODM in October 2014 to pilot this new PIP approach in the State of Ohio. Appendix C details the crosswalk of the validation protocols.

For this new PIP framework, HSAG developed five modules with an accompanying companion guide. Although these modules are submitted chronologically by the MCPs, activities incorporated in the modules are ongoing, reflecting the continual learning inherent to continuous quality improvement.

- ◆ **Module 1—PIP Initiation:** Module 1 outlines the framework for the project. The framework follows the Model for Improvement by clearly articulating what accomplishment is desired through articulating how the project fits into a larger Global Aim of the agency (prevention of infant mortality) and precisely stating a project-specific SMART Aim (specific, measureable, attainable, relevant and time-bound) including the topic rationale and supporting data, so that the alignment with larger initiatives as well as feasibility is clear, building a PIP team consisting of internal and external stakeholders and customer, and completing a key driver diagram that summarizes the changes that are agreed upon by the team as having sufficient evidence to lead to improvement.
- ◆ **Module 2—SMART Aim Data Collection:** In Module 2, the SMART Aim measure is operationalized, and the data collection methodology is described. The data for the SMART Aim will be displayed using statistical process control (SPC) tools, such as run charts or control charts.

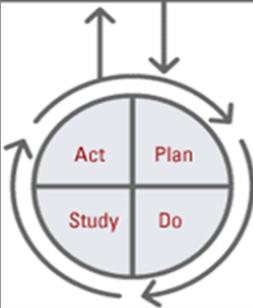
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<sup>D-1</sup> Department of Health and Human Services, Centers for Medicare & Medicaid Services. *EQR Protocol 3: Validating Performance Improvement Projects (PIPs): A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012. Available at: <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Quality-of-Care-External-Quality-Review.html>. Accessed on: Feb 19, 2013.

- ◆ **Module 3—Intervention Determination:** In Module 3, there is a deeper dive into the quality improvement activities that are reasonably thought to impact the SMART Aim and interventions in addition to those in the original key driver diagram. Through the use of tools such as process mapping, failure modes and effects analysis (FMEA), Pareto charts, and failure mode priority ranking, interventions are selected for testing in Module 4.
- ◆ **Module 4—Plan-Do-Study-Act:** The interventions selected in Module 3 are tested and evaluated through a thoughtful and incremental series of PDSA cycles.
- ◆ **Module 5—PIP Conclusions:** Module 5 summarizes key findings and presents comparisons of successful and unsuccessful interventions, outcomes achieved, and lessons learned.

The following is an illustration of ODM’s Medicaid Managed Care PIP Framework.

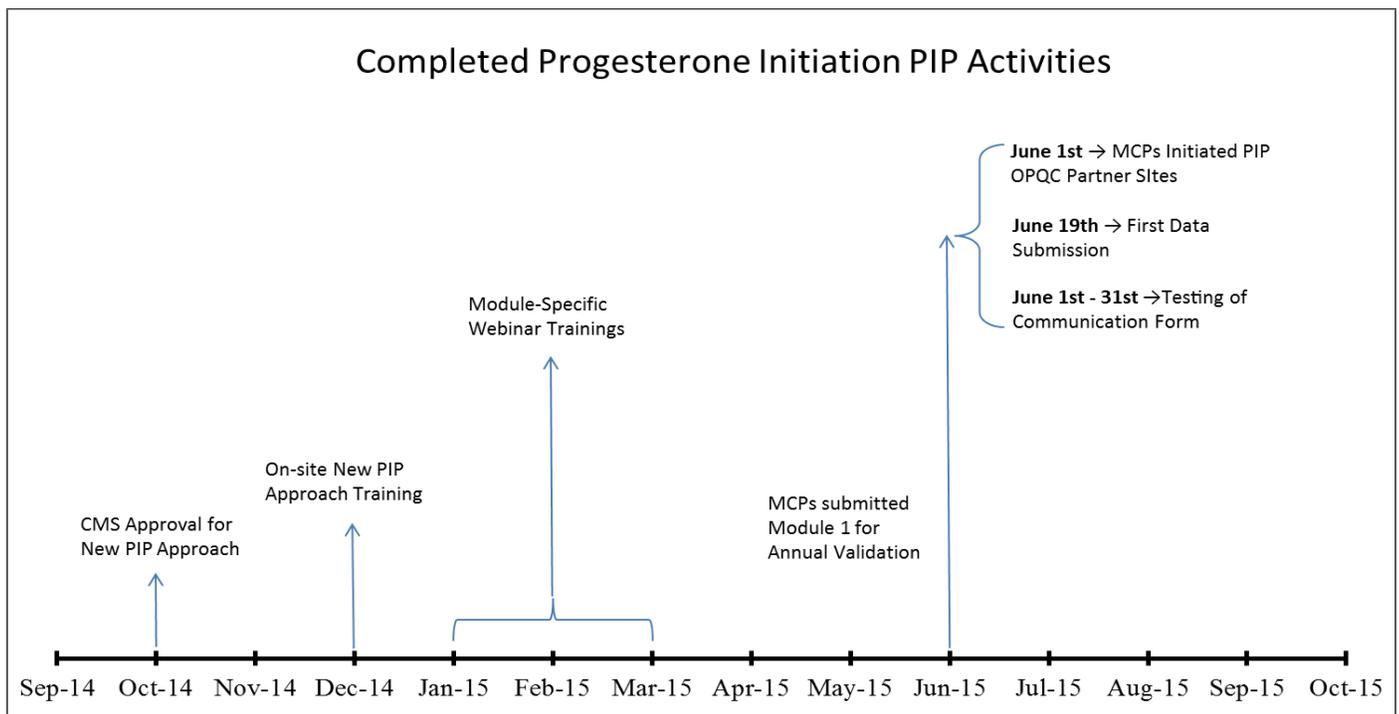
### ODM’s Medicaid Managed Care PIP Framework

|                                                                                     |                                                     |                                                                                                                                     |
|-------------------------------------------------------------------------------------|-----------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------|
| <p>What are we trying to accomplish?</p>                                            | <p><b>Module 1:<br/>Initiation</b></p>              | <p>Literature reviews; defining the problem; forming teams; developing the SMART Aim; Key Driver Diagram.</p>                       |
| <p>How will we know that a change is an improvement?</p>                            | <p><b>Module 2:<br/>Feedback</b></p>                | <p>Determine methods for data collection; collect baseline data</p>                                                                 |
| <p>What changes can we make that will result in improvement?</p>                    | <p><b>Module 3:<br/>Determine Interventions</b></p> | <p>Map the process; identify key drivers, identify and quantify process failures</p>                                                |
|  | <p><b>Module 4:<br/>Test Interventions</b></p>      | <p>Select interventions to test; execute small tests of change; analyze test results; adapt, adopt, or abandon</p>                  |
|                                                                                     | <p><b>Module 5:<br/>Conclusions</b></p>             | <p>Summarize key findings from entire PIP; compare to predictions; interpret the work; evaluate limitations; discuss next steps</p> |

#### Training and Implementation

HSAG worked with ODM to develop a plan for training, monitoring, and oversight of the PIP. With this new PIP approach, HSAG and ODM are involved at the onset of a PIP to determine its methodological soundness and to ensure the MCPs have the knowledge and guidance needed to be successful, not only in documentation of their approach but in the application of the rapid-cycle quality improvement methods that are central to achieving improved outcomes and sustained success. The MCPs are also able to seek individual, ongoing technical assistance as needed. The MCPs participate in monthly, individualized technical assistance calls and periodic learning sessions with more experienced quality improvement entities, and they are encouraged to hold periodic clinical huddles with their partner sites.

The following graph illustrates the timeline of completed PIP activities for SFY 2015.



The MCPs, ODM, and OPQC worked together and made significant progress during the implementation phase of this PIP resulting in the following accomplishments:

- ◆ Standardization of the clinical requirements for progesterone candidacy across all MCPs.
- ◆ Development of a standardized pregnancy risk assessment form in collaboration with ODM, the MCPs, and OPQC for notification of pregnancy, as well as communication of progesterone candidacy and psychological risk factors. During the SFY 2015 report period, this communication form was being tested at the initial six pilot sites to determine whether it facilitated the communication of information collected during the initial OB appointment to the MCPs and ODM.
- ◆ Testing the removal of prior authorization on the first dose of progesterone to determine whether the removal reduced the time from identification of need to medication initiation.
- ◆ Development of a measures table by ODM for the MCPs that includes standardized codes. This table will increase consistency for data collection across all MCPs.
- ◆ MCP quality improvement directors and MCP medical directors associated with the PIP completed quality improvement training aligned with the IHI model by June 30, 2015.

## Validation Protocols

The purpose of a PIP is to assess and improve processes and, thereby, outcomes of care. For such projects to achieve real and meaningful improvements, and for interested parties to have confidence in the interventions that are responsible for reported improvements, PIPs must reflect methodological

soundness in their design, administration, and documentation. To ensure methodological soundness while meeting all state and federal requirements, HSAG follows guidelines established in the CMS publication, *EQR Protocol 3: Validating Performance Improvement Projects (PIPs): A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012.

HSAG's validation of PIPs includes the following two key components of the quality improvement process:

1. Evaluation of the technical structure to determine whether a PIP's initiation (e.g., topic rationale, PIP team, aims, key driver diagram, and data collection methodology) is based on sound methods and could demonstrate reliably positive outcomes. Successful execution of this component ensures accurately reported PIP results that are capable of achieving sustained improvement.
2. Evaluation of the quality improvement activities conducted. Once designed, a PIP's effectiveness in improving outcomes depends on thoughtful and relevant intervention determination, intervention testing and evaluation using PDSA cycles, and sustainability and spreading of successful change. This component evaluates how well the MCP executed its quality improvement activities and whether the desired aim was achieved and sustained.

The goal of HSAG's PIP validation is to ensure that the MCP and key stakeholders can have confidence that any reported improvement is related to and can be directly linked to the quality improvement strategies and activities conducted during the life of the PIP.

## PIP Scoring Methodology

HSAG's methodology for evaluating and documenting PIP activities is a consistent, structured process and mechanism for providing the MCP with specific feedback and recommendations for recording PIP activities. HSAG uses this methodology to determine the overall validity and reliability of PIP documentation, and to report the level of confidence in the PIP results.

Each module consists of validation criteria necessary for successful completion of a valid PIP. Each evaluation element is scored as either *Achieved* or *Failed*. Using the PIP Validation Tool and standardized scoring, HSAG reports the overall validity and reliability of the PIP activities as one of the following:

- ◆ *High confidence* = the PIP was methodologically sound, achieved meaningful improvement for the SMART Aim measure, and the demonstrated improvement was clearly linked to the quality improvement processes conducted.
- ◆ *Confidence* = the PIP was methodologically sound; achieved meaningful improvement for the SMART Aim measure; and some of the quality improvement processes were clearly linked to the demonstrated improvement, but there was not a clear link between all quality improvement processes and the demonstrated improvement.
- ◆ *Low confidence* = (1) the PIP was methodologically sound, but improvement was not achieved for the SMART Aim measure; or (2) improvement was achieved for the SMART Aim measure, but the quality improvement processes and interventions were poorly executed and could not be linked to the improvement.

**MCP Progress Toward Addressing Prior Year Recommendations**  
Period: July 1, 2014, Through June 30, 2015

| EQR Recommendation from SFY 2014 Activities                                                                                                                                             | MCP Response                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | Data Source for HSAG Recommendation                                                                                                                                                                                                                                                                                                                                          |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>ADMINISTRATIVE REVIEW</b>                                                                                                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                                                                                                                                                                                                                                                                                              |
| <p>MCPs should ensure there is a formal monitoring process to conduct follow-up review of providers not meeting access standards until performance meets the established standards.</p> | <ul style="list-style-type: none"> <li>◆ Buckeye reported continued monitoring of providers who do not meet access standards.</li> <li>◆ CareSource outlined a process for pulling weekly Ohio market reports for network adequacy to review for access deficits.</li> <li>◆ Molina reported a thorough review of findings upon receipt of survey results and use of corrective action plans and continued monitoring until the provider is compliant.</li> <li>◆ Paramount provider representatives contact providers who are identified as noncompliant with access standards and review the standards.</li> <li>◆ UnitedHealthcare is developing a comprehensive provider access review mechanism in partnership with its United Health Network partners that will audit provider accessibility and remove providers from the UHCCP network who demonstrate repeated performance issues.</li> </ul> | <ul style="list-style-type: none"> <li>◆ HSAG closing comments provided to MCPs during the on-site portion of the Comprehensive Administrative Reviews.</li> <li>◆ SFY 2014 External Quality Review of Compliance Standards (Issued in July 2014).</li> <li>◆ HSAG Teleconference Presentation of Comprehensive Administrative Review Findings on August 6, 2014.</li> </ul> |
| <p>MCPs should ensure consistency in the application of credentialing policies and develop formalized processes for monitoring of credentialing timeliness.</p>                         | <ul style="list-style-type: none"> <li>◆ All MCPs reported formalized processes for monitoring of credentialing timeliness.</li> <li>◆ Paramount tracks timeliness of all credentialing and recredentialing processes to assure compliance with requirements.</li> <li>◆ UnitedHealthcare has developed credentialing policies that serve as a benchmark for monitoring credentialing timeliness.</li> </ul>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                                                                                                              |
| <p>MCPs should ensure that credentialing decisions are reported to the credentialing committee (or equivalent</p>                                                                       | <ul style="list-style-type: none"> <li>◆ All MCPs reported the compilation of comprehensive, formal meeting minutes that reflect committee decisions.</li> </ul>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                                                                                                                                                                                                                                                                              |

**MCP Progress Toward Addressing Prior Year Recommendations**  
Period: July 1, 2014, Through June 30, 2015

| EQR Recommendation from SFY 2014 Activities                                                                                                                                                       | MCP Response                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | Data Source for HSAG Recommendation |
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| committee) and that meeting minutes are maintained.                                                                                                                                               | <ul style="list-style-type: none"> <li>◆ Molina reported that its credentialing standards meet or exceed NCQA guidelines.</li> </ul>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                     |
| MCPs should implement a process that ensures monthly delegation logs are used in the delegate oversight process and clearly identify the staff member responsible for oversight of the delegates. | <ul style="list-style-type: none"> <li>◆ Buckeye added a new delegation oversight manager position in September 2014 to ensure there is an appropriate staff member who is responsible for reviewing reports.</li> <li>◆ CareSource creates an annual work plan identifying all key members responsible for ensuring compliance.</li> <li>◆ Molina reported monthly delegate reporting, reviewed by the delegation oversight manager, that summarizes the status of each delegate’s activities.</li> <li>◆ Paramount has implemented a de-centralized delegation oversight program in which the business owners establish and maintain relationships with the delegates.</li> <li>◆ UnitedHealthcare has developed a delegation monthly reporting policy which outlines the process and guidelines for obtaining monthly reporting and submitting it to the Ohio delegation oversight manager.</li> </ul>                                                                                                                                                                                                                                |                                     |
| MCPs should review their monitoring of delegate corrective action plans (CAPs) and develop a formalized monitoring process to ensure CAPs are implemented and completed.                          | <ul style="list-style-type: none"> <li>◆ Buckeye reported continued improvement of its oversight processes to include monitoring of corrective action plans (CAPs).</li> <li>◆ CareSource has a vendor oversight process, which includes a defined process for vendor CAPs, including due diligence to determine the responsible party (CareSource, the vendor, or both); the initiation, deployment, and collection of the vendor’s response; and ongoing monitoring which includes weekly updates and a monthly roll-up to the Delegation Oversight Committee (DOC).</li> <li>◆ Molina completes annual reassessments for each delegate to assure ongoing compliance with all regulatory requirements. When deficiencies are identified, the findings are sent to the DOC for review and recommendations.</li> <li>◆ Paramount’s business owner defines the time frames for the delegates’ CAPs and is responsible for monitoring all elements of the CAP.</li> <li>◆ UnitedHealthcare’s delegation oversight manager follows the established plan/template for the development, implementation, monitoring, and completion</li> </ul> |                                     |

**MCP Progress Toward Addressing Prior Year Recommendations**  
Period: July 1, 2014, Through June 30, 2015

| EQR Recommendation from SFY 2014 Activities                                                                                                     | MCP Response                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | Data Source for HSAG Recommendation                                                              |
|-------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------|
|                                                                                                                                                 | of a CAP as a result of deficiencies identified through monthly oversight meetings and annual assessments.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                  |
| MCPs should review their current committee structures to ensure that all key activities are being reported through the appropriate committees.  | <ul style="list-style-type: none"> <li>◆ Buckeye reported continued review of current committee structures.</li> <li>◆ CareSource developed a new annual QI work plan and calendar to ensure that all departmental activities with reporting requirements to QEC do so in a timely and consistent manner.</li> <li>◆ Molina reviews committee structures annually and as needed to ensure all key activities are being reported through the appropriate committees.</li> <li>◆ Paramount established a Medicaid Operations Oversight Council to provide oversight of all quality activities.</li> <li>◆ UnitedHealthcare instituted a monthly quality check of the MCPN that reviews multiple data points.</li> </ul> |                                                                                                  |
| MCPs should implement a process for routine review of the Managed Care Provider Network (MCPN) data to ensure that the information is accurate. | <ul style="list-style-type: none"> <li>◆ All MCPs identified routine monitoring activities to ensure MCPN data are accurate.</li> <li>◆ Buckeye implemented a new process for submitting MCPN data directly into its database.</li> <li>◆ UnitedHealthcare also initiated a new project that revamped its method for sending files to AHS for loading into the MCPN.</li> </ul>                                                                                                                                                                                                                                                                                                                                       |                                                                                                  |
| <b>PERFORMANCE MEASURES</b>                                                                                                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                  |
| MCPs should perform careful analysis to identify potential causes of poor performance for measures needing improvement.                         | <ul style="list-style-type: none"> <li>◆ All MCPs reported continued monitoring and analysis of metrics.</li> <li>◆ Buckeye reported discussion of specific measures during its monthly HEDIS/STARS program committee meeting to gain feedback and suggestions.</li> <li>◆ CareSource uses its persona and clinical scenario methodology, along with ACG methodology, for predictive modeling to group consumers based on disease prevalence, age, and utilization.</li> </ul>                                                                                                                                                                                                                                        | <ul style="list-style-type: none"> <li>◆ HEDIS 2013 Results (Calendar Year 2012 data)</li> </ul> |

## MCP Progress Toward Addressing Prior Year Recommendations

Period: July 1, 2014, Through June 30, 2015

| EQR Recommendation from SFY 2014 Activities                                                                                                                                                                 | MCP Response                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | Data Source for HSAG Recommendation |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------|
| MCPs should conduct research to identify specific interventions and tactics shown to improve performance.                                                                                                   | <ul style="list-style-type: none"> <li>◆ Buckeye recently began incorporating research for information related to HEDIS measures to assist with improvement initiatives.</li> <li>◆ CareSource reported that implementation of the personal clinical scenario model will allow for more in-depth analysis of intervention outcomes.</li> <li>◆ Molina participates in a Clinical Best Practices Workgroup with enterprise partners and conducts annual reviews of all interventions.</li> <li>◆ Paramount conducts ongoing research.</li> <li>◆ UnitedHealthcare examines interventions for effectiveness based on claims runoff after an event.</li> </ul>                                                                                                                                                              |                                     |
| MCPs should develop performance improvement plans specific to measures needing improvement, including interventions targeting low-performing providers and/or consumers not receiving recommended services. | <ul style="list-style-type: none"> <li>◆ Buckeye reported recent implementation of work groups to address HEDIS measures that would benefit from improvement.</li> <li>◆ CareSource revised its IVR outreach to consumers not receiving recommended services.</li> <li>◆ Molina implemented a provider engagement program to promote consumer and provider interventions to improve HEDIS, CAHPS, and Health Outcomes Survey results, and Medicare Star rates and risk scores.</li> <li>◆ Paramount continues to target specific measures that need improvement.</li> <li>◆ UnitedHealthcare targets noncompliant consumers for outreach calls, home visits, and reminder letters. Additionally, UnitedHealthcare identifies low-performing providers and provides interventions for performance improvement.</li> </ul> |                                     |
| MCPs should share interventions shown to improve low measure rates.                                                                                                                                         | <ul style="list-style-type: none"> <li>◆ Buckeye, Molina, Paramount, and UnitedHealthcare reported participation in the Ohio Association of Health Plans organization.</li> <li>◆ CareSource reported the implementation of the persona identification methodology, allowing for more detailed analysis of outcomes.</li> </ul>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                     |
| MCPs should identify individuals with asthma and ensure those individuals get                                                                                                                               | <ul style="list-style-type: none"> <li>◆ All MCPs reported identification methods used to ensure that consumers with asthma receive education and care.</li> </ul>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                     |

**MCP Progress Toward Addressing Prior Year Recommendations**  
Period: July 1, 2014, Through June 30, 2015

| EQR Recommendation from SFY 2014 Activities                                                                                                                                                                                  | MCP Response                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | Data Source for HSAG Recommendation |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------|
| <p>the care and education they need to manage the disease effectively.</p>                                                                                                                                                   | <ul style="list-style-type: none"> <li>◆ Buckeye consumers with asthma are identified via Impact Pro predictive modeling, referral from plan staff, referral from provider, and member self-referral. These consumers are triaged to determine if they should be enrolled in care coordination, complex care management, or disease management to ensure that they get the care and education needed to manage their disease effectively.</li> <li>◆ Molina uses disease management nurses to promote care for consumers with asthma, provide asthma education, and assist in scheduling needed services.</li> </ul>                                                                                                                                                                                                                                                                                                                                                                                                    |                                     |
| <p>MCPs should maintain a routine follow-up schedule for individuals with asthma to monitor their progress and determine if additional support is needed.</p>                                                                | <ul style="list-style-type: none"> <li>◆ Buckeye care managers and disease health coaches create communication plans with asthmatic consumers to monitor progress and identify any additional needs.</li> <li>◆ CareSource completes monthly monitoring of utilization data, and high-risk disease management consumers receive ongoing support through follow-up calls by the nurse as needed but no greater than 45 days.</li> <li>◆ Molina introduced the new Moderate Level Pulmonary Education Program to facilitate outreach to consumers who need support to increase self-management, prevent exacerbation, and manage their disease process.</li> <li>◆ Paramount has developed asthma follow-up guidelines that can be modified based on consumers' needs and provides continuous monitoring for changes in asthma management.</li> <li>◆ UnitedHealthcare care managers follow all consumers in all levels of care management and develop care plans that are individualized to consumers' needs.</li> </ul> |                                     |
| <p>MCPs should focus on improving women's general health over their life cycle by managing and treating health conditions such as diabetes, asthma, obesity, and mental illness that are related to poor birth outcomes.</p> | <ul style="list-style-type: none"> <li>◆ All MCPs reported continued monitoring and management of chronic medical conditions.</li> <li>◆ Additionally, Buckeye outlined an enhanced maternal/newborn program that focuses on improving women's general health over their life cycle by managing and treating health conditions related to poor birth outcomes.</li> <li>◆ UnitedHealthcare focuses on women with diabetes and mental health/substance abuse who are more likely to develop future health problems.</li> </ul>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                     |

**MCP Progress Toward Addressing Prior Year Recommendations**  
Period: July 1, 2014, Through June 30, 2015

| EQR Recommendation from SFY 2014 Activities                                                                                                                                                                                               | MCP Response                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | Data Source for HSAG Recommendation                                                                                                                               |
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| <p>MCPs should provide family planning strategies to women to decrease the incidence of high-risk pregnancies by reducing unwanted births, closely spaced births, and births to teenage mothers.</p>                                      | <ul style="list-style-type: none"> <li>◆ All MCPs reported programs to provide family planning strategies to women.</li> <li>◆ Buckeye provides an enhanced maternal/newborn program which includes family planning strategies for women to decrease the incidence of high-risk pregnancies.</li> <li>◆ CareSource has created formal collaborative relationships with various community agencies to interface with consumers before, during, and after pregnancy. CareSource is also currently exploring a digital strategy to provide another vehicle for information sharing for pregnant consumers.</li> <li>◆ Paramount provides education and strategies for family planning, including safe sex and abstinence, birth spacing, healthy nutrition, and substance and domestic abuse.</li> <li>◆ UnitedHealthcare engages with community pathways hubs in Toledo, Cincinnati, and Athens that include family planning education and adoption as a standard pathway.</li> </ul> |                                                                                                                                                                   |
| <p>MCPs can stress the importance of proper prenatal care and smoking cessation by providing educational materials and offering support services to pregnant women (e.g., transportation services and interactive training sessions).</p> | <ul style="list-style-type: none"> <li>◆ All MCPs reported provision of educational materials and support services for smoking cessation.</li> <li>◆ Molina encourages pregnant consumers to participate in the Stop Smoking Program and provides educational materials to all consumers.</li> <li>◆ Paramount offers prenatal education, smoking cessation, and transportation information to its consumers through member newsletters, the member handbook, direct mailings, on-hold messages, online website access, Prenatal to Cradle program, and care management interactions.</li> </ul>                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                                                   |
| <b>PERFORMANCE IMPROVEMENT PROJECTS</b>                                                                                                                                                                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                                                                                   |
| <p>MCPs should revisit their causal/barrier analysis more frequently than annually and complete a drill-down analysis in addition to periodic analyses of their most recent data.</p>                                                     | <ul style="list-style-type: none"> <li>◆ Buckeye reported continuous performance improvement project (PIP) process improvements.</li> <li>◆ CareSource outlined frequent casual/barrier analysis and a drill-down analysis as needed.</li> </ul>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | <ul style="list-style-type: none"> <li>◆ State Fiscal Year (SFY) 2014 PIP Validation Report – Increasing Access to Comprehensive Diabetes Services for</li> </ul> |

**MCP Progress Toward Addressing Prior Year Recommendations**  
Period: July 1, 2014, Through June 30, 2015

| EQR Recommendation from SFY 2014 Activities                                                                                                                                                             | MCP Response                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | Data Source for HSAG Recommendation                                 |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------|
|                                                                                                                                                                                                         | <ul style="list-style-type: none"> <li>◆ Molina completes a monthly analysis of all HEDIS metrics to identify barriers and root causes, and PIP staff complete a weekly drill-down analysis for appropriate Plan-Do-Study-Act (PDSA) activities.</li> <li>◆ Paramount continues to perform quarterly review of performance measures to mitigate identified barriers.</li> <li>◆ UnitedHealthcare reviews interventions and data to determine if the interventions should be continued or dropped from the quality strategy.</li> </ul>                                                                                                                   | Members Aged 18-75 Year with Diabetes: Year 2-Validated in SFY 2014 |
| MCPs should investigate the reasons for a decline in performance, and based on the findings, implement strategies to improve performance.                                                               | <ul style="list-style-type: none"> <li>◆ All MCPs reported continued performance monitoring to identify performance issues as compared to previous years' issues.</li> <li>◆ Paramount conducts a barrier analysis to identify new strategies to increase performance outcomes.</li> <li>◆ Molina reported continued participation in a Clinical Best Practices Workgroup with enterprise partners to discuss performance improvement.</li> </ul>                                                                                                                                                                                                        |                                                                     |
| MCPs should prioritize identified barriers from most to least critical, implementing active interventions that are logically linked to barriers and that will directly impact study indicator outcomes. | <ul style="list-style-type: none"> <li>◆ Buckeye reported continued improvement of its PIP process.</li> <li>◆ CareSource has partnered with a community entity to conduct a progesterone PIP to improve the initiation of progesterone for the high-risk maternity Medicaid population.</li> <li>◆ Molina and UnitedHealthcare use the failure mode and effects analysis (FMEA) process to identify failure modes and determine priority levels.</li> <li>◆ Paramount prioritizes barriers based on number of consumers affected, resources required to make a positive impact, severity of impact from low performance, and State mandates.</li> </ul> |                                                                     |
| MCPs should implement a method for evaluating the effectiveness of each intervention. If interventions are not having the desired impact, MCPs should address those deficiencies by                     | <ul style="list-style-type: none"> <li>◆ Buckeye reported continued improvement of its PIP process.</li> <li>◆ CareSource is currently using the PDSA cycle to evaluate the effectiveness of interventions.</li> <li>◆ Molina's Quality Improvement (QI) department, in conjunction with other departments, identifies deficiencies and develops process improvements that</li> </ul>                                                                                                                                                                                                                                                                    |                                                                     |

**MCP Progress Toward Addressing Prior Year Recommendations**  
Period: July 1, 2014, Through June 30, 2015

| EQR Recommendation from SFY 2014 Activities                                                                                                                              | MCP Response                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | Data Source for HSAG Recommendation |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------|
| <p>modifying or discontinuing current interventions or by implementing new improvement strategies. Successful interventions should become standard practice.</p>         | <p>target the identified deficiencies. Once a program is completed, the Molina QI department will review the deficient areas for process improvement.</p> <ul style="list-style-type: none"> <li>◆ Paramount documents evaluation of each intervention in the MCP’s annual QI Program Evaluation, and successful interventions are continued from year to year.</li> <li>◆ UnitedHealthcare used performance improvement methodology to identify strategies with no impact that are then recommended for discontinuation; strategies with positive impact are integrated into the work flow.</li> </ul>                                                                                                                                           |                                     |
| <p>MCPs should ensure that all information documented in the PIP Summary Form is accurate and comprehensive.</p>                                                         | <ul style="list-style-type: none"> <li>◆ Buckeye reported continued improvement of its PIP process.</li> <li>◆ CareSource has a dedicated multidisciplinary team that is instrumental in the development and review of the PIP Summary Forms to assure accuracy and completeness.</li> <li>◆ Molina reported that the PIP Summary Form is completed by the PIP team and reviewed by the facilitator for accuracy prior to submission to ODM.</li> <li>◆ Paramount stated that it will continue to assure all information, including data and statistical significance, is accurate and comprehensive.</li> <li>◆ UnitedHealthcare reported that the PIP Summary Form is reviewed with the State and corrections are made as necessary.</li> </ul> |                                     |
| <p>MCPs should reference the PIP Completion Instructions and seek technical assistance to ensure that all of the requirements for each activity have been completed.</p> | <ul style="list-style-type: none"> <li>◆ Buckeye reported continued improvement of its PIP process.</li> <li>◆ CareSource sought technical assistance from HSAG during the postpartum QIP and, if needed, will do so at its conclusion.</li> <li>◆ Molina and Paramount use the PIP instructions and seek technical assistance from ODM when needed.</li> <li>◆ UnitedHealthcare has monthly meetings with ODM to ensure all PIP requirements are met.</li> </ul>                                                                                                                                                                                                                                                                                 |                                     |