



Ohio Medicaid Managed Health Care Program PremierCare

PROGRESS REPORT January - December 2002

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, 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 FFS program. Medicaid consumers enrolled in MCPs receive the following extras:

- 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 as 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 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 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 (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 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 Financial 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 PCP, 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 ODJFS toll-free number to respond to consumer questions and provide information
- 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 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.

2002 Statewide Health Care Market Summary

While the most recent data available shows enrollment in Ohio's commercial and Medicare managed care organizations decreased during the first half of the year enrollment in Medicaid MCPs increased.

The year began with six plans operating in the Ohio Medicaid managed care program. Effective September 1, 2002, Renaissance Health Plan's (RHP) participation ended when its members were transferred temporarily to the Medicaid fee-for-service program pending re-enrollment in another plan. This action was taken by ODJFS after the Ohio Department of Insurance placed RHP in rehabilitation due to financial issues. As of December 31, 2002, five plans were under contract to serve Medicaid enrollees in fifteen counties.

Preferred Option, an MCP enrollment initiative introduced in January 2001, grew to five counties with the addition of Lorain County in June 2002.

Key program enhancements and initiatives in the Medicaid managed care program implemented during 2002:

- C BMHC began the process of revising the program requirements in response to the June issuance of the final federal regulations implementing the 1997 Balanced Budget Act. The new requirements will become effective in Ohio with the SFY 2004 MCP Provider Agreement and programs rules effective in July 2003.
- C In April, the Centers for Medicare and Medicaid Services approved Ohio's 1915(b) waiver amendment to implement Preferred Option in a managed care county with two operating MCPs, with one plan designated as a "Preferred Option MCP." Previously, Preferred Option was available only in designated counties with one MCP.
- C For the first time, using the ODJFS-contracted actuary prompt pay audits were conducted on selected MCPs. The compliance audits provided baseline data which confirmed the prompt pay information previously reported by three MCPs and allowed BMHC to develop further enhancements to the prompt pay report which must be completed by all MCPs.
- C MCP Performance Improvement Agreements focused on assessment of MCP fraud and abuse programs to verify operation in accordance with federal guidelines.
- C During the year, several Ohio Administrative Code rules for MCPs were revised. Some of the revisions included the addition of language concerning the new Consumer Contact Record (used in the enrollment process) and changes in the MCP marketing rule.
- C In January, BMHC implemented MCP call center standards, adopting nationally recognized Health Call Center Standard quality measures for abandonment rate, blockage rate, and average speed of answer, for MCP member services and 24-hour medical advice lines. MCPs are required to report this information to ODJFS on a monthly basis.
- C Beginning in October, BMHC required MCPs to identify which specialists on their panel maintain a full-time practice. This requirement helps identify specialists that maintain a full-time practice, insuring better access to services for enrollees.
- C BMHC conducted a second telephone survey of selected MCP members residing in Preferred Option counties. The survey addressed members' satisfaction with their plan and ease of access to health care.

Enrollment

Enrollment continues to increase

As of May 2003, the Ohio Medicaid managed care program was operating in fifteen counties. The Ohio Medicaid Covered Families and Children population statewide was 1,066,385; the population in MCP served counties was 645,504. MCP enrollment was approximately 40 percent of the statewide total and 67 percent in the counties with Medicaid MCP enrollment. (The Medicaid Aged, Blind, and Disabled population is not eligible for managed care enrollment).

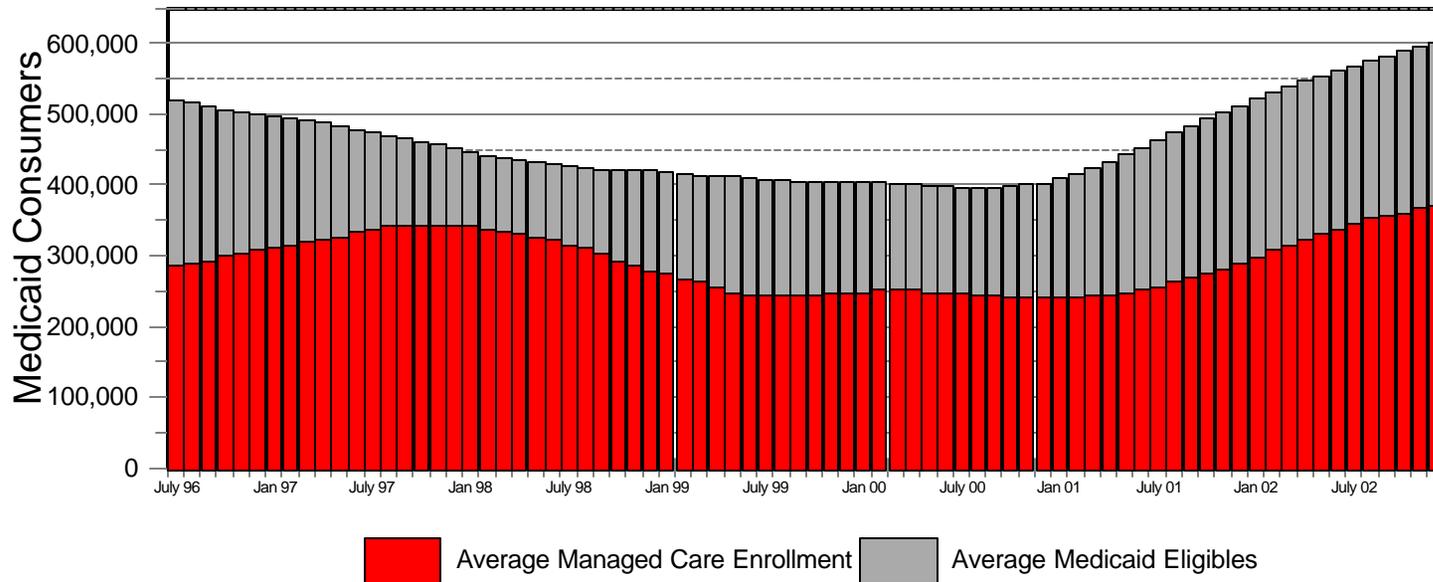
Enrollment in the counties in which Ohio's Medicaid managed care program operates is classified as mandatory, voluntary, or Preferred Option. In voluntary enrollment counties consumers have a choice between enrolling in an MCP or utilizing the traditional FFS program. In mandatory enrollment counties, 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 enrollment or if there is a justifiable reason or "just cause" as determined by BMHC in accordance with program rules. In the third category, Preferred Option, eligible consumers have the option of receiving health care services through Medicaid FFS or the participating MCP. Enrolled consumers may request to disenroll at any time from the MCP and return to Medicaid FFS or choose another MCP, if available. Unlike mandatory or voluntary enrollment counties, there are no enrollment change restrictions in Preferred Option counties.

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 2002 was 403,497.

Enrollment Trend July 1996 - December 2002



Consumer Satisfaction

Medicaid consumers' satisfaction with MCPs remains high

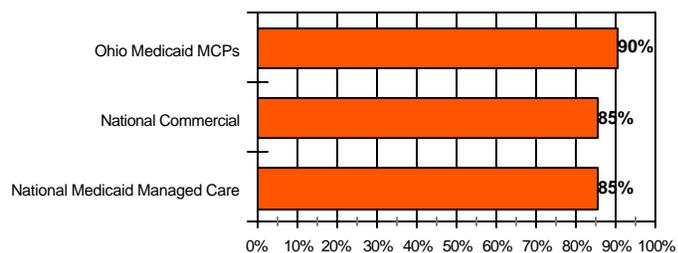
Tools used to assess consumer satisfaction include:

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

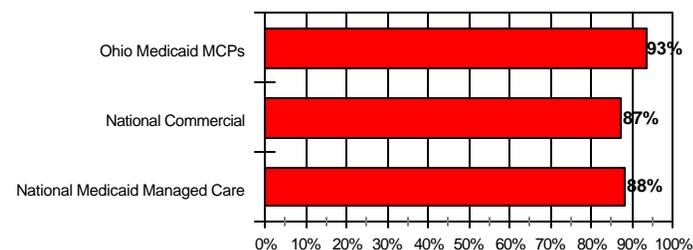
- C Consumers' satisfaction with their MCP exceeds national Medicaid and commercial managed care by 5%
- C Consumers' satisfaction with the care received through their MCP exceeds national Medicaid and commercial managed care by 6% and 5% respectively

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

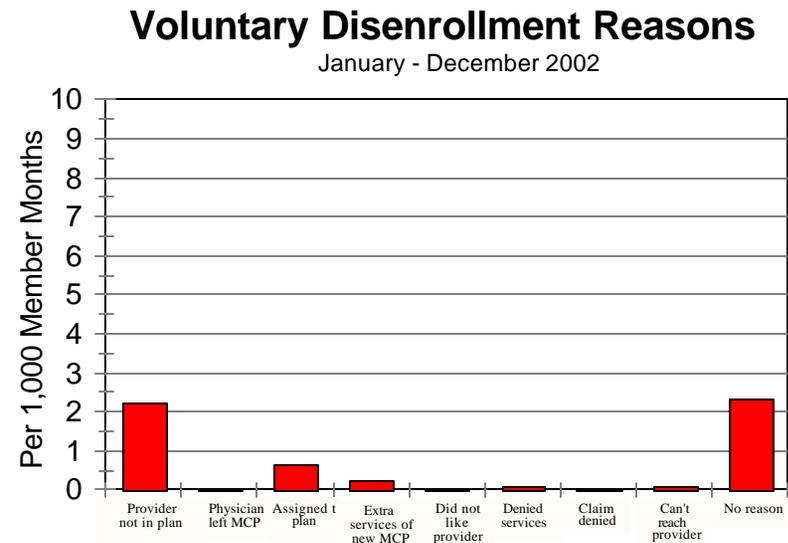
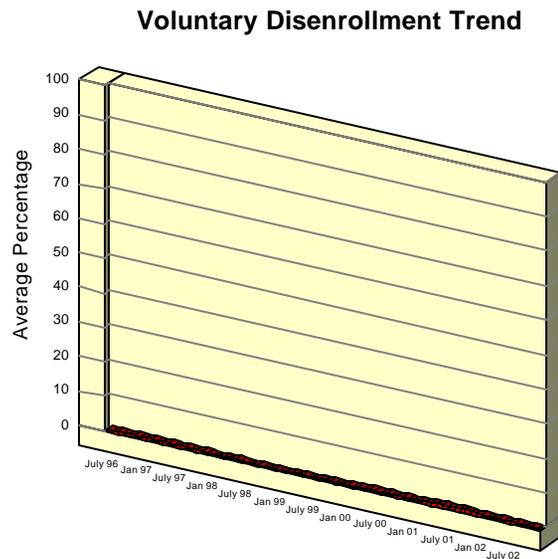


Overall Rating of Child's Clinical Care- Percent of consumers (age 17 or younger) who rated their care a "7" "8" "9" or "10." 10 is the highest possible score.

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 1996 and continues to be so for 2002, with voluntary disenrollment rates equal to or 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.

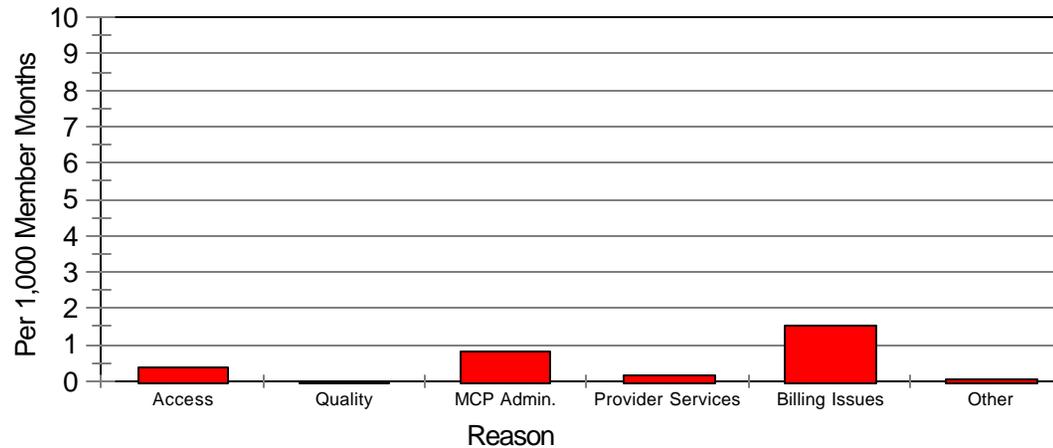


Access and quality issues create few enrollee problems

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 2002



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:

- 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 Monitoring MCP call centers for abandonment rate, blockage rate, and average speed of telephone response
- C Monitoring of full-time practice status of MCP contracting provider panel specialists
- C A review of health services utilization data
- C National (HEDIS) access measures

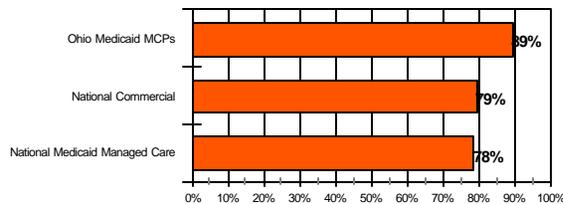
If there are problems accessing services, enrollees can complain to ODJFS or file a grievance with their MCP. In addition, they may request a state hearing. Complaints and grievances are reviewed and MCP response time monitored by the BMHC. Enrollees are linked to a medical home by selecting a primary 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 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 below, consumers in Ohio Medicaid MCPs were easily able to locate a PCP or obtain referrals to specialists.

EASE IN FINDING A DOCTOR OR NURSE

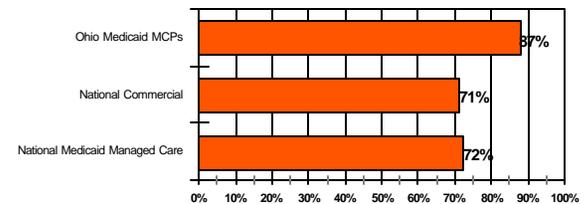
Consumers reporting it was not a problem to find a personal doctor or nurse



Provider for child in consumer's household

EASE IN GETTING A REFERRAL TO A SPECIALIST

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



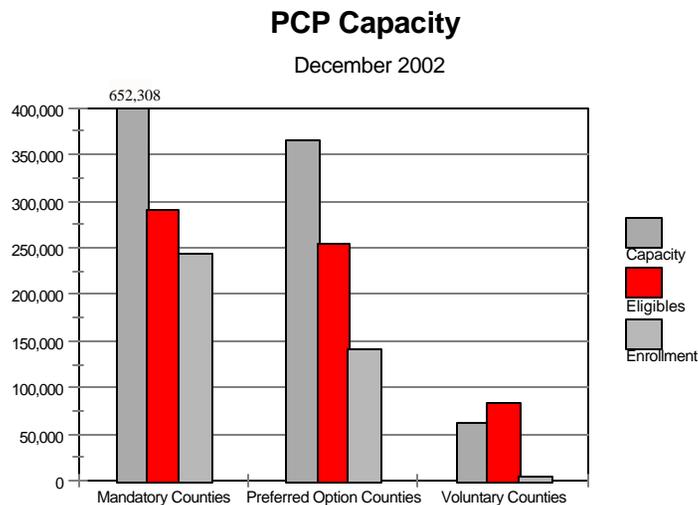
Specialty services for child care in consumer's household

PCP capacity far exceeds the number of eligibles or enrollees

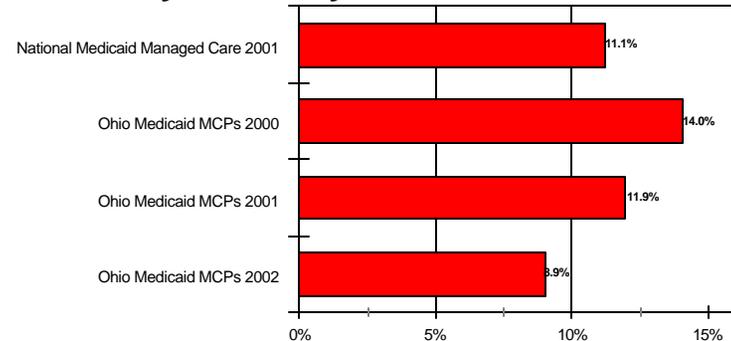
PCP capacity represents the number and service capacity of primary care providers available to MCP enrollees in a specific county. In the PCP Capacity graph, the amount of service capacity available is compared to both the number of enrollees and Medicaid eligibles. In all county types, capacity greatly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

MCPs' PCP turnover rates continue to decline

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 2002. 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. In the past, monitoring of this measure indicated a higher than acceptable average turnover rate, resulting in additional measures to improve MCP performance. This resulted in a drop of over five percent in 2002 as compared to the 2000 rate.



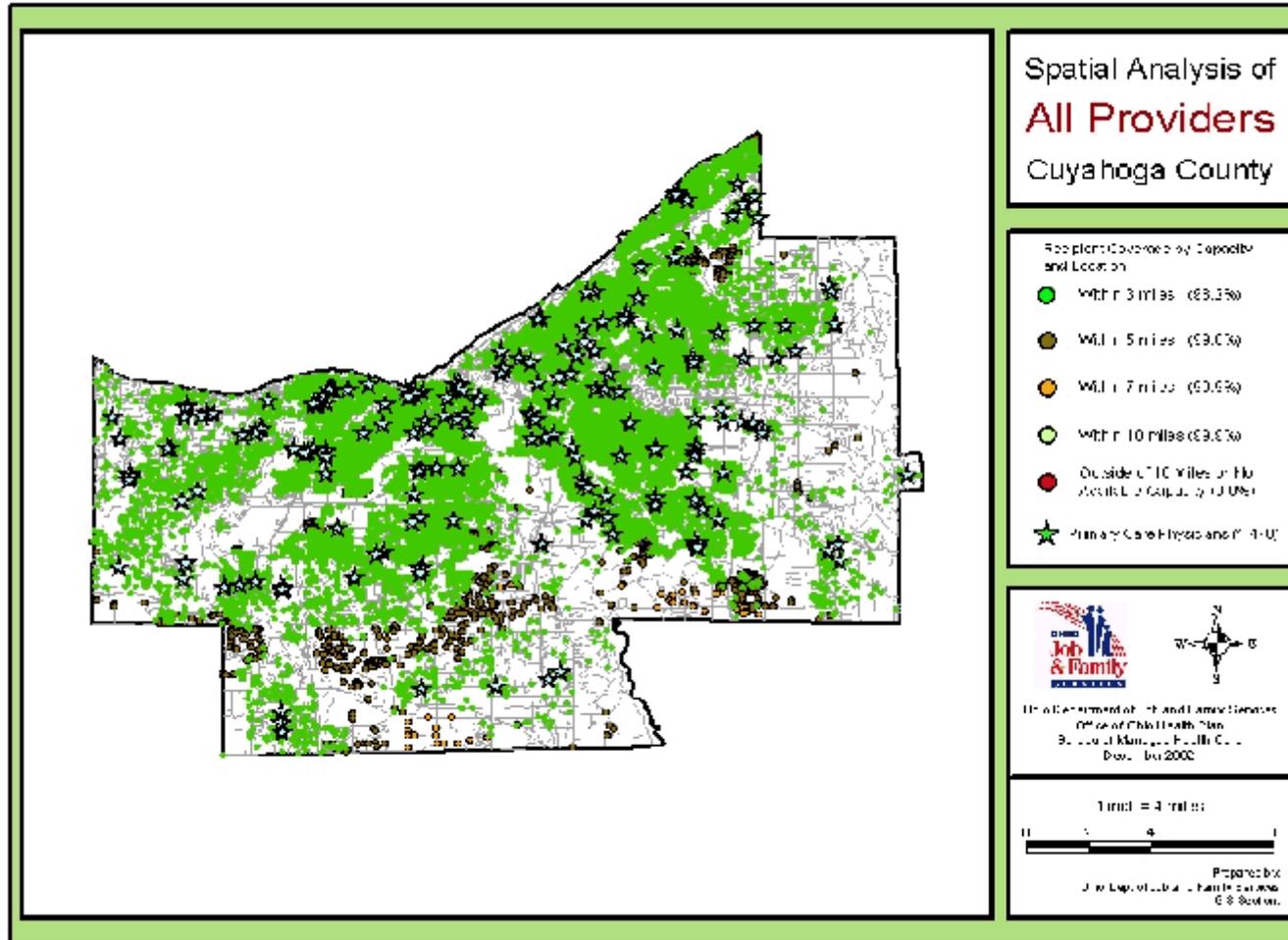
Primary Care Physician Turnover Rates



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

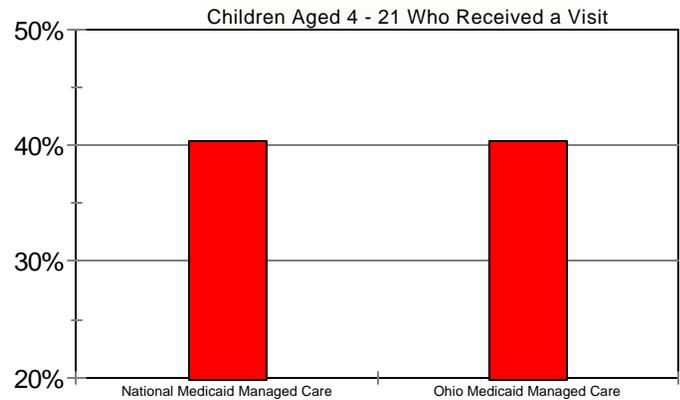
Below is an example of the geographical analysis of an MCP's PCP panel. The analysis compares the location and capacity of PCPs on an MCP's panel to the location of all eligibles in the county. The large number of green circles, each representing one or more enrollees, indicates a close proximity of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



High utilization of primary care services by enrollees continue

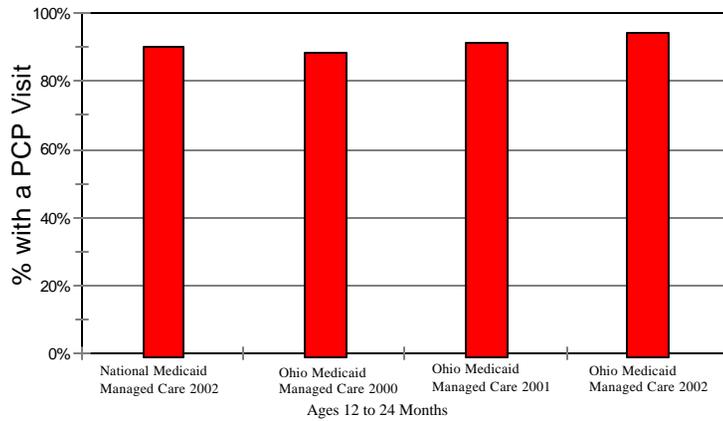
While comparing favorably to national results, BMHC recognizes the need to increase the number of children that receive dental services. To assist in achieving this goal, dental visits have been designated by BMHC as a clinical performance measure for the MCPs. Currently, MCPs are also required to develop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

Annual Dental Visit

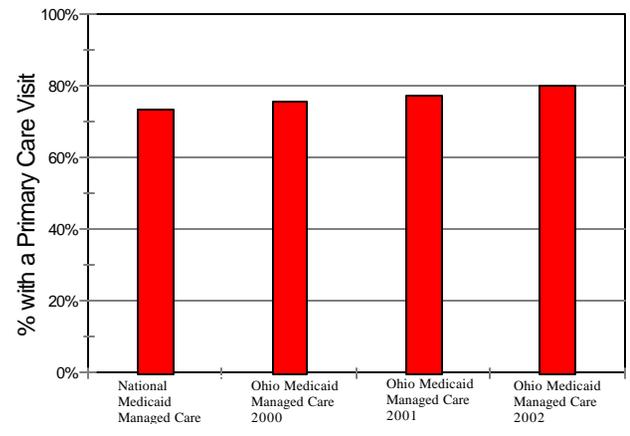


Ohio: CY 2002, National: HEDIS 2001

Children's Access to PCPs



Adult's Access to Primary Care



Quality of Care

Medicaid MCPs emphasize preventive care

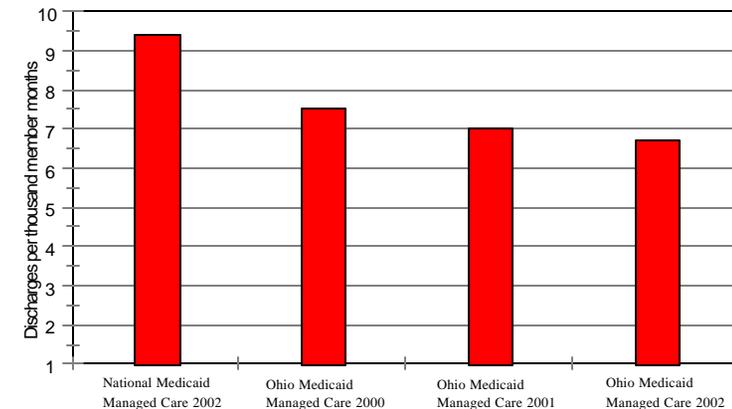
BMHC has measures in place to assure that the quality of care received through MCPs meets or exceeds set standards. Quality of care measures include:

- 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 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 increased use of outpatient services which is more cost effective.

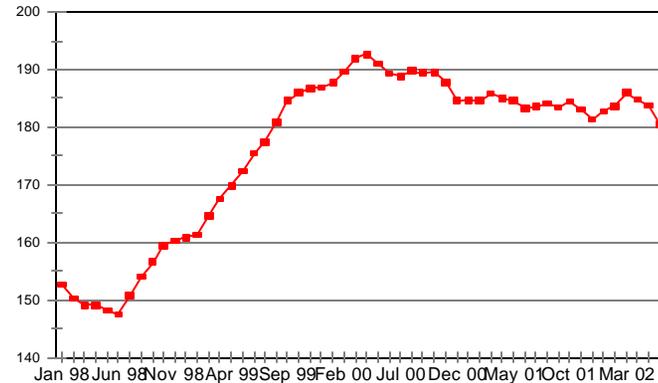
Inpatient Hospital Discharges



National: National Medicaid HEDIS 2002

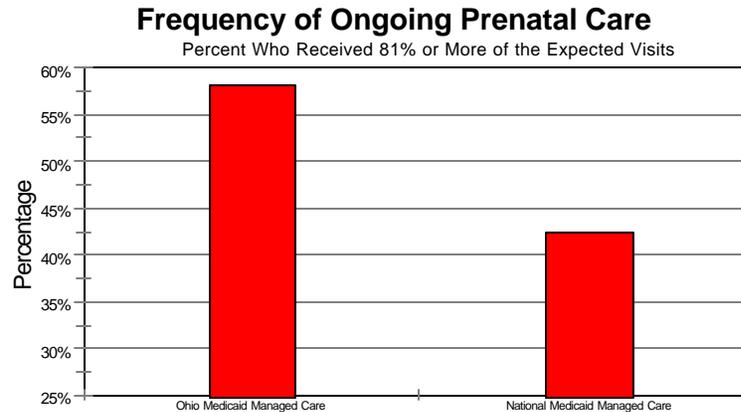
Outpatient Hospital Visits

Per 1000 MCP Enrollees

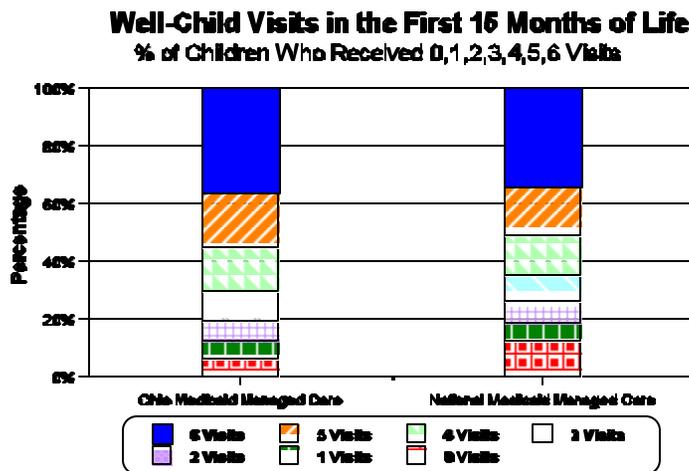


Medicaid MCPs deliver preventive care for pregnant women, children, & asthmatics

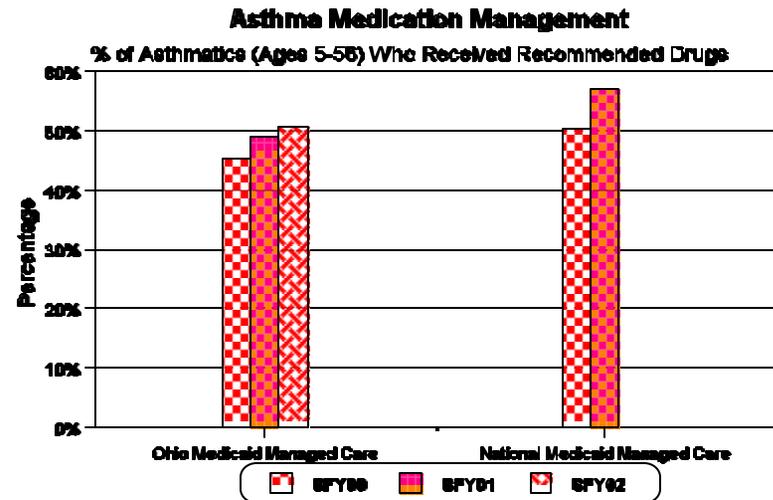
Various clinical performance measures are monitored to insure the quality of medical services rendered by the MCPs. One of these addresses prenatal care. The top graph represents the percentage of enrollees who received 81% or more of the expected prenatal visits as set by a nationally recognized entity. 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.



Ohio: CY 2002, National: HEDIS 2001



Ohio: CY 2002
National: HEDIS 2001



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:

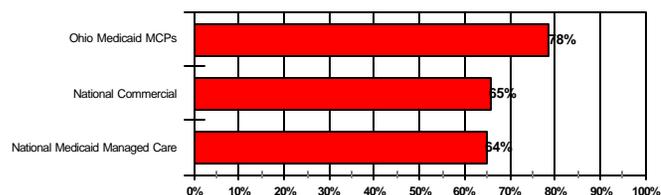
- C Requiring MCPs to manage their member service and medical advice phone lines using industry standards
- C Review of complaints and grievances filed by MCP enrollees
- C Review of related responses on the annual MCP consumer satisfaction survey

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.

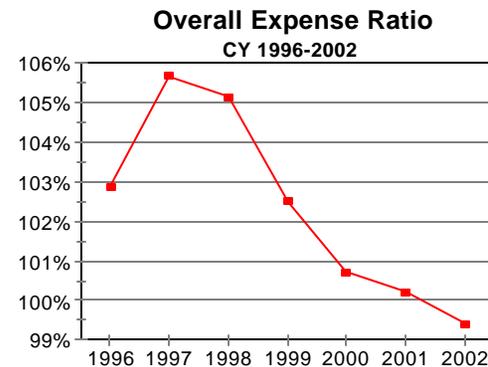
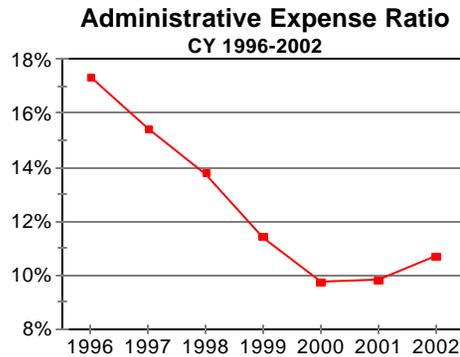
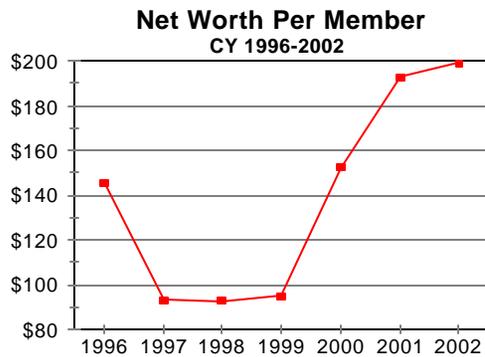


Not a problem when calling MCP's customer service.

MCPs' financial position continues to improve

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 continues to improve. The next graph indicates that MCPs have reduced administrative costs, a reflection of more efficient operations. Finally, the third graph shows that MCPs continue to reduce their overall losses resulting in MCPs showing a stronger profit.



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

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(614) 728-4516 fax

