



PremierCare

Ohio Medicaid Managed Health Care Program

PROGRESS REPORT

January - December 2001

Bureau of Managed Health Care
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Ohio PremierCare

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 received federal approval to continue the managed care program as PremierCare.

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 MCPs receive the following extras:

- Guaranteed access to a Primary Care Physician
- Case management for special health care needs children
- Choice of PCPs, hospitals, & specialists listed in a provider directory
- Guaranteed sufficient hospital & specialist networks
- Guidance as to the appropriate use of services
- Extended office hours (varies among MCPs)
- Expanded benefits including transportation, vision & pharmacy (varies among MCPs)
- A member handbook explaining how to access member & health services
- 24 hour medical advice & direction via a hotline
- 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 focusing on four areas of responsibility. ODJFS holds MCPs accountable by setting standards in the areas of quality of care, access to services, consumer satisfaction, and administrative capacity. Specific measures used to evaluate MCP performance include:

<u>Quality of Care</u>	<u>Access</u>	<u>Consumer Satisfaction</u>	<u>Administrative Capacity</u>
<ul style="list-style-type: none">• External Quality Review (EQRO)	<ul style="list-style-type: none">• Provider Panel Requirements	<ul style="list-style-type: none">• Consumer Satisfaction Survey	<ul style="list-style-type: none">• MCP Member Services (URAC)¹
<ul style="list-style-type: none">• Clinical Performance Standards (HEDIS)¹	<ul style="list-style-type: none">• PCP Turnover Monitoring	<ul style="list-style-type: none">• MCP Grievances & State Hearings for Enrollees	<ul style="list-style-type: none">• Performance Improvement Agreements
<ul style="list-style-type: none">• Care Coordination	<ul style="list-style-type: none">• Geographic Information System (GIS)	<ul style="list-style-type: none">• MCP Disenrollments	<ul style="list-style-type: none">• MCP Encounter Data Submissions to ODJFS
<ul style="list-style-type: none">• Case Management of Children with Special Health Care Needs	<ul style="list-style-type: none">• Appropriate & Timely Access to Services	<ul style="list-style-type: none">• Marketing & Member Services Materials Review	<ul style="list-style-type: none">• MCP Financials Reviews

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:

- Unbiased enrollment information and assistance by telephone, mail, and local outreach
- General managed care information brochures, videos, and MCP comparison information
- A centralized toll-free number to respond to consumer questions, provide information, and offer a referral mechanism to facilitate the resolution of complaints/grievances
- Program requirements for MCP grievance procedures and the monitoring of MCPs' grievance logs to assess the nature and assure the timely resolution of grievances, and to develop consumer reporting mechanisms
- Access to the state hearing process when appropriate

¹ A national healthcare accreditation organization.

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 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.

2001 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. According to data obtained from the Centers for Medicare and Medicaid Services, the number of managed care organizations serving Medicaid consumers decreased from 337 in 2000 to 324 in 2001; however, Medicaid managed care enrollment increased 13% during the period. In the Ohio program, the number of contracting plans decreased by two from January to December 2001. As of December 2001, seven plans were under contract to serve Medicaid enrollees in fifteen counties.

Preferred Option, a new MCP enrollment initiative, was introduced January 2001 in Hamilton and Montgomery counties, followed by its introduction in Butler and Franklin Counties in February 2001. Under Preferred Option, Healthy Start, Healthy Families eligibles must choose between enrolling in a managed care plan or remaining on the Medicaid fee-for-service program. Individuals who fail to make a choice are enrolled in the designated Preferred Option MCP. There are no limitations on enrollment changes in Preferred Option counties.

SuperMed terminated participation in the Ohio Medicaid managed care program with its September 30, 2001, withdrawal from Cuyahoga County. SuperMed enrollees were given the opportunity to enroll in another participating MCP, or to return to Medicaid fee-for-service (FFS) until they receive a notice to choose an MCP following their next redetermination for Healthy Start, Healthy Families Medicaid. Approximately 22,930 members were returned to FFS. HMO Health Ohio terminated its participation in the Ohio program with its withdrawal from Lucas County in December 31, 2001. Its members were transferred to Family Health Plan.

Key program enhancements and initiatives in the Medicaid managed care program implemented during this reporting period:

- C The Centers for Medicare and Medicaid Services approved Ohio's request to continue the Medicaid managed health care program under a new waiver [1915(b)]. The new waiver took effect July 1, 2001 along with the new name of the program, "PremierCare."
- C ODJFS implemented a core set of requirements designed to enhance the screening and identification of children with special health care needs, ensure a timely and thorough assessment of health care conditions, and provide case management services appropriate to the needs of the child.
- C An incentive program based on MCP performance was implemented in July, 2001, which places a portion of the capitation payment at risk. MCPs performing at standard levels of performance on 15 measures will retain the incentive dollars, whereas MCPs performing below the standard levels will be required to return the incentive amount. Additional incentive dollars are available for MCPs that have superior performance across all measures.
- C MCP Performance Improvement Agreements focused on provider fraud and abuse policies and further improving consumer satisfaction.
- C During the year a majority of the eighteen Ohio Administrative Code rules for MCPs were revised. Some of the areas addressed included MCP reimbursement of emergency services, information provided to enrollees by MCPs, and a new rule that impacts MCP non-contracting providers who nevertheless deliver certain services to MCP enrollees. This rule requires that these providers accept a reimbursement rate from MCPs for emergency and Qualified Family Planning Provider services at the lesser of 100% of the Medicaid provider reimbursement rate or billed charges.
- C In July 2001, ODJFS implemented a new process by which MCP eligibles in mandatory counties who, after receiving two notices, fail to enroll in an MCP will be assigned to an MCP. The previous "round robin" process was replaced with a methodology that takes into account where an MCP eligible has received services (previous MCP or FFS provider). This new process will support continuity of care for consumers and encourage MCPs to enhance existing PCP panels.
- C ODJFS conducted a survey of MCP enrollees residing in Preferred Option counties. The first survey was conducted in order to determine enrollee satisfaction with the enrollment process. A second survey, which will be conducted in 2002, will focus on issues of provider access and quality of care.
- C As required by federal law and effective July 1, 2001, a wraparound payment procedure for services delivered to Medicaid-contracting MCP enrollees by Federally Qualified Health Centers (FQHC) was implemented. This procedure allows FQHCs and rural health clinics to submit a direct claim to ODJFS for supplemental payment for services provided to MCP enrollees.

Enrollment

Enrollment is increasing

As of May, 2002, the Ohio Medicaid managed care program consists of seven MCPs operating in fifteen counties. The Ohio Medicaid Covered Families and Children population statewide was 970,624; the population in MCP served counties was 587,344. MCP enrollment was approximately 38 percent of the statewide total and 63 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 FFS 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. The third category, Preferred Option, is described in a previous section of this report (2001 Statewide Health Care Market Summary).

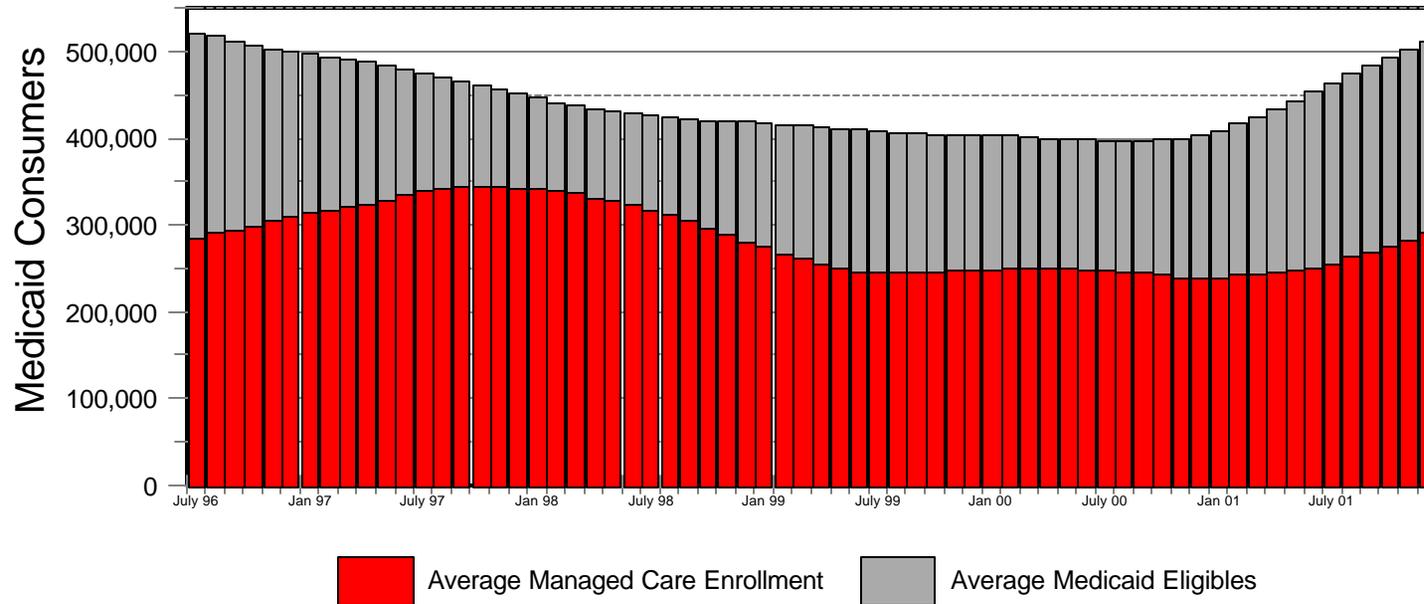
From a consumer perspective, several options are offered to provide information needed to choose an MCP. MCP information sources include:

- Unbiased MCP information and enrollment assistance by telephone and mail through an independent contractor
- Local outreach activities conducted by the independent contractor such as health fairs and information booths in public settings
- Ⓒ General managed care consumer guides, videos and comparison charts
- Ⓒ 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
- Ⓒ MCP 1-800 numbers

The number of Medicaid consumers who are eligible to enroll in an 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 three such factors: the caseload size of the eligible population in MCP-served counties, MCP transitions within those counties, and changes in county managed care enrollment status. Total enrollment as of December 2001 was 334,400.

Enrollment Trend

July 1996 - December 2001



Consumer Satisfaction

Medicaid consumers' satisfaction with MCPs remains high

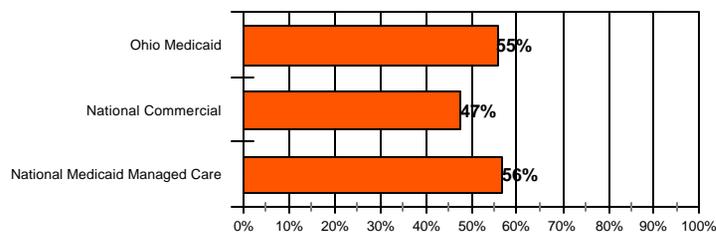
Tools used to assess consumer satisfaction include:

- Ⓒ An independent consumer satisfaction survey
- Ⓒ MCP assessment of enrollee satisfaction
- Ⓒ Reviews of complaints filed with ODJFS and grievances filed with the enrollee's MCP
- Ⓒ Reviews of voluntary disenrollment rates and reasons
- Ⓒ 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 continue to be low while Ohio Medicaid managed care consumer satisfaction remains high:

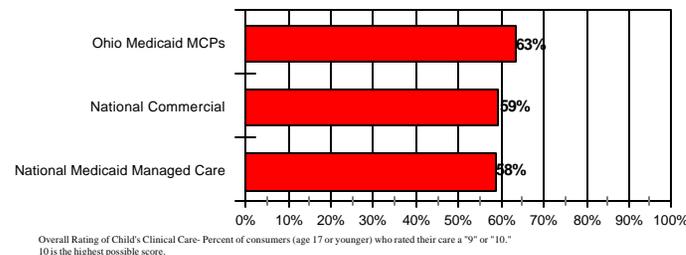
- Ⓒ Consumers' satisfaction with their MCP is extremely close to national Medicaid managed care with only a 1% difference in score.
- Ⓒ Consumers' satisfaction with the care received through their MCP exceeds national Medicaid managed care by 5 %.

SATISFACTION WITH HEALTH PLAN



Overall Rating of Child's Health Plan- Percent of consumers (age 17 or younger) who rated their plans a "9" or "10." 10 is the highest possible score.

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.

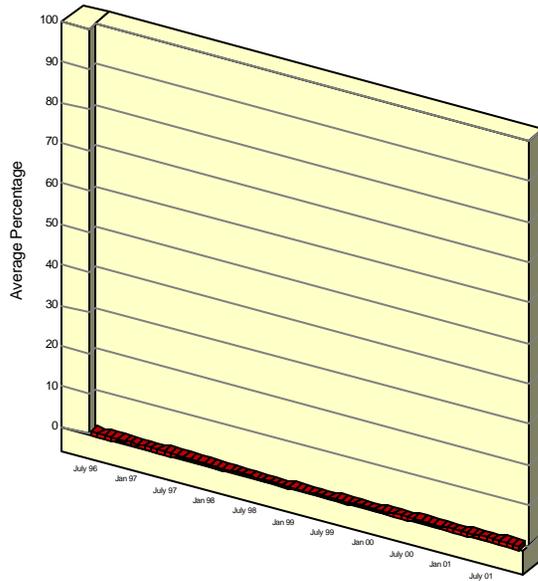
Due to differences in survey methodology, results cannot be compared to previous years' results.

Few enrollees choose to disenroll

The voluntary disenrollment rate, which is the most immediate indicator of member dissatisfaction, continues to be very low. The average voluntary disenrollment rate has remained low since 1996 and continues to be so for 2001. All MCPs except one had voluntary disenrollment rates equal to or less than one percent. The one plan with a higher rate, due to the loss of a major provider on its panel, is no longer in the program.

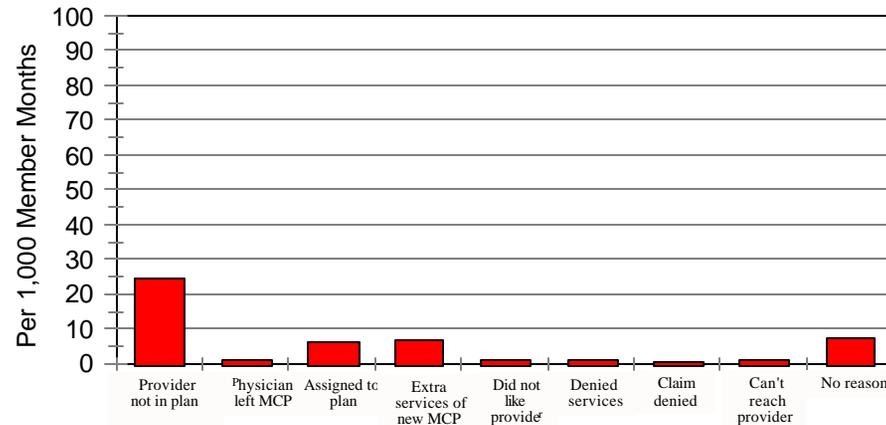
Disenrollment reasons listed are those provided by enrollees at the time of disenrollment. An enrollee may indicate more than one reason for disenrolling from an MCP. The relatively high proportion of reasons designated as “provider not in plan” may be due to consumers who did not select an MCP and thus were assigned to an MCP which may not have had their preferred provider on its panel.

Voluntary Disenrollment Trend



Voluntary Disenrollment Reasons

January - December 2001

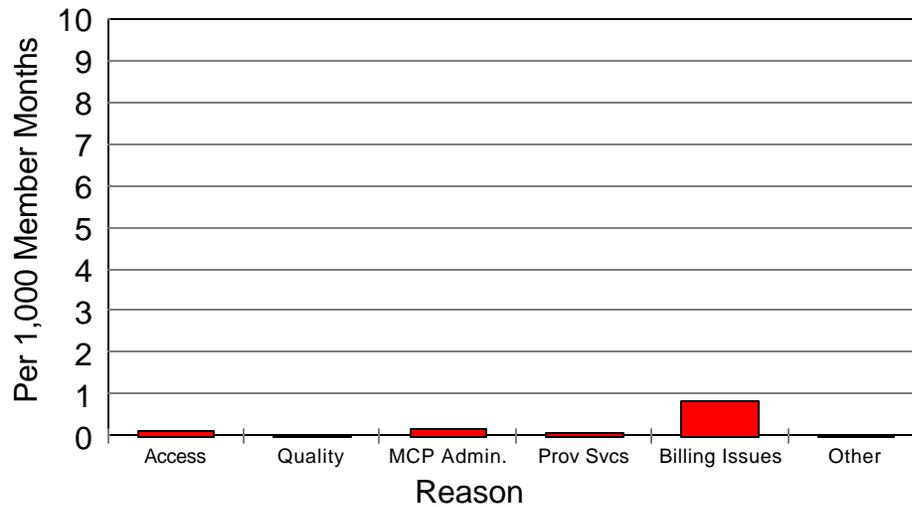


Access and Quality issues create few enrollee problems

While MCP enrollees overall filed a minimal number of complaints and grievances, BMHC has determined that certain types of complaints and grievances are important indicators of enrollee access and satisfaction with services provided by their MCPs. The largest number of enrollee complaints and grievances were related to enrollees being inappropriately billed for services they have received. Often these billing problems result from the use of centralized billing entities that automatically bill all of a provider's patients for any outstanding balance due. Also, sometimes enrollees mistake an MCP-provided Explanation of Benefits form for an actual bill.

Grievance and Complaint Reasons

January - December 2001



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, billing issues, and satisfaction with providers
- C Annual Medicaid Managed Care Consumer Satisfaction Survey
- C A review of health services utilization data
- C National (HEDIS) access measures

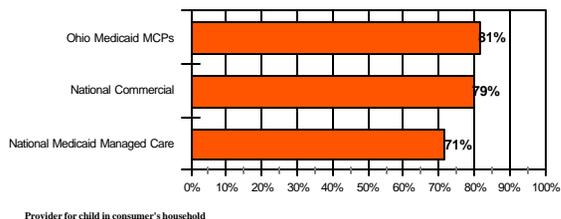
If there are problems accessing services, enrollees can complain to ODJFS or file a grievance with their MCP. In addition, they may request a state hearing. Complaints and grievances are reviewed and MCP response time monitored by the BMHC. Enrollees are linked to a medical home by selecting a primary care provider (PCP) prior to or upon enrollment. MCPs distribute member handbooks and provider directories to each new member to help enrollees choose a PCP. These materials are also available to eligibles prior to enrollment from the enrollment services center.

Medicaid consumers are satisfied with their access to care in managed care

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

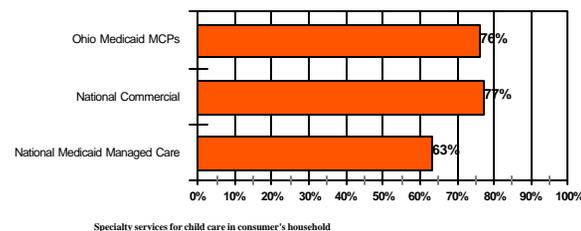
EASE IN FINDING A DOCTOR OR NURSE

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



EASE IN GETTING A REFERRAL TO A SPECIALIST

Consumers responding it was not a problem to get a referral to a specialist



PCP capacity far exceeds the number of eligibles or enrollees

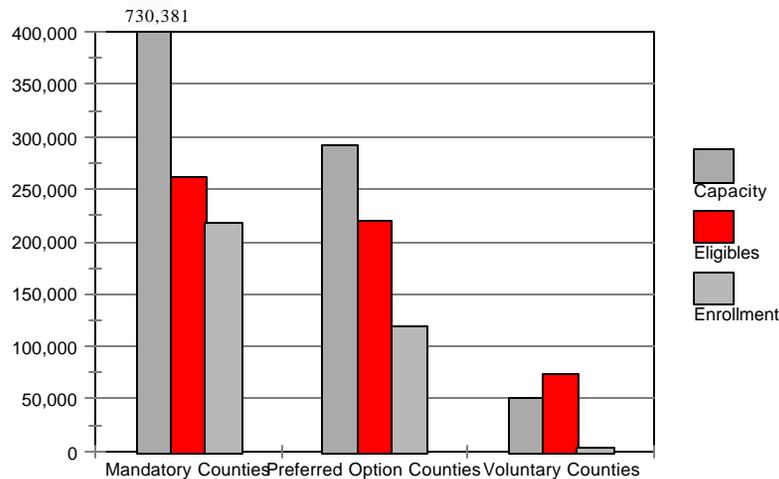
PCP capacity represents the number and service capacity of primary care providers available to MCP enrollees in a specific county. In the PCP Capacity graph, the amount of service capacity available is compared to both the number of enrollees and Medicaid eligibles. In all county types, capacity greatly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

MCPs' PCP panels stabilize in 2001

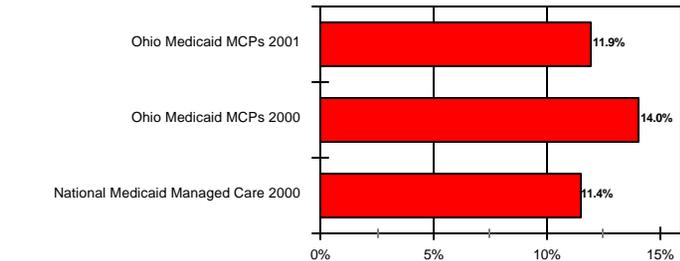
The PCP Turnover measure is used in conjunction with other measures to hold MCPs accountable for Medicaid consumers' ability to access care. It represents an MCP's PCP provider panel continuity from year to year and can serve as a proxy for provider satisfaction. Specifically, turnover represents the percentage of an MCP's PCP provider panel that left the panel during 2001. Additional PCPs may have joined the MCP's panel during the year as well. Large turnover rates may create access difficulties for enrollees if preferred PCPs leave an MCP's panel. Routine monitoring of this measure indicated a high turnover rate and so the MCPs were held accountable to achieve acceptable rates. This resulted in a drop of over two percent in 2001 to match the national rate.

PCP Capacity

January 2002



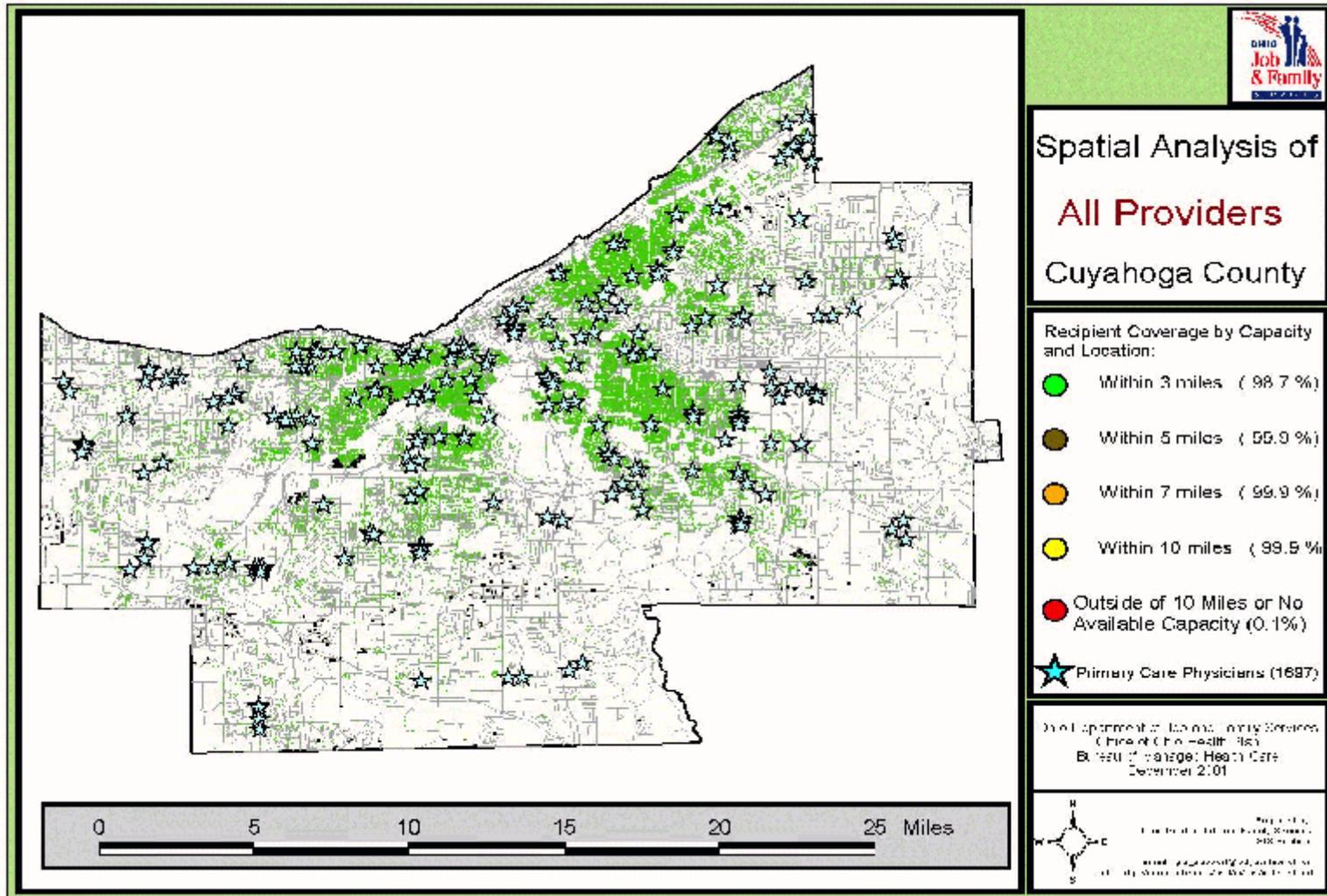
Primary Care Physician Turnover Rates



The percentage of primary care physicians affiliated with the MCP as of December 31 of the year preceding the measurement year who were not affiliated with the MCP as of December 31 of the measurement year.

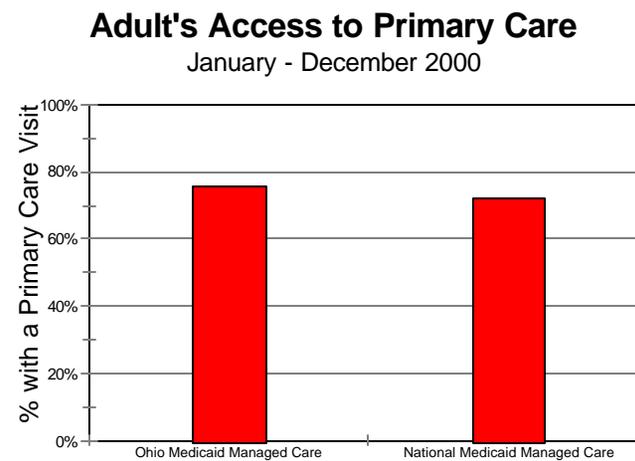
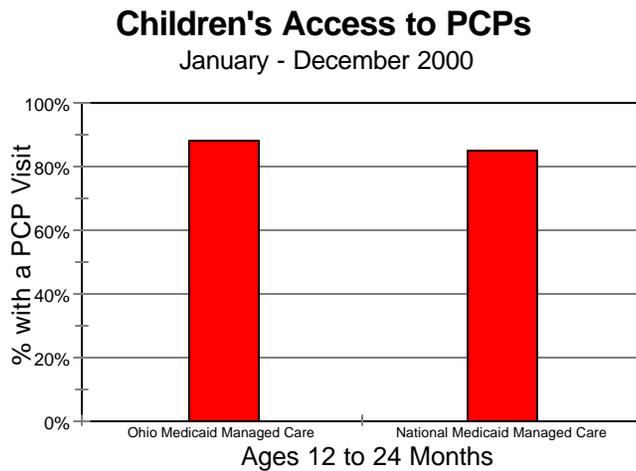
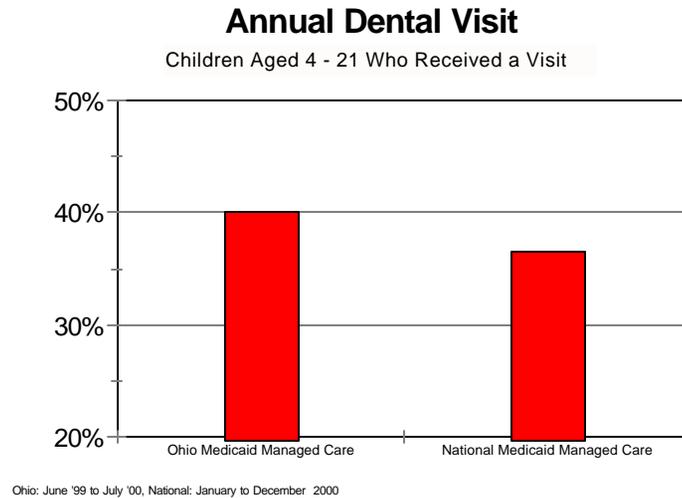
PCPs with capacity are located near Medicaid consumers

Below 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.



High utilization of primary care services indicates access is excellent

The top graph represents the percentages of children who received a dental visit. The lower two represent the percentages of children who had a visit with a MCP PCP and adults who had a primary care service during the reporting year. These results show to what extent enrollees received medical services. Ohio's Medicaid managed care population had a higher access rate for these services than the same services at the national level.



Quality of Care

Medicaid 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:

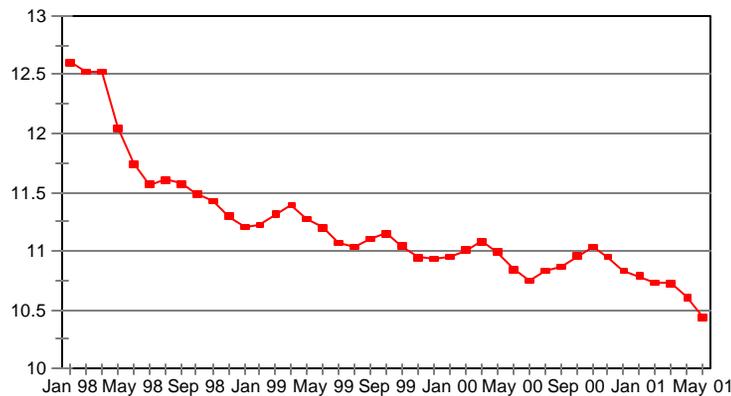
- C An annual quality improvement (QI) survey performed by an external quality review organization that includes medical record audits, a corporate MCP review, which includes a grievance audit, and quality of care studies of clinical processes and outcomes
- C Encounter data-based performance measures 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, including quality issues

Medicaid MCPs effectively manage hospital services

These two graphs show that, over time, inpatient hospital utilization is being reduced while outpatient use is increasing. 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.

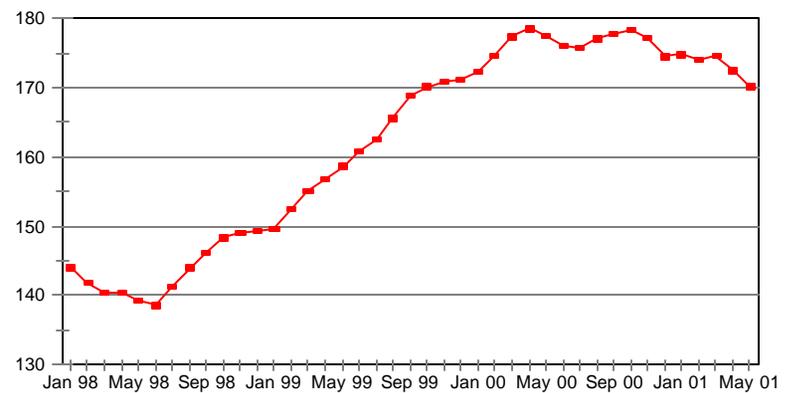
Inpatient Hospital Admissions

Per 1000 MCP Enrollees



Outpatient Hospital Visits

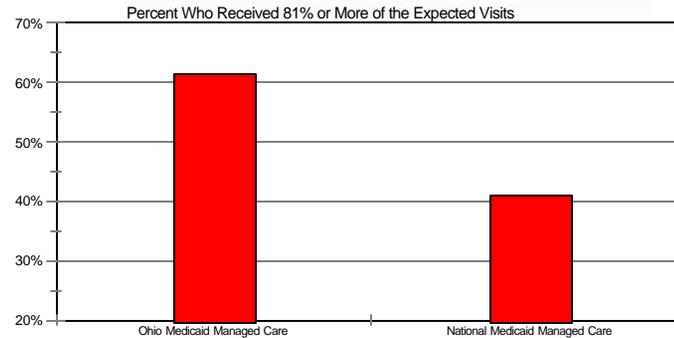
Per 1000 MCP Enrollees



Medicaid MCPs deliver preventive care for pregnant women, children, & asthmatics

Various clinical performance measures are monitored to insure the quality of medical services rendered by the MCPs. One of these addresses prenatal care. The top graph represents the percentage of enrollees who received 81% or more of the expected prenatal visits as set by a nationally recognized entity. The well-child visit graph shows that more children enrolled in Ohio's Medicaid MCPs received at least one visit than those in national Medicaid MCPs. Asthma medication management is a focus area for Ohio's program as indicated by the increasing number of patients receiving appropriate medications.

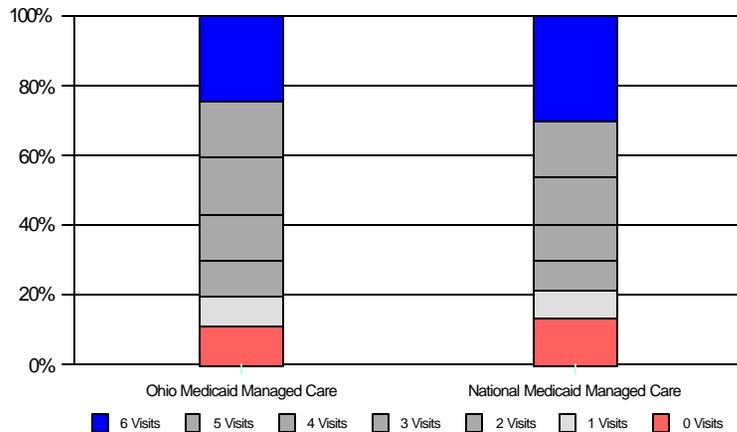
Frequency of Ongoing Prenatal Care



Ohio: June '99 to July '00, National: January to December 2000

Well-Child Visits in the First 15 Months of Life

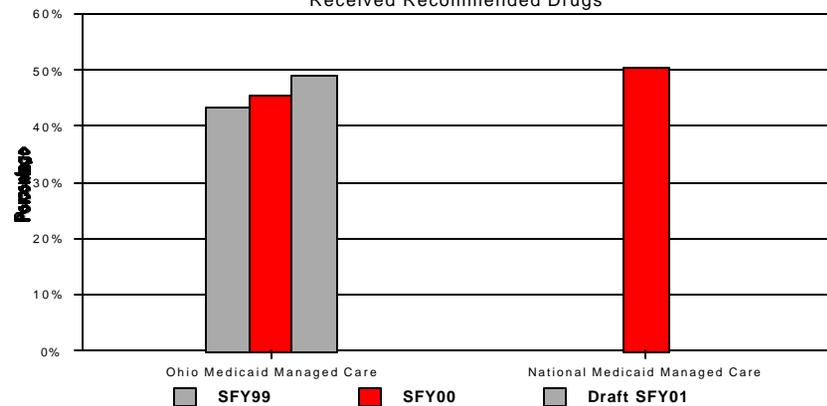
% of Children Who Received 0,1,2,3,4,5,6 Visits (SFY 2001)



Source of Data: Encounter Data and NCQA (Calendar Year 2000)

Asthma Medication Management

% of Members With Persistent Asthma (Ages 5-56) Who Received Recommended Drugs



Source of Data: Encounter Data and NCQA (Calendar Year 2000)

Administrative Services

Medicaid consumers rank MCP member services high

Managed care plans perform at varying levels of sophistication in the area of enrollee administrative service. The ability of MCPs' customer service departments to provide information to enrollees, assist with problem filing and resolution, and to otherwise assist their members contributes to the efficacious provision of health care services. Tools used by BMHC to assess MCP administrative service include:

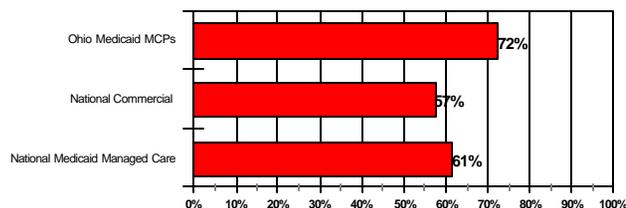
- C Requiring MCPs to manage their member service and medical advice phone lines using industry standards
- C Review of complaints and grievances filed by MCP enrollees
- C Review of related responses on the annual MCP consumer satisfaction survey

Administrative Services also includes the ability of MCPs to report information, such as encounter data and claims payment data, accurately and completely to ODJFS in order to make assessments regarding access, quality, and other performance indicators. Deficiencies in many administrative areas result in the assessment of points and other penalties under the managed care program's "Compliance Assessment System." BMHC works with each MCP to develop Performance Improvement Agreements which serve as an early warning system and an outline of activities the MCP can carry out to increase performance beyond minimum program requirements.

The results of this graph indicate that MCPs did a better job at providing assistance to their enrollees than did national managed care organizations.

ADMINISTRATIVE SERVICE

Consumers reporting it was not a problem to get information from MCP.



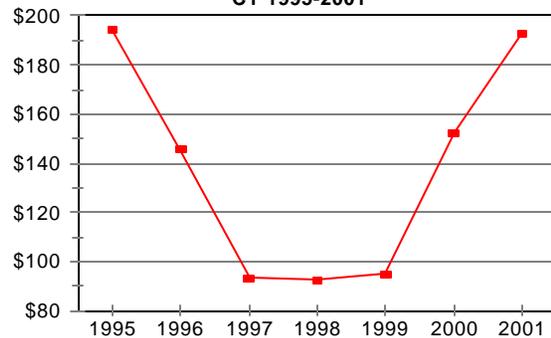
Not a problem when calling MCP's customer service

Financial monitoring expands

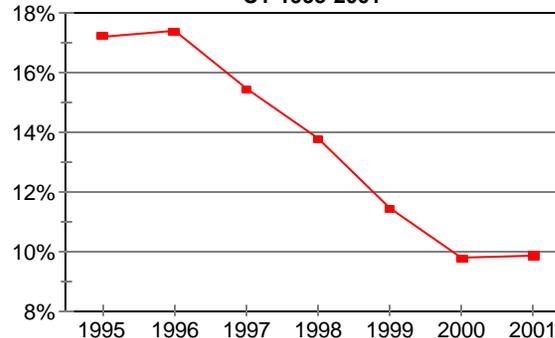
While oversight of the financial solvency of all health insuring corporations in the state is the statutory responsibility of the Ohio Department of Insurance (ODI) and only plans licensed by ODI are currently considered for Medicaid full-risk contracts, ODJFS does monitor MCP financial reports for signs 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 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 improve after a couple of years of decline. The next graph indicates that MCPs have reduced administrative costs, a reflection of more efficient operations. Finally, the third graph shows that MCPs are reducing their overall losses; although the overall Expense Ratio is still above 100%, more MCPs are showing a slight profit.

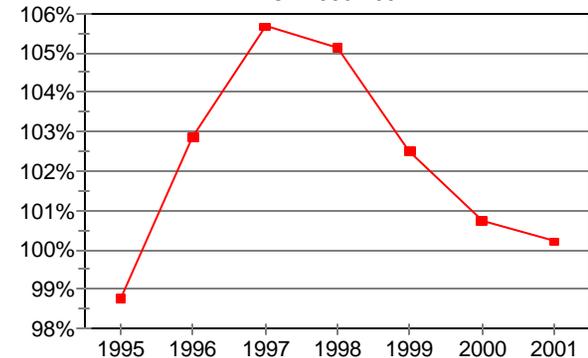
Net Worth Per Member
CY 1995-2001



Administrative Expense Ratio
CY 1995-2001



Overall Expense Ratio
CY 1995-2001



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

Ohio Department of Job and Family Services
Bureau of Managed Health Care
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(614) 728-4516 fax