



Ohio Medicaid Comprehensive Managed Care Program

Progress Report
January through December 2003



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 Ohio Medicaid's Comprehensive Managed Care program, a full risk program for the Covered Families and Children population.

Ohio Medicaid managed health care is designed to assure access to appropriate services and quality of care for enrolled Medicaid members, to improve provider accountability, and to increase cost predictability. Since 1978, the ODJFS has contracted with managed care plans (MCPs, 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, ODJFS requested and received federal approval to continue the Comprehensive Managed Care program.

The Bureau of Managed Health Care (BMHC) within OHP is responsible for the development, administration, and assessment of the Medicaid managed health care program. The Bureau's work includes the design of MCP contracting specifications, selection of qualified MCPs, contract monitoring, performance evaluations, reporting, and development and implementation of new program initiatives. The Bureau is also responsible for developing 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 FFS program. Medicaid consumers enrolled in MCPs receive the following extra services:

- Guaranteed access to a primary care physician (PCP)
- Case management for special health care needs children
- Choice of PCPs, hospitals, & specialists listed in a provider directory
- Guaranteed sufficient hospital & specialist networks
- Guidance to the appropriate use of services
- Extended office hours (varies among MCPs)
- Expanded benefits including transportation, vision, & prenatal care incentives (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 member complaints

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 tools and 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 Survey by an 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
<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 Members 	<ul style="list-style-type: none"> Performance Improvement Projects
<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 Disenrollment Reviews 	<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 Requirements 	<ul style="list-style-type: none"> Marketing & Member Services Materials Review 	<ul style="list-style-type: none"> MCP Financial Report Reviews

Consumer Focus

The program continues to emphasize the interest of the consumer at every point of the managed care delivery system, including the initial notification of enrollment and selection of a PCP. Members are assured provider 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 and MCP comparison information
- A centralized ODJFS toll-free number to respond to consumer questions and provide information
- Program requirements for MCP complaint procedures and the monitoring of MCPs' complaint logs to assess the nature of and to assure the timely resolution of complaints, and to develop consumer reporting mechanisms
- Access to the state hearing process when appropriate

¹ A set of standardized performance measures supported by 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 Medicaid's Comprehensive Managed Care program.

MCP 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 to 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.

2003 Statewide Health Care Market Summary

The year began with five plans operating in the Ohio Medicaid managed care program. After a period of absence from the program, MediPlan renewed its participation with enrollment in Stark County beginning in June. During December, Buckeye Community Health Plan signed a Provider Agreement with ODJFS and an asset transfer was approved which allowed them to receive Family Health Plan's enrollment in Lucas County effective January 1, 2004, when Family Health Plan left the program.

Enrollment in the counties in which Ohio's Medicaid managed care program operates is classified as mandatory, voluntary, or Preferred Option. In mandatory enrollment counties, all eligible consumers must enroll in one of the participating MCPs in order to receive Medicaid-covered services. In voluntary enrollment counties consumers have a choice between enrolling in an MCP or utilizing the traditional FFS program. In Preferred Option enrollment counties, eligible consumers also have the option of receiving health care services through Medicaid FFS or the participating MCP, however, Preferred Option eligible consumers who do not contact the Enrollment Services Center upon receiving eligibility notification, will be enrolled in the participating MCP.

Stark County's enrollment designation changed from Preferred Option to mandatory with the addition of MediPlan's operation in the county. This increased the number of mandatory counties to four. The number of Preferred Option counties grew from five to six with the addition of Clark County, previously a voluntary county.

During the year BMHC began work on the development of the Enhanced Care Management program for certain consumers in the Medicaid Aged, Blind, and Disabled category. In October, ODJFS issued a Request for Applications for service delivery and in November an applicant information conference was held.

Current information and updated reports concerning the program can be found at: <http://jfs.ohio.gov/ohp/bmhc/managed.stm>

Key program enhancements and initiatives in the Medicaid managed health care program implemented during 2003:

- C BMHC successfully completed the renewal of the 1915(b) federal waiver authorizing the managed care program.
- C BMHC completed the process of revising program requirements in response to the issuance of the 1997 Balanced Budget Act. Ohio was one of the first states to be in full compliance with the new federal regulations.
- C COMPASS, an MCP evaluation tool that includes almost all of the performance measurement standards used by BMHC, was developed.
- C A new MCP, Buckeye Community Health Plan, met all program procurement requirements and signed a provider agreement to serve members in Lucas County.
- C The managed health care program's "Performance Evaluation and Incentive System" was fully implemented based on a series of plan performance indicators.
- C Successful competitive procurements for an external quality review organization and enrollment selection services vendor were conducted.
- C State hearing rights were extended to Medicaid consumers whose request for MCP termination via the "Just Cause" or a justifiable reason as determined by BMHC in accordance with program rules, was denied.
- C HIPAA 834 and 820 transactions were implemented and MCPs began receiving HIPAA-compliant transaction data.
- C Due to budget constraints, a rate freeze was imposed on MCPs for the first half of CY 2003. To mitigate the impact of the freeze, only the first half of the SFY 2003 contract year designated at-risk amounts were considered "at risk."

Enrollment

Enrollment continues to increase

As of December 2003, the Ohio Medicaid managed care program was operating in fifteen counties. The Ohio Medicaid Covered Families and Children population statewide was 1,108,631; the population in MCP served counties was 670,922. MCP enrollment was approximately 44 percent of the statewide total and 73 percent in the counties with Medicaid MCP enrollment. (The Medicaid Aged, Blind, and Disabled population is not eligible for managed care enrollment).

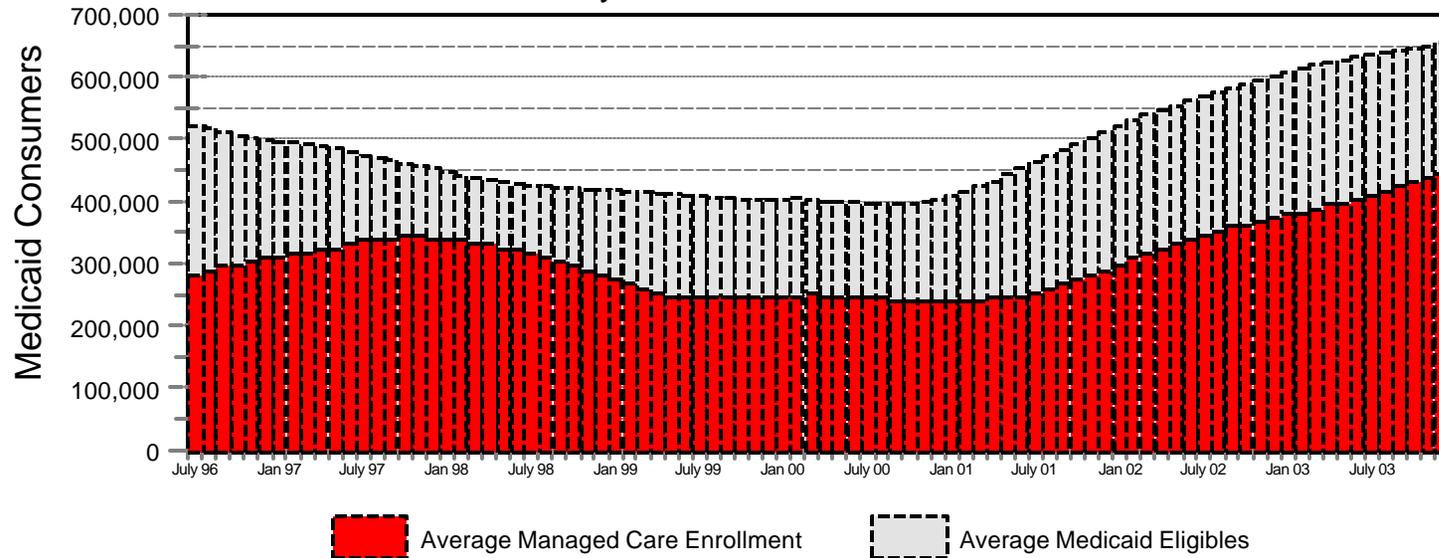
In voluntary and mandatory enrollment counties, members must remain in the selected MCP for up to a year, although disenrollment during this period is permitted within the first three months of enrollment or if there is a justifiable reason or “just cause”. Unlike mandatory or voluntary enrollment counties, MCP members in Preferred Option counties may request to disenroll at any time from the MCP and return to Medicaid FFS or choose another MCP, if available. 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
- Ⓒ Direct toll-free number for the Selection Services Contractor (1-800-605-3040 or TDD 1-800-292-3572)
- Ⓒ 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 2003 was 486,745.

Enrollment Trend

July 1996 - December 2003



Consumer Satisfaction

Medicaid consumers' satisfaction with MCPs remains high

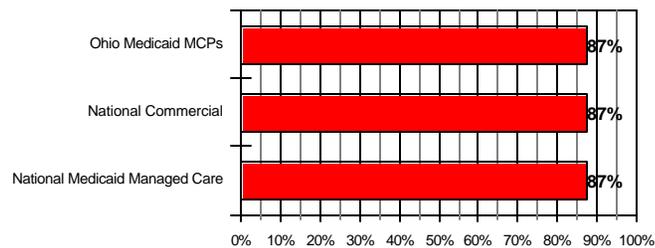
Tools used to assess consumer satisfaction include:

- Ⓒ An independent consumer satisfaction survey
- Ⓒ MCP assessment of enrollee satisfaction
- Ⓒ Reviews of complaints filed with ODJFS and with the member'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:

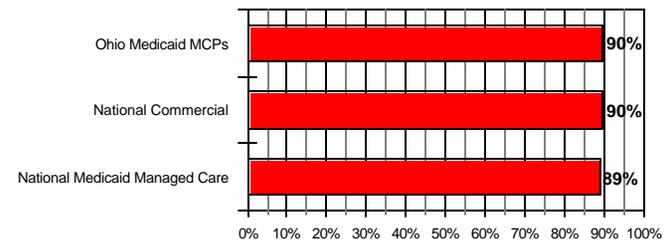
- Ⓒ Consumers' satisfaction with their MCP compares favorably to national Medicaid and commercial managed care
- Ⓒ Consumers' satisfaction with the care received through their MCP compares favorably to national Medicaid and commercial managed care

SATISFACTION WITH HEALTH PLAN



Overall Rating of Child's Health Plan- Percent of consumers (age 17 or younger) who rated their plans a "7" "8" "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 "7" "8" "9" or "10." 10 is the highest possible score.

Few enrollees choose to disenroll

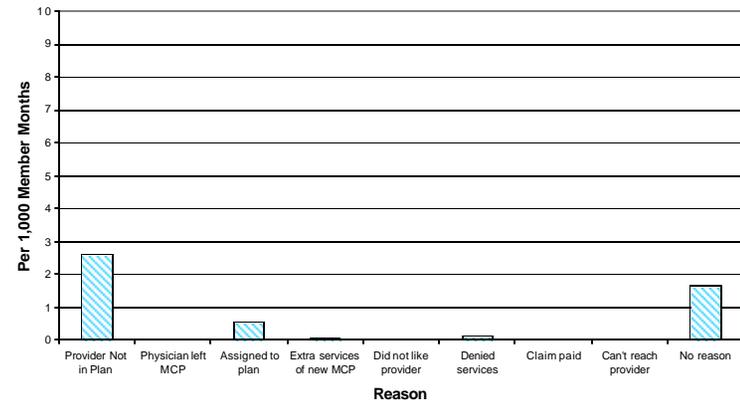
The voluntary disenrollment rate, which is an immediate indicator of member dissatisfaction, continues to be very low. The average voluntary disenrollment rate has remained low since the program expanded in 1996 and continues to be so for 2003, with overall voluntary disenrollment rates less than one percent.

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
July 1996 - December 2003



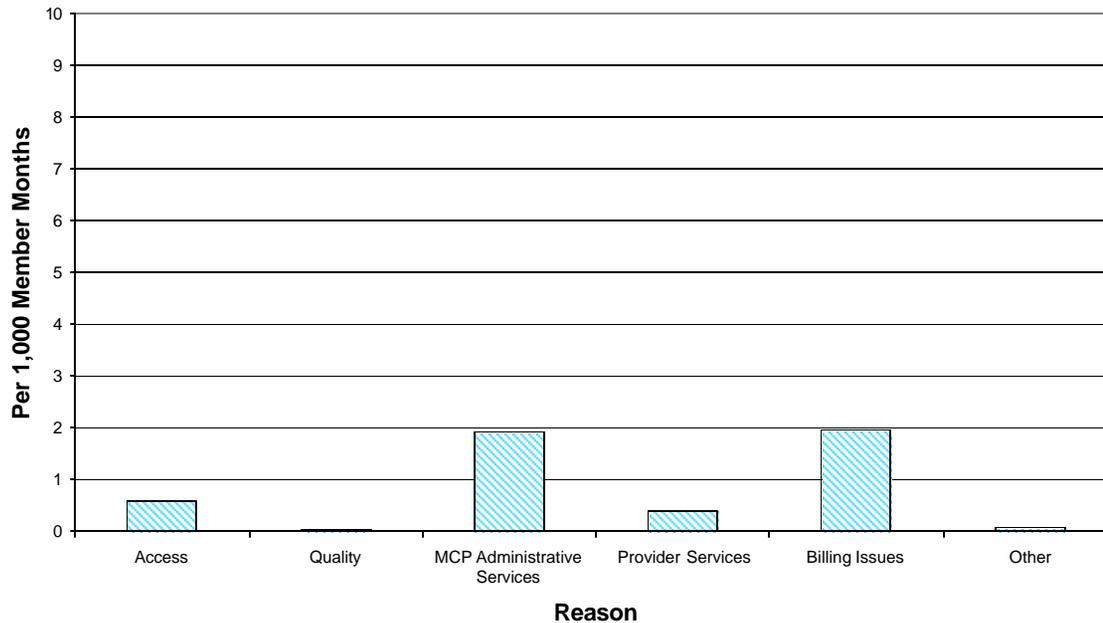
Voluntary Disenrollment Reasons
January - December 2003



Access and quality issues create few enrollee problems

While MCP enrollees overall filed a minimal number of complaints, BMHC has determined that certain types of complaints are important indicators of enrollee access and satisfaction with services provided by their MCPs. The largest number of enrollee complaints 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 a notice that a provider has been denied payment for performing a non-medically necessary service for an actual bill.

Complaint Reasons
January - December 2003



Access to Care

Access to care remains very high for MCP members

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

- Ⓒ Monitoring of MCP provider panels for size and composition
- Ⓒ Primary care physician capacity and geographical location in relation to Medicaid consumers
- Ⓒ Complaint monitoring by type such as access, quality, billing issues, and satisfaction with providers
- Ⓒ Annual Medicaid Managed Care Consumer Satisfaction Survey
- Ⓒ Monitoring MCP call centers for abandonment rate, blockage rate, and average speed of telephone response
- Ⓒ Monitoring of full-time practice status of designated MCP contracting provider panel specialists
- Ⓒ A review of health services utilization data
- Ⓒ National (HEDIS) access measures

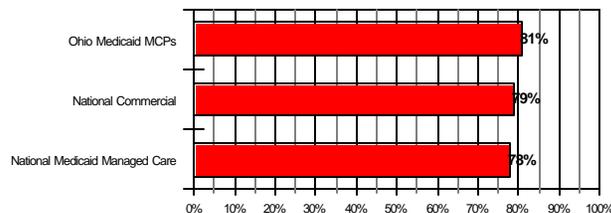
If there are problems accessing services, enrollees can complain to ODJFS or file a complaint with their MCP. In addition, they may request a state hearing. Complaints are reviewed and MCP response time monitored by the BMHC. Enrollees are linked to a medical home by selecting a primary care physician (PCP) prior to or upon enrollment. MCPs distribute member handbooks and provider directories to each new member to help them choose a PCP. These materials are also available to eligible consumers 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, consumers in Ohio Medicaid MCPs were able to locate a PCP and obtain the health care services they need.

EASE IN FINDING A DOCTOR OR NURSE

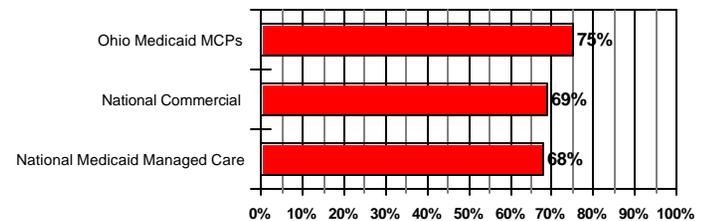
Consumers reporting it was not a problem to find a personal doctor or nurse



Provider for child in consumer's household

GETTING NEEDED CARE

Consumers responding it was not a problem to get needed care



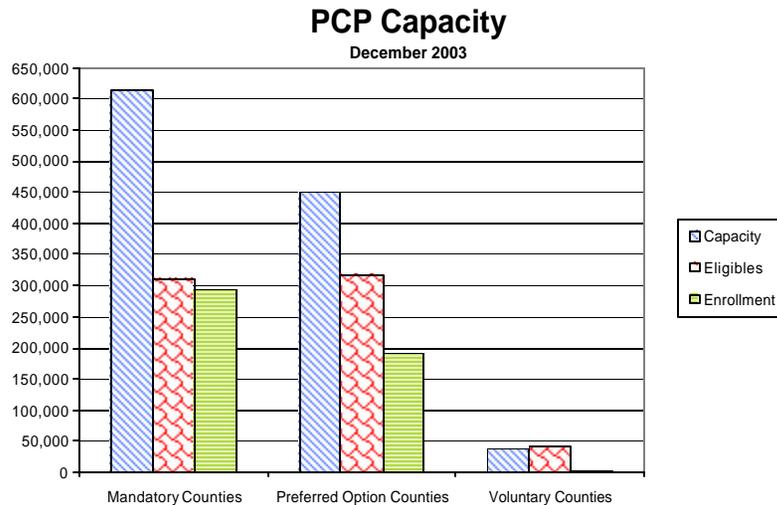
Specialty services for child care in consumer's household

PCP capacity far exceeds the number of eligibles or enrollees

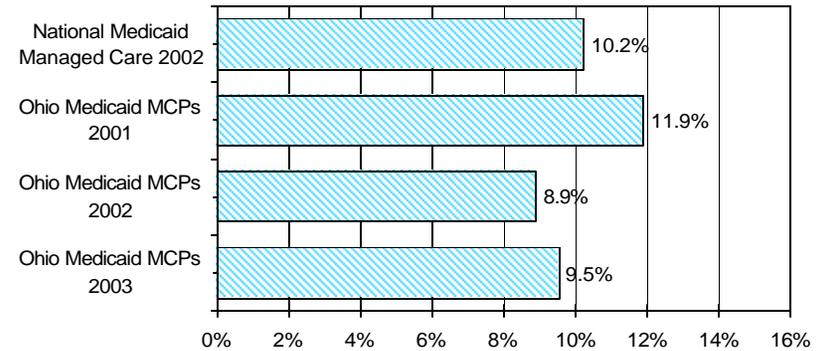
PCP capacity represents the number and service capacity of PCP's available to MCP enrollees in a specific county. In the PCP Capacity graph, the amount of service capacity available is compared to both the number of enrollees and Medicaid eligibles. In all county types, capacity greatly exceeds MCP enrollment.

MCPs' PCP turnover rates continue to decline

The PCP Turnover measure is used in conjunction with other measures to hold MCPs accountable for their members' 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 during 2003. 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. The PCP turnover rate for the Ohio Medicaid MCP was 9.5%, which is less than the national Medicaid Managed Care rate of 10.2%.



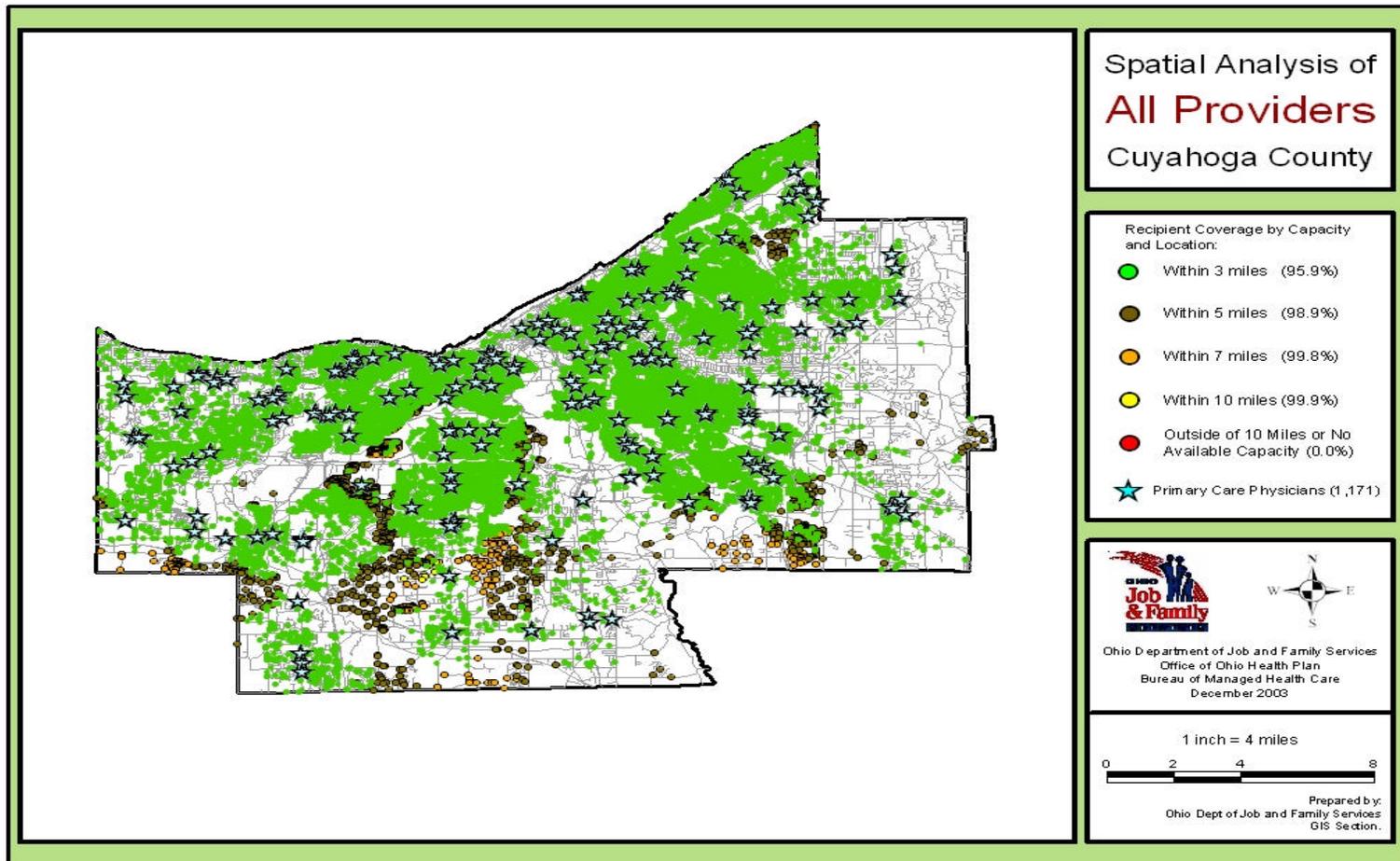
Primary Care Physician Turnover Rates



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.

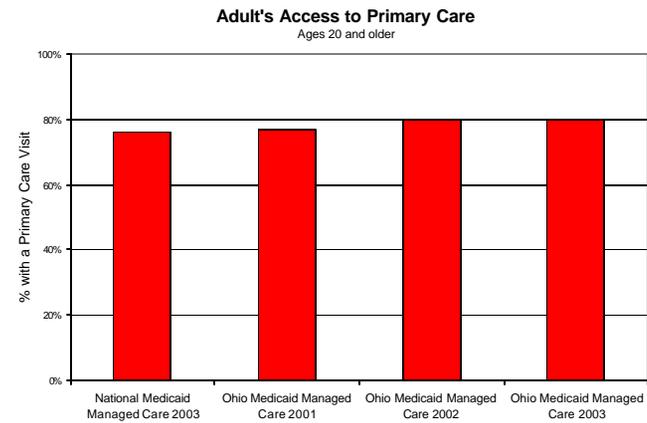
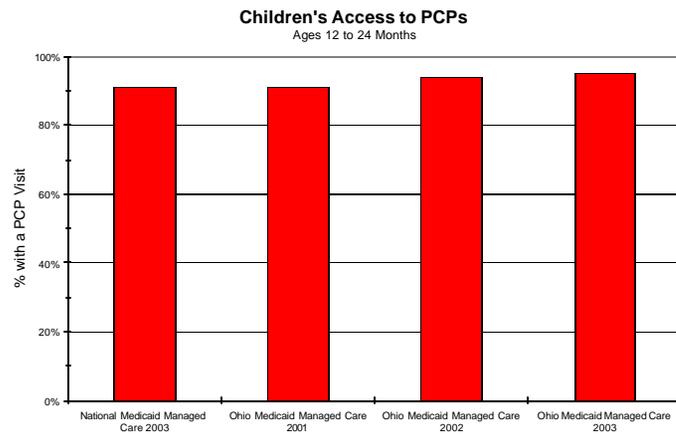
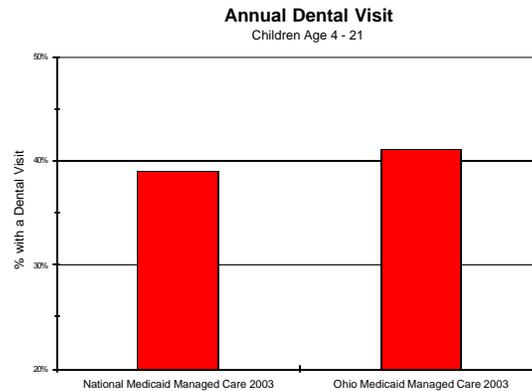
PCPs with capacity are located near Medicaid consumers

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 eligibles, indicates a close proximity of eligibles and PCPs.



High utilization of primary care services by enrollees continue

While comparing favorably to national results, BMHC recognizes the need to increase the number of children that receive dental services. To assist in achieving this goal, dental visits have been designated by BMHC as a clinical performance measure for the MCPs. Currently, MCPs are also required to develop performance improvement projects in order to increase the number of children receiving preventive health care services.



Quality of Care

Medicaid MCPs emphasize preventive care

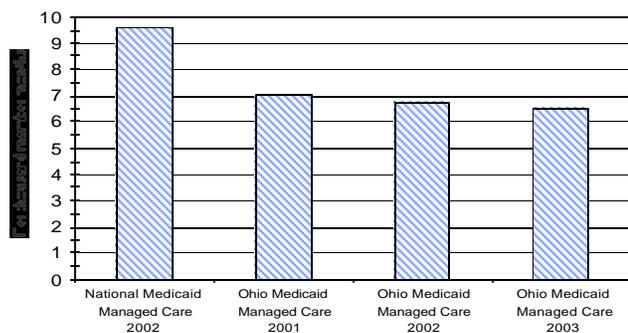
BMHC has measures in place to assure that the quality of care received through MCPs meets or exceeds set standards. Quality of care measures include:

- 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 complaint 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 Complaint monitoring by type, including quality issues

Medicaid MCPs utilize more preventive care & less hospital services

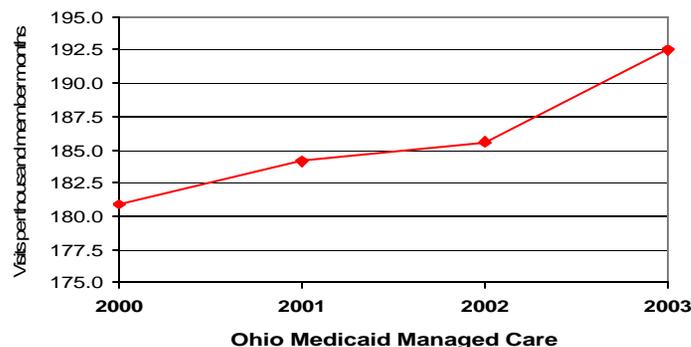
The first graph shows that, over time, inpatient hospital utilization continues to be reduced. MCPs' greater attention to preventive health and care management may explain reductions in the use of inpatient hospital services. A portion of decreased inpatient utilization may result from the continued use of outpatient services which is more cost effective.

Inpatient Hospital Discharges



National: National
Medicaid HEDIS 2002

Outpatient Hospital Visits

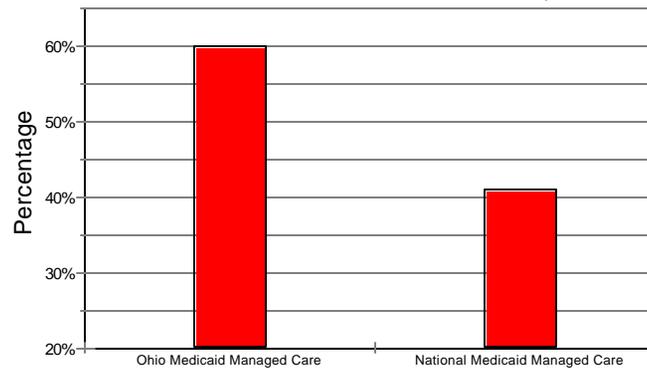


Medicaid MCPs deliver preventive care for pregnant women, children, & asthmatics

Various clinical performance measures are monitored to insure the quality of medical services rendered by the MCPs. One of these measures 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 four or five visits 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

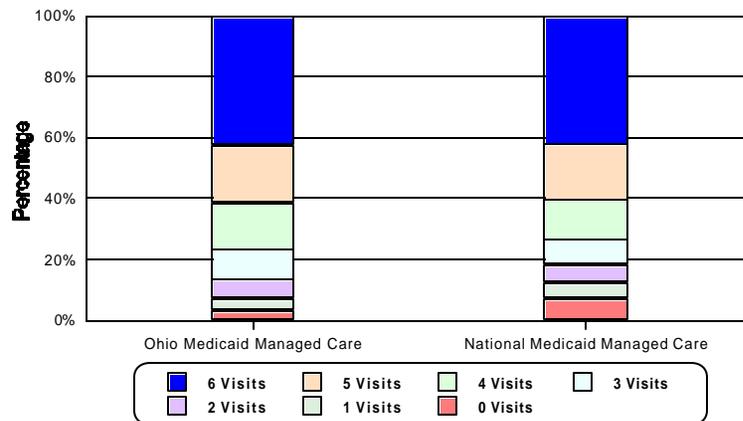
Percent Who Received 81% or More of the Expected



Ohio: CY 2003, National: HEDIS 2002

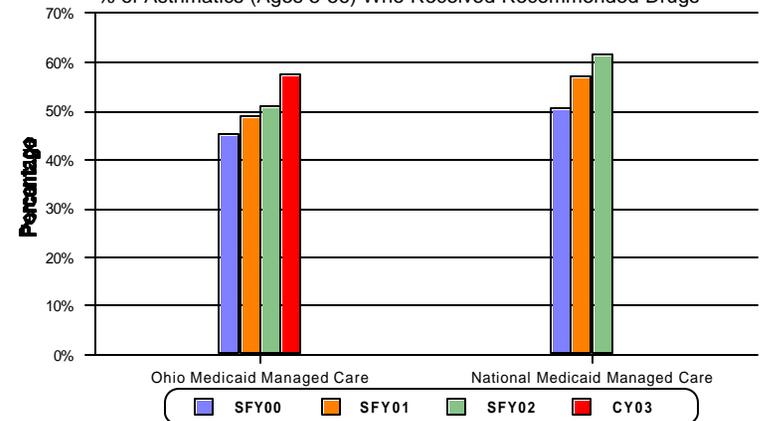
Well-Child Visits in the First 15 Months of Life

% of Children Who Received 0,1,2,3,4,5,6 Visits



Asthma Medication Management

% of Asthmatics (Ages 5-56) Who Received Recommended Drugs



Administrative Services

MCPs continue to provide excellent administrative services

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:

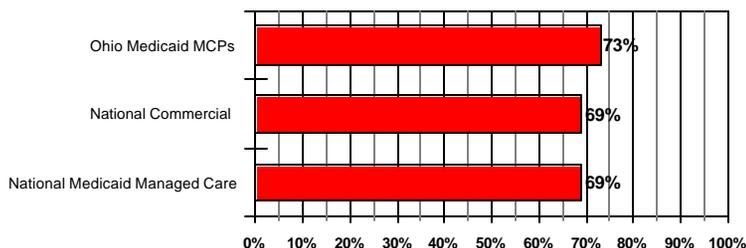
- Requiring MCPs to manage their member service and medical advice phone lines using industry standards
- Review of complaints filed by MCP members
- Review of related responses on the annual MCP consumer satisfaction survey

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."

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

ADMINISTRATIVE SERVICE

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

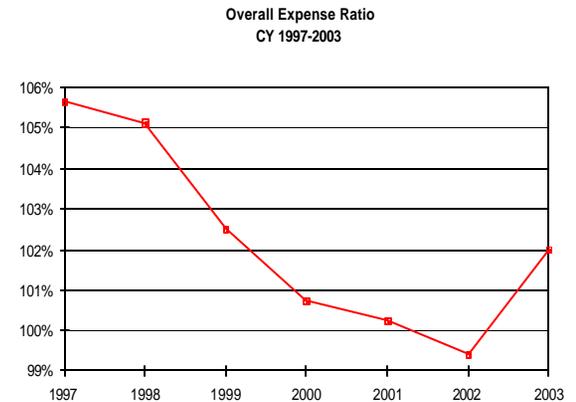
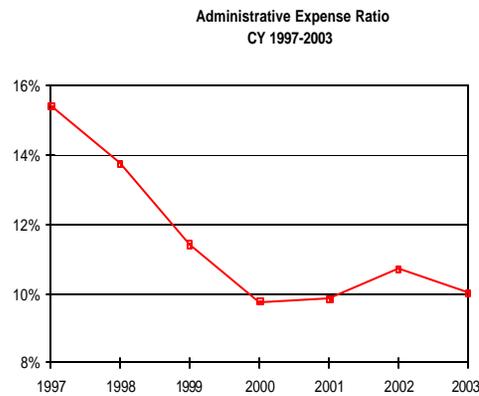
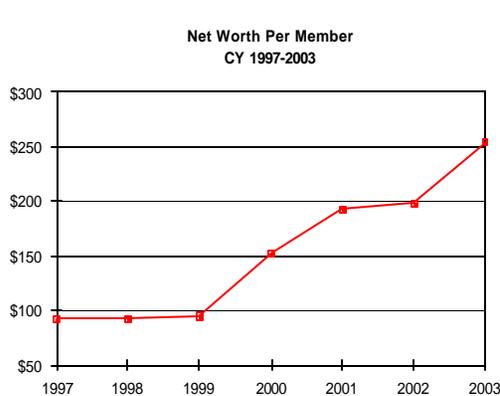


Not a problem when calling MCP's customer service

MCPs' financial position continues to improve

While oversight of the financial solvency of all MCP's 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 continues to improve. The next graph indicates that MCPs have reduced administrative costs, a reflection of more efficient operations. Finally, the third graph shows a slight increase in overall expense of two percent, possibly due to the increasing cost of health care services.



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

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