



## **Medicaid Managed Health Care Program**

# **PROGRESS REPORT**

**January - December 2000**

Source: Bureau of Managed Health Care, August 2001

## Ohio Medicaid Managed Health Care Program

### Background

Within the Ohio Department of Job and Family Services (ODJFS), the Office of Ohio Health Plans (OHP) administers the Ohio Medicaid program. The Medicaid program offers two major benefit packages: long-term care services and primary and acute care services. The primary and acute care benefit package is provided through either a traditional indemnity model, the fee-for-service (FFS) system, or through a Managed Health Care model. This report focuses on the current status of the Medicaid managed care program.

Ohio Medicaid managed care is designed to assure access to appropriate services and quality of care for enrolled Medicaid consumers, to improve accountability, and to increase cost predictability. Since 1978, the ODJFS has contracted with managed care plans (also known as “health maintenance organizations”) for the coverage of some Medicaid consumers, with major program expansions occurring in the late 1980s and in July 1996 as part of the “OhioCare” program, a five-year research and demonstration project approved by the federal government. Although OhioCare ended as of June 30, 2001, the ODJFS requested and has received federal approval to continue the managed care program.

The Bureau of Managed Health Care (BMHC) within OHP is responsible for the development, administration, and assessment of the Medicaid managed care program. Bureau work includes the design of purchasing specifications, selection of qualified managed care plans (MCPs), contract monitoring, performance reviews, reporting, and development and implementation of new program initiatives. The Bureau is also responsible for managed care enrollment policies and procedures.

### Value-Added Services

MCPs add value to Ohio’s dollars spent on health care by providing services not offered in the traditional Medicaid fee-for-service program. Medicaid consumers enrolled in managed care plans receive the following extras:

- Guaranteed access to a Primary Care Physician
- Choice of PCPs, hospitals, & specialists listed in a provider directory
- Guaranteed sufficient hospital & specialist networks
- Guidance as to the appropriate use of services
- 24 hour medical advice & direction via a hotline
- Extended office hours
- Expanded benefits including transportation, vision & pharmacy
- A member handbook explaining how to access member & health services
- Provider networks that are monitored for quality care
- Health education materials & activities that encourage the use of preventive care services
- Preventive care reminders
- Member services department to assist members
- Opportunity to submit & resolve grievances

## **Accountability**

Contracting MCPs are held accountable for performance, which is measured through a multi-faceted approach including:

- An annual quality of care and services evaluation performed by an external quality review organization (EQRO), including clinical quality of care process and outcome studies;
- The submission of all plan-developed marketing and member materials to ODJFS;
- The development and monitoring of corrective action plans for certain problems or deficiencies;
- The use of individual “Performance Improvement Agreements” developed with each plan to target and encourage superior plan performance beyond basic program requirements;
- Reviews of enrollee complaints, grievances, and state hearing requests;
- The ongoing monitoring of reports identifying providers who have joined or left the MCP’s panel;
- The use of independent enrollee satisfaction surveys;
- The timely and accurate submission of patient-specific encounter data to enhance performance measurement;
- An annual review of utilization statistics;
- Reviews of audited financial reports and disclosure statements.

## **Consumer Focus**

The program continues to emphasize the interest of the consumer at every point of the managed care delivery system, from the initial notification of enrollment, to the selection of a primary care provider, assurance of access and quality, availability of problem resolution, and ongoing provision of information and education. As a result of their experience with Medicaid managed health care, consumers are further prepared to successfully transition to employment and private health insurance coverage.

Some highlights of the program’s consumer-focused strategies are:

- The provision of unbiased enrollment information and assistance by telephone and local outreach;
- The development of general managed care information brochures, videos, and MCP comparison information;
- Access to a centralized toll-free number to respond to consumer questions, provide information, and offer a referral mechanism to facilitate the resolution of complaints/grievances;
- The continued use of managed care program requirements for MCP grievance procedures and the expanded monitoring of logs maintained by the MCP to assess the nature of grievances, to assure timely resolution, and to develop consumer reporting mechanisms;
- Access to the state hearing process when appropriate.

## **Purpose of the Progress Reports**

An essential component of accountability is the availability of information. Progress reports consolidate and summarize information available about Ohio's Medicaid managed care program.

Plan performance in the key areas of access, quality, and consumer satisfaction is crucial to the overall value of the program. Administrative capacity, the ability to provide accurate and complete information and operate required program elements such as member services and grievance systems, is also essential to program value. The "Quality Agenda," (see end of report) identifies the information used to assess plan performance in each of the value components (Access, Quality, Consumer Satisfaction, Administrative Capacity). The Progress Report describes the status of the program during the twelve month reporting period, summarizes performance for that time period in each of the value components, and includes data reports in specific areas. It is important to note that individual MCP performance should not be assessed based on any one indicator in isolation but by reviewing a combination of indicators.

## **2000 Statewide Health Care Market Summary**

During this reporting period, the Medicaid managed care program continued to be affected by the volatile environment in the overall health care industry. Mergers and acquisitions occurred throughout the industry and across the country, resulting in a decrease in the number of managed care plans. In the Ohio program, the number of contracting plans decreased by two from January to December 2000 and other MCPs left some counties of operation. As of December 2000, nine plans were under contract to serve Medicaid enrollees in fourteen counties. This decline in the number of plans serving the Medicaid managed care consumers reflects a national trend of more closely aligning the appropriate number of financially and programmatically solid plans with the number of consumers.

By the end of the year, three mandatory enrollment counties (Franklin, Stark, and Wood) became voluntary enrollment counties. This change in designation was made due to the withdrawal or termination of one or more MCPs from these counties. The total number of mandatory counties as of December 2000 was four, with eleven counties designated as voluntary.

Effective March 31, 2000, MediPlan withdrew its operation in Stark County thus terminating its participation in the Medicaid managed care program. MediPlan enrollees were returned to the Medicaid fee-for-service program effective April 1, 2000.

The ODJFS proposed several adjudication orders during the year to terminate Total Health Care Plan's (THCP) provider agreement due to noncompliance with a number of ODJFS program requirements. THCP requested and was granted an administrative hearing. In November 2000, the Ohio Department of Insurance, acting as the court-ordered rehabilitator for THCP, withdrew all appeals. In

January 2001, the final adjudication order concluding ODJFS' contractual relationship with THCP was signed by the ODJFS director. THCP enrollees were transferred to CareSource.

Two key program enhancements and initiatives in the Medicaid managed care program were implemented during this reporting period:

- C In January, ODJFS released a Request for Proposals (RFP) to obtain proposals from MCPs interested in working in the current managed care counties as well as several new ones.
- C During the year a majority of the eighteen Ohio Administrative Code rules for MCPs were revised. Some of the areas addressed included the preferred option program, information MCPs must include in member handbooks, and MCP resolution of grievances.

MCP abbreviations used in the following data reports:

|     |                                   |
|-----|-----------------------------------|
| CS  | CareSource (DAHP)                 |
| REN | Renaissance Health Plan (Emerald) |
| FHP | Family Health Plan                |
| GEN | Genesis Health Plan               |
| HMO | HMO Health Ohio                   |
| MP  | Mediplan                          |
| PAR | Paramount                         |
| QC  | QualChoice                        |
| SC  | SummaCare                         |
| SM  | SuperMed HMO                      |
| THC | Total Health Care                 |

# Enrollment

## Enrollment is increasing

Currently, the Ohio Medicaid Managed Health Care Program consists of eight MCPs operating in fifteen counties. The August Ohio Medicaid Covered Families and Children population statewide was 856,112; the population in MCP served counties was 520,745. MCP enrollment was approximately 36 percent of the statewide total and 59 percent in the counties with Medicaid MCP enrollment. (The Medicaid Aged, Blind, and Disabled population is not eligible for managed care enrollment).

Enrollment in the counties in which Ohio's Medicaid managed care program operates is classified as mandatory, voluntary, or "Preferred Option." In voluntary enrollment counties consumers have a choice between enrolling in an MCP or utilizing the traditional fee-for-service program. In mandatory enrollment counties, all eligible consumers must enroll in one of the participating MCPs in order to receive Medicaid-covered services. Enrollees are "locked-in" the selected MCP for up to a year in voluntary and mandatory enrollment counties. Disenrollment during this period is permitted within the first three months of their initial enrollment or if there is a justifiable reason or "just cause" as determined by BMHC in accordance with program rules.

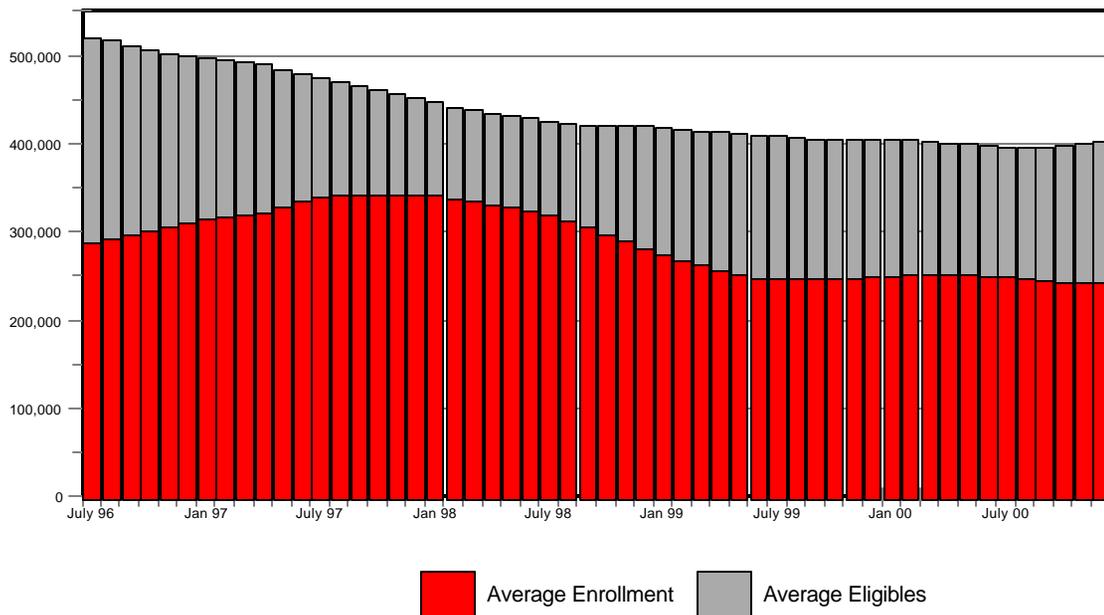
Early in 2001, a third enrollment category, Preferred Option, began in four counties. While managed care enrollment is still voluntary in Preferred Option counties, an eligible consumer is automatically enrolled in the MCP if the consumer fails to select Medicaid fee-for-service. Enrollees are not "locked-in" to an MCP for any specific period of time and may choose fee-for-service Medicaid at any time. Since Preferred Option is a new category of managed care enrollment, an assessment of the program will be conducted during the next year.

From a consumer perspective, several options are offered to provide information needed to choose an MCP. MCP information sources include:

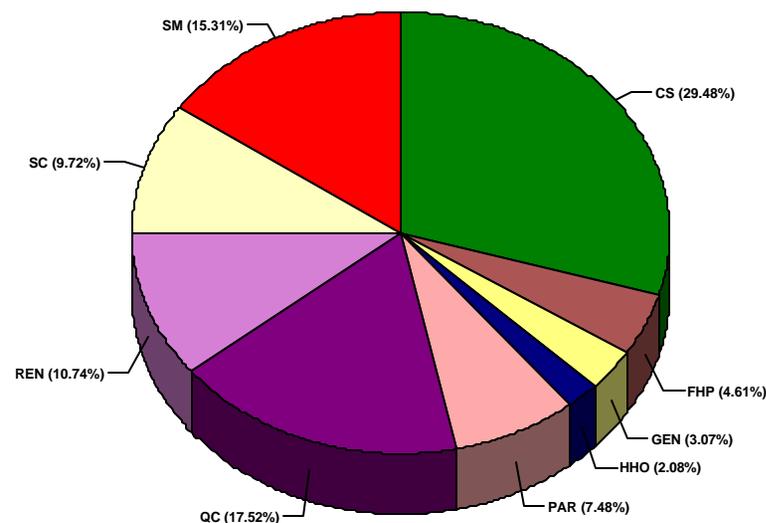
- Unbiased MCP information and enrollment assistance by telephone and local outreach through an independent contractor
- C General managed care consumer guides, videos and comparison charts
- C A centralized toll-free number (1-800-324-8680 or TDD 1-800-292-3572) to respond to consumer questions, provide information and offer a referral mechanism to facilitate the resolution of complaints
- C MCP 1-800 numbers

The number of Medicaid consumers who are eligible to enroll in a managed care plan (MCP) in MCP-served counties and the number of those eligibles who are MCP enrolled are influenced by many factors. The comparison, below, of the number of eligibles to MCP enrollment over the last five years reflects two such factors: the caseload size of the eligible population in MCP-served counties and MCP transitions within those counties. The circular graph represents the percentage of total Medicaid managed care enrollment by MCP as of December 2000. Total enrollment at this time was 251,079.

**Enrollment Trend**  
July 1996 - December 2000



**Enrollment Percentages**  
December 2000



# Consumer Satisfaction

## Satisfaction with MCPs remains high

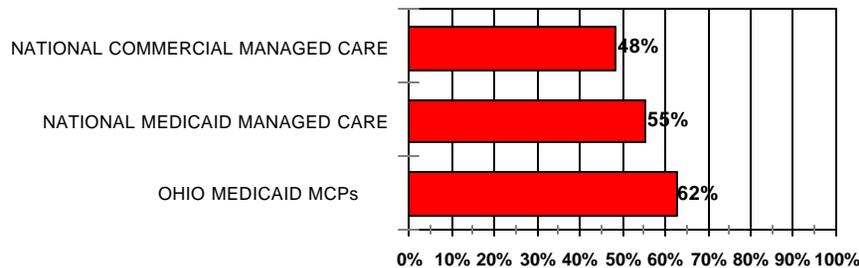
Tools used to assess consumer satisfaction include:

- C An independent consumer satisfaction survey & required MCP enrollee surveys
- C Reviews of complaints and grievances
- C Reviews of voluntary disenrollment rates and reasons
- C Reviews of the number of and reasons for just cause disenrollments (“just cause” are reasons which allow an individual to make an enrollment change outside of the annual open enrollment month)

Ohio Medicaid managed care voluntary disenrollments and complaints and grievances continue to be low while Ohio Medicaid managed care consumer satisfaction remains high:

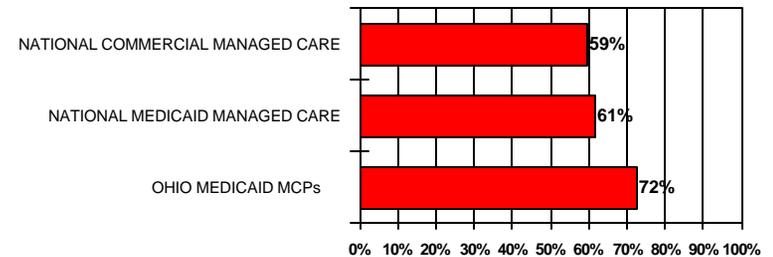
- C Consumers’ satisfaction with their MCP exceeds national Medicaid managed care by 7 %; commercial managed care by 14 %.
- C Consumers’ satisfaction with the care received through their MCP exceeds national Medicaid managed care by 11 %; commercial managed care by 13 %.

### SATISFACTION WITH HEALTH PLAN



Overall Rating of Child’s Health Plan - Percent of consumers (age 17 or younger) who rated their plan a “9” or “10.”  
10 is the highest possible score.  
MCP = Managed Care Plan

### SATISFACTION WITH CLINICAL CARE

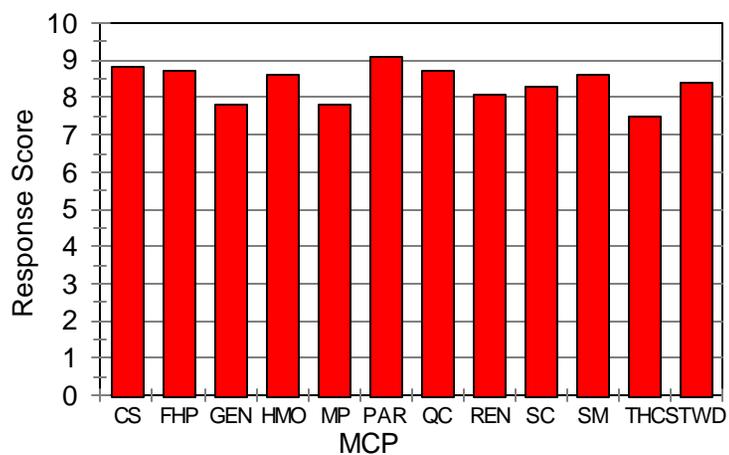


Overall Rating of Child’s Clinical Care - Percent of consumers (age 17 or younger) who rated their care a “9” or “10.”  
10 is the highest possible score  
MCP = Managed Care Plan

With all MCPs scoring high on this indicator, the differences between MCPs is small. However, as an indication of the importance of enrollee satisfaction and BMHC monitoring efforts, the three lowest performing MCPs are no longer participating in the managed care program.

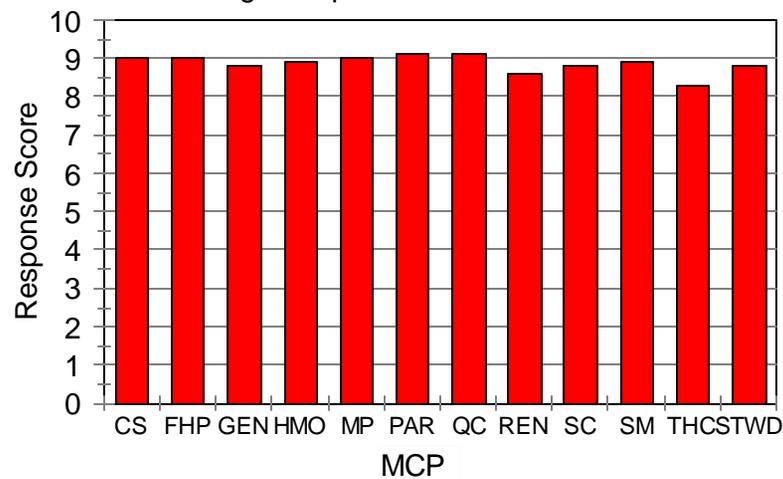
### Satisfaction with Health Plan

Average Response - Scale of 0 to 10



### Satisfaction with Health Care

Average Response - Scale of 0 to 10

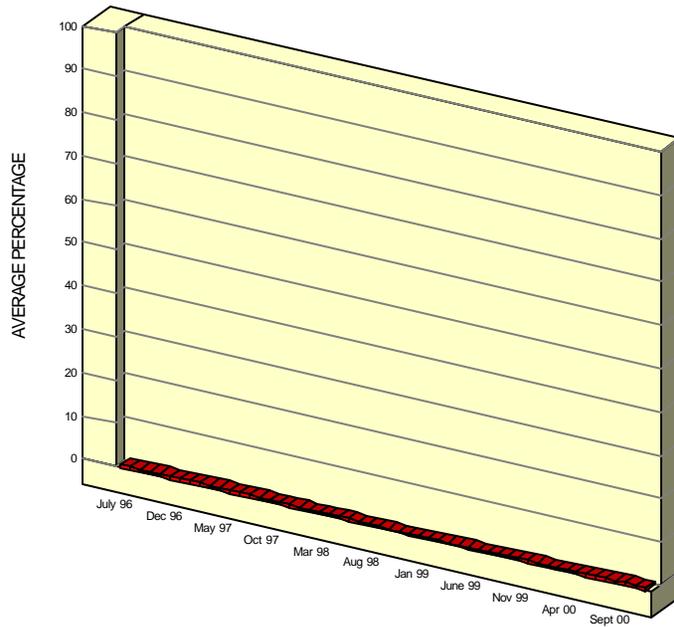


### Few enrollees choose to disenroll

The voluntary disenrollment rate, which is the best indicator of strong member dissatisfaction, continues to be very low. The average voluntary disenrollment rate has remained low since 1996 and is for 2000. Most MCPs had less than an one percent voluntary disenrollment rate. The two MCPs that did exceed one percent are no longer participating in the managed care program. When currently nonparticipating MCPs' results are excluded, the average voluntary disenrollment rate falls to an extremely low rate of 2.73 per 1,000 members months.

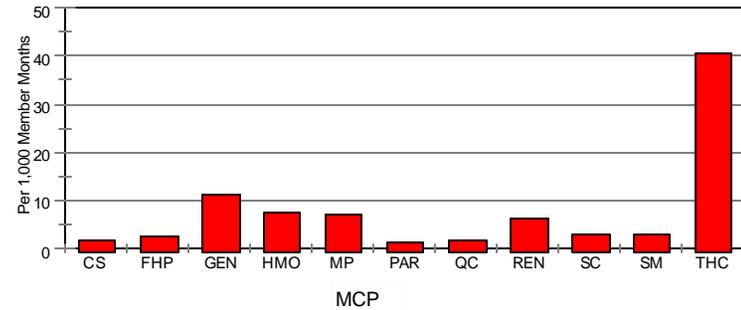
Disenrollment reasons listed are those provided by enrollees at the time of disenrollment. An enrollee may indicate more than one reason for disenrolling from an MCP. The large number (as compared to other reasons) of "provider not in plan" may be due to consumers who did not select an MCP and thus were assigned to an MCP which may not have had their preferred provider on their panel.

**Voluntary Disenrollment Trend**



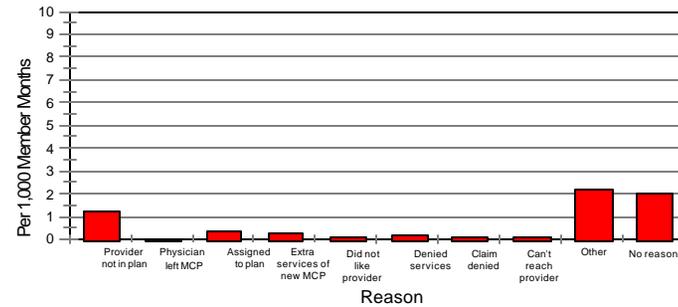
**Voluntary Disenrollment Rate**

January - December 2000



**Voluntary Disenrollment Reasons**

January - December 2000

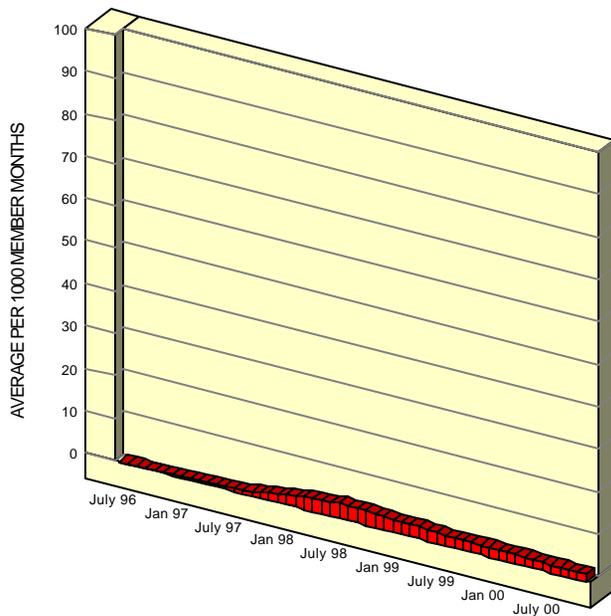


### Few complaints with MCPs

In calendar year 2000, as for previous years, the number of complaint and grievances filed by enrollees against their MCPs continues to be very low. Enrollees may express problems they are experiencing with their MCP to either their MCP's customer service department or directly to the BMHC.

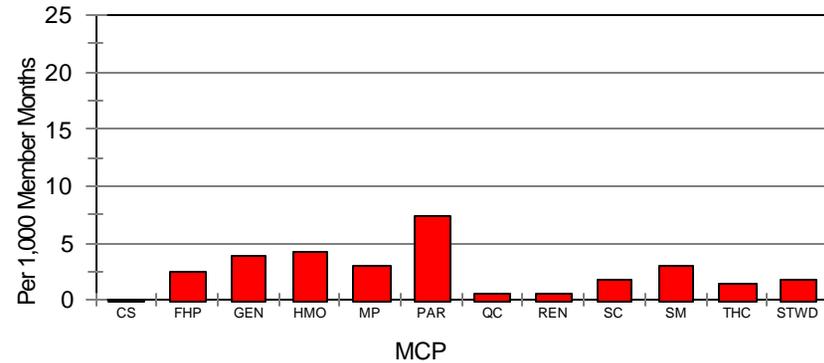
Grievance and complaint reasons are those determined by BMHC to be important to enrollees' access and satisfaction with services provided by their MCPs. A large number of billing issues are due to inappropriate billing on the part of providers or entities that perform billing services for providers. In many cases enrollees may mistake an MCP submitted Explanation of Benefits form for a bill.

**Complaint and Grievance Trend**



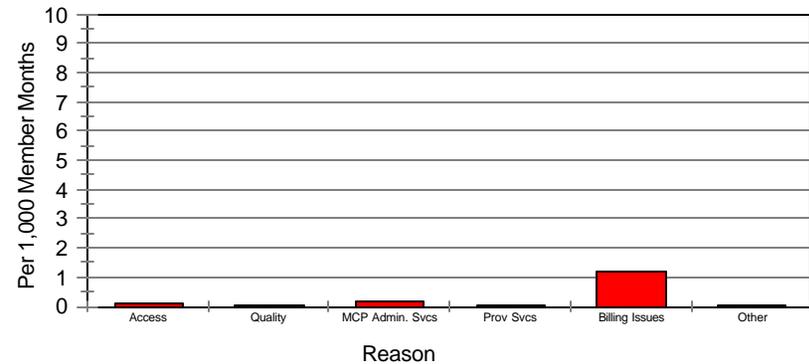
**Complaint and Grievance Rate**

January - December 2000



**Complaint and Grievance Reasons**

January - December 2000



## Access to Care

### Access to care remains very high for enrollees

BMHC has measures in place to assure that access to care received through MCPs meets or exceeds set standards. Access measures include:

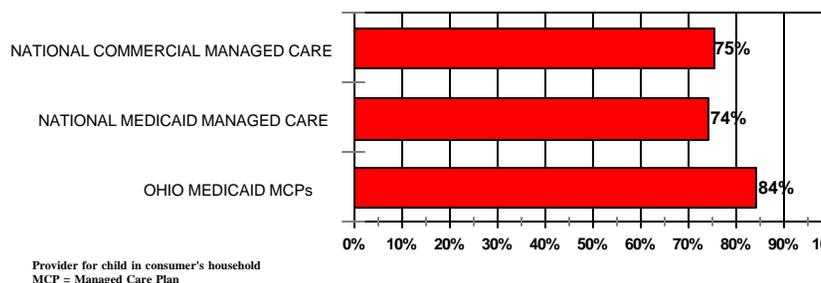
- C Monitoring of MCP provider panels for size and composition
- C Primary care physician capacity and geographical location in relation to Medicaid consumers
- C Grievance/Complaint monitoring by type such as access, quality, provider satisfaction, and billing issues
- C Annual Medicaid Managed Care Consumer Satisfaction Survey
- C A review of health services utilization data

If there are problems accessing services, enrollees can complain or file a grievance with their MCP. These complaints and grievances are reviewed and MCP response time monitored by the BMHC. Enrollees are linked to a medical home by selecting a primary care provider (PCP) upon enrollment. MCPs distribute member handbooks and provider directories to each new member to help enrollees choose a PCP.

As seen on the graphs below, consumers in Ohio Medicaid MCPs experienced little difficulty locating a PCP or obtaining referrals to specialists.

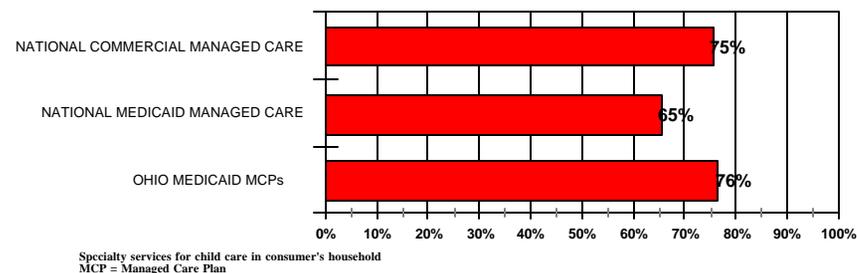
### EASE IN FINDING A DOCTOR OR NURSE

Consumers reporting it was not a problem to find a personal doctor or nurse.



### EASE IN GETTING A REFERRAL TO A SPECIALIST

Consumers reporting it was not a problem to get a referral to a specialist.



**PCP capacity far exceeds the number of eligibles or enrollees**

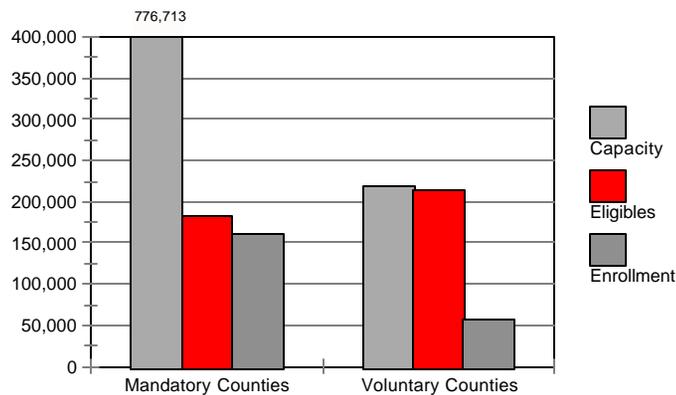
PCP capacity represents the quantity of primary care services available to MCP enrollees in a specific county. In the PCP Capacity graph, the amount of services available is compared to both the number of enrollees and Medicaid eligibles. In all county types, capacity exceeds MCP enrollment and eligibles.

Provider turnover represents the percentage of an MCP’s provider panel that left the panel during 2000. Additional providers may have joined the MCP’s panel during the year as well. Large turnover rates may create access difficulties for enrollees if preferred providers leave an MCP’s panel.

On the following page is an example of the geographical analysis of an MCP’s PCP panel. The analysis compares the location and capacity of PCPs on an MCP’s panel to the location of all eligibles in the county. The large number of green circles, each representing one or more enrollees, indicates a close proximity of enrollees and PCPs.

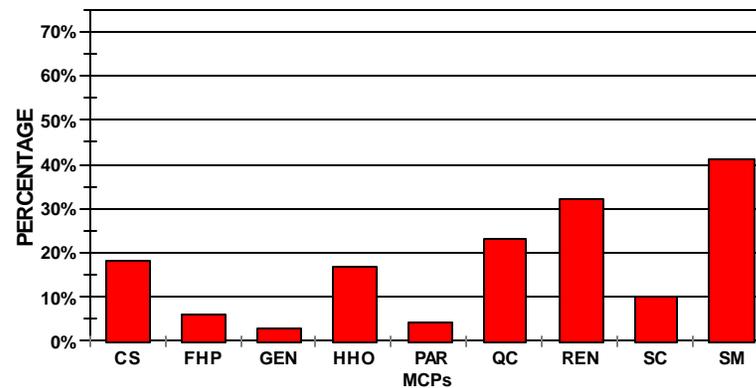
**PCP Capacity**

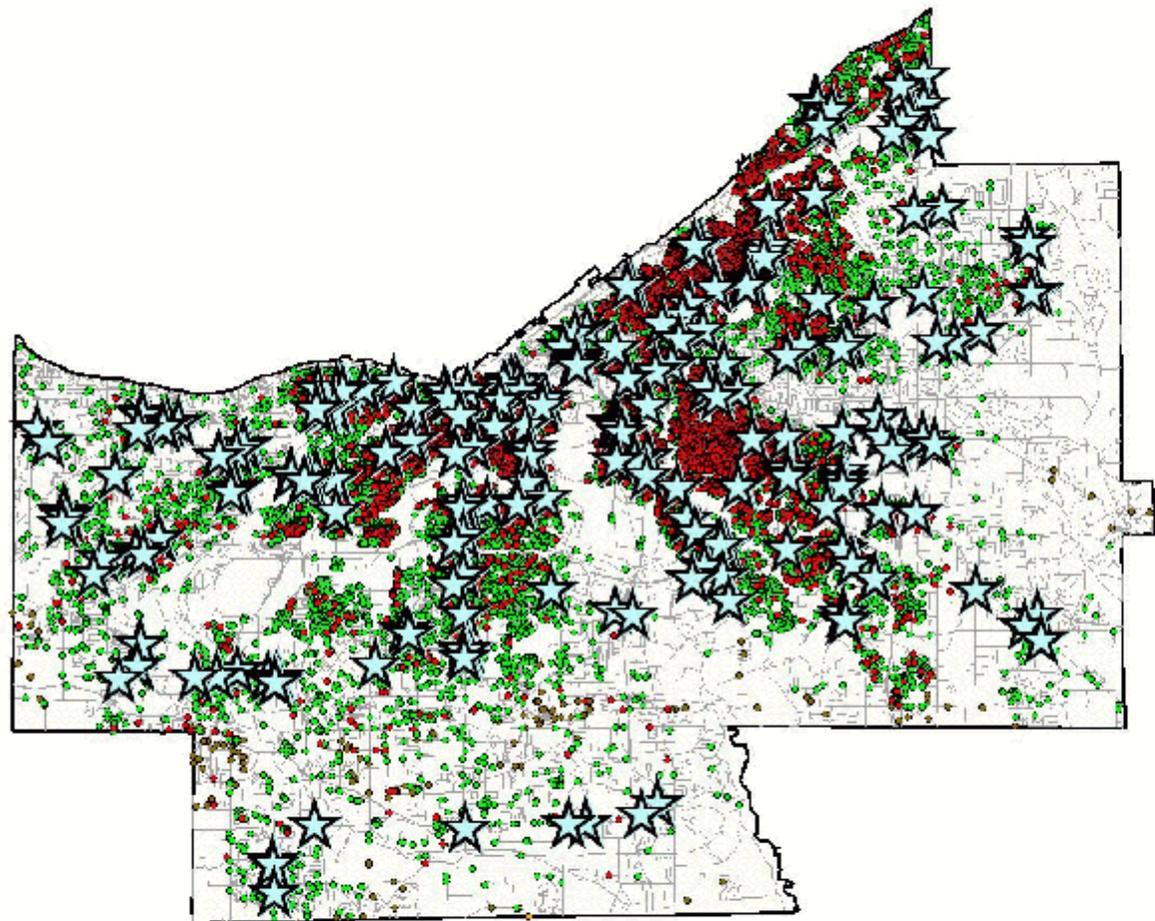
December 2000



**PCP PROVIDER TURNOVER RATES**

January - December 2000





## Spatial Analysis of ALL Providers Cuyahoga County

- Recipient Coverage by Capacity and Location:
- Within 3 miles ( 89.1 %)
  - Within 5 miles ( 89.6 %)
  - Within 7 miles ( 89.6 %)
  - Within 10 miles ( 89.6 %)
  - Outside of 10 Miles or No Available Capacity ( 10.4 %)
  - ★ Primary Care Physicians (2131)

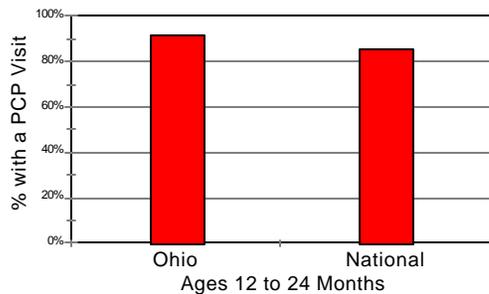
Ohio Department of Job and Family Services  
Office of Health Care  
Bureau of Managed Health Care  
LRA 2011

Prepared by:  
Christopher J. ...  
913 Sector  
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These graphs represent the percentages of children who had a visit with a MCP PCP and adults who had an ambulatory care service during the reporting year. Factors that can influence how well an MCP performs in this area are the availability of transportation services for enrollees, size and composition of the MCP's provider panel, and MCP efforts to educate enrollees on the need to obtain preventive health services. MCPs performed well in assuring that enrollees received medical services. This is also reflected in the fact that Ohio's Medicaid managed care population had a higher access rate for these services than those at the national level.

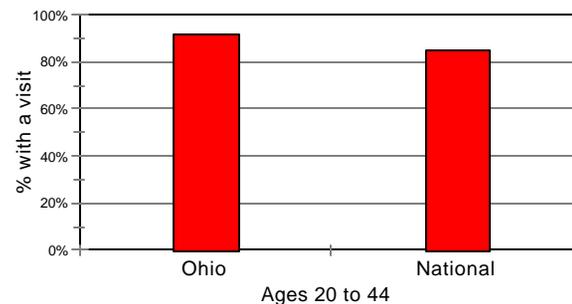
### Children's Access to PCPs

July 1999 - June 2000



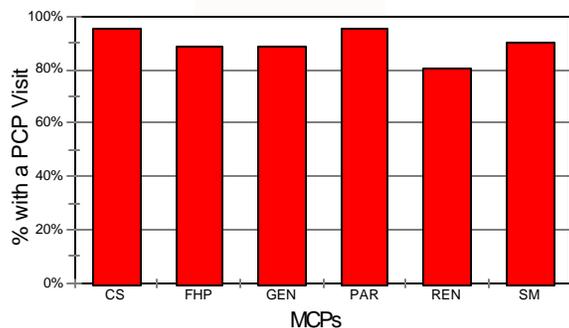
### Adult's Access to Ambulatory Care

July 1999 - June 2000



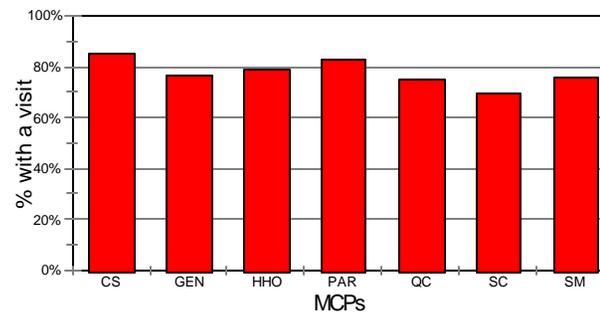
### Children's Access to PCPs

July 1999 - June 2000



### Adults Access to Ambulatory Care

July 1999 - June 2000



Analysis for these measures were adjusted for poor data quality

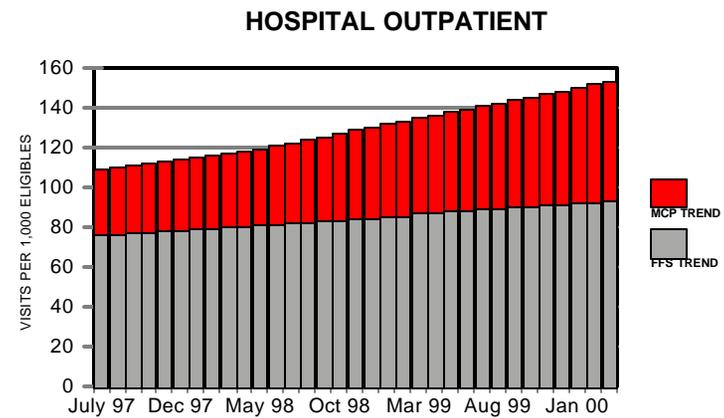
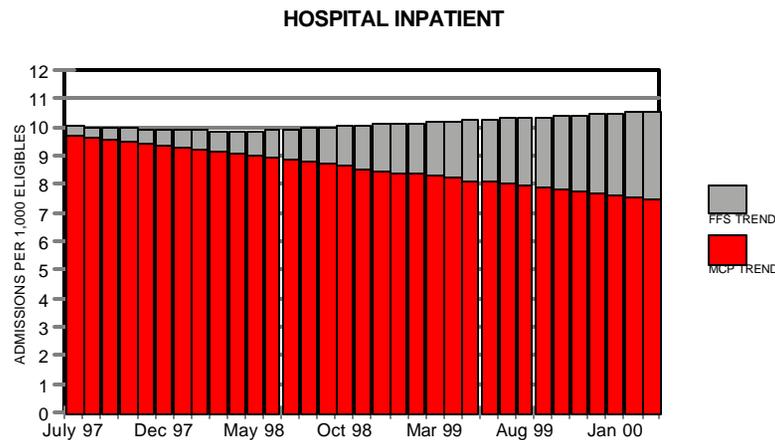
# Quality of Care

## MCPs emphasize preventive care

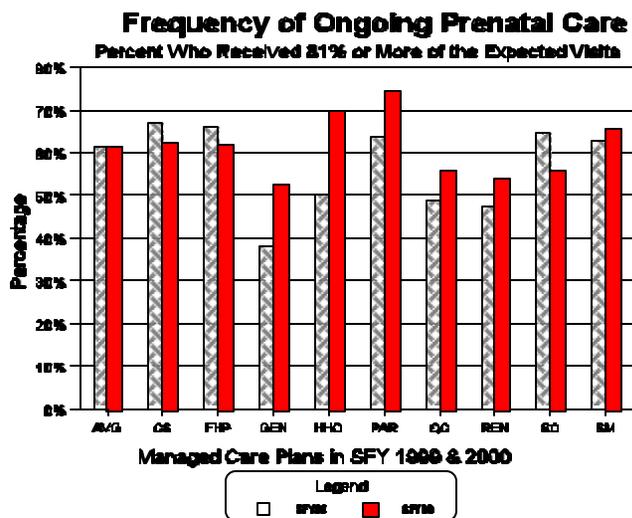
BMHC has measures in place to assure that the quality of care received through MCPs meets or exceeds set standards. Quality of care measures include:

- C An annual quality improvement (QI) survey performed by an external quality review organization that includes a medical record audit, a corporate MCP review, which includes a grievance audit, and quality of care studies of clinical processes and outcomes
- C Encounter data-based performance measures for prenatal care, preventive care for children and adolescents which includes HEALTHCHEK and immunizations, and pediatric asthma
- C A review of health services utilization data
- C Grievance/Complaint monitoring by type such as access, quality, provider satisfaction, and billing issues

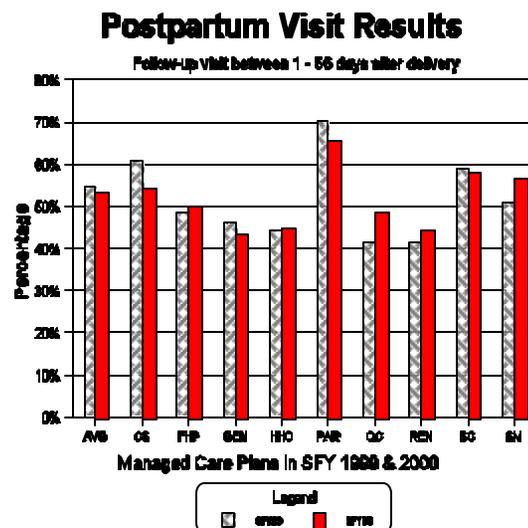
These two graphs compare the hospital utilization rates of the Ohio Medicaid fee-for-service system and Ohio Medicaid managed care program. MCPs' greater attention to preventive health and care management may explain reductions in the use of inpatient hospital services. A portion of decreased inpatient utilization may result from the increased use of outpatient services which is more cost effective.



Various clinical performance measures are monitored to insure the quality of medical services rendered by the MCPs. Two of these address prenatal care. The first graph represents the percentage of enrollees who received 81% or more of the expected prenatal visits as set by a nationally recognized entity. All MCPs performed about the same or improved from 1999 to 2000. The second graph represents the percentage of enrollees that had a follow-up medical visit between one and fifty-six days after delivery. The majority of MCPs performed the same or improved from 1999 to 2000.



Results may vary among plans due to administrative problems in reporting and may not represent the clinical performance of the providers within the MCP.



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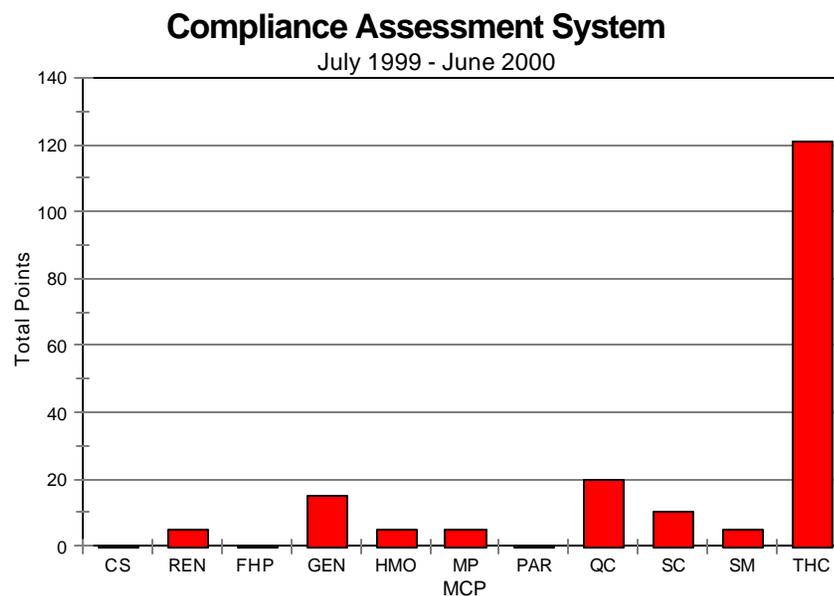
# Administrative Capacity

## Program compliance good among most MCPs

Managed care plans perform at varying levels of sophistication in the area of administrative capacity. The ability to report information accurately and completely is essential to the determination of value; otherwise, there will continue to be uncertainty with the assessment of access, quality, and other performance indicators.

Performance Improvement Agreements (PIA) have been created for each MCP. These documents, mutually developed by both the MCP and BMHC, serve as both an early warning system and an outline of activities the MCP can carry out to increase performance beyond minimum program requirements.

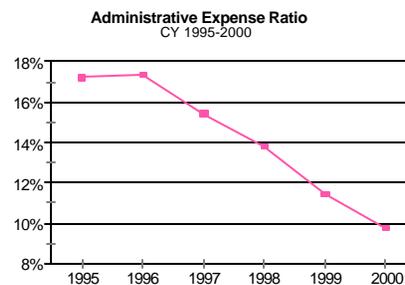
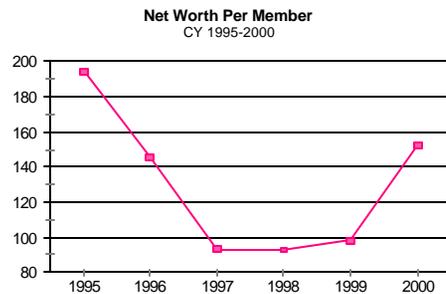
Deficiencies in many administrative areas result in the assessment of points under the managed care program's "Compliance Assessment System." After a specified number of occurrences, points are accrued and/or fines, enrollment freezes, and other penalties may be assessed along with required corrective action. The chart below reflects the administrative difficulties of Total Health Care Plan (THCP) which led to the end of its provider agreement with ODJFS.



### Financial monitoring expands

While oversight of the financial solvency of all MCPs in the state is the statutory responsibility of the Ohio Department of Insurance and only plans licensed by ODI are currently considered for Medicaid full-risk contracts, ODJFS does monitor MCP financial reports for signs of difficulties which could create access or quality concerns. As a partial indicator of financial stability, ODJFS established a measure of net worth per member (NWPM) for Medicaid contracting plans which is assessed annually. Any plan found to be below the standard is further reviewed and monitored for any indication of compromised quality or access. In addition, the BMHC has recently imposed two additional standards (Administrative Expense Ratio, Overall Expense Ratio) that MCPs must meet.

As seen in the first graph, Ohio Medicaid MCPs' overall financial condition is beginning to stabilize after a couple of years of decline. The next graph indicates that MCPs are reducing administrative costs, a reflecting of more efficient operations. Finally, the third graph shows that MCPs are reducing their overall losses; as a result more MCPs are showing a slight profit.



Net Worth is equal to an MCP's total admitted assets minus total liabilities divided by the number of MCP members.  
Administrative Expense Ratio is equal to an MCP's administrative expenses divided by total revenue.  
Overall Expense Ratio is equal to the sum of an MCP's administrative expense ratio and medical expense ratio.

| <b>Quality of Care</b>   | <b>Access</b>  | <b>Consumer Satisfaction</b>  | <b>Administrative Capacity</b>   |
|--|--|---|--|
| MCP Internal Quality Program   | Provider Panel Requirements  | ODJFS Annual Consumer Survey on Satisfaction  | Encounter Data Submissions   |
| Annual External Quality Review (EQRO)  | Geographic Information System (GIS)  | MCP Annual Consumer Satisfaction Surveys  | Reporting  |
| ◆ Clinical Studies   | PCP Turnover   | MCP Grievance Monitoring  | <ul style="list-style-type: none"> <li>◆ Grievances</li> <li>◆ Utilization</li> <li>◆ Cost</li> <li>◆ Provider Additions</li> <li>◆ Deletions</li> </ul> |
| Care Coordination  | Children's and Adult's Access to Primary Care Services Measure   | ODJFS Complaint Monitoring  | MCP Internal Quality Program   |
| <ul style="list-style-type: none"> <li>◆ Emergency Department Diversion</li> <li>◆ Case Management</li> <li>◆ Triage Procedures</li> </ul> | ODJFS Annual Consumer Survey on Access to Services   | State Hearings  | Member Services  |
| Clinical Performance Standards   | MCP Grievance & ODJFS Complaint Monitoring   | Prior approval of marketing and member services materials                           | ODJFS Annual Consumer Survey on MCP Member Services  |
| <ul style="list-style-type: none"> <li>◆ Prenatal Care</li> <li>◆ Preventive Care for Children</li> <li>◆ Annual Dental Visits</li> </ul>  | State Hearings   | Minimum Enrollment Requirements   | Information Technology   |
| ODJFS Annual Consumer Survey on Quality  | 24 Hour Call-In System   | Disenrollment   |  |
| Utilization Reports  | Appropriate, timely access   | <ul style="list-style-type: none"> <li>◆ Voluntary</li> <li>◆ Just Cause</li> </ul> |  |
| Quality of Care Grievances   | <ul style="list-style-type: none"> <li>◆ Emergency Department Diversion</li> <li>◆ Triage Procedures</li> <li>◆ Case Management</li> </ul> |   |  |
|  | Utilization Reports  |   |  |
|  | Disenrollment <ul style="list-style-type: none"> <li>◆ Voluntary</li> <li>◆ Just Cause</li> </ul>  |   |  |

For additional information about Ohio's Medicaid managed care program, please contact:

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