Department of Medicaid

External Quality Review Annual Technical Report

April 26, 2024

State Fiscal Year 2023–2024 External Quality Review Activities Performed July 1, 2022–December 31, 2023

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I. Executive Summary

Purpose of Report

States contracting with managed care organizations (MCOs), prepaid inpatient health plans (PIHPs), and prepaid ambulatory health plans (PAHPs) [referred to collectively as managed care entities (MCEs)] for Medicaid services are required to conduct an annual assessment of the quality, timeliness, and accessibility of health care services furnished to Medicaid beneficiaries.[1] Protocols for conducting the assessments are, in most instances, provided by the Centers for Medicaid and Medicare Services (CMS).[2] The Ohio Department of Medicaid (ODM) contracted with IPRO, an external quality review organization (EQRO), to conduct the state fiscal year (SFY) 2023-2024 external quality review (EQR) activities for the MCEs participating in the Medicaid Managed Care (MMC) program; the MyCare Ohio program for dually eligible Medicare and Medicaid members; Ohio's Resilience through Integrated Systems and Excellence (OhioRISE) program, a prepaid inpatient health plan (PIHP) for youth with complex behavioral health and multi-system needs; and Ohio's single pharmacy benefit manager (SPBM), a prepaid ambulatory health plan (PAHP). This report presents aggregate and MCE-level results.

Until January 31, 2023, the Ohio Medicaid managed care organizations (MCOs) participating in the MMC program were Buckeye Health Plan (Buckeye), CareSource, Molina Healthcare of Ohio (Molina), Paramount Advantage (Paramount), and UnitedHealthcare Community Plan (UnitedHealthcare or UHC). As part of the Next Generation of Managed Care, Ohio Medicaid selected the following MCOs to begin providing services as of February 1, 2023: AmeriHealth Caritas Ohio (AmeriHealth), Anthem Blue Cross and Blue Shield (Anthem), Buckeye, CareSource, Humana Healthy Horizons (Humana), Molina, and UnitedHealthcare. Assessments presented in this report may include legacy and new MCOs based on the data collection period.

The five MyCare Ohio plans (MCOPs) participating in the MyCare Ohio program remain unchanged: Buckeye, CareSource, Molina, UnitedHealthcare, and Aetna Better Health of Ohio (Aetna). Aetna is also the PIHP for OhioRISE, which began July 1, 2022. Gainwell Technologies (Gainwell) is the SPBM, which began October 1, 2022.

This report includes four federally mandated and two (out of six) optional types of reviews, described in *Title 42 Code of Federal Regulations (CFR) Section (§) 438.358* and CMS protocol guidance:

- **Validation of Performance Improvement Projects (Protocol 1)** – This activity validated that the performance improvement projects (PIPs) were designed, conducted, and reported in a methodologically sound manner, supporting measurable improvements in care and services.
- **Validation of Performance Measures (Protocol 2)** – This activity assessed the accuracy of performance measures reported by each MCO and determined the extent to which the rates calculated by the MCOs follow state specifications and reporting requirements.
- **Review of Compliance with Medicaid and CHIP Managed Care Regulations (Protocol 3)** – This activity determined MCO compliance with its provider agreement and with state and federal regulations.
- **Validation of Network Adequacy (Protocol 4)** – In the absence of a final CMS protocol for validating network adequacy, Ohio developed a network validation methodology that includes secret shopper and revealed shopper surveys of primary care and specialty care providers (four surveys in SFY 2023, as well as validation of information available to members in provider directories).
- **Validation of Encounter Data (Protocol 5)** – This activity evaluated the accuracy and completeness of encounter data that is considered critical to effective MCO operation and oversight.
- **Administration or Validation of Quality-of-Care Surveys (Protocol 6)** – This activity analyzed the experience of care surveys conducted of adult and child members to assess their experience with care received, providers, and health plan operations.

[1] *Title 42 Code of Federal Regulations (CFR) Section (§) 438.364*.

[2] CMS External Quality Review Protocols, February 2023. The optional EQR protocols not performed in Ohio are the calculation of additional performance measures, additional PIPs, and focus studies. Due to the timing of implementation of the Next Generation of Managed Care, the quality rating system was not included this year.

Findings

Results are presented in individual activity sections of this report, each of which describes data collection, analysis methodologies, and comparative findings. IPRO used the results of the most recent analyses approved by ODM. The duration between receipt of data from the MCEs, data analysis, and finalizing results ranges from six months to over a year, in some cases, due to the reporting cycle for Healthcare Effectiveness Data and Information Set (HEDIS®) measures.

MCOs and MCOPs were compared to each other, statewide rates, historical trends, and/or national benchmarks when available, to develop conclusions and recommendations for improvement for each activity, summarized in **Chapter IX: Strengths, Opportunities for Improvement, and EQR Recommendations**. Findings related to quality, timeliness, and accessibility of the new PIHP (OhioRISE) and new PAHP (SPBM) services are limited in this report due to the data submission and processing runout period. In addition, the three new MCOs that began February 1, 2023, could not be included in measurement activities that required data prior to their start date.

Validation of Performance Improvement Projects

In December 2023, MCOs and MCOPs completed an 18-month, statewide *Diabetes Management and Disparity Reduction* collaborative PIP to improve diabetes control and reduce disparities for the Hispanic and non-Hispanic Black populations. PIP validation occurred monthly through December 2023, and final PIP validation results will be calculated once the full year of claims are available in April 2024. Validation activities to date have found that the PIPs are methodologically sound and produce evidence of improvement; moreover, at least some of the quality improvement (QI) processes are linked to measurable improvements. At the end of calendar year (CY) 2023, the MCOs had achieved the Specific, Measurable, Achievable, Realistic, and Timely (SMART) Aim goal for using continuous glucose monitoring (CGM) but not quite for diabetes self-management education (DSME). The MCOPs were approaching achievement but had not yet reached the SMART Aim goal rate for either measure.

In March 2023, ODM began a collaborative PIP with Aetna OhioRISE, the SPBM, and the MCOs to improve antipsychotic metabolic monitoring (APMM) with the aim of increasing the percentage of children (ages 1−17 years) who received two or more antipsychotic prescriptions and received both cholesterol and blood glucose metabolic monitoring. The plans were in the early stages of building their theories for improvement through the end of SFY 2023 and began testing their interventions in SFY 2024.

Validation of Performance Measures

Each MCO and MCOP was found to be compliant with the requirements of *Title 42 CFR § 438.330(c) Performance measurement*.

Information Systems Capabilities Assessment

IPRO used the results of the final audit reports (FARs) and each MCO and MCOP's independent Information Systems (IS) assessment as the basis for the IS review. Four of the five MCOs and all five MCOPs were determined to be fully compliant with all seven of the applicable National Committee for Quality Assurance (NCQA) HEDIS IS standards, and one plan was fully compliant in six of seven areas.

Performance Measures − MCOs

In 2023, IPRO validated MCOs' measurement year (MY) 2022 measures, which plans reported with an appropriate lag as defined by NCQA's HEDIS reporting standards. ODM required MCOs to report 78 measure indicators, including 43 measures with minimum performance standards (MPSs), which IPRO compared to benchmarks defined in the MMC provider agreement. Additionally, the measurement set included reporting-only measures, some of which have multiple indicators. The measures related to Ohio's population streams at the time, which were: Healthy Children, Healthy Adults, Women's Health, Behavioral Health, and Chronic Conditions. Thirty-six of the 86 measures had performance standards, which IPRO compared to the NCQA's *2022 Quality Compass®* national Medicaid benchmarks.

All five MCOs achieved rates at or above the *Quality Compass* 75th percentile for 3 of the 36 measures for which benchmarks were available:

- Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics, Total;
- Follow-up After Emergency Department Visit for Substance Use, 7-Day Follow-Up, Total; and
- Follow-up After Emergency Department Visit for Substance Use, 30-Day Follow-Up, Total.

All five MCOs achieved rates at or above the *Quality Compass* 50th percentile for an additional six measures:

- Follow-up After Emergency Department Visit for Mental Illness, 30-Day Follow-Up, Total;
- Follow-up After Emergency Department Visit for Mental Illness, 7-Day Follow-Up, Total;
- Blood Pressure Control for Patients with Diabetes (< 140/90 mm Hg);
- Eye Exam for Patients with Diabetes (Retinal) Performed;
- Well-Child Visits in the First 30 Months of Life – Well-Child Visits in the First 15 Months, Six or More Visits; and
- Follow-up Care for Children Prescribed Attention Deficit Hyperactivity Disorder (ADHD) Medication, Initiation Phase.

All MCOs except Paramount and Buckeye had more than half of their MPS measures above the national 50th percentile, with a rate between 40.0% and 62.5%. CareSource had the most MPS measures above the national 75th percentile (11 of 40 measures). Molina and UnitedHealthcare had the fewest measures below the 25th percentile (4 of 40 measures). Every MCO had measures below the 10th national percentile. The statewide average was above the national 25th percentile for 84.2% of the MPS measures.

Performance Measures – MCOPs

ODM required each contracted MCOP to collect and report on 15 measure indicators for MY 2022. The measurement set includes five rates with MPSs used for compliance assessment. Additionally, the measurement set includes reporting-only measures, some of which have multiple indicators. Measures are grouped into four population streams: Behavioral Health, Chronic Conditions, Healthy Adults, and Integrating Care.

Every MCOP except Buckeye have all their MPS measures below the national 50th percentile. Aetna, Molina, and UnitedHealthcare have the most measures (80%) below the national 25th percentile. Every MCOP except for Buckeye has at least one MPS measure below the 10th national percentile. The statewide average is above the national 25th percentile for 20% of the MPS measures.

Review of Compliance with Medicaid Managed Care Regulations

IPRO conducted a comprehensive administrative review of the MCOs and MCOPs between September and December 2023, consistent with *Title 42 CFR 438* and *Title 42 CFR 457*. The review covered the period from February 1, 2023, to July 31, 2023.

The MCOs achieved an overall high rate of compliance with the standards reviewed for the comprehensive administrative review. Rates of compliance with all 14 standards by MCO ranged from 88.3% to 97.2%. Standards for which all plans achieved compliance scores of 100% were in the following areas: Availability of Services, Assurances of Adequate Capacity and Services, Coverage and Authorization of Services, Confidentiality, Subcontractual Relationships and Delegation, Health Information Systems, and Quality Assessment and Performance Improvement Program.

The MCOPs also achieved an overall high rate of compliance with the standards reviewed for the comprehensive administrative review, with MCOP scores ranging from 84.8% to 96.6%. Standards for which all plans achieved compliance scores of 100% were in the following areas: Emergency and Post-stabilization Services, Availability of Services, Assurances of Adequate Capacity and Services, Coordination and Continuity of Care, Coverage and Authorization of Services, Confidentiality, Practice Guidelines, Health Information Systems, and Quality Assessment and Performance Improvement Program.

Validation of Network Adequacy

Validation of Primary Care Access

In SFY 2023, IPRO conducted surveys of primary care providers (PCPs) in November 2022 and June 2023, to verify access and availability of primary care for new and established patients. IPRO identified opportunities for the MCOs and MCOPs to improve the accuracy of information in provider directories, including plan contracting status, contact information, and availability to see new patients. Approximately 78% of the PCPs in the samples were ineligible to complete the survey because their phone numbers were incorrect, they were no longer at the practice, they were not participating as a PCP, or they declined to participate in the survey. Further, appointments for sick and well-check visits were not always available within acceptable time parameters. In the June 2023 survey, for example, surveyors calling PCP offices to assess wait times for appointments for new and existing patients found the following:

- Of the PCPs who could be reached and confirmed they were accepting new patients, the proportion that offered timely well-check visits (within 30 days) averaged 63.9% for MCOs and 72.0% for MCOPs.
- Of the PCPs who could be reached and confirmed they were accepting new patients, the proportion that offered timely sick visits (within two days) was 37.4% for MCOs and 41.9% for MCOPs.

Appointment availability for existing patients was better:

- PCPs offered timely well-check visits (within 30 days) to established patients on average 71.2% of the time for MCO members and 73.0% of the time for MCOP members.
- The proportion offering timely sick visits (within two days) averaged 59.1% for MCOs and 63.1% for MCOPs.

Administration or Validation of Member Experience Quality-of-Care Surveys

IPRO evaluated the quality-of-care survey data submitted by the MCOs and MCOPs who had the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) survey conducted. IPRO compared each MCE's scores to national benchmarks, to the other plans, and to the prior year's scores. Additionally, children with chronic conditions (CCC) were compared to child members without a chronic condition.

Adult Population in MCOs

The Medicaid Program demonstrated above average performance at the national level on the four global measures, the four composite measures, and the one individual item measure. The program's performance was similar to the previous year with no statistically significant differences between MY 2021 and MY 2022. The statewide comparisons analysis for the global ratings, composite measures, and individual items for the adult population revealed no statistically significant differences between any MCO's score when compared to the program average. The trend analysis for the adult population revealed no statistically significantly different scores in MY 2022 compared to MY 2021, though there was continued improvement in satisfaction with care coordination at the statewide level increasing from 84.9% in MY 2020 to 87.5% in MY 2021 and 89.5% in MY 2022.

General Child Population in MCOs

For the general child population, the Ohio Medicaid program demonstrated above average performance at the national level on two of four global ratings, three of four composite measures, and the one individual item measure. The program's performance declined slightly from the previous year on six of nine measures. However, none of the differences between measures in MY 2022 and MY 2021 were statistically significant. The statewide comparisons analysis for the global ratings, composite measures, and individual item measure for the general child population revealed one statistically significant difference between any MCO's score when compared to the program average, and that was for Molina whose members were more satisfied with how well their doctors communicate than the statewide satisfaction rate (97.3% compared to 95.3%). Molina's rate was also statistically significantly better in MY 2022 than its MY 2021 rate for how well doctors communicate.

Children with Chronic Conditions Population in MCOs

The CCC population reported higher levels of satisfaction with plans and care than the non-CCC population on three composite measures out of nine measures assessed, but differences were not statistically significant. The CCC population's scores did not statistically significantly improve from MY 2020 to MY 2021 for any measures. The overall rating of their health plan was statistically significantly lower in MY 2022 than in MY 2021.

Adult Population in MCOPs

The MyCare Ohio program demonstrated above average performance at the national level on 10 of 13 measures. The MyCare Ohio program's performance declined from the previous year on most of the measures (9 of 13 measures). The statewide comparisons analysis for the global ratings, composite measures, and other measures revealed one MCOP score that was statistically significantly lower than the program average and five MCOP scores that were statistically significantly higher than the program average. The trend analysis revealed five statistically significantly lower scores in 2022 than in 2021. None of the MCOPs had statistically significantly higher scores in 2021 than in 2020.

Validation of Encounter Data

Encounter data validation (EDV) is an ongoing process involving the MCEs (including the MCOs, MCOPs, OhioRISE, and SPBM), the state encounter data unit, and the EQRO. Yearly EDV activities identify incomplete data, perform missing-data quality checks, and assess frequency and impact of late encounter data submissions. Encounter data that are accurate and reliable support agencies in driving healthcare improvements that can positively affect the total Medicaid population and particularly members with high-risk health concerns.

The SFY 2023 EDV study compared MCEs' dental, pharmacy, inpatient, and professional encounter data to the data in IPRO's data warehouse (DW) that originated with the Ohio Medicaid Information Technology System (MITS). IPRO reviewed selected encounter data files obtained from the MCEs, sampled records, identified and researched the discrepant values, reviewed discrepant reason codes received from MCOs, and discussed findings with the MCO to resolve discrepancies. At the completion of the process, IPRO found no major encounter data issues. However, there were areas that required further research by encounter type by the MCEs, ODM, and IPRO.

Conclusion and Recommendations for MCEs and ODM

Findings from EQR activities discussed in this report highlight the MCEs' continued commitment to achieving the goals of the Ohio Medicaid quality strategy. Strengths related to **quality** of care, **timeliness** of care, and **access** to care were observed across all population streams; however, there were also important shortcomings in each that can be addressed through ongoing quality measurement, reporting, and improvement activities. ODM has developed a plan to increase MCEs' focus on population health, care coordination, and addressing disparities. This plan is embodied in ODM's Next Generation of Ohio Medicaid Managed Care, through its emphasis on MCEs' responsibility to center individual member needs by increasing program transparency, improving care for members with complex needs, supporting providers, and personalizing care. These priorities are also described in Ohio's new quality strategy, published in November 2022, which aligns with the recommendations in the following sections and is summarized in **Chapter II: Ohio Medicaid Managed Care Program**.

II. Ohio Medicaid Managed Care Program

This section describes the history of MMC in Ohio and highlights the state's quality strategy and Medicaid initiatives, providing context for the activities described in subsequent sections.

Managed Care in Ohio

ODM is responsible for the implementation and administration of Ohio's combined Medical Assistance Program authorized under Title XIX of the Social Security Act (SSA; also referred to as Medicaid) and Title XXI of the SSA (also referred to as the state Children's Health Insurance Program [CHIP]), implemented in Ohio as a Medicaid expansion program. Launched in July 2013, ODM is Ohio's first executive-level Medicaid agency.

ODM has been contracting with MCOs since 1978 and has mandated managed care enrollment for selected populations since 1989. Ohio's risk-based, comprehensive MMC program was initially approved by the CMS in 2005 and subsequently in 2006 for statewide MMC expansion. Ohio currently operates its mandatory MMC program under a State Plan Amendment for the Aged, Blind or Disabled population and the Modified Adjusted Gross Income (MAGI) population, formerly known as the Covered Families and Children (CFC) population, with limited exceptions. As a supplement to Ohio's existing 1932(a)(1)(A) authority, effective July 1, 2013, Ohio added children under the age of 21 receiving Supplemental Security Income (SSI) to the MMC program under a 1915(b) waiver approved by CMS. CMS subsequently approved a 1915(b)(c) waiver, effective March 1, 2014, which allows Ohio to enroll Medicaid-Medicare duals in managed care through the Integrated Care Delivery System (ICDS) Demonstration, also known as the MyCare Ohio program (MCOP). MCOP was implemented effective May 1, 2014.

Effective August 1, 2016, Ohio amended its Medicaid eligibility methodology authority from 209(b) to 1634, including the addition of populations eligible under 1915(i) SPA and Miller Trust authorities. The April 1, 2018, 1915(b) waiver renewal reflected the changes associated with the 1634 methodology and added two mandatory child populations to Ohio's existing managed care program effective January 1, 2017. ODM added the MAGI children population to the waiver effective January 15, 2017, upon expansion of the respite benefit.

In 2019, ODM began reimagining the way the Ohio managed care program provides quality services to improve the health of the individual, their family, and community. The resulting Next Generation managed care program was influenced by input from more than 1,100 providers, stakeholders, members, and community partners; lessons learned from QI initiatives; and identified gaps in previous managed care models that have been oriented towards managing risk as the sole mechanism for controlling costs. The recent SPBM, OhioRISE, and MCO procurements highlight the evolving nature of Ohio's managed care program and quality strategy. This evolution is informed by the following population health management framework steps: develop the system, get everyone in the system, identify higher risk subpopulations, provide evidenced based care and enhanced services, and maintain and support life course continuity.

This Next Generation Ohio Medicaid program includes strong cross-agency coordination and partnership between ODM and MCEs, vendors, sister state agencies, community-based organizations, colleges of medicine, and health systems to support specialization in addressing critical needs. ODM is working in collaboration with the Ohio Department of Job and Family Services (ODJFS), County Departments of Job and Family Services (CDJFS), Ohio Department of Mental Health and Addiction Services (OhioMHAS), Ohio Department of Developmental Disabilities (DODD), Ohio Department of Aging (ODA), and other state health and human services agencies to support a more seamless and personalized experience for individuals and providers.

As of February 2024, Ohio had enrolled 3,189,392 Medicaid and CHIP beneficiaries of whom 2,883,133, were enrolled in MCEs.

Ohio Medicaid Quality Strategy

ODM's *Managed Care Population Health and Quality Strategy* (quality strategy), shown in **Figure 1**, covers all MCEs. Building on the Institute for Healthcare Improvement's Quintuple aim[3], the quality strategy incorporates a population health management approach to improving healthcare quality, patient and clinician experience, and health outcomes while reducing cost and pursuing health equity. The model includes the intelligent use of health data to identify individual and population needs in a timely manner; the use of population health approaches such as QI, care management, and cross-system collaboration; support for innovation and sustained improvements through supportive payment practices; and capturing actionable, accurate, and timely data for effective decision making. Delivering healthcare through a person-centered lens is integral to the success of each approach and is interwoven throughout the fabric of ODM's population health improvement efforts.

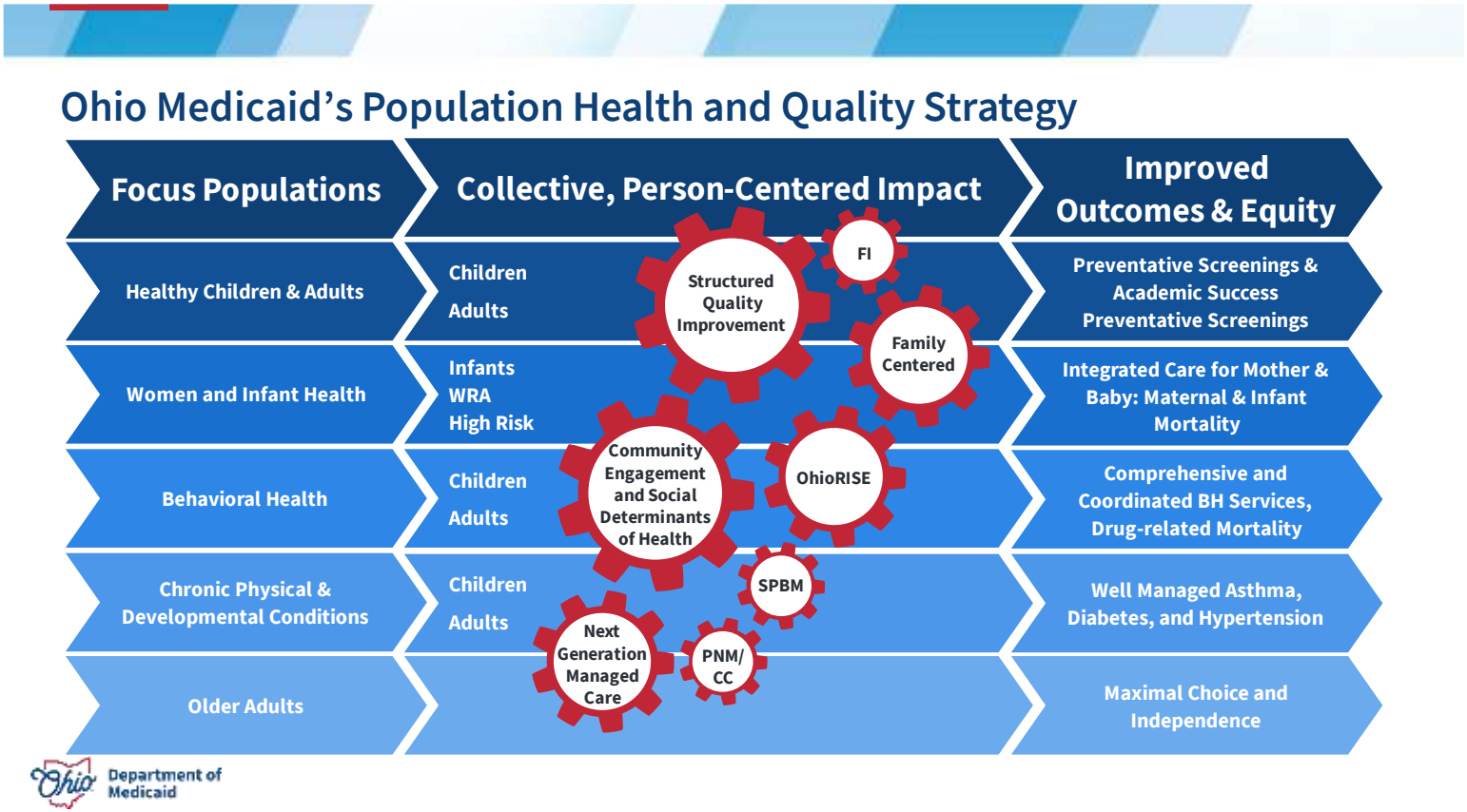

Figure 1: Ohio Medicaid's Population Health and Quality Strategy, November 2022 FI: Fiscal Intermediary; WRA: women of reproductive age; OhioRISE: Ohio's Resilience through Integrated Systems and Excellence; BH: behavioral health; SPBM: single pharmacy benefit manager; PNM: Provider Network Management; CC: Centralized Credentialing.

[3] Nundy S, Cooper LA, Mate KS. The quintuple aim for health care improvement: A new imperative to advance health equity. *JAMA*. 2022;327(6):521-522.

Medicaid's relationships with clinicians, provider associations, private insurers, other state agencies, academic medical centers, and state-level QI collaboratives also contribute to the success of ODM's quality strategy. Each plays a role by ensuring that patient planning is coordinated, and objectives are aligned across complementary initiatives. These partnerships are strengthened by the alignment of the Ohio Medicaid quality strategy and the State Health Improvement Plan (SHIP; **Figure 2**), supporting ODM's and the MCEs' work with other state agencies on improvement goals.

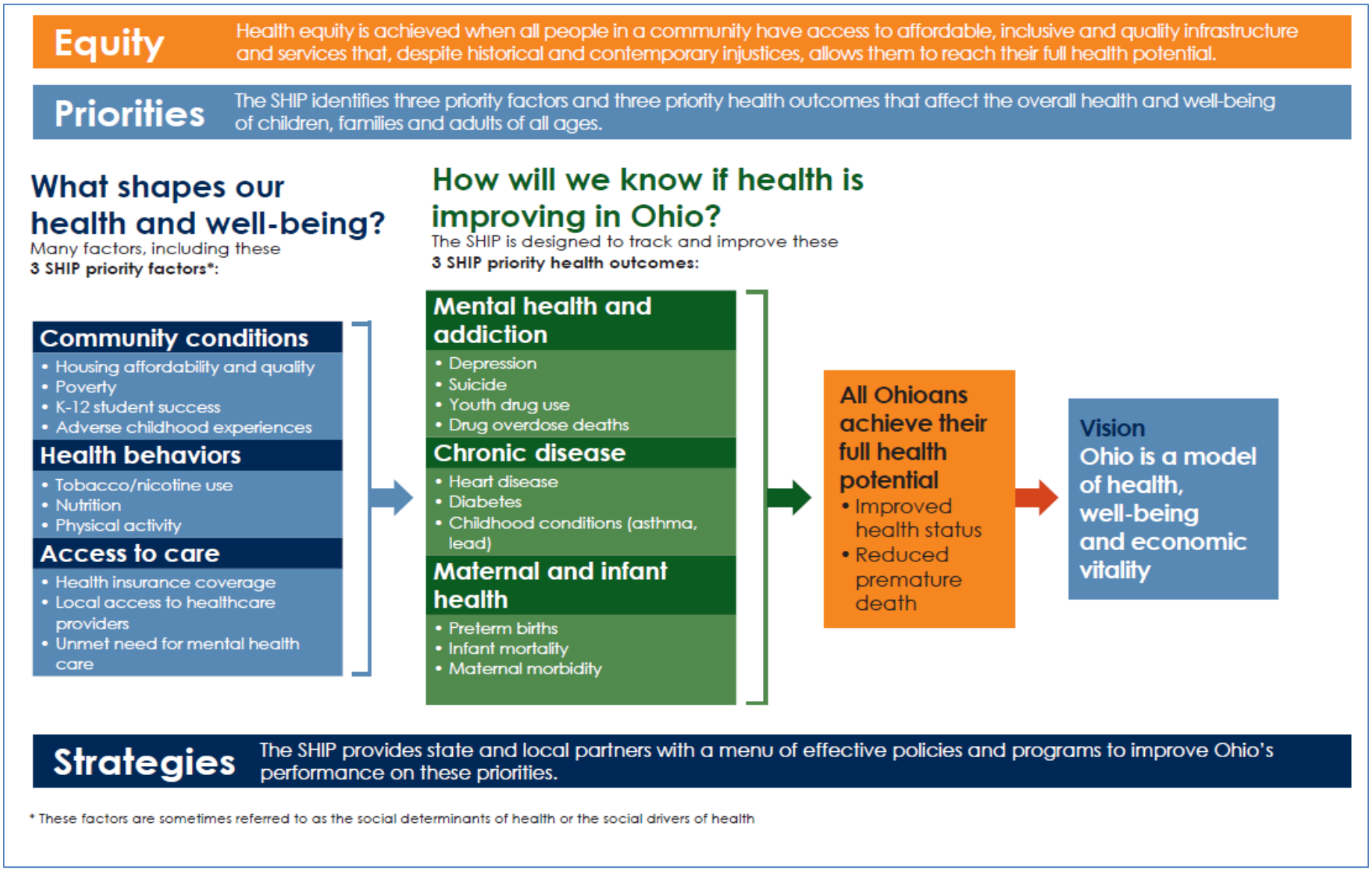

Figure 2: 2020-2022 Ohio State Health Improvement Plan SHIP: State Health Improvement Plan.

Working closely with stakeholders, advocates, medical professionals, and fellow state agencies, ODM continues to modernize the Medicaid program and improve Ohio's healthcare landscape. ODM's mission is to improve population health by pursuing the priorities of evidence-based care, engaging in person and family in care, promoting communication and coordination, promoting prevention and treatment, working with communities to enable health living, and making quality care affordable. Ohio's managed care program is designed to achieve these priorities by focusing on targeted goals within the context of family and community while also keeping the individual at the forefront of all efforts. High-level priorities of ODM include:

- improving wellness and health outcomes;
- emphasizing a personalized care experience;
- supporting providers in better patient care;
- improving the care of children and adults with complex needs; and
- increasing program transparency and accountability.

Each goal is supported by specific strategies, described in the following sections.

Goal 1. Improved Wellness and Health Outcomes

ODM's population health framework recognizes the necessity of early and ongoing connection to primary care as key to improving the health and wellness of the population served by its managed care program. Specific strategies for improving health and wellness span the life course and include:

- Partnering with clinicians and clinical practices to address the complexities of delivering high quality care through the establishment of multiple collaborative opportunities (e.g., learning networks and QI opportunities), providing consistent messaging about health and wellness, building community supports, and creating novel payment structures that value quality over quantity.
- Collaboration with other state agencies (e.g., the Ohio Department of Health [ODH], OhioMHAS, the Ohio Department of Education and Workforce [ODEW]).
- Proactive use of data to inform population health approaches, including the identification of patterns, analysis of linked vital statistics-claims data, use of clinical data, early identification of pregnancy, and the incorporation of feedback from members, providers, families, and communities.
- Collaboration with academic medical centers to improve chronic conditions.
- Regular assessments of population needs and access to care through standardized health risk assessments (e.g., MCO Health Risk Assessments, Child and Adolescent Needs and Strengths [CANS], and Pregnancy Risk Assessment Forms [PRAFs]).
- Use of geo-analysis to assess Ohio Medicaid provider network adequacy.
- Development and maintenance of a standardized pregnancy risk assessment and referral platform providing referrals to the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC®), smoking cessation programs, home visits, and other services designed to improve birth outcomes.
- Connections to health information exchanges (HIEs) within Ohio to connect clinical and claims information to close gaps in care and referrals to health-related social services.
- Collaborative MCE improvement efforts focused on improving wellness and health outcomes.
- Development of the OhioRISE program to improve outcomes for children involved in multiple systems of care.

ODM has outlined objectives, quality measures, and performance targets for this goal, including key measures intended to monitor progress towards the elimination of disparities with the ultimate goal of health equity. Given the procurement of new health plans, many of the performance targets were designed as informational, or "reporting only," until sufficient data are available to set minimum performance standards (MPSs).

Goal 2. Create a Personalized Care Experience Customized for Ohioans Served

The individuals served by Ohio Medicaid are at the center of the Next Generation managed care program, with customized services to meet individual and family needs, and a focus on community and provider partner connections. Individualized services promoting a positive patient experience are essential to achieving population health. In order to customize services to the needs of individuals and families, ODM prioritizes timely identification of risk and needed

services, a risk tiered approach to providing care coordination, tailored delivery of evidence-based services and provision of enhanced services based on specialized needs, culturally relevant care delivery, simplification of member benefits and improvements in information exchange, and community reinvestment.

Timely Identification of Needs

ODM's managed care program utilizes several mechanisms to identify the needs of members and sub-populations:

- Individual level
  - MCOs are required to assess the social and medical needs of all members within 90 days of the effective date of enrollment using a standardized health risk assessment form. Additional attempts must be made if the initial attempt is unsuccessful.
- Sub-population needs
  - Health systems and community based organizations serving women who are identified as pregnant can complete a PRAF or the Report of Pregnancy (ROP) to quickly communicate the pregnancy and related needs to Medicaid and the MCOs. This allows for maintenance of Medicaid enrollment during the pregnancy and postpartum, as well as connecting women to services such as WIC® and evidence-based home visiting.
  - Youth with complex behavioral health and multi-system needs may be eligible for OhioRISE based on the CANS assessment which is completed by a care management entity (CME). If enrolled in OhioRISE, the CANS assessment is required every six months, which assists with assessing the member's functional progress within the course of OhioRISE plan treatment.
- Macro-level
  - Analysis of claims data and data based on the geographical distribution of social needs, such as the Ohio Opportunity Index (OOI) are used to determine needs of populations, subpopulations, and the supports available within the communities in which they live, work, and play.

Care Coordination Across the Care Continuum

Care coordination encompasses the full spectrum of care coordination activities, ranging from short-term assistance for meeting care gaps to longer, more intensive, and holistic care management for the higher-risk individuals. Care coordination identifies and addresses physical, behavioral, and psychosocial needs of members; supports member goals and choices through a person-centered, trauma-informed, and culturally attuned approach; and provides care continuity while honoring member experience and choice.

ODM ensures that cross-system care coordination is a priority between the MCOs, the OhioRISE plan, the SPBM, community partners, health systems, and other state agencies. In support of this priority, ODM specifically requires that the MCEs ensure staffing is sufficient to support care coordination efforts. ODM also specifies that MCEs maintain robust information systems that identify the level of care coordination a member is receiving (i.e., Care Manager, Care Manager Plus, Care Guide, and Care Guide Plus), the primary entity providing care management and/or care coordination, and the person-centered care plan contents (e.g., goals, interventions, outcomes, and completion dates).

ODM prioritizes care coordination as an essential component to the quality strategy in relation to provider-specific programs, including Comprehensive Primary Care (CPC) and Comprehensive Maternal Care (CMC), requiring that provider entities have strong policies, procedures, and workflows in place to track and follow patients through the medical neighborhood, as well as to work closely with MCOs, MCEs, and other agencies in support of shared patients' care continuity.

Tailored Program Delivery – OhioRISE

The design of OhioRISE was informed by input from stakeholders that included families, advocates, providers, provider associations, and partner state agencies, redefining ODM's approach to Medicaid managed behavioral health services for children and youth with complex or multi-system needs. ODM and its partner agencies are required to continually focus on tailoring the structure and design of the OhioRISE program to focus on the needs of multi-system youth (MSY) due to the need to address inconsistencies in the availability of services needed by MSY and their caretakers. Examples of entities from which MSY require services include the ODJFS, the OhioMHAS, Ohio Department of Youth Services

(ODYS), Ohio Family and Children First councils (OFCFCs), County Alcohol, Drug and Mental Health Boards, and County Boards of Developmental Disabilities.

Specialized Services for High-Risk Populations

MCOs and OhioRISE are required to provide services and resources tailored by population, community, and risk tier along the care continuum from low to high risk. Additionally, each MCO must include a description of specialized services and other resources for each population stream tailored to risk level and community demographics in their *Managed Care Population Health and Quality Strategy* submitted to ODM.

MCOs are required to build working relationships with locally based organizations to support the provision of services and resources to their members, ensuring services are designed to be person-centered, meet the needs of the members, and honor members preferences while not duplicating other services paid for by the MCO or ODM. QI principles must be used to assess and enhance these services and resources. For example, person-centered transportation might be structured so it can be ordered "on-demand" via a cell phone app and may include options such as having car-seat availability for accompanying children, allowing the rider to choose the driver based on ratings, and giving riders the opportunity to rate their own experience. The transportation service would then be assessed and refined based on rider feedback.

Culturally Relevant Care Delivery Strategies that Foster Respect and Empathy

In order to deliver culturally relevant care, ODM has sought to understand the perspectives of populations served. For example, in communities that have experienced a disproportionately high degree of infant mortality, ODM assesses the perspectives of women of reproductive age every six months to inform policy and programmatic development aimed to reduce infant mortalities. Women have expressed several barriers related to accessing healthcare, including a lack of trust in the healthcare system, lack of effective communication from Medicaid providers, lack of provider empathy, and lack of Medicaid coverage of alternative providers and services. This feedback led ODM to work with Ohio's academic medical centers to develop a series of simulated training modules, Medicaid Care Experience Simulations (MCarES), aimed at reducing implicit bias and improving cultural awareness and empathy among entities and individuals working with the Ohio Medicaid population.[4] Additional programs resulting from understanding member perspectives include the Ohio's Maternal Infant Support Program (MISP) which is focused on improving Medicaid coverage retention during pregnancy and postpartum, increasing services available to women during pregnancy, and provide a patient-centered maternity medical home that improves the quality of care to women during pregnancy; and OhioRISE which was developed in response to intensive listening sessions with stakeholders that highlighted the need for a highly integrated, multi-system approach with intensive care coordination for children and youth involved with multiple systems.

Simplification in Benefit Design and Increased Information Exchange

The shift from multiple, MCO-contracted pharmacy benefit managers to an SPBM simplifies and improves information exchange between pharmacies, providers, and MCOs, leading to improved member care coordination and allowing additional member-valued services and benefits, such as home delivery, 90-day medication refills, and medication management and adherence programs that benefit all members.

Community Reinvestment

Each MCO and the OhioRISE Plan must contribute 3% of its annual profits to community reinvestment and increase the percentage of contributions by 1% each subsequent year to a maximum of 5% of the entities' annual profits. Community reinvestment funds must be used to support population health strategies within the region or regions the MCO or OhioRISE Plan serves, and it must not be used to pay for Medicaid covered services.

Goal 3. Support Providers in Continuously Improving Patient Care

Several strategies are used by ODM to support providers in continuously improving patient care, including removing administrative barriers and redundant contractual requirements, promoting clinical and payer best practices through instituting science-based QI projects; aligning with academic medical centers and health system partners, and

[4] Examples: Medicaid Care Experience Simulation Project | Ohio Colleges of Medicine Government Resource Center (osu.edu).

promoting specialized services; enhancing care coordination; monitoring and evaluating utilization trends; and deploying value-based payment models.

Removal of Administrative Barriers and Contractual Redundancy

Modernized Provider Network Management System

ODM developed a modernization roadmap for updating its management information system, including a transition to a modular system, the Ohio Medicaid Enterprise System (OMES), that supports ODM in meeting modernization goals, such as reducing administrative burden for providers by streamlining processes. The Provider Network Management system, one component of OMES, progresses toward this goal by:

- accepting the same National Provider Identifier (NPI) for multiple provider types and allowing multiple provider Medicaid IDs to be linked to one NPI;
- giving providers the ability to view specialties and effective dates;
- allowing provider change or update requests to also be reviewed and accepted within the PNM, eliminating email or letters to communicate acceptance;
- provisioning of a comprehensive provider directory at the state level;
- offering the ability to opt in or out of text message notification for providers;
- eliminating paper agreements for long-term care facilities; and
- centralizing the provider credentialing and review process.

Fiscal Intermediary

The fiscal intermediary lightens provider administrative load and streamlines processes by serving as a single point of entry for all provider claims and prior authorization requests. This not only facilitates processing of and transitioning claims and requests to Ohio Medicaid's MCEs, but it is also able to convey updates from those organizations back to providers, expediting the review and reimbursement cycle. The fiscal intermediary provides ODM with greater insight into claims and prior authorization requests, allowing for more efficient and effective identification and addressing of trends.

Single Pharmacy Benefit Manager

Pharmacists and prescribers see benefits from streamlining to a SPBM, including streamlining inventory for the pharmacists and reduction of administrative burden on providers by simplifying clinical and prior authorization policies and claims processes. This streamlining and simplification allows greater focus on patient care.

Clinical and Payer Best Practice Guidelines

ODM is committed to the promotion of evidence-based practices. MCEs must continuously improve all aspects of the care delivery system to optimize the health of members, achievable through the inclusion of input from members, providers, and other partners across the care continuum. MCEs must develop and apply clinical and payer best practice guidelines for service delivery decisions pertaining to utilization management (UM), member grievance and appeals, provider dispute resolution, member education, coverage of services, QI projects, addressing disparities, and other areas to which these guidelines apply.

Quality Improvement Projects

MCEs must engage in quality improvement projects (QIPs), including EQRO-validated PIPs, which focus on patient experience. MCEs should obtain the perspective of members and providers to determine barriers to optimal care, collaboratively designing interventions to address these barriers. Examples of QI projects that the MCEs engaged in during the reporting period include the Antipsychotic Metabolic Monitoring PIP (the first collaboration between the single pharmacy benefit manager, OhioRISE, and Ohio's Medicaid MCOs), collaborative Medicaid MCO efforts to improve the utilization of the Pregnancy Risk Assessment Form (PRAF), and Medicaid and MyCare MCO collaborative efforts to improve self-management of diabetes through increasing the clinically appropriate use of continuous glucose monitors and diabetes self-management education.

Promoting Specialized Services

The OhioRISE Program

OhioRISE supports providers using the following strategies:

- Develop and enhance initiatives to assist providers in identifying and recruiting staff for key supervisory and direct service positions.
- Create opportunities for network providers to locate formal and informal support for OhioRISE members with unique needs.
- Partner with providers to develop and implement innovative approaches to workforce and network development.

ODM's designated Centers of Excellence (COE) supports development of evidence-based practices and services, ongoing fidelity reviews, and workforce development, as well as collaborate with ODM and other partners to build and sustain a comprehensive standardized assessment process, effective services, and care coordination approaches for children with complex behavioral health needs. The COE assists Ohio's system transformation efforts by supplying the provider orientation, training, coaching, mentoring, and other functions/supports needed to build and sustain the delivery of these services.

Value-Based Payment Models

ODM through its provider agreements with MCOs has laid the foundation for using VBP models to support population health goals. ODM requires MCOs to design and implement payment reform initiatives to transform the healthcare delivery system through rewarding innovation and results, over volume of service delivery. This transformation is aimed at improving individual and population health outcomes and member experience while containing costs. To this end, MCOs must develop value-oriented payment methodologies that reduce unnecessary payment and care while promoting quality, enhancing market competition and consumerism, engaging and partnering with providers and other payers, and promoting transparent mechanisms for engaging members in making informed provider and care choices in the selection of evidence-based, cost-effective care.

MCOs must not only encourage provider participation in, and support of, value-based payment initiatives, but must also support provider readiness (e.g., data and analytic capabilities, financial stability); tailor payment reform strategies to provider type (e.g., BH providers, hospital providers, dental providers, federally qualified health centers), geography (e.g., rural providers) and size (e.g., small providers, hospital systems). In addition, MCOs must assist providers in identifying and addressing barriers to value-based payment efforts and encourage member utilization of providers that demonstrate value and quality by contributing to the design of ODM initiatives to transparently give information to members on providers, quality, cost, and member experience by sharing data and publishing results.

In 2018, ODM transitioned from an incentive-based, pay-for-performance model to a quality-withhold model in which performance measures were categorized into indices to underscore the necessity of managing whole conditions in a person-centered manner rather than focusing on a single performance measure at a particular point in a person's disease progression. With this framework, ODM used indices focused on conditions to evaluate an MCOs ability to improve outcomes. During 2020, the COVID-19 pandemic necessitated converting quality withhold from a retrospective assessment of HEDIS measure improvement, requiring assessment of claims and EHR data, to an assessment of the MCOs' ability to collaboratively improve the safety and well-being of their members during the COVID-19 pandemic.

Structured QI processes were facilitated by ODM to assist the MCOs in meaningfully addressing: 1) safety and connectivity for restored citizens; 2) infection prevention and reduced isolation for nursing facility (NF) residents; 3) improved and safe transportation for medical, pharmacy, and food needs; 4) greater adoption of telehealth services; and 5) improved immunizations for children. The success of the 2020 collaborative QI efforts led ODM to continue using QI science in 2021 and 2022 to guide MCOs in helping patients manage their diabetes and increasing COVID-19 vaccination rates.

Comprehensive Primary Care Program (CPC)

Ohio's CPC program is a patient-centered medical home program that incentivizes PCPs to provide more coordinated care, enhance access to care, promote team-based care, improve quality of care, and reduce the total cost of patient care. Launching on January 1, 2017, the program now includes nearly 1.25 million members statewide (approximately 40% of the Medicaid population). Two additional payment streams are available for which CPC practices can be eligible, including a per-member-per-month (PMPM) payment to support CPC activities and an annual shared savings payment awarded to practices for achieving total cost of care savings. Practices must attest to meeting a minimum requirement in order to enroll in the program. To be eligible for payment, practices must meet these requirements, as well as 50% of applicable clinical quality metrics and 50% of program efficiency metrics.

Comprehensive Maternal Care Program (CMC)

CMC is a community-based program aimed at improving the health and well-being of moms, birthing parents, and infants covered by Medicaid. The program incentivizes maternal and family medicine entities to develop community connections and culturally-aligned supports for birthing people and their families, while providing quality care, improving patient experiences, and reducing disparities. Launched in January 2023, entities must meet the requirements of 9 comprehensive maternal health activities to participate. Activities address patient-centered medical home goals, ranging from enhanced access, risk stratification, and care coordination to patient experience, patient engagement, and community integration. CMC places specific emphasis on addressing poor and inequitable maternal and infant health outcomes in the state. The program now includes 44,651 members and 137 practices.

Goal 4. Improved Care for Children and Adults with Complex Needs

Individuals with complex needs include those with multiple or severe chronic conditions, individuals with behavioral health needs, children served by multiple state systems, and children with behavioral health needs. Ohio's Next Generation Managed Care designed OhioRISE to specifically focus on the coordination of care and services for these children.

Special Services for High-Risk Populations

OhioRISE

OhioRISE is designed to support and stabilize children and youth coping with complex, behavioral health treatment needs and multisystem involvement. The program aims to keep youth united in their home, school, and community by using specialized assessments to determine the appropriate intensity of services needed and then delivering an individualized, family-centric, coordinated approach to care. An outstanding need to develop specialized services intended for this population was identified across state agencies. Specialized services within OhioRISE include varied levels of care coordination, intensive home-based treatment (IHBT), psychiatric residential treatment facilities (PRTF), behavioral health respite, primary flex funds, SUD services, and mobile response and stabilization services (MRSS).

Value-Based Payment Models

Care Innovation and Community Improvement Program

The Care Innovation and Community Program (CICIP) was developed to increase alignment of QI strategies and goals among ODM, MCOs, and four public health and nonprofit hospital participating agencies: the MetroHealth System, UC Health, University of Toledo Medical Center, and The Ohio State University Wexner Medical Center. CICIP goals align with ODM goals to improve healthcare for Medicaid beneficiaries. From July 2022 through June 2025, the quality measures for the CICIP program are as follows:

1. Rate of opioid solid doses dispensed (without Suboxone®) for members of practitioners prescribing opiates;
2. Rate of members receiving opioids also receiving Benzodiazepines;
3. Rate of members with opioid scripts receiving greater than 80mg Morphine Milligram Equivalent (MME);
4. Initiation and engagement of alcohol and other drug dependence (HEDIS measure);
5. Follow-up after inpatient stay for mental health within seven calendar days (HEDIS measure);
6. Timeliness of prenatal care (HEDIS measure);
7. Postpartum care (HEDIS measure);

8. Emergency room utilization reduction;
9. Continuity of pharmacotherapy for opioid use disorder (OUD; reporting only);
10. Rate of medication-assisted therapy (MAT) for OUD (reporting only); and
11. Number of members with electronically submitted PRAFs 2.0 (reporting only).

Specific Improvement Projects Aimed at Improving Care for Individuals with Complex Needs

MOMS+ Dyad Care Project

ODM is collaborating with the Ohio Perinatal Quality Collaborative to develop and test best practices for caring for the mother-baby dyad throughout the first-year postpartum, aimed to retain the mother in care while ensuring the infant has all the care needed during their first year of life. Strategies include partnerships across the healthcare continuum including social services systems, the use of standardized communication tools (e.g., PRAF 2.0) to facilitate communication regarding identified needs, and the use of checklists of recommended clinical care.

Focus on Me

Focus on ME, a project comprised of primary care providers across Ohio, is focused on improving health care related to depression and anxiety for women in Ohio seen at primary care practices by focusing on evidence-based behavioral health screening and treatment. Over the project period anxiety screening rates increased from 6.2% to 40.6% and depression screenings increased from 74.5% to 87.1%. The average rate of clinical responsiveness also increased during this time for both moderate anxiety (24.6% to 79.6%) and severe anxiety (29.6% to 85.1%).

Chronic Conditions Improvement Projects

Chronic Conditions Improvement Projects, such as those focused on diabetes management through appropriate use of continuous glucose monitors and diabetes self-management education, work to identify, standardize, and share best clinical and payer practices for the management of chronic conditions, such as hypertension and diabetes.

Goal 5. Increased Program Transparency and Accountability

ODM is committed to quickly identifying problems and issues through transparent accountability mechanisms in an effort to constantly improve the managed care program. Although ODM's provider agreements, fee schedule, quality strategy, data reports, and eligibility and coverage policy have all been publicly available for a number of years, Next Generation Managed Care employed additional changes toward achieving transparency and accountability, including: the provision of a single fiscal intermediary for all provider claims and prior authorization requests, the use of a single pharmacy benefit manager and a pharmacy pricing and audit consultant, the creation and management of public facing dashboards and report cards.

Fiscal Intermediary for All Provider Claims and Prior Authorization Requests

ODM's fiscal intermediary provides a single clearinghouse for all provider claims and prior authorization requests, validating transactions and routing requests to the appropriate MCO for resolution and reimbursement. This streamlines the claims process and strengthens ODM's ability to assess compliance with MMC regulations, review encounter data, and track performance measures. Use of the fiscal intermediary aims to:

- reduce the time needed for managed care claim processing,
- increase real-time access to critical healthcare transactions,
- increase greater transparency and improve agency oversight of clinical coverage policies by allowing an end-to-end view of claims processing, and
- increase effectiveness in meeting member and provider needs by improving the agility of programs, policies, and services.

Single Pharmacy Benefit Manager

In 2019, ODM began the process of transitioning to the Ohio Medicaid pharmacy benefit program from multiple MCO-managed pharmacy benefit managers to an SPBM serving all MMC enrollees.

Pharmacy Pricing and Audit Consultant

In April 2021, ODM hired Myers and Stauffer as its pharmacy pricing and audit consultant (PPAC) in order to achieve transparency in managing pharmacy benefits. The PPAC was responsible for determining ODM's reimbursement methodology, conducting Cost of Dispensing and Actual Acquisition Cost (AAC) surveys, maintaining accurate and up-to-date AAC rates, and conducting oversight of the financial and operational functions of both the SPBM and the ODM's fee-for-service pharmacy benefits administrator (FFS PBA). ODM is gauging the success of this pharmacy benefit administration model, and the PPAC specifically, through fair, accurate, and value-based reimbursement to pharmacies, as well as oversight to ensure the SPBM and the FFS PBA comply with ODM's expectations, improve provider and member satisfaction, and engage in continuous improvement of the pharmacy program.

Checks and balances were built into the model to avoid consolidation of power and functions, increase transparency and accountability, monitoring and closing loopholes, and a focus on increasing member and provider satisfaction. The redesign of the pharmacy program aims to achieve the objectives of:

- improving management of pharmacy benefits to better meet the needs of covered populations, and
- increasing financial transparency and accountability.

This structure also allows the SPBM to actively participate in collaborative improvement work with the MCEs - such as adherence to medications for chronic medications (e.g., asthma controllers) and ensuring safety in prescribing (e.g., opioids, antipsychotic medications).

Demographics and Expenditures Dashboards

The demographics and expenditures of the Ohio Medicaid program are made publicly available,[5] increasing program transparency.

Managed Care Dashboards

The ODM, Office of Managed Care publishes quarterly dashboards[6] that visually depict Medicaid and MyCare Managed Care performance in the following areas:

- member complaints, appeals, and state hearings;
- inpatient psychiatric stays for children (ages ≤ 21 years) and adults (ages > 21 years) stratified by stays of less than 16 days and 16 days or more, as well as number of admissions;
- provider panel compliance; and
- Medicaid provider complaints, prior authorization, and prompt pay.

Assessment of Ohio Medicaid Quality Strategy

ODM completed a comprehensive update of the Medicaid quality strategy, titled *The Ohio Department of Medicaid Next Generation Population Health and Quality Strategy*, in May 2022. Ohio's Medicaid quality strategy aligns with CMS's guidance for developing an effective strategy. Goals and aims are clearly stated and supported by well-designed interventions, and methods for measuring and monitoring MCO progress toward improving health outcomes incorporate EQR activities. The numerous clinical and nonclinical initiatives established by ODM, along with its enforcement of MCE accountability, affirm that improving health remains a priority. IPRO has undertaken an evaluation of the quality strategy underway, following guidance from CMS's *Managed Care Quality Strategy Toolkit*. Results will be included in next year's EQR annual technical report.

Recommendations to ODM

IPRO recommends that ODM consider the following:

- Continue to monitor statewide and plan-specific performance toward achieving Medicaid quality strategy goals based on the quantifiable targets for each health outcome that ODM has selected. Report the data in numerous ways to allow comparisons between plans, populations, geography, and providers.

[5] Ohio Department of Medicaid | Medicaid | Demographics and Expenditures Dashboards

[6] Managed Care Dashboards (ohio.gov)

- In partnership with the MCEs, develop a process and more frequent cadence for assessment of quality strategy goal progress and metrics for contributing activities. Share feedback with the MCEs.
- Within the population health strategy, delineate specific health equity objectives for each population health stream. Pursue balanced representation of health streams when determining performance metrics and setting goals and objectives.

III. Validation of Performance Improvement Projects

Objectives

ODM requires its contracted MCEs to conduct PIPs to improve the quality of healthcare services, as set forth in *Title 42 CFR § 438.330(d)*. ODM contracts with IPRO to validate the PIPs.

ODM has convened the MCOs and MCOPs to participate in the Diabetes Management and Disparity Reduction PIP (Diabetes PIP) collaborative to increase the number of members with diabetes who are using a CGM and the number of members with diabetes who attend DSME. The PIP started in September 2022 and continued through December 2023, with IPRO conducting the final validation in spring 2024. The following results are preliminary.

Specific objectives for the Diabetes PIP are to:

- promote evidence-based interventions for diabetes;
- increase the percentage of those who acquire or have evidence of use of a CGM and those who attended DSME;
- establish a data collection methodology, including claims and manually collected data;
- develop process and outcome measures to track PIP progress and sustainability of improvements; and
- engage in QI activities to identify, modify, and adapt best practice interventions into practice sites and MCE processes for sustainability.

In March 2023, ODM began a collaborative PIP with Aetna OhioRISE, the SPBM, and the MCOs to improve APMM, with the aim of increasing the percentage of children (ages 1−17 years) who received two or more antipsychotic prescriptions and received both cholesterol and blood glucose metabolic monitoring.

Specific objectives for the APMM PIP are to:

- increase the percentage of children prescribed antipsychotic medication who have received metabolic monitoring;
- promote evidence-based interventions for antipsychotic metabolic monitoring;
- establish a data collection methodology, including claims and manually collected data;
- develop process and outcome measures to track PIP progress and sustainability of improvements; and
- engage in QI activities to identify, modify, and adapt best practice interventions into practice sites and MCE processes for sustainability.

Technical Methods of Data Collection and Analysis

The Diabetes and APMM PIPs apply an improvement framework similar to the Institute for Healthcare Improvement (IHI) framework that incorporates the Associates in Process Improvement's Model for Improvement and a modified version of the IHI Breakthrough Series Model to guide project activities. The key components of the rapid-cycle PIP framework include forming a PIP team (internal and external stakeholders), setting aims, establishing measures, determining interventions, testing interventions, monitoring measures to determine levels of improvement using run chart and statistical process control chart special cause rules, and sustaining and spreading successful changes. At the core of the rapid-cycle approach is testing changes on a small scale using a series of rapid plan-do-study-act (PDSA) cycles to identify and scale up effective interventions. Policy and procedures are then modified to ensure long-term sustainability.

The MCOs and MCOPs submit monthly status reports and engage in biweekly phone calls with ODM and IPRO. During each call, plans describe their progress working through the PIP process, updating documents and synthesizing data throughout the year to reflect the learning garnered through testing interventions. Calls conclude with reviews of process and outcome measures, as well as discussions about data quality and completeness that may impact measurement.

PIP Methodology

Diabetes PIP

The Diabetes PIP seeks to improve the health of adults with type 1 and type 2 diabetes and poorly controlled hemoglobin A1c (HbA1c), particularly improving enrollment in DSME and the use of CGMs for members. The Global Aim is to reduce complications of type 1 and type 2 diabetes in members. The SMART Aims for the collaborative MCO PIP are to increase the percentage of those who acquire or have evidence of use of a CGM from 9.5% to 17.7% and increase the percentage of those who attend DSME from 0.7% to 1.5% by December 31, 2023. The SMART Aims for the collaborative MCOP PIP are to increase the percentage of those who acquire or have evidence of use of a CGM from 8.7% to 12.4% and increase the percentage of those who attend DSME from 2.0% to 3.1% by December 31, 2023.

The measure specifications for CGM are:

- numerator: the number of members with diabetes who have a claim for CGM equipment or supplies with a date of service between 1/1/2023 and 12/31/2023;
- denominator: members ages 18−75 years with diabetes for the 12-month period ending December 31, 2023, identified in accordance with the HEDIS MY 2023 Hemoglobin A1c Control for Patients with Diabetes (HBD) technical specifications;
- baseline period: 1/1/21 to 12/31/21;
- measurement period: 7/1/22 to 12/31/23; and
- measurement interval: once per month.

The measure specifications for DSME are:

- numerator: the number of members with diabetes who have a claim for DSME with a date of service in the MY;
- denominator: members ages 18−75 years with diabetes, identified in accordance with HEDIS administrative specifications for the HBD measure. For the eligible population/measure denominator calculation, continuous enrollment will be determined at the overall MMC level (instead of at the individual plan level) for the SMART Aim measure calculations;
- baseline period: 1/1/21 to 12/31/21;
- measurement period: 7/1/22 to 12/31/23; and
- measurement interval: once per month.

MyCare Ohio members are excluded from the MCO denominators, and MyCare Medicaid-only members are excluded from the MyCare denominators.

Data sources used to calculate SMART Aim measures include CGM Current Procedural Terminology (CPT®)/Healthcare Common Procedure Coding System (HCPCS) claims submitted by MCOs and MCOPs and CGM pharmacy claims generated using ODM's IS.

APMM PIP

The Global Aim of the APMM PIP is to improve the health and functioning of children in the Medicaid program, with a specific objective to increase the percentage of children prescribed antipsychotic medication who have received both glucose and cholesterol metabolic monitoring on an annual basis. The SMART Aim for this project is to increase the percentage of children (ages 1−17 years) with two or more antipsychotic medication prescribing events who have received both glucose and cholesterol metabolic monitoring by 12/31/2024. The plans were in the early stages of building their theories for improvement through the end of SFY 2023 and began testing their interventions in SFY 2024. The MCOs, Aetna OhioRISE, Gainwell SPBM, and IPRO participate in weekly calls with ODM to discuss progress. They will continue to do so until the end of December 2024 while working to implement, spread, and sustain their successful interventions.

The measure specifications for the APMM PIP are:

- numerator: children in the denominator who had at least one test for blood glucose or HbA1c and at least one test for low density lipoprotein cholesterol (LDL-C);

- denominator: children and adolescents ages 1−17 years who have had two or more antipsychotic medications dispensed on separate dates of service during the MY;
- baseline period: to be determined;
- measurement period: 3/1/23 to 12/31/24; and
- measurement interval: once per month (rolling 12-month measurement period).

Excluded members include those in hospice or using hospice services anytime during the MY, members enrolled in MyCare, and individuals served through FFS Medicaid. The MCOs used data provided by Gainwell to establish their baseline rates and set their SMART Aims. They retrieve utilization data from the portal monthly and plot outcome and process measures on run charts and/or control charts to assess progress. Due to changes in Ohio's claims payment systems, at the time of this report, the plans had not yet set the baseline SMART Aim goal.

PIP Validation

To ensure methodological soundness while meeting all state and federal requirements, IPRO follows guidelines established in the Department of Health and Human Services, CMS publication, *EQR Protocol 1: Validation of Performance Improvement Projects* (2023). IPRO's validation of PIPs includes the following key components of the QI process:

- Evaluation of the technical structure to determine whether the components of a PIP's initiation (e.g., topic rationale, PIP team, aim, key driver diagram [KDD], and SMART Aim data collection methodology) were based on sound methods and were designed to reliably measure outcomes.
- Evaluation of the QI activities conducted. Once designed, a PIP's effectiveness in improving outcomes depends on thoughtful and relevant interventions, intervention testing and assessment using PDSA cycles, and spreading successful changes. IPRO evaluates how well the MCEs execute the QI activities and whether the SMART Aim goal was achieved.

IPRO's PIP validation seeks to ensure that ODM and key stakeholders can have confidence that any reported improvement is related to and can be directly linked to the interventions and QI processes and activities conducted by the MCEs during the PIP.

Scoring Methodology

IPRO developed and applies a PIP Validation Tool to evaluate and document PIP activities and provide the MCEs with specific feedback and recommendations. PIP validation has two parts: determining if the activities were correctly conducted and assessing the likelihood that the interventions affected change. Each evaluation element is scored as *Met, Partially Met, Not Met,* or *Not Applicable*, based on the information provided by the MCEs. The criteria for each score are presented in **Table 1**. To draw conclusions about impact, IPRO analyzes the MCEs' PIP data and evaluates trends in the SMART Aim measurements in comparison with the reported baseline and goal rates, aligning the data with improvement activities. IPRO reports the overall validity and reliability of the PIP activities using confidence levels. These confidence levels are displayed in

Table 2.

Table 1: PIP Validation Review Criteria

Determination	Criteria Description
Met	The MCEs have demonstrated that they have fully addressed the requirement.
Partially Met	The MCEs have demonstrated that they have addressed the requirement, however not in its entirety.
Not Met	The MCEs have not addressed the requirement.
Not Applicable	The requirement was not applicable for review.

PIP: performance improvement project; MCE: managed care entity.

Table 2: PIP Validation Confidence Levels

Confidence Level	Level Description
High confidence	The PIP was methodologically sound, produced evidence of significant improvement, and the demonstrated improvement was clearly linked to the QI processes implemented.
Moderate confidence	The PIP was methodologically sound, produced some evidence of improvement, and some of the QI processes were clearly linked to the demonstrated improvement.
Low confidence	a) The PIP was methodologically sound; however, no evidence of improvement was produced; or b) The QI processes and interventions were poorly executed and could not be linked to any improvement that may have occurred.
No confidence	The PIP methodology did not follow an IHI-like approach, as illustrated by the MCEs not testing changes under the payer's influence.

PIP: performance improvement project; QI: quality improvement; IHI: Institute for Healthcare Improvement; MCE: managed care entity.

Conclusions and Comparative Findings

Diabetes PIP

Validation findings for the seven MCOs are in **Table 3** for CGM and **Table 4** for DSME, with SMART Aim results in **Table 5**. PIP validation continued monthly through December 2023, and final PIP validation results will be calculated once the full year of claims are available in 2024. Validation activities to date have found that the PIPs are methodologically sound, produce evidence of improvement, and at least some of the QI processes are linked to measurable improvements. As of September 2023, the percentage of MCO members with diabetes using CGM has increased from 9.5% to 17.8% (reaching the SMART Aim goal of 17.7%). The percentage of MCO members with diabetes participating in DSME has increased from 0.7% to 1.3%, which does not yet reach the SMART Aim goal rate of 1.5%.

Validation findings for the five MCOPs are in **Table 6** for CGM and **Table 7** for DSME, with SMART Aim results in **Table 8.** The percentage of MCOP members with diabetes using CGM has increased from 8.7% to 11.0%, which does not yet reach the SMART Aim goal rate of 12.4%. The percentage of members with diabetes participating in DSME has decreased from the baseline rate of 2.0% to an interim rate of 1.5%, which is also short of the SMART Aim goal rate of 3.1%.

CGM QI activities to date have included:

- removal of CGM prior authorization in the pharmacy and durable medical equipment (DME) benefits;
- increased CGM availability in providers' offices;
- collaborative efforts with community-based organization life coaches to engage members living with diabetes in PCP appointments to discuss the benefits of CGMs and getting members on CGMs when clinically appropriate;
- member CGM data transfer support utilizing Pulsewrx phones, member linkages to provider, and ConferMED® partnership for PCP referral to diabetes specialist;
- co-design and testing of a CGM Provider Toolkit (including DSME resources) with provider practice sites; and
- interventions implemented without testing: transportation for diabetic appointments, expansion of CGM device/supplies coverage for type 2 diabetes, and standardization of plan process for ordering and dispensing non-CGM diabetic supplies.

DSME QI activities to date have included:

- member linkage to provider through Best Foot Forward for hard-to-reach members;
- promotion of the Patient Activation Measure (PAM) readiness assessment for use by providers;
- promotion of DSME telehealth (currently adopting);
- promotion of DSME uptake through community-based partnerships;
- abandoned interventions: Pre-Paid DSME appointment slots and Dedicated DSME slots; and
- intervention implemented without testing: the enhanced reimbursement for DSME to the medical nutrition therapy (MNT) equivalent.

APMM PIP

The APMM PIP will continue until December 2024. Progress is reported in **Table 9**. IPRO's initial assessment is reported in
Table 10.

APMM QI activities to date have included:

- completion of Milestone 1 − Project Planning and Scoping;
- project charters identifying the target population, population inclusions, and exclusions, as well as disparities to be addressed;
- summary of current evidence and best practices;
- reviewed data to help identify health disparities;
- stakeholder analysis that emphasized community gatekeepers; and
- voice of the customer (VOC) data obtained from members of the target population.

Table 3: MCO PIP CGM Validation Results (September 2023)

Review Element	Overall Review Determination[1]	AmeriHealth Review Determination[1]	Anthem Review Determination[1]	Buckeye Review Determination[1]	CareSource Review Determination[1]	Humana Review Determination[1]	Molina Review Determination[1]	UnitedHealthcare Review Determination[1]
Project Topic								
Project topic impacts the maximum proportion of members feasible	Met	Met	Met	Met	Met	Met	Met	Met
Potential for meaningful impact on member health, functional status, or satisfaction	Met	Met	Met	Met	Met	Met	Met	Met
Topic reflects high-volume or high-risk conditions	Met	Met	Met	Met	Met	Met	Met	Met
Project topic aligns with state/national priorities	Met	Met	Met	Met	Met	Met	Met	Met
Topic supported by MCO member data	Met	Met	Met	Met	Met	Met	Met	Met
Goal sets a target improvement rate that is bold, feasible, and based upon baseline data	Met	Met	Met	Met	Met	Met	Met	Met
Topic considers disparate population(s)	Met	Met	Met	Met	Met	Met	Met	Met
Project Aim								
In the event disparate populations have been identified and targeted, there are two SMART Aims: one reflective of the overall population, and the other of the disparate population	Not Met	Not Met	Not Met	Not Met	Not Met	Not Met	Not Met	Not Met
SMART Aim(s) are specific, measurable, achievable (goal[s] that are bold, feasible, and based upon baseline and benchmark rates and/or state guidance), relevant, and timely	Met	Met	Met	Met	Met	Met	Met	Met
There is alignment among the Global Aim, SMART Aim, drivers, and potential interventions such	Met	Met	Met	Met	Met	Met	Met	Met

Review Element	Overall Review Determination[1]	AmeriHealth Review Determination[1]	Anthem Review Determination[1]	Buckeye Review Determination[1]	CareSource Review Determination[1]	Humana Review Determination[1]	Molina Review Determination[1]	UnitedHealthcare Review Determination[1]
that the interventions and drivers are reasonably thought to be able to contribute to the achievement of the SMART Aim								
Methodology								
Project uses objective, clearly defined, measurable, time-specific measures to track performance	Met	Met	Met	Met	Met	Met	Met	Met
Measures may include process and balancing measures to assess progress on key drivers and monitoring/prevention of unintended consequences, as well as outcome measures	Met	Met	Met	Met	Met	Met	Met	Met
Measures are calculated and reported consistently over time	Met	Met	Met	Met	Met	Met	Met	Met
Eligible population is clearly defined and reflective of the provider practices that have been identified by ODM	Met	Met	Met	Met	Met	Met	Met	Met
Data sources are well-defined	Met	Met	Met	Met	Met	Met	Met	Met
Data collection procedures are valid and reliable	Met	Met	Met	Met	Met	Met	Met	Met
How and when data are collected is specified, as well as the individuals responsible and instruments/tools utilized	Met	Met	Met	Met	Met	Met	Met	Met
Assessment of Improvement Strategies								
Change ideas (interventions) are developed in response to appropriately identified key drivers and are active, suitable for PDSA cycle testing, and influenced by the MCOs	Met	Met	Met	Met	Met	Met	Met	Met

Review Element	Overall Review Determination[1]	AmeriHealth Review Determination[1]	Anthem Review Determination[1]	Buckeye Review Determination[1]	CareSource Review Determination[1]	Humana Review Determination[1]	Molina Review Determination[1]	UnitedHealthcare Review Determination[1]
When appropriate, healthcare disparities were considered in the intervention development process	Partially Met	Partially Met	Partially Met	Partially Met	Partially Met	Partially Met	Partially Met	Partially Met
Each tested intervention addressed at least one or more of the key drivers	Met	Met	Met	Met	Met	Met	Met	Met
If the intervention was successful and sustained, it was expanded, and the expansion was supported by PDSA cycles and relevant data showing effectiveness in other situations/populations. If unsuccessful, the intervention was adapted or abandoned, and the decision was supported by a rationale	Partially Met	Partially Met	Partially Met	Partially Met	Partially Met	Partially Met	Partially Met	Partially Met
Data Analysis and Interpretation of PIP Results								
Analysis and interpretation of the PIP data is based on a continuous quality improvement philosophy and reflects an understanding of lessons learned and opportunities for improvement	Met	Met	Met	Met	Met	Met	Met	Met
Run/control charts include all necessary elements, as outlined within the ODM monthly QI call template	Met	Met	Met	Met	Met	Met	Met	Met
Validity and Reliability of PIP Results								
Assess likelihood that significant improvement occurred. Significant improvement: Results (annotated within run/control charts and	Partially Met	Not Met	Partially Met	Not Met	Partially Met	Partially Met	Not Met	Not Met

Review Element	Overall Review Determination[1]	AmeriHealth Review Determination[1]	Anthem Review Determination[1]	Buckeye Review Determination[1]	CareSource Review Determination[1]	Humana Review Determination[1]	Molina Review Determination[1]	UnitedHealthcare Review Determination[1]
explained/interpreted by MCO staff during monthly calls) were likely attributable to the MCO's PIP interventions (as opposed to random chance). Changes have been implemented for the target population in all drivers where changes are being tested. Plans for spread beyond the target population are in place for at least one implemented change.								
Assess likelihood that sustained improvement occurred. Sustained improvement: Improvement in process/outcomes measures observed over time, based upon repeated measurements that demonstrated the improvement was due to special cause as reflected by a shift in the baseline and supported by theory. Spread beyond the target population has begun for at least one implemented change.	Not Met	Not Met	Not Met	Not Met	Not Met	Not Met	Not Met	Not Met
Overall Credibility of Results[2]	Moderate confidence = the PIP was methodologically sound; produced some evidence of improvement; and some of the quality improvement	Low confidence = The PIP was methodologically sound; however, no evidence of improvement was produced.	Moderate confidence = the PIP was methodologically sound; produced some evidence of improvement; and some of the quality improvement	Low confidence = The PIP was methodologically sound; however, no evidence of improvement was produced.	Moderate confidence = the PIP was methodologically sound; produced some evidence of improvement; and some of the quality improvement	Moderate confidence = the PIP was methodologically sound; produced some evidence of improvement; and some of the quality improvement	Low confidence = The PIP was methodologically sound; however, no evidence of improvement was produced.	Low confidence = The PIP was methodologically sound; however, no evidence of improvement was produced.

Review Element	Overall Review Determination[1]	AmeriHealth Review Determination[1]	Anthem Review Determination[1]	Buckeye Review Determination[1]	CareSource Review Determination[1]	Humana Review Determination[1]	Molina Review Determination[1]	UnitedHealthcare Review Determination[1]
	processes were clearly linked to the demonstrated improvement.		processes were clearly linked to the demonstrated improvement.		processes were clearly linked to the demonstrated improvement.	processes were clearly linked to the demonstrated improvement.		

[1] Review determinations: Met, Partially Met, Not Met, Not Applicable (N/A).
[2] Note that while low or moderate confidence has been determined, the project is currently at the interim stage, and thus there remains an opportunity for the MCO to demonstrate significant improvement by the end of the project period.
MCO: managed care organization; PIP: performance improvement project; CGM: continuous glucose monitoring; SMART: Specific, Measurable, Achievable, Realistic, and Timely; ODM: Ohio Department of Medicaid; PDSA: plan-do-study-act; QI: quality improvement.

Table 4: MCO PIP DSME Validation Results (September 2023)

Review Element	Overall Review Determination[1]	AmeriHealth Review Determination[1]	Anthem Review Determination[1]	Buckeye Review Determination[1]	CareSource Review Determination[1]	Humana Review Determination[1]	Molina Review Determination[1]	UnitedHealthcare Review Determination[1]
Project Topic								
Project topic impacts the maximum proportion of members feasible	Met	Met	Met	Met	Met	Met	Met	Met
Potential for meaningful impact on member health, functional status, or satisfaction	Met	Met	Met	Met	Met	Met	Met	Met
Topic reflects high-volume or high-risk conditions	Met	Met	Met	Met	Met	Met	Met	Met
Project topic aligns with state/national priorities	Met	Met	Met	Met	Met	Met	Met	Met
Topic supported by MCO member data	Met	Met	Met	Met	Met	Met	Met	Met
Goal sets a target improvement rate that is bold, feasible, and based upon baseline data	Met	Met	Met	Met	Met	Met	Met	Met
Topic considers disparate population(s)	Met	Met	Met	Met	Met	Met	Met	Met
Project Aim								
In the event disparate populations have been identified and targeted,	Not Met	Not Met	Not Met	Not Met	Not Met	Not Met	Not Met	Not Met

Review Element	Overall Review Determination[1]	AmeriHealth Review Determination[1]	Anthem Review Determination[1]	Buckeye Review Determination[1]	CareSource Review Determination[1]	Humana Review Determination[1]	Molina Review Determination[1]	UnitedHealthcare Review Determination[1]
there are two SMART Aims: one reflective of the overall population, and the other of the disparate population								
SMART Aim(s) are specific, measurable, achievable (goal[s] that are bold, feasible, and based upon baseline and benchmark rates and/or state guidance), relevant, and timely	Met	Met	Met	Met	Met	Met	Met	Met
There is alignment among the Global Aim, SMART Aim, drivers, and potential interventions such that the interventions and drivers are reasonably thought to be able to contribute to the achievement of the SMART Aim	Met	Met	Met	Met	Met	Met	Met	Met
Methodology								
Project uses objective, clearly defined, measurable, time-specific measures to track performance	Met	Met	Met	Met	Met	Met	Met	Met
Measures may include process and balancing measures to assess progress on key drivers and monitoring/prevention of unintended consequences, as well as outcome measures	Met	Met	Met	Met	Met	Met	Met	Met
Measures are calculated and reported consistently over time	Met	Met	Met	Met	Met	Met	Met	Met
Eligible population is clearly defined and reflective of the provider practices that have been identified by ODM	Met	Met	Met	Met	Met	Met	Met	Met
Data sources are well-defined	Met	Met	Met	Met	Met	Met	Met	Met

Review Element	Overall Review Determination[1]	AmeriHealth Review Determination[1]	Anthem Review Determination[1]	Buckeye Review Determination[1]	CareSource Review Determination[1]	Humana Review Determination[1]	Molina Review Determination[1]	UnitedHealthcare Review Determination[1]
Data collection procedures are valid and reliable	Met	Met	Met	Met	Met	Met	Met	Met
How and when data are collected is specified, as well as the individuals responsible and instruments/tools utilized	Met	Met	Met	Met	Met	Met	Met	Met
Assessment of Improvement Strategies								
Change ideas (interventions) are developed in response to appropriately identified key drivers and are active, suitable for PDSA cycle testing, and influenced by the MCOs	Met	Met	Met	Met	Met	Met	Met	Met
When appropriate, healthcare disparities were considered in the intervention development process	Partially Met	Partially Met	Partially Met	Partially Met	Partially Met	Partially Met	Partially Met	Partially Met
Each tested intervention addressed at least one or more of the key drivers	Met	Met	Met	Met	Met	Met	Met	Met
If the intervention was successful and sustained, it was expanded, and the expansion was supported by PDSA cycles and relevant data showing effectiveness in other situations/populations. If unsuccessful, the intervention was adapted or abandoned, and the decision was supported by a rationale	Partially Met	Partially Met	Partially Met	Partially Met	Partially Met	Partially Met	Partially Met	Partially Met
Data Analysis and Interpretation of PIP Results								
Analysis and interpretation of the PIP data is based on a continuous	Met	Met	Met	Met	Met	Met	Met	Met

Review Element	Overall Review Determination[1]	AmeriHealth Review Determination[1]	Anthem Review Determination[1]	Buckeye Review Determination[1]	CareSource Review Determination[1]	Humana Review Determination[1]	Molina Review Determination[1]	UnitedHealthcare Review Determination[1]
quality improvement philosophy and reflects an understanding of lessons learned and opportunities for improvement								
Run/control charts include all necessary elements, as outlined within the ODM monthly QI call template	Met	Met	Met	Met	Met	Met	Met	Met
Validity and Reliability of PIP Results								
Assess likelihood that significant improvement occurred. Significant improvement: Results (annotated within run/control charts and explained/interpreted by MCO staff during monthly calls) were likely attributable to the MCO's PIP interventions (as opposed to random chance). Changes have been implemented for the target population in all drivers where changes are being tested. Plans for spread beyond the target population are in place for at least one implemented change.	Partially Met	Not Met	Partially Met	Partially Met	Partially Met	Not Met	Partially Met	Partially Met
Assess likelihood that sustained improvement occurred. Sustained improvement: Improvement in process/outcomes measures observed over time, based upon repeated measurements that demonstrated the improvement				Not Met	Not Met	Not Met	Not Met	Not Met

Review Element	Overall Review Determination[1]	AmeriHealth Review Determination[1]	Anthem Review Determination[1]	Buckeye Review Determination[1]	CareSource Review Determination[1]	Humana Review Determination[1]	Molina Review Determination[1]	UnitedHealthcare Review Determination[1]
was due to special cause as reflected by a shift in the baseline and supported by theory. Spread beyond the target population has begun for at least one implemented change.								
Overall Credibility of Results[2]	Moderate confidence = the PIP was methodologically sound; produced some evidence of improvement; and some of the quality improvement processes were clearly linked to the demonstrated improvement.	Low confidence = The PIP was methodologically sound; however, no evidence of improvement was produced.	Moderate confidence = the PIP was methodologically sound; produced some evidence of improvement; and some of the quality improvement processes were clearly linked to the demonstrated improvement.	Moderate confidence = the PIP was methodologically sound; produced some evidence of improvement; and some of the quality improvement processes were clearly linked to the demonstrated improvement.	Moderate confidence = the PIP was methodologically sound; produced some evidence of improvement; and some of the quality improvement processes were clearly linked to the demonstrated improvement.	Low confidence = The PIP was methodologically sound; however, no evidence of improvement was produced.	Moderate confidence = the PIP was methodologically sound; produced some evidence of improvement; and some of the quality improvement processes were clearly linked to the demonstrated improvement.	Moderate confidence = the PIP was methodologically sound; produced some evidence of improvement; and some of the quality improvement processes were clearly linked to the demonstrated improvement.

[1] Review determinations: Met, Partially Met, Not Met, Not Applicable (N/A).
[2] Note that while low confidence has been determined, the project is currently at the interim stage, and thus there remains an opportunity for the MCO to demonstrate significant improvement by the end of the project period.
MCO: managed care organization; PIP: performance improvement project; DSME: diabetes self-management education; SMART: Specific, Measurable, Achievable, Realistic, and Timely; ODM: Ohio Department of Medicaid; PDSA: plan-do-study-act; QI: quality improvement.

Table 5: MCO CGM and DSME SMART Aim Measure Results (September 2023)

SMART Aim Measure	Indicator Description	Overall	AmeriHealth	Anthem	Buckeye	CareSource	Humana	Molina	UnitedHealthcare
Percentage of members with diabetes who have a claim for CGM in the 12-month measurement period	Baseline Rate	9.5%	9.5%	9.5%	9.5%	9.5%	9.5%	9.5%	9.5%
	SMART Aim Goal Rate	17.7%	17.7%	17.7%	17.7%	17.7%	17.7%	17.7%	17.7%
	Interim Rate Achieved	17.8%	11.1%	20.5%	15.3%	18.6%	18.8%	17.0%	16.7%
	Confidence Level[1]	Moderate confidence	Low confidence	Moderate confidence	Low confidence	Moderate confidence	Moderate confidence	Low confidence	Low confidence

SMART Aim Measure	Indicator Description	Overall	AmeriHealth	Anthem	Buckeye	CareSource	Humana	Molina	UnitedHealthcare
Percentage of members with diabetes who have a claim for DSME in the 12-month measurement period	Baseline Rate	0.7%	0.7%	0.7%	0.7%	0.7%	0.7%	0.7%	0.7%
	SMART Aim Goal Rate	1.5%	1.5%	1.5%	1.5%	1.5%	1.5%	1.5%	1.5%
	Interim Rate Achieved	1.3%	NA[2]	1.3%	1.1%	1.5%	NA[2]	1.0%	1.2%
	Confidence Level[1]	Moderate confidence	Low confidence	Moderate confidence	Moderate confidence	Moderate confidence	Low confidence	Low confidence	Moderate confidence

[1] Note that while low or moderate confidence has been determined, the project is currently at the interim stage, and thus there remains an opportunity for the MCO to demonstrate significant improvement by the end of the project period. [2] There was not enough data from AmeriHealth or Humana as a result of information system issues to determine performance.
MCO: managed care organization; CGM: continuous glucose monitoring; DSME: diabetes self-management education; SMART: Specific, Measurable, Attainable, Relevant, and Timely.

Table 6: MCOP PIP CGM Validation Results (September 2023)

Review Element	Overall Review Determination[1]	Aetna Review Determination[1]	Buckeye Review Determination[1]	CareSource Review Determination[1]	Molina Review Determination[1]	UnitedHealthcare Review Determination[1]
Project Topic						
Project topic impacts the maximum proportion of members feasible	Met	Met	Met	Met	Met	Met
Potential for meaningful impact on member health, functional status, or satisfaction	Met	Met	Met	Met	Met	Met
Topic reflects high-volume or high-risk conditions	Met	Met	Met	Met	Met	Met
Project topic aligns with state/national priorities	Met	Met	Met	Met	Met	Met
Topic supported by MCOP member data	Met	Met	Met	Met	Met	Met
Goal sets a target improvement rate that is bold, feasible, and based upon baseline data	Met	Met	Met	Met	Met	Met
Topic considers disparate population(s)	Met	Met	Met	Met	Met	Met
Project Aim						
In the event disparate populations have been identified and targeted, there are two SMART Aims: one reflective of the overall population, and the other of the disparate population	Met	Met	Met	Met	Met	Met
SMART Aim(s) are specific, measurable, achievable (goal[s] that are bold, feasible,	Met	Met	Met	Met	Met	Met

Review Element	Overall Review Determination[1]	Aetna Review Determination[1]	Buckeye Review Determination[1]	CareSource Review Determination[1]	Molina Review Determination[1]	UnitedHealthcare Review Determination[1]
and based upon baseline and benchmark rates and/or state guidance), relevant, and timely						
There is alignment among the Global Aim, SMART Aim, drivers, and potential interventions such that the interventions and drivers are reasonably thought to be able to contribute to the achievement of the SMART Aim	Met	Met	Met	Met	Met	Met
Methodology						
Project uses objective, clearly defined, measurable, time-specific measures to track performance	Met	Met	Met	Met	Met	Met
Measures may include process and balancing measures to assess progress on key drivers and monitoring/prevention of unintended consequences, as well as outcome measures	Met	Met	Met	Met	Met	Met
Measures are calculated and reported consistently over time	Met	Met	Met	Met	Met	Met
Eligible population is clearly defined and reflective of the provider practices that have been identified by ODM	Met	Met	Met	Met	Met	Met
Data sources are well-defined	Met	Met	Met	Met	Met	Met
Data collection procedures are valid and reliable	Met	Met	Met	Met	Met	Met
How and when data are collected is specified, as well as the individuals responsible and instruments/tools utilized	Met	Met	Met	Met	Met	Met
Assessment of Improvement Strategies						
Change ideas (interventions) are developed in response to appropriately identified key drivers and are active, suitable for PDSA cycle testing, and influenced by the MCOPs	Met	Met	Met	Met	Met	Met

Review Element	Overall Review Determination[1]	Aetna Review Determination[1]	Buckeye Review Determination[1]	CareSource Review Determination[1]	Molina Review Determination[1]	UnitedHealthcare Review Determination[1]
When appropriate, healthcare disparities were considered in the intervention development process	Partially Met	Partially Met	Partially Met	Partially Met	Partially Met	Partially Met
Each tested intervention addressed at least one or more of the key drivers	Met	Met	Met	Met	Met	Met
If the intervention was successful and sustained, it was expanded, and the expansion was supported by PDSA cycles and relevant data showing effectiveness in other situations/populations. If unsuccessful, the intervention was adapted or abandoned, and the decision was supported by a rationale	Partially Met	Partially Met	Partially Met	Partially Met	Partially Met	Partially Met
Data Analysis and Interpretation of PIP Results						
Analysis and interpretation of the PIP data is based on a continuous quality improvement philosophy and reflects an understanding of lessons learned and opportunities for improvement	Met	Met	Met	Met	Met	Met
Run/control charts include all necessary elements, as outlined within the ODM monthly QI call template	Met	Met	Met	Met	Met	Met
Validity and Reliability of PIP Results						
Assess likelihood that significant improvement occurred. Significant improvement: Results (annotated within run/control charts and explained/interpreted by MCOP staff during monthly calls) were likely attributable to the MCOP's PIP interventions (as opposed to random chance). Changes have been implemented for the target population in all drivers where changes are being tested.	Not Met	Not Met	Not Met	Partially Met	Not Met	Not Met

Review Element	Overall Review Determination[1]	Aetna Review Determination[1]	Buckeye Review Determination[1]	CareSource Review Determination[1]	Molina Review Determination[1]	UnitedHealthcare Review Determination[1]
Plans for spread beyond the target population are in place for at least one implemented change.						
Assess likelihood that sustained improvement occurred. Sustained improvement: Improvement in process/outcomes measures observed over time, based upon repeated measurements that demonstrated the improvement was due to special cause as reflected by a shift in the baseline and supported by theory. Spread beyond the target population has begun for at least one implemented change.	Not Met	Not Met	Not Met	Not Met	Not Met	Not Met
Overall Credibility of Results[2]	Low confidence = The PIP was methodologically sound; however, no evidence of improvement was produced.	Low confidence = The PIP was methodologically sound; however, no evidence of improvement was produced.	Low confidence = The PIP was methodologically sound; however, no evidence of improvement was produced.	Moderate confidence = the PIP was methodologically sound; produced some evidence of improvement; and some of the quality improvement processes were clearly linked to the demonstrated improvement.	Low confidence = The PIP was methodologically sound; however, no evidence of improvement was produced.	Low confidence = The PIP was methodologically sound; however, no evidence of improvement was produced.

[1] Review determinations: Met, Partially Met, Not Met, Not Applicable (N/A).

[2] Note that while low confidence has been determined, the project is currently at the interim stage, and thus there remains an opportunity for the MCOP to demonstrate significant improvement by the end of the project period.

MCOP: MyCare Ohio plan; PIP: performance improvement project; CGM: continuous glucose monitoring; SMART: Specific, Measurable, Achievable, Realistic, and Timely; ODM: Ohio Department of Medicaid; PDSA: plan-do-study-act; QI: quality improvement.

Table 7: MCOP PIP DSME Validation Results (September 2023)

Review Element	Overall Review Determination[1]	Aetna Review Determination[1]	Buckeye Review Determination[1]	CareSource Review Determination[1]	Molina Review Determination[1]	UnitedHealthcare Review Determination[1]
Project Topic						
Project topic impacts the maximum proportion of members feasible	Met	Met	Met	Met	Met	Met
Potential for meaningful impact on member health, functional status, or satisfaction	Met	Met	Met	Met	Met	Met
Topic reflects high-volume or high-risk conditions	Met	Met	Met	Met	Met	Met
Project topic aligns with state/national priorities	Met	Met	Met	Met	Met	Met
Topic supported by MCOP member data	Met	Met	Met	Met	Met	Met
Goal sets a target improvement rate that is bold, feasible, and based upon baseline data	Met	Met	Met	Met	Met	Met
Topic considers disparate population(s)	Met	Met	Met	Met	Met	Met
Project Aim						
In the event disparate populations have been identified and targeted, there are two SMART Aims: one reflective of the overall population, and the other of the disparate population	Met	Met	Met	Met	Met	Met
SMART Aim(s) are specific, measurable, achievable (goal[s] that are bold, feasible, and based upon baseline and benchmark rates and/or state guidance), relevant, and timely	Met	Met	Met	Met	Met	Met
There is alignment among the Global Aim, SMART Aim, drivers, and potential interventions such that the interventions and drivers are reasonably thought to be able to contribute to the achievement of the SMART Aim	Met	Met	Met	Met	Met	Met
Methodology						
Project uses objective, clearly defined, measurable, time-specific measures to track performance	Met	Met	Met	Met	Met	Met

Review Element	Overall Review Determination[1]	Aetna Review Determination[1]	Buckeye Review Determination[1]	CareSource Review Determination[1]	Molina Review Determination[1]	UnitedHealthcare Review Determination[1]
Measures may include process and balancing measures to assess progress on key drivers and monitoring/prevention of unintended consequences, as well as outcome measures	Met	Met	Met	Met	Met	Met
Measures are calculated and reported consistently over time	Met	Met	Met	Met	Met	Met
Eligible population is clearly defined and reflective of the provider practices that have been identified by ODM	Met	Met	Met	Met	Met	Met
Data sources are well-defined	Met	Met	Met	Met	Met	Met
Data collection procedures are valid and reliable	Met	Met	Met	Met	Met	Met
How and when data are collected is specified, as well as the individuals responsible and instruments/tools utilized	Met	Met	Met	Met	Met	Met
Assessment of Improvement Strategies						
Change ideas (interventions) are developed in response to appropriately identified key drivers and are active, suitable for PDSA cycle testing, and influenced by the MCOPs	Met	Met	Met	Met	Met	Met
When appropriate, healthcare disparities were considered in the intervention development process	Met	Met	Met	Met	Met	Met
Each tested intervention addressed at least one or more of the key drivers	Met	Met	Met	Met	Met	Met
If the intervention was successful and sustained, it was expanded, and the expansion was supported by PDSA cycles and relevant data showing effectiveness in other situations/ populations. If unsuccessful, the intervention was adapted or abandoned, and the decision was supported by a rationale	Partially Met	Partially Met	Partially Met	Partially Met	Partially Met	Partially Met

Review Element	Overall Review Determination[1]	Aetna Review Determination[1]	Buckeye Review Determination[1]	CareSource Review Determination[1]	Molina Review Determination[1]	UnitedHealthcare Review Determination[1]
Data Analysis and Interpretation of PIP Results						
Analysis and interpretation of the PIP data is based on a continuous quality improvement philosophy and reflects an understanding of lessons learned and opportunities for improvement	Met	Met	Met	Met	Met	Met
Run/control charts include all necessary elements, as outlined within the ODM monthly QI call template	Met	Met	Met	Met	Met	Met
Validity and Reliability of PIP Results						
Assess likelihood that significant improvement occurred. Significant improvement: Results (annotated within run/control charts and explained/interpreted by MCOP staff during monthly calls) were likely attributable to the MCOP's PIP interventions (as opposed to random chance). Changes have been implemented for the target population in all drivers where changes are being tested. Plans for spread beyond the target population are in place for at least one implemented change.	Not Met	Not Met	Not Met	Not Met	Not Met	Not Met
Assess likelihood that sustained improvement occurred. Sustained improvement: Improvement in process/outcomes measures observed over time, based upon repeated measurements that demonstrated the improvement was due to special cause as reflected by a shift in the baseline and supported by theory. Spread beyond the target population has begun for at least one implemented change.	Not Met	Not Met	Not Met	Not Met	Not Met	Not Met

Review Element	Overall Review Determination[1]	Aetna Review Determination[1]	Buckeye Review Determination[1]	CareSource Review Determination[1]	Molina Review Determination[1]	UnitedHealthcare Review Determination[1]
Overall Credibility of Results	Low confidence[2] = The PIP was methodologically sound; however, no evidence of improvement was produced.	Low confidence[2] = The PIP was methodologically sound; however, no evidence of improvement was produced.	Low confidence[2] = The PIP was methodologically sound; however, no evidence of improvement was produced.	Low confidence[2] = The PIP was methodologically sound; however, no evidence of improvement was produced.	Low confidence[2] = The PIP was methodologically sound; however, no evidence of improvement was produced.	Low confidence[2] = The PIP was methodologically sound; however, no evidence of improvement was produced.

[1] Review determinations: Met, Partially Met, Not Met, Not Applicable (N/A).
[2] Note that while low confidence has been determined, the project is currently at the interim stage, and thus there remains an opportunity for the MCOP to demonstrate significant improvement by the end of the project period.
MCOP: MyCare Ohio plan; PIP: performance improvement project; DSME: diabetes self-management education; SMART: Specific, Measurable, Achievable, Realistic, and Timely; ODM: Ohio Department of Medicaid; PDSA: plan-do-study-act; QI: quality improvement.

Table 8: MCOP CGM and DSME SMART Aim Measure Results (September 2023)

SMART Aim Measure	Indicator Description	Overall	Aetna	Buckeye	CareSource	Molina	UnitedHealthcare
Percentage of members with diabetes who have a claim for CGM in the 12-month measurement period	Baseline Rate	8.7%	8.7%	8.7%	8.7%	8.7%	8.7%
	SMART Aim Goal Rate	12.4%	12.4%	12.4%	12.4%	12.4%	12.4%
	Interim Rate Achieved	11.0%	11.6%	4.1%	19.5%	7.9%	7.5%
	Confidence Level	Low confidence[1]	Low confidence[1]	Low confidence[1]	Moderate confidence[1]	Low confidence[1]	Low confidence[1]
Percentage of members with diabetes who have a claim for DSME in the 12-month measurement period	Baseline Rate	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%
	SMART Aim Goal Rate	3.1%	3.1%	3.1%	3.1%	3.1%	3.1%
	Interim Rate Achieved	1.5%	1.7%	1.6%	1.9%	1.1%	1.3%
	Confidence Level	Low confidence[1]	Low confidence[1]	Low confidence[1]	Low confidence[1]	Low confidence[1]	Low confidence[1]

[1] Note that while low or moderate confidence has been determined, the project is currently at the interim stage, and thus there remains an opportunity for the MCOP to demonstrate significant improvement by the end of the project period.
MCOP: MyCare Ohio plan; CGM: continuous glucose monitoring; DSME: diabetes self-management education; SMART: Specific, Measurable, Attainable, Relevant, and Timely.

Table 9: APMM Preliminary PIP Validation Results (September 2023)

Review Element	Overall Review Determination[1]	Aetna Review Determination[1]	AmeriHealth Review Determination[1]	Anthem Review Determination[1]	Buckeye Review Determination[1]	CareSource Review Determination[1]	Gainwell Review Determination[1]	Humana Review Determination[1]	Molina Review Determination[1]	UnitedHealthcare Review Determination[1]
Project Topic										
Project topic impacts the maximum proportion of members feasible	Met	Met	Met	Met	Met	Met	Met	Met	Met	Met
Potential for meaningful impact on member health, functional status, or satisfaction	Met	Met	Met	Met	Met	Met	Met	Met	Met	Met
Topic reflects high-volume or high-risk conditions	Met	Met	Met	Met	Met	Met	Met	Met	Met	Met
Project topic aligns with state/national priorities	Met	Met	Met	Met	Met	Met	Met	Met	Met	Met
Topic supported by member data	Met	Met	Met	Met	Met	Met	Met	Met	Met	Met
Goal sets a target improvement rate that is bold, feasible, and based upon baseline data[2]	Not Met	Not Met	Not Met	Not Met	Not Met	Not Met	Not Met	Not Met	Not Met	Not Met
Topic considers disparate population(s)	Met	Met	Met	Met	Met	Met	Met	Met	Met	Met

[1] Review determinations: met, partially met, not met, not applicable (N/A).

[2] Goal was not set due to lack of data, which was caused by information system issues.

APMM: antipsychotic metabolic monitoring; PIP: performance improvement project; SMART: Specific, Measurable, Achievable, Realistic, and Timely.

Table 10: Preliminary APMM PIP Summary

PIP Topic: Antipsychotic Metabolic Monitoring (APMM)
Validation Summary: IPRO's assessment of the overall MCO, OhioRISE, and SPBM collaborative APMM PIP will be completed in FY 2025. The PIP was validated to be methodologically sound; however, no evidence of improvement was produced yet due to the PIP being in the beginning stages of data collection at the time of this report.

PIP: performance improvement project; OhioRISE: Ohio's Resilience through Integrated Systems and Excellence; SPBM: single pharmacy benefit manager.

IV. Validation of Performance Measures

Objectives

ODM has established quality measures and standards to evaluate MCE performance in priority program areas. The selected measures align with specific priorities, goals, and/or focus areas of the Ohio Medicaid quality strategy. *Title 42 CFR § 438.358 Activities related to external quality review* requires that these performance measures be validated by the state, its agent, or an EQRO. ODM contracted with IPRO to conduct the functions associated with validating performance measures. In SFY 2023, IPRO validated performance measures for the managed care program and MyCare Ohio for MY 2022. No OhioRISE or SPBM performance measures were reported for MY 2022. All reported measures will be validated in FY 2024 and included in the April 2025 EQR Technical Report.

Technical Methods of Data Collection and Analysis

Managed Care Program

ODM required each contracted MCO to collect and report on 78 measure indicators for MY 2022. The measurement set includes 43 measures with MPSs. Additionally, the measurement set includes reporting-only measures, some of which have multiple indicators. Measures are grouped according to the following populations:

- Healthy Children,
- Women's Health,
- Behavioral Health,
- Chronic Conditions, and
- Healthy Adults.

Table 11 shows the HEDIS MY 2022 measures, grouped by the five population streams, and differentiates those that are used for reporting only. Footnotes additionally differentiate between two types of benchmarks as defined in the MMC provider agreement:

- Measures with a minimum performance standard outlier (MPSO)/performance standards footnote are based on outliers identified when all MCOs' results are compared. The MPSs have been calculated in accordance with ODM's *MCP Minimum Performance Standards Outlier (MPSO) Methodology for Measurement Year (MY) 2022*.
- Measures with an MPSO methodology/MY 2022 outlier threshold footnote are those that are compared to national Medicaid benchmarks.

Table 11: MCO 2023 HEDIS Measures by Population Stream, MY 2022

HEDIS Measure	ID
Healthy Children	
Well-Child Visits in the First 30 Months of Life – Well-Child Visits in the First 15 Months, Six or More Visits[1]	W30
Well-Child Visits in the First 30 Months of Life – Well-Child Visits for Ages 15 Months–30 Months, Two or More Visits[1]	W30
Child and Adolescent Well-Care Visits: Ages 3–11 years[2]	WCV
Child and Adolescent Well-Care Visits: Ages 12–17 years[2]	WCV
Child and Adolescent Well-Care Visits: Ages 18–21 years[2]	WCV
Child and Adolescent Well-Care Visits: Total[2]	WCV
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents, BMI Percentile Documentation: Ages 3–11 years[3]	WCC
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents, BMI Percentile Documentation: Ages 12–17 years[3]	WCC
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents, BMI Percentile Documentation: Age Total[2]	WCC
Appropriate Testing for Pharyngitis[3]	CWP

HEDIS Measure	ID
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents, Counseling for Nutrition: Ages 3–11 years[3]	WCC
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents, Counseling for Nutrition: Ages 12–17 years[3]	WCC
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents, Counseling for Nutrition: Age Total[3]	WCC
Annual Dental Visits, Total[1]	ADV
Childhood Immunization Status, Combination 3[2]	CIS
Childhood Immunization Status, Combination 10[3]	CIS
Immunizations for Adolescents, Combination 1[3]	IMA
Immunizations for Adolescents, Human Papillomavirus (HPV) Vaccine[3]	IMA
Immunization for Adolescents, Combination 2[1]	IMA
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents, Counseling for Physical Activity: Ages 3–11 years[3]	WCC
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents, Counseling for Physical Activity: Ages 12–17 years[3]	WCC
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents, Counseling for Physical Activity: Age Total[3]	WCC
Lead Screening in Children[1]	LSC
Women's Health	
Prenatal and Postpartum Care, Timeliness of Prenatal Care[1]	PPC
Prenatal and Postpartum Care, Postpartum Care[1]	PPC
Breast Cancer Screening[1]	BCS
Cervical Cancer Screening[1]	CCS
Chlamydia Screening in Women, Total[1]	CHL
Behavioral Health	
Initiation and Engagement of Substance Use Disorder Treatment: Initiation Total[2]	IET
Initiation and Engagement of Substance Use Disorder Treatment: Engagement, ages 13–17 years[2]	IET
Initiation and Engagement of Substance Use Disorder Treatment: Engagement, ages 18–64 years[2]	IET
Follow-up After Hospitalization for Mental Illness, 7-Day Follow-up, ages 6–17 years[1]	FUH
Follow-up After Hospitalization for Mental Illness, 7-Day Follow-up, ages 18–64 years[1]	FUH
Follow-up After Hospitalization for Mental Illness, 30-Day Follow-up, Total[1]	FUH
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics, Total[1]	APP
Antidepressant Medication Management, Effective Acute Phase Treatment[1]	AMM
Antidepressant Medication Management, Effective Continuation Phase Treatment[1]	AMM
Follow-up Care for Children Prescribed ADHD Medication, Initiation Phase[1]	ADD
Follow-up Care for Children Prescribed ADHD Medication, Continuation and Maintenance Phase[1]	ADD
Follow-up After Emergency Department Visit for Mental Illness, 7-Day Follow-up, Total[2]	FUM
Follow-up After Emergency Department Visit for Mental Illness, 30-Day Follow-up, Total[2]	FUM
Follow-up After Emergency Department Visit for Substance Use, 7-Day Follow-up, Total[2]	FUA
Follow-up After Emergency Department Visit for Substance Use, 30-Day Follow-up, Total[2]	FUA
Use of Opioids at High Dosage[3]	HDO
Use of Opioids from Multiple Providers, Multiple Prescribers[1]	UOP
Use of Opioids from Multiple Providers, Multiple Pharmacies[2]	UOP
Use of Opioids from Multiple Providers, Multiple Prescribers and Multiple Pharmacies[2]	UOP
Risk of Continued Opioid Use: Covered 15 or more days[3]	COU
Risk of Continued Opioid Use: Covered 31 or more days[3]	COU

HEDIS Measure	ID
Chronic Conditions	
Hemoglobin A1c Control for Patients with Diabetes (< 8.0%)[1]	HBD
Hemoglobin A1c Control for Patients with Diabetes (> 9.0%)[2]	HBD
Blood Pressure Control for Patients with Diabetes (< 140/90 mm Hg)[1]	BPD
Eye Exam for Patients with Diabetes[1]	EED
Kidney Health Evaluation for Patients with Diabetes: Ages 18–64 years[3]	KED
Kidney Health Evaluation for Patients with Diabetes: Ages 65–74 years[3]	KED
Kidney Health Evaluation for Patients with Diabetes: Ages 75–85 years[3]	KED
Kidney Health Evaluation for Patients with Diabetes: Total[3]	KED
Statin Therapy for Patients with Diabetes, Received Statin Therapy[1]	SPD
Controlling High Blood Pressure[1]	CBP
Statin Therapy for Patients with Cardiovascular Disease, Received Statin Therapy, Total[2]	SPC
Cardiac Rehabilitation: Initiation, ages 18–64 years[3]	CRE
Cardiac Rehabilitation: Initiation, ages 65 years and older[3]	CRE
Cardiac Rehabilitation: Initiation Total[3]	CRE
Cardiac Rehabilitation: Engagement 1, ages 18–64 years[3]	CRE
Cardiac Rehabilitation: Engagement 1, ages 65 years and older[3]	CRE
Cardiac Rehabilitation: Engagement 1 Total[3]	CRE
Cardiac Rehabilitation: Engagement 2, ages 18–64 years[3]	CRE
Cardiac Rehabilitation: Engagement 2, ages 65 years and older[3]	CRE
Cardiac Rehabilitation: Engagement 2 Total[3]	CRE
Cardiac Rehabilitation: Achievement, ages 18–64 years[3]	CRE
Cardiac Rehabilitation: Achievement, ages 65 years and older[3]	CRE
Cardiac Rehabilitation: Achievement Total[3]	CRE
Pharmacotherapy Management of COPD Exacerbation, Systemic Corticosteroid within 14 days[3]	PCE
Pharmacotherapy Management of COPD Exacerbation, Bronchodilator within 30 days[3]	PCE
Healthy Adults	
Adults' Access to Preventive/Ambulatory Health Services, Total[1]	AAP
Ambulatory Care, Emergency Department Visits, Total[2]	AMB
Inpatient Utilization, General Hospital/Acute Care, Total Discharges[3]	IPUA
Inpatient Utilization, General Hospital/Acute Care, Total Average Length of Stay[3]	IPUA

[1] MPSO methodology/MY 2022 outlier threshold.
[2] MPSO methodology/standard = benchmark.
[3] Reporting-only/measures without an MPS.
HEDIS: Healthcare Effectiveness Data and Information Set; ID: HEDIS character code; BMI: body mass index; ADHD: attention-deficit/hyperactivity disorder; COPD: chronic obstructive pulmonary disease; MY: measurement year; MPSO: minimum performance standard outlier; MPS minimum performance standard.

Each MCO contracted with an independent licensed organization (LO) and underwent a National Committee for Quality Assurance (NCQA) HEDIS Compliance Audit™ for HEDIS MY 2022. In accordance with the MY 2022 NCQA *HEDIS Compliance Audit: Standards, Policies, and Procedures*, *Volume 5*, the LOs evaluated the MCOs' compliance with NCQA's IS standards which address:

- **IS 1.0 Medicaid Services Data**: Sound Coding Methods and Data Capture, Transfer, and Entry;
- **IS 2.0 Enrollment Data**: Data Capture, Transfer, and Entry;
- **IS 3.0 Practitioner Data**: Data Capture, Transfer, and Entry;
- **IS 4.0 Medical Record Review Processes**: Training, Sampling, Abstraction, and Oversight;
- **IS 5.0 Supplemental Data**: Capture, Transfer, and Entry;

- **IS 6.0 Data Production Processing**: Transfer, Consolidation, Control Procedures that Support Measure Reporting Integrity; and
- **IS 7.0 Data Integration and Reporting**: Accurate Reporting, Control Procedures that Support Measure Reporting Integrity.

The term "IS" included the computer and software environment, data collection procedures, and abstraction of medical records for hybrid measures. The IS evaluation included a review of any manual processes used for HEDIS reporting. The LOs determined the extent to which the MCOs had the automated systems, information management practices, processing environment, and control procedures to capture, access, translate, analyze, and report each HEDIS measure.

To ensure that each MCO calculated its rates based on complete and accurate data and according to NCQA's established standards and that each MCO's independent auditors performed the audit using NCQA's guidelines, IPRO reviewed the FARs produced by the MCO's independent auditor. IPRO then analyzed the MCOs' MY 2022 results and evaluated each MCO's performance levels relative to MY 2021 *Quality Compass* national Medicaid percentiles.

MyCare Ohio

ODM required each contracted MCOP to collect and report on 15 measure indicators for MY 2022. The measurement set includes five rates with MPSs used for compliance assessment. Additionally, the measurement set includes reporting-only measures, some of which have multiple indicators. Measures are grouped into four population streams: Behavioral Health, Chronic Conditions, Healthy Adults, and Integrating Care. **Table 12** contains the measures for MY 2022 with footnotes indicating which ones are quality withhold measures/indicators and reporting-only measures/indicators.

Table 12: MCOP 2023 HEDIS Measures by Population Stream, MY 2022

HEDIS Measure	ID
Behavioral Health	
Follow-up After Hospitalization for Mental Illness: 30-Day Follow-up[1]	FUH
Antidepressant Medication Management: Effective Acute Phase Treatment[2]	AMM
Antidepressant Medication Management: Effective Continuation Phase Treatment[2]	AMM
Chronic Conditions	
Controlling High Blood Pressure[1]	CBP
Hemoglobin A1c Control for Patients with Diabetes (< 8.0%)[2]	HBD
Hemoglobin A1c Control for Patients with Diabetes (> 9.0%)[1]	HBD
Comprehensive Diabetes Care – Eye Exam[3]	EED
Healthy Adults	
Annual Flu Vaccine[1]	FVO
Breast Cancer Screening[4]	BCS
Transitions of Care – Medication Reconciliation Post-Discharge[1]	TRC
Colorectal Cancer Screening[1]	COL-E
Plan All Cause Readmissions – Observed-to-Expected (O/E) Ratio[1]	PCR
Integrating Care	
Adults' Access to Preventive/Ambulatory Health Services[2]	AAP
Getting Appointments and Care Quickly Composite	GCQ
Satisfaction with Customer Service Composite	SCS

[1] Quality withhold measure/indicator.
[2] Minimum performance standard is the measurement year (MY) 2021 standard (or comparable benchmark).
[3] Reporting-only measure/indicator.
[4] Minimum performance standard is the MY 2021 minimum performance standard outlier (MPSO) threshold.
HEDIS: Healthcare Effectiveness Data and Information Set; ID: HEDIS character code.

Each MCOP contracted with an LO and underwent an NCQA HEDIS Compliance Audit for MY 2022. In accordance with the MY 2022 NCQA *HEDIS Compliance Audit: Standards, Policies, and Procedures*, *Volume 5*, the LOs evaluated the MCOPs' compliance with NCQA's IS standards described previously. To ensure that each MCOP calculated its rates based on complete and accurate data and according to NCQA's established standards and that each MCOP's independent auditors performed the audit using NCQA's guidelines, IPRO reviewed the FARs produced by the MCOP's independent auditor. Subsequently, IPRO analyzed the MCOPs' MY 2022 results and evaluated each MCOP's current performance levels relative to MY 2021 *Quality Compass* national Medicaid percentiles.

Description of Data Obtained

IPRO used the FAR and final audit results as the primary data sources. The FAR includes information on the MCOs' IS capabilities, findings for each measure, supplemental data validation results, medical record review validation (MRRV) results, results of any corrected programming logic (including corrections to numerators, denominators, or sampling used for final measure calculation), and opportunities for improvement. The final audit results included final determinations of validity made by the auditor for each performance measure.

Conclusions and Comparative Findings

Managed Care Program Findings

Audit Results

Based on a review of the MY 2022 FARs issued by each MCO's independent auditor, IPRO found that four of the five MCOs were *fully compliant* with all seven of the applicable NCQA IS standards and one (Buckeye) partially met the criteria for IS 6.0. The MCOs' independent auditors based their determinations on rates reported by the MCOs compared to NCQA's defined specifications. Buckeye's auditor noted that multiple issues were encountered due to incorrect extraction of data fields and delays in recognizing and/or remediating the underlying issues. There were no data collection or reporting issues identified by the other MCOs' independent auditors. **Table 13** displays the results of IS reviews for each MCO, as well as the name of the independent auditor for MY 2022.

Table 13: MCO 2023 HEDIS Compliance with IS Standards, MY 2022

IS Standard	Buckeye	CareSource	Molina	Paramount	UHC
HEDIS Auditor	**Attest Health Care Advisors**	**HealthcareData Company, LLC**	**Advent Advisory Group**	**HealthcareData Company, LLC**	**Attest Health Care Advisors**
1.0 Medical Services Data	Compliant	Compliant	Compliant	Compliant	Compliant
2.0 Enrollment Data	Compliant	Compliant	Compliant	Compliant	Compliant
3.0 Practitioner Data	Compliant	Compliant	Compliant	Compliant	Compliant
4.0 Medical Record Review Processes	Compliant	Compliant	Compliant	Compliant	Compliant
5.0 Supplemental Data	Compliant	Compliant	Compliant	Compliant	Compliant
6.0 Data Preproduction Processing	Partially Met	Compliant	Compliant	Compliant	Compliant
7.0 Data Integration and Reporting	Compliant	Compliant	Compliant	Compliant	Compliant

MCO: managed care organization; HEDIS: Healthcare Effectiveness Data and Information Set; MY: measurement year; IS: information systems; UHC: UnitedHealthcare Community Plan.

National Percentile Rankings

MCO performance is compared to MY 2021 *Quality Compass* national Medicaid percentiles below. Percentile ranking results are derived by comparing performance measures rates to national Medicaid benchmarks. **Figure 3** presents the percentage of MCO-specific and statewide rates by percentile ranking for the 43 performance measure rates that have an established MPS for compliance assessment and also have a *Quality Compass* percentile (three measures with MPSs do not have a *Quality Compass* percentile).

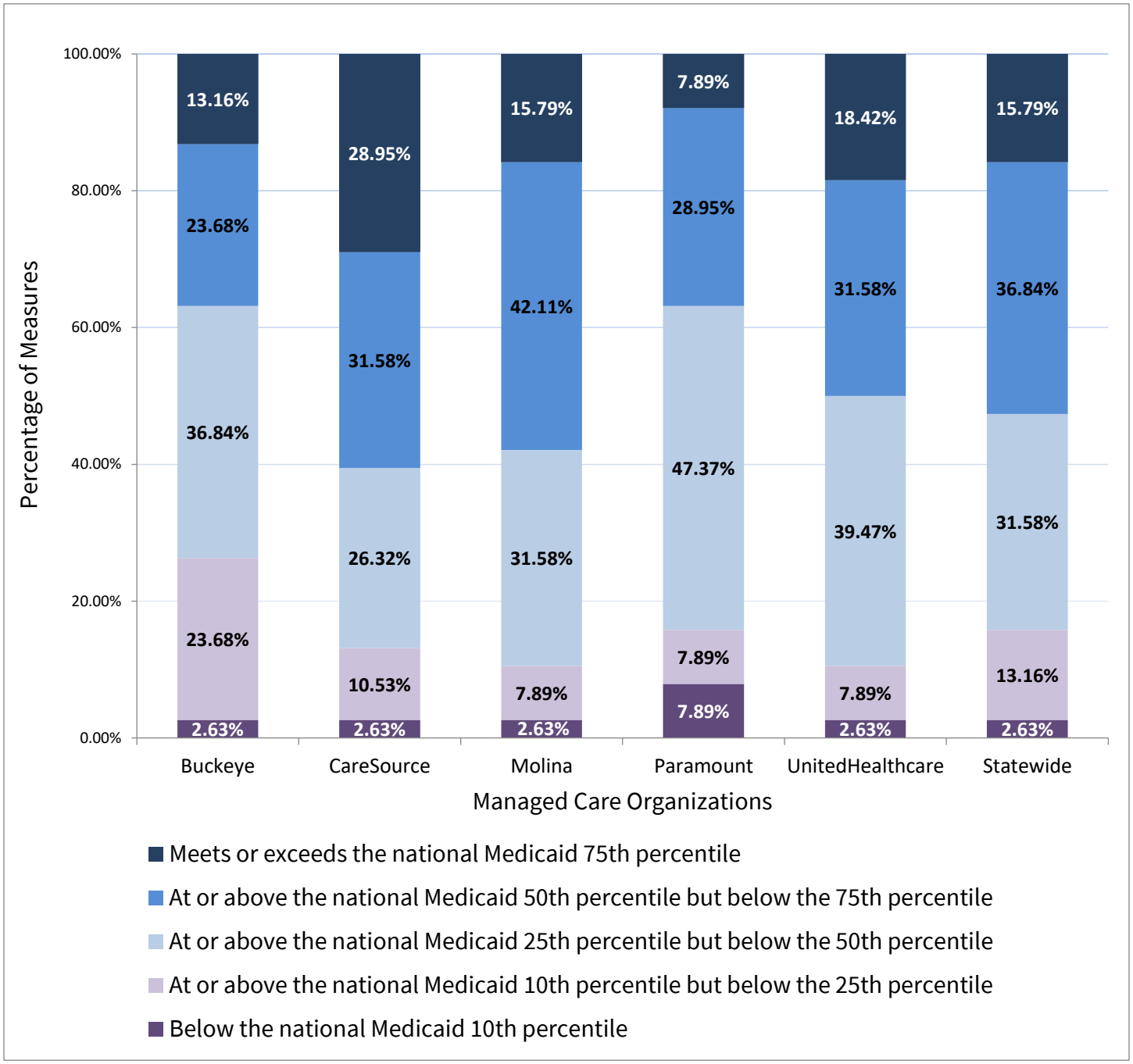

Figure 3: MCO and Statewide Percentage of Performance Measures by Percentile Range, MY 2022
MCO: managed care organization; MY: measurement year

For each HEDIS measure, the MCO received a star rating depending on how the rate compared to the MY 2021 *Quality Compass* national Medicaid HMO percentiles. **Table 14** displays the star rating system and the corresponding national percentile ranges.

Table 14: MY 2022 HEDIS Star Ratings and National Percentile Ranges

Star Rating	National Percentile Range
★★★★★	At or above the 75th percentile
★★★★	At or above the 50th percentile and below the 75th percentile
★★★	At or above the 25th percentile and below the 50th percentile
★★	At or above the 10th percentile and below the 25th percentile
★	Below the 10th percentile

MY: measurement year; HEDIS: Healthcare Effectiveness Data and Information Set.

Table 15 displays a count of the star ratings corresponding to percentile benchmarks for those measures for which an MPS has been established.

Table 15: Count of HEDIS Star Ratings by Percentile Benchmarks for Measures with MPS by MCO, MY 2022

MCO	< P10 ★	P10–P25[1] ★★	P25–P50[1] ★★★	P50–P75[1] ★★★★	≥ P75 ★★★★★
Buckeye	1	9	14	9	5
CareSource	1	4	10	12	11
Molina	1	3	12	16	6
Paramount	3	3	18	11	3
UnitedHealthcare	1	3	15	12	7
Statewide	1	5	12	14	6

[1] This benchmark range/star rating includes the lower, but not the upper, *Quality Compass* percentile.
MPS: minimum performance standard; MCO: managed care plan; P: percentile.

As specified in the MMC provider agreement, MPSs were established based on outliers identified when all MCOs' results were compared. Rates for the following measures are at or above the 75th percentile for all five MCOs and the statewide average:

- Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics, Total;
- Follow-up After Emergency Department Visit for Substance Use, 7-Day Follow-up, Total; and
- Follow-up After Emergency Department Visit for Substance Use, 30-Day Follow-up, Total.

All MCOs' rates and the statewide average are at or above the 50th percentile for the following measures:

- Follow-up Care for Children Prescribed ADHD Medication, Initial Phase;
- Blood Pressure Control for Patients with Diabetes (< 140/90 mm Hg);
- Eye Exam for Patients with Diabetes (Retinal) Performed;
- Follow-up After Emergency Department Visit for Mental Illness, 7-Day Follow-up, Total;
- Follow-up After Emergency Department Visit for Mental Illness, 30-Day Follow-up, Total; and
- Well-Child Visits in the First 30 Months of Life – Well-Child Visits in the First 15 Months, Six or More Visits.

All MCOs except Paramount and Buckeye have more than half of their MPS measures above the national 50th percentile, with a rate between 40.0% and 62.5%. CareSource has the most MPS measures above the national 75th percentile (11of 40 measures). Molina and UnitedHealthcare have the fewest measures below the 25th percentile (4 of 40 measures; **Table 15**). Every MCO has measures below the 10th national percentile. The statewide average is above the national 25th percentile for 85.0% of the MPS measures.

Minimum Performance Standings

Figure 4 presents the overall percentage of MPSs met by each MCO. Only Molina met all measures with MPSs (100.0%), while Buckeye, CareSource, and UnitedHealthcare met approximately 98% of the MPSs, and Paramount had the lowest percentage (93.0%; **Figure 4**). This is a slight decline from MY 2020 and MY 2021 when three of five MCOs met all MPSs.

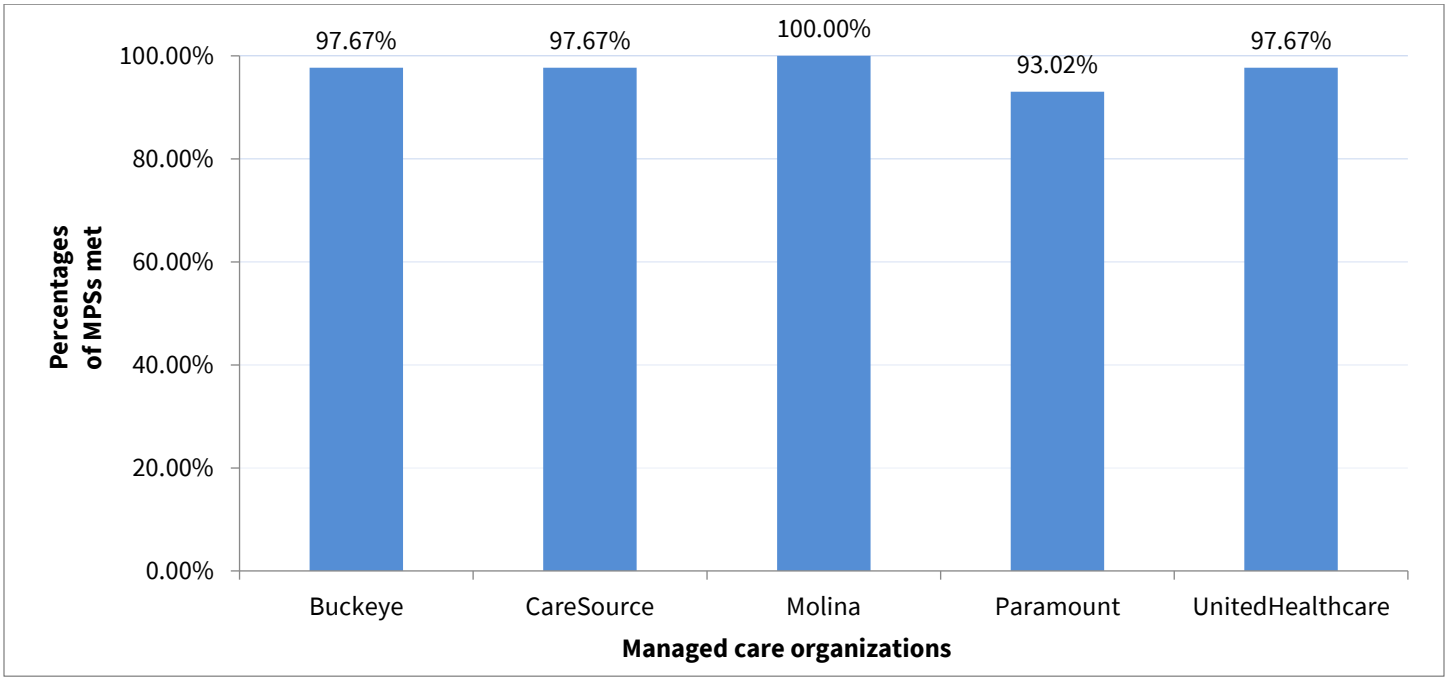

Figure 4: Percentage of MPSs Met by MCO MPS: minimum performance standard.

Table 16 displays the number of measure indicators that met or exceeded the MPSs by MCO for each population stream. Only Molina met all MPSs for all five population streams.

Table 16: MCO Measures with MPSs Met by Population Stream, MY 2022

Population Stream	Buckeye	CareSource	Molina	Paramount	UnitedHealthcare	Measures with MPS
Healthy Children	10	11	11	10	11	11
Women's Health	5	5	5	5	5	5
Behavioral Health	18	18	18	16	17	18
Chronic Conditions	7	6	7	7	7	7
Healthy Adults	2	2	2	2	2	2
Total	42	42	43	40	42	43

MCO: managed care organization; MPS: minimum performance standard.

MyCare Ohio Findings

Audit Results

Based on a review of the MY 2022 FARs issued by each MCOP's independent auditor, IPRO found that all MCOPs were *fully compliant* with all seven of the applicable NCQA IS standards. The MCOPs' independent auditors determined that the rates reported by the MCOPs were calculated in accordance with NCQA's defined specifications. There were no data collection or reporting issues identified by the MCOPs' independent auditors. **Table 17** displays the results of IS reviews for each MCOP, as well as the name of the independent auditor for MY 2022

Table 17: MCOP 2023 HEDIS Compliance with IS Standards, MY 2022

IS Standard	Aetna	Buckeye	CareSource	Molina	UHC
HEDIS Auditor	Advent Advisory Group	Attest Health Care Advisors	HealthcareData Company, LLC	Advent Advisory Group	Attest Health Care Advisors
1.0 Medical Services Data	Compliant	Compliant	Compliant	Compliant	Compliant
2.0 Enrollment Data	Compliant	Compliant	Compliant	Compliant	Compliant
3.0 Practitioner Data	Compliant	Compliant	Compliant	Compliant	Compliant
4.0 Medical Record Review Processes	Compliant	Compliant	Compliant	Compliant	Compliant
5.0 Supplemental Data	Compliant	Compliant	Compliant	Compliant	Compliant
6.0 Data Preproduction Processing	Compliant	Compliant	Compliant	Compliant	Compliant
7.0 Data Integration and Reporting	Compliant	Compliant	Compliant	Compliant	Compliant

MCOP: MyCare Ohio Plan; HEDIS: Healthcare Effectiveness Data and Information Set; MY: measurement year; IS: information systems; UHC: UnitedHealthcare Community Plan.

National Percentile Rankings

Figure 5 presents the percentage of MCOP-specific and statewide rates by percentile ranking for the five performance measure rates that have an established MPS for compliance assessment. Percentile ranking results in this figure are derived by comparing performance measure rates to national Medicaid benchmarks.

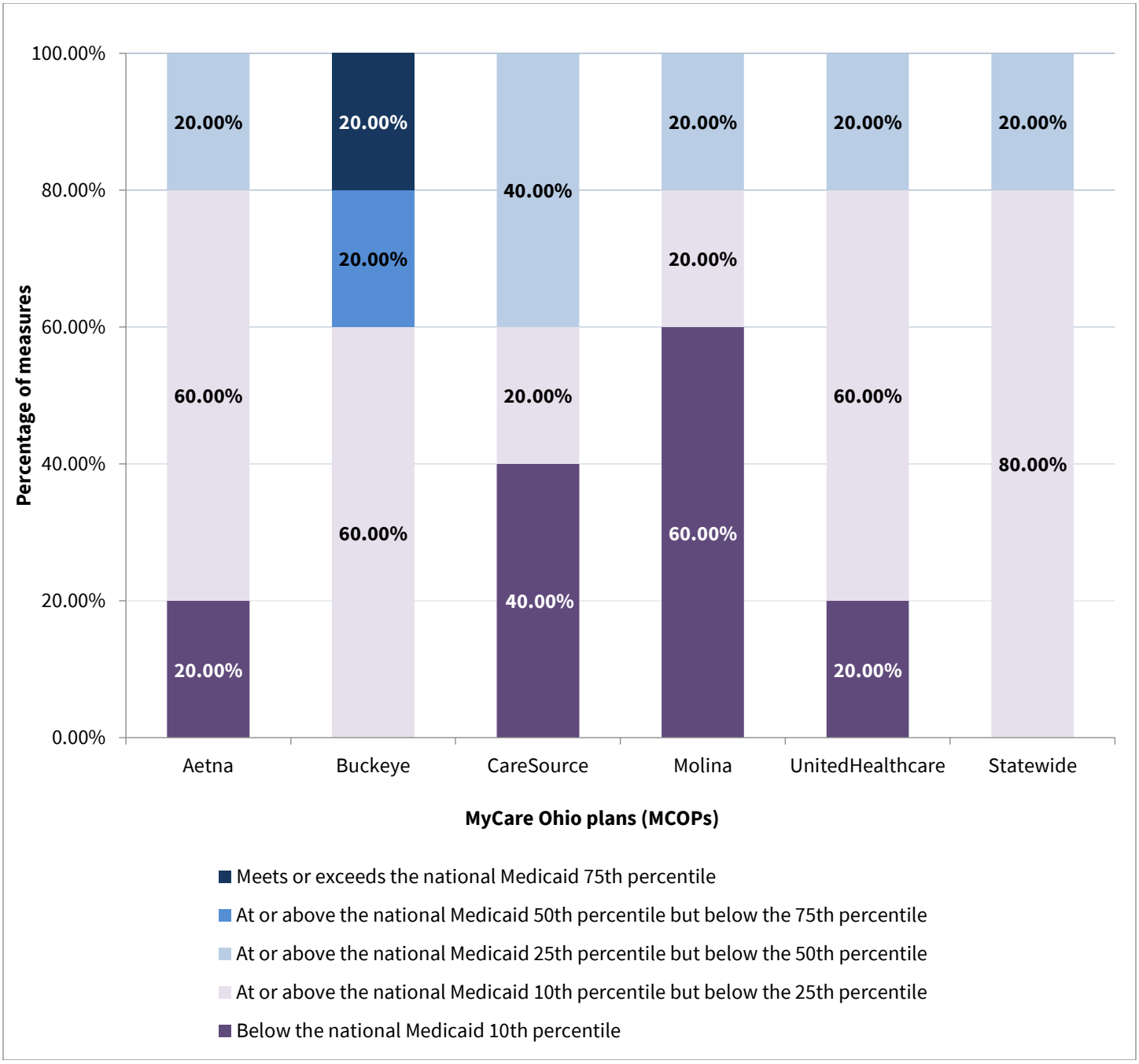

Figure 5: MCOP and Statewide Percentage of Performance Measures by Percentile Range, MY 2022

Table 18 displays a count of the star ratings corresponding to percentile benchmarks for those measures for which an MPS has been established. Every MCOP except Buckeye have all their MPS measures below the national 50th percentile; Aetna, Molina, and UnitedHealthcare have the most measures (80.0%) below the national 25th percentile. Every MCOP except for Buckeye has at least one MPS measure below the 10th national percentile. The statewide average is above the national 25th percentile for 20.0% of the MPS measures.

Table 18: Count of HEDIS 2023 Star Ratings by Percentile Benchmarks for Measures with MPS by MCOP, MY 2022

MCOP	< P10 ★	P10–P25[1] ★★	P25–P50[1] ★★★	P50–P75[1] ★★★★	≥ P75 ★★★★★
Aetna	1	3	1	-	-
Buckeye	-	3	-	1	1
CareSource	2	1	2	-	-
Molina	3	1	1	-	-
UnitedHealthcare	1	3	1	-	-
Statewide average	-	4	1	-	-

[1] This benchmark range/star rating includes the lower, but not the upper, *Quality Compass* percentile.
MPS: minimum performance standard; MCOP: MyCare Ohio plan; P: percentile.

Minimum Performance Standings

Figure 6 presents the overall percentage of MPSs met by each MCOP. All MCOPs met or exceeded all their MPSs.

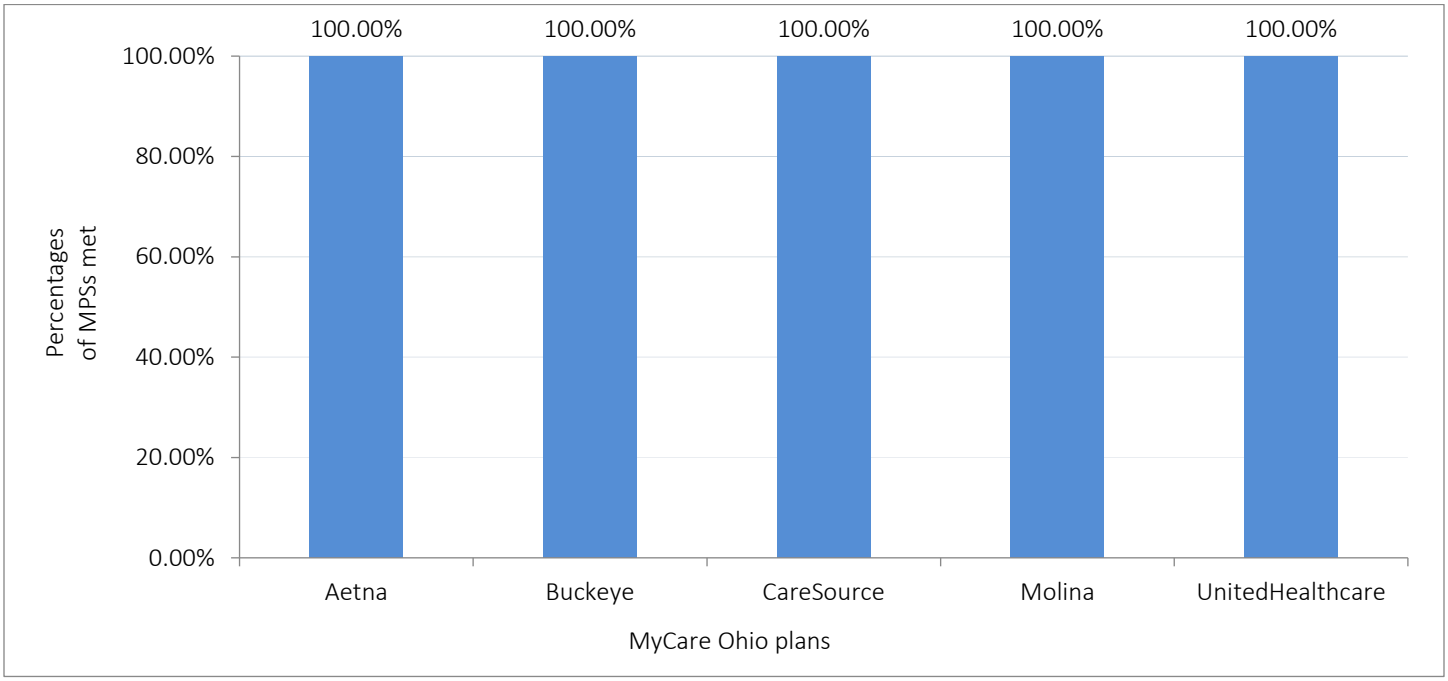

Figure 6: Percentage of MPSs Met by MCOP MPS: minimum performance standard; MCOP: MyCare Ohio plan.

Table 19 displays the number of measure indicators that met or exceeded the MPSs by MCOP for each population stream. All five MCOPs met all MPSs for all five population streams.

Table 19: MCOP Measures with MPSs by Population Stream, MY 2022

Population Stream	Aetna	Buckeye	CareSource	Molina	UnitedHealthcare	Measures with MPS
Behavioral Health	2	2	2	2	2	2
Chronic Conditions	1	1	1	1	1	1
Healthy Adults	1	1	1	1	1	1
Integrating Care	1	1	1	1	1	1
Total	5	5	5	5	5	5

MCOP: MyCare Ohio plan; MPS: minimum performance standard; MY: measurement year.

V. Review of Compliance with Medicaid and CHIP Managed Care Regulations

Objectives

According to *Title 42 CFR § 438.358*, a review must be conducted within the previous three-year period that determines a plan's adherence to standards established by the state related to member rights and protections, access to services, structure and operations, measurement and improvement, and grievance system standards, as well as applicable elements of ODM's MMC provider agreement with the plans. IPRO conducted a comprehensive administrative review of the MCOs and MCOPs between September and December 2023, covering a review period from February 1, 2023, to July 31, 2023. OhioRISE and the SPBM will be reviewed in SFY 2024 and included in the April 2025 Technical Report.

The scope of the review included the 14 federal standards presented in **Table 20**. IPRO based the review on CMS's *EQR Protocol 3: Review of Compliance with Medicaid and CHIP Managed Care Regulations* (February 2023) and included planning, developing evaluation tools, preliminary reviews, site meetings, evaluation and analysis, and reporting. A full compliance review was conducted previously in SFY 2020.

Table 20: Federal Standards for Compliance

Title 42 CFR § 438 (Medicaid)	Federal Standard
438.56	Disenrollment: Requirements and Limitations
438.100	Enrollee Rights
438.114	Emergency and Post-stabilization Services
438.206	Availability of Services
438.207	Assurances of Adequate Capacity and Services
438.208	Coordination and Continuity of Care
438.210	Coverage and Authorization of Services
438.214	Provider Selection
438.224	Confidentiality
438.228	Grievance and Appeal System
438.230	Subcontractual Relationships and Delegation
438.236	Practice Guidelines
438.242	Health Information Systems
438.330	Quality Assessment and Performance Improvement Program

CFR: Code of Federal Regulations; §: section.

Technical Methods of Data Collection and Analysis

The review process included the three phases: pre-site visit, site visit, and post-site visit (**Figure 7**).

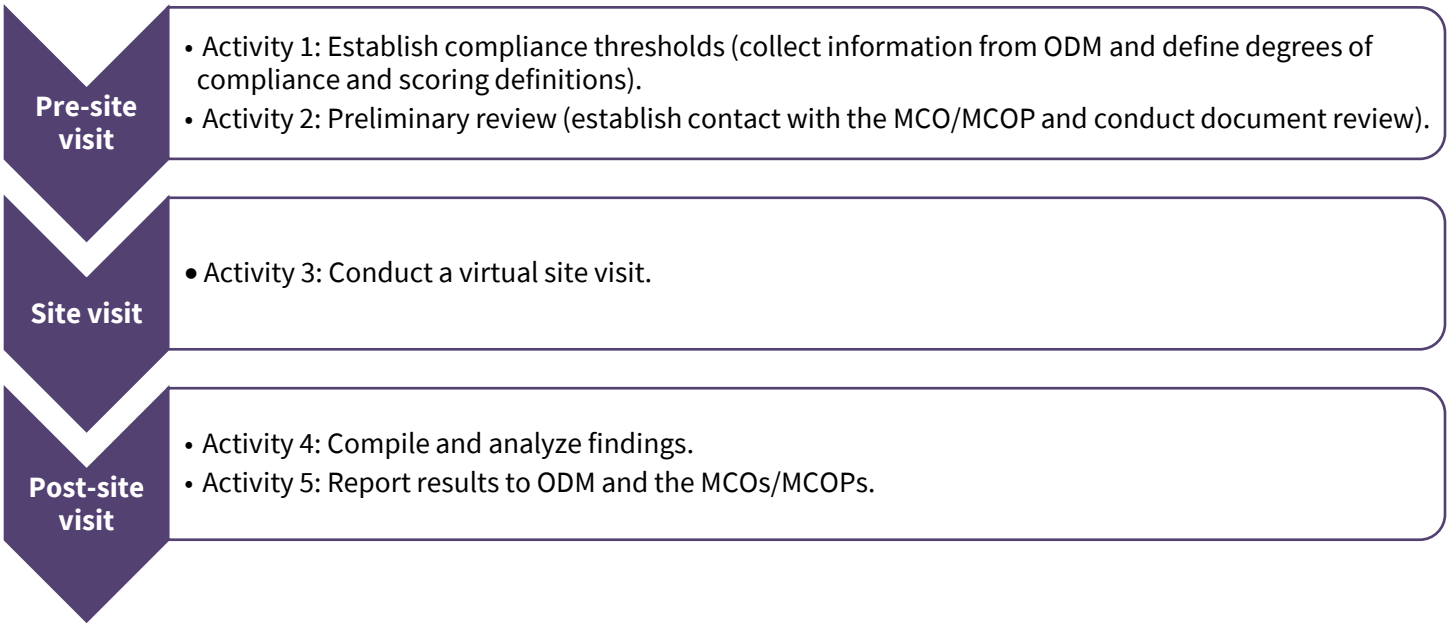

Figure 7: Comprehensive Administrative Review Process. ODM: Ohio Department of Medicaid; MCO: managed care organization; MCOP: MyCare Ohio Plan.

Pre-site Visit

Define the Scope of the Review

IPRO collaborated with ODM to establish the scope of work for the comprehensive administrative review. This included determining the frequency of reviews, defining compliance levels and thresholds, and incorporating ODM-specific regulations or requirements. IPRO requested access to all relevant provider agreements, contract documents, and written communications (e.g., emails and policy memos issued by ODM to create the evaluation tools).

Establish Scoring Methodology

For each standard, a total score was calculated by summing the score for each "Met" (1 point) and "Not Met" (0 points) element, dividing the sum by the total number of applicable elements in the evaluation tool for that standard, and multiplying by 100 to achieve a rate. Definitions of Met, Not Met, and not applicable are described in **Table 21**.

Table 21: Compliance Review Determination Definitions

Determination	Description
Met	Met indicates full compliance defined as the following: All documentation and data sources reviewed, including MCO/MCOP data and documentation, ODM data and documentation, and systems demonstrations for a regulatory provision, or component thereof, are present and provide supportive evidence of congruence; and staff members provide responses to reviewers that are consistent with each other, with the data and documentation reviewed, and with the regulatory provision.
Not Met	Not Met indicates noncompliance defined as any of the following: • Documentation and data sources are not present and/or do not provide supportive evidence of congruence with the regulatory provision. • Staff members have little or no knowledge of processes or issues addressed by the regulatory provisions. • For those provisions with multiple components, key components of the provision could not be identified and/or do not provide sufficient evidence of congruence with the

Determination	Description
	regulatory provision. Any findings of Not Met for these components would result in an overall provision finding of noncompliance, regardless of the findings noted for the remaining components.
Not applicable	Any criteria not applicable during the current review period for any contractual reason or not applicable to the Medicaid line of business.

MCO: managed care organization; MCOP: MyCare Ohio plan; ODM: Ohio Department of Medicaid.

Evaluation Tools

IPRO developed evaluation tools aligned with state and federal requirements. The tools were structured for maximum clarity and incorporated references to relevant federal regulations, state-specific contract requirements, and standards, and reviewer determinations.

Compliance Team Training

All IPRO reviewers were trained in the Ohio compliance review processes, including all relevant facets of the Ohio MMC programs, regulatory provisions, compliance thresholds, agenda, logistics, and timelines.

MCO Orientation Session

IPRO conducted an orientation session on August 2, 2023, to familiarize the MCOs/MCOPs with the comprehensive administrative review process and timeline, assist them in preparing for the reviews, and answer questions they had regarding any aspects of the review. IPRO distributed a pre-review letter incorporating information on document requirements (e.g., MCOs'/MCOPs' policies and procedures, sample contracts, program descriptions, committee minutes, and various program reports), submission instructions, and the evaluation tools.

Preliminary Review (Desk Review)

All documents containing confidential information were exchanged between IPRO and the MCOs/MCOPs via IPRO's secure site using Secure File Transfer Protocol (SFTP) that is compliant with The Health Insurance Portability and Accountability Act of 1996 (HIPAA). IPRO conducted a preliminary review of the documents to identify gaps in information necessary to demonstrate full compliance with a standard and to enable efficient and productive interactions with the MCO/MCOP during the review. IPRO assessed the following:

- Structure. To determine structural compliance, policies and procedures, processes, and program descriptions were evaluated.
- Communication. Once structural compliance was verified, IPRO evaluated the accessibility of information and the effectiveness of communication with members, providers, staff, and the community. Organizational publications such as member and provider handbooks, resource guides, and newsletters were reviewed, as applicable.
- Implementation. Evidence of implementation of a requirement was established by assessing documented outcomes including committee minutes, reports, program evaluations, audits, data, surveys, or studies that showed evidence that the MCO/MCOP was monitoring the required element/criterion.

Inter-Rater Reliability

Reviewers worked in two-person teams for each standard under the direction of the IPRO lead. Each team evaluated the same assigned standards for all MCOs/MCOPs to maintain consistency in scoring. Each member of the team conducted an independent review of the team's assigned standards, and then conferred with each other on the findings. Variances were referred to a third "gold star" reviewer who investigated and weighed the evidence to make the final determination.

Site Visit (Virtual)

The IPRO team conducted an opening session on Day 1 of the site meetings. This session included introductions and a brief presentation by the MCO/MCOP to highlight any corporate changes or new initiatives, a review of the evaluation process, and the agenda.

Systems Demonstrations
Demonstrations of the MCOs'/MCOPs' operations were sometimes, but not always, conducted.

Interviews
The IPRO review team asked questions regarding their assigned standards based on CMS's EQR Protocol 3, ODM feedback, and other information gathered during the preliminary document reviews. The MCO/MCOP staff were provided with an opportunity to describe their processes and respond to specific questions about requirements that appeared to be less than fully compliant during the preliminary review. The interviews also assisted the reviewers in confirming that the MCOs'/MCOPs' actual practices were consistent with their policies, procedures, and processes. Finally, the interviews allowed the MCO/MCOP to highlight process improvements or system changes since the prior review. MCOs/MCOPs were allowed to submit additional documentation up to 5pm the next business day.

Findings
IPRO maintained documentation by adding to the tools any findings based on additional information or documents provided by the MCO/MCOP during the interview sessions.

If an MCO/MCOP did not have documentation to comply with a requirement during the review period (February 1, 2023, to July 31, 2023) but updated a document after IPRO identified the deficiency during the preliminary review, they did not receive credit for the updated documents.

Closing
A closing conference was held at the end of each review period.

Post-site Visit

Compile and Analyze Findings
IPRO updated the evaluation tools with information obtained during the review. The IPRO lead reviewed all findings and determinations to ensure consistency, internal logic, and reasonability across reviews.

Description of Data Obtained
IPRO gathered documentation and data from multiple sources prior to conducting the evaluation. The plans' noncompliance logs provided by ODM aided in directing IPRO to areas needing focused review. The plans were required to submit evidence that supported implementation of policies and procedures related to the requirements included as part of the review. Examples of documentation IPRO reviewed included, but were not limited to, the following: copies of committee minutes, reports, member materials, provider materials, training agendas, letter templates, and data reports.

Conclusions and Comparative Findings
Table 22 and **Table 23** present an overview of the MCOs' and MCOPs' scores from the comprehensive administrative review for Medicaid standards.

Table 22: MCO Compliance with Federal Medicaid Standards

Standard	CFR Citation	AmeriHealth (%)	Anthem (%)	Buckeye (%)	CareSource (%)	Humana (%)	Molina (%)	UHC (%)
Disenrollment: Requirements and Limitations	438.56	75.0	50.0	25.0	50.0	50.0	75.0	50.0
Enrollee Rights	438.100	100.0	100.0	82.6	95.7	100.0	100.0	65.2
Emergency and Post-stabilization Services	438.114	83.3	100.0	100.0	100.0	66.7	100.0	100.0
Availability of Services	438.206	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Assurances of Adequate Capacity and Services	438.207	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Coordination and Continuity of Care	438.208	100.0	100.0	88.9	100.0	100.0	100.0	100.0
Coverage and Authorization of Services	438.210	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Provider Selection	438.214	100.0	100.0	100.0	100.0	100.0	100.0	33.3
Confidentiality	438.224	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Grievance and Appeal System	438.228	91.4	85.7	91.4	74.3	80.0	91.4	82.9
Subcontractual Relationships and Delegation	438.230	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Practice Guidelines	438.236	83.3	100.0	100.0	83.3	100.0	100.0	100.0
Health Information Systems	438.242	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Quality Assessment and Performance Improvement Program	438.330	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Overall compliance rate	**-**	**95.9**	**95.2**	**92.4**	**91.0**	**92.4**	**97.2**	**87.6**

MCO: managed care organization; SFY: state fiscal year; CFR: Code of Federal Regulations; UHC: UnitedHealthcare Community Plan.

Overall, the MCOs achieved a high rate of compliance with the standards reviewed for the comprehensive administrative review (**Table 22)**. Standards for which all plans achieved compliance scores of 100.0% were in the following areas: Availability of Services, Assurances of Adequate Capacity and Services, Coverage and Authorization of Services, Confidentiality, Subcontractual Relationships and Delegation, Health Information Systems, and Quality Assessment and Performance Improvement Program.

Table 23: MCOP Compliance with Federal Medicaid Standards

Standard	CFR Citation	Aetna (%)	Buckeye (%)	CareSource (%)	Molina (%)	UHC (%)
Disenrollment: Requirements and Limitations	438.56	100.0	50.0	25.0	25.0	0.0
Enrollee Rights	438.100	100.0	82.6	95.7	100.0	65.2
Emergency and Post-stabilization Services	438.114	100.0	100.0	100.0	100.0	100.0
Availability of Services	438.206	100.0	100.0	100.0	100.0	100.0
Assurances of Adequate Capacity and Services	438.207	100.0	100.0	100.0	100.0	100.0
Coordination and Continuity of Care	438.208	100.0	100.0	100.0	100.0	100.0
Coverage and Authorization of Services	438.210	100.0	100.0	100.0	100.0	100.0
Provider Selection	438.214	66.7	100.0	100.0	100.0	33.3
Confidentiality	438.224	100.0	100.0	100.0	100.0	100.0
Grievance and Appeal System	438.228	68.6	85.7	68.6	94.3	77.1
Subcontractual Relationships and Delegation	438.230	100.0	100.0	80.0	100.0	100.0
Practice Guidelines	438.236	100.0	100.0	100.0	100.0	100.0
Health Information Systems	438.242	100.0	100.0	100.0	100.0	100.0
Quality Assessment and Performance Improvement Program	438.330	100.0	100.0	100.0	100.0	100.0
Overall compliance rate	**-**	**91.7**	**92.4**	**89.0**	**96.6**	**84.8**

MCOP: MyCare Ohio plan; SFY: state fiscal year; CFR: Code of Federal Regulations; UHC: UnitedHealthcare Community Plan.

Overall, the MCOPs achieved a high rate of compliance with the standards reviewed for the comprehensive administrative review (**Table 23**). Standards for which all plans achieved compliance scores of 100.0% were in the following areas: Emergency and Post-stabilization Services, Availability of Services, Assurances of Adequate Capacity and Services, Coordination and Continuity of Care, Coverage and Authorization of Services, Confidentiality, Practice Guidelines, Health Information Systems, and Quality Assessment and Performance Improvement Program.

VI. Validation of Network Adequacy

Objectives

ODM requires that sufficient providers be available to assure timely access to care for Medicaid members and that specific information be available to assist members in selecting and reaching an appropriate provider. In SFY 2023, ODM contracted with IPRO to monitor MCO and MCOP adherence to these requirements through two telephone surveys to examine PCP network adequacy, and one telephone survey to examine specialty care network adequacy (with the specialty selected annually on a rotating basis). In SFY 2023, ODM selected oral surgeons for the specialty provider survey. OhioRISE and pharmacy network adequacy are being assessed in early SFY 2025 and will be included in the subsequent EQR Technical Report.

Primary Care Providers Surveys

Technical Methods of Data Collection and Analysis

IPRO conducted two revealed shopper telephone surveys of a sample of PCPs participating in the MMC networks. The first one was conducted in November 2022 and included MCOs. The second was conducted in June 2023 and included MCOs and MCOPs. Random samples of PCPs from each MCO or MCOP were drawn from the managed care provider network (MCPN) files.

The surveys assessed two domains:

1. MCPN File Validation - Provider Information: included checking the accuracy of each provider's telephone number, location, MCO or MCOP contract status, and new patient acceptance status.
2. New and Existing Patient Access: among those who were reached and were still contracted with the MCO or MCOP, the survey collected information on the soonest available appointment with any provider at the location for a sick visit and a well-check visit for new members (if accepting new members) and established members.

Description of Data Obtained – November 2022 Survey

Using the October 2022 MCPN file, IPRO drew a random sample of PCPs in Ohio Medicaid's MMC program. In November 2022, IPRO called 2,370 providers across five MCOs following a standardized protocol and script.

Conclusions and Comparative Findings – November 2022 Survey

For the MCPN file validation portion of the survey, questions assessed four elements of access:

- The provider's office could be reached within three attempts without extensive hold time.
- The provider was practicing as a PCP as indicated in the MCPN.
- The provider accepts members of the MCO that was indicated.
- Office personnel were willing to participate in the survey.

In total, 798 providers were unreachable, 424 providers stated the PCP was not at that number, 91 providers did not take the plan, 35 providers were not participating as PCPs, and 264 providers declined to participate in the survey (including 28 providers who could not query their scheduling system without a member identification number). **Table 24** shows the number of providers who met all four elements of access for inclusion in the appointment availability questions by plan. These providers were used as the final sample size for the remainder of the survey.

Table 24: Provider Directory Accuracy by MCO, November 2022

MCO	Providers Surveyed (n)	Inclusion Criteria Met (n)	Rate (%)
Buckeye	473	162	34.2%
CareSource	480	184	38.3%
Molina	475	146	30.7%
Paramount	464	169	36.4%
UnitedHealthcare	478	97	20.3%
Total	**2,370**	**758**	**32.0%**

MCO: managed care organization.

Among PCPs listed in the MCPN as accepting new patients, between 62.9% and 69.0% stated they were accepting new patients (**Table 25**).

Table 25: Provider Directory Accuracy for Accepting New Patients by MCO, November 2022

MCO	Providers (n)	Verified Accepting (n)	Accuracy Rate (%)
Buckeye	162	105	64.8%
CareSource	184	127	69.0%
Molina	146	96	65.8%
Paramount	169	110	65.1%
UnitedHealthcare	97	61	62.9%
Total	**758**	**499**	**65.8%**

MCPN: managed care provider network; MCO: managed care organization.

Tables 26–27 show the proportion of providers who could provide timely appointments, by MCO. Appointments were considered timely when the well-check visit could be scheduled within 30 calendar days of the call and within two calendar days for sick visits.

For new patients (**Table 26**), of the 499 PCPs that could be reached, were in-network, and were verified to be accepting new patients, between 53.3% and 57.4% offered timely, well-check appointments to new patients at their practice. Appointment availability rates for sick visits for new patients were between 22.0% and 29.5% of PCPs.

For existing patients (**Table 27**), of the 758 PCPs that could be reached and who were in-network, between 58.6% and 62.9% offered timely well-check appointments to established patients. Appointment availability rates for sick visits for established patients were between 47.4% and 48.9% of PCPs reached.

Table 26: New Patient Appointment Access by Appointment Type per MCO, November 2022

MCO	Timely Well-check Appointment (n)	Timely Well-check Appointment Rate (%)	Timely Sick Appointment (n)	Timely Sick Appointment Rate (%)
Buckeye (n=105)	56	53.3%	29	27.6%
CareSource (n=127)	72	56.7%	28	22.0%
Molina (n=96)	54	56.3%	25	26.0%
Paramount (n=110)	58	52.7%	25	22.7%
UnitedHealthcare (n=61)	35	57.4%	18	29.5%
Total (n=499)	**275**	**55.1%**	**125**	**25.1%**

MCO: managed care organization.

Table 27: Established Patient Appointment Access by Appointment Type per MCO, November 2022

MCO	Timely Well-check Appointment (n)	Timely Well-check Appointment Rate (%)	Timely Sick Appointment (n)	Timely Sick Appointment Rate (%)
Buckeye (n=162)	97	59.9%	78	48.1%
CareSource (n=184)	108	58.7%	90	48.9%
Molina (n=146)	87	59.6%	70	47.9%
Paramount (n=169)	99	58.6%	79	46.7%
UnitedHealthcare (n=97)	61	62.9%	46	47.4%
Total (n=758)	**452**	**59.6%**	**363**	**47.9%**

MCO: managed care organization.

Description of Data Obtained – June 2023 Survey

The PCP survey was repeated in June 2023 and included seven MCO and five MCOP plans. IPRO called a total of 2,467 PCPs, including 1,861 providers across the MCO plans and 606 providers across the MCOP plans.

Conclusions and Comparative Findings – June 2023 Survey

More than twice as many providers were unreachable in the June 2023 survey as the November 2022 survey (n = 1,654 in the summer compared to n = 798 in the winter). Additionally, about twice as many providers in the June 2023 survey (n = 126) compared to the November 2022 survey (n = 260) were not participating as PCPs or did not take the stated plan. Slightly fewer declined to participate (n = 233 in June 2023 compared to n = 264 in November 2022). **Table 28** and **Table 29** show the number of providers who met all criteria to be included in the appointment availability questions. These providers were used as the final sample size for the remainder of the survey.

Table 28: Proportion of Included Providers per MCO, June 2023

MCO	Providers Surveyed (n)	Inclusion Criteria Met (n)	Rate (%)
AmeriHealth	292	16	5.5%
Anthem	550	17	3.1%
Buckeye	194	20	10.3%
CareSource	242	27	11.2%
Humana	188	70	37.2%
Molina	173	29	16.8%
UnitedHealthcare	222	19	8.6%
Total	**1,861**	**198**	**10.6%**

MCO: managed care organization.

Table 29: Proportion of Included Providers per MCOP, June 2023

MCOP	Providers Surveyed (n)	Inclusion Criteria Met (n)	Rate (%)
Aetna	134	25	18.7%
Buckeye	138	23	16.7%
CareSource	128	20	15.6%
Molina	118	37	31.4%
UnitedHealthcare	88	17	19.3%
Total	**606**	**122**	**20.1%**

MCOP: MyCare Ohio plan.

Among providers shown in the directory as accepting new patients, new patient acceptance rates for MCOs ranged from 60% to 95% (**Table 30**) and between 64.0% and 85.0% for MCOPs (**Table 31**).

Table 30: Provider Directory Accuracy for Accepting New Patients by MCO, June 2023

MCO	Providers (n)	Verified Accepting (n)	Accuracy Rate (%)
AmeriHealth	16	14	87.5%
Anthem	17	15	88.2%
Buckeye	20	12	60.0%
CareSource	27	23	85.2%
Humana	70	51	72.8%
Molina	29	22	75.8%
UnitedHealthcare	19	18	94.7%
Total	**198**	**155**	**78.3%**

MCPN: managed care provider network; MCO: managed care organization.

Table 31: Provider Directory Accuracy for Accepting New Patients by MCOP, June 2023

MCOP	Providers (n)	Verified Accepting (n)	Accuracy Rate (%)
Aetna	25	16	64.0%
Buckeye	23	18	78.3%
CareSource	20	17	85.0%
Molina	37	29	78.4%
UnitedHealthcare	17	13	76.5%
Total	**122**	**93**	**76.2%**

MCPN: managed care provider network; MCOP: MyCare Ohio plan.

Tables 32–35 show the proportion of providers who indicated wait times of fewer than 30 days for well-check appointment availability and two days for sick visit appointment availability for new and existing patients.

- For new patients (**Table 32** and **Table 33**):
  - Of the PCPs who confirmed they were accepting new patients, the proportion that offered timely well-check appointments averaged 63.9% for MCOs and 72.0% for MCOPs.
  - Of the PCPs who confirmed they were accepting new patients, the proportion that offered timely sick visits was 37.4% for MCOs and 41.9% for MCOPs.
- For existing patients (**Table 34** and **Table 35**):
  - Wait times for existing patients were better. PCPs offered timely well-check appointments to established patients on average 71.2% of the time for MCO members and 73.0% of the time for MCOP members.
  - For sick appointments, the proportion offering timely sick visits averaged 59.1% for MCOs and 63.1% for MCOPs.

Table 32: New Patient Appointment Access by Appointment Type by MCO, June 2023

MCO	Timely Well-check Appointment (n)	Timely Well-check Appointment Rate (%)	Timely Sick Appointment (n)	Timely Sick Appointment Rate (%)
AmeriHealth (n=14)	10	71.4%	8	57.1%
Anthem (n=15)	10	66.7%	6	40.0%
Buckeye (n=12)	8	66.7%	3	25.0%
CareSource (n=23)	16	69.6%	9	39.1%
Humana (n=51)	28	54.9%	18	35.3%
Molina (n=22)	18	81.8%	8	36.4%
UnitedHealthcare (n=18)	9	50.0%	6	33.3%
Total (n=155)	**99**	**63.9%**	**58**	**37.4%**

MCO: managed care organization.

Table 33: New Patient Appointment Access by Appointment Type by MCOP, June 2023

MCOP	Timely Well-check Appointment (n)	Timely Well-check Appointment Rate (%)	Timely Sick Appointment (n)	Timely Sick Appointment Rate (%)
Aetna (n=16)	10	62.5%	7	43.8%
Buckeye (n=18)	14	77.8%	5	27.8%
CareSource (n=17)	9	52.9%	8	47.1%
Molina (n=29)	24	82.8%	13	44.8%
UnitedHealthcare (n=13)	10	76.9%	6	46.2%
Total (n=93)	**67**	**72.0%**	**39**	**41.9%**

MCOP: MyCare Ohio plan.

Table 34: Established Patient Appointment Access by Appointment Type by MCO, SFY 2023

MCO	Timely Well-check Appointment (n)	Timely Well-check Appointment Rate (%)	Timely Sick Appointment (n)	Timely Sick Appointment Rate (%)
AmeriHealth (n=16)	12	75.0%	8	50.0%
Anthem (n=17)	13	76.5%	9	52.9%
Buckeye (n=20)	12	60.0%	10	50.0%
CareSource (n=27)	21	77.8%	19	70.4%
Humana (n=70)	45	64.3%	42	60.0%
Molina (n=29)	25	86.2%	19	65.5%
UnitedHealthcare (n=19)	13	68.4%	10	52.6%
Total (n=198)	**141**	**71.2%**	**117**	**59.1%**

MCO: managed care organization.

Table 35: Established Patient Appointment Access by Appointment Type by MCOP, SFY 2023

MCOP	Timely Well-check Appointment (n)	Timely Well-check Appointment Rate (%)	Timely Sick Appointment (n)	Timely Sick Appointment Rate (%)
Aetna (n=25)	18	72.0%	18	72.0%
Buckeye (n=23)	16	69.6%	12	52.2%
CareSource (n=20)	14	70.0%	14	70.0%
Molina (n=37)	28	76.5%	23	62.2%
UnitedHealthcare (n=17)	13	76.5%	10	58.8%
Total (n=122)	**89**	**73.0%**	**77**	**63.1%**

MCOP: MyCare Ohio plan.

Specialty Surveys

Oral Surgeon

Technical Methods of Data Collection and Analysis

IPRO conducted a secret shopper telephone survey of access and availability of oral surgeons to MCO members in the fall of SFY 2023. IPRO drew a sample of oral surgeons from the MCPN and telephoned them to assess accuracy of the information in the MCPN and wait times for appointments.

Description of Data Obtained

Using the September 2022 MCPN data extract, IPRO drew a sample of 331 oral surgeons. Between October–November 2022, IPRO conducted 331 surveys, resulting in 247 responses.

Conclusions and Comparative Findings

Of the 331 oral surgeons' offices called, 247 (74.6%) were successfully reached, and 74 of those (30.0%) confirmed their MCO participation and specialty as matching the MCPN. Surveyors asked the 74 oral surgeon offices about their next available appointment, and on average, just 10.8% offered appointments within the next 30 calendar days.

VII. Validation of Quality-of-Care Surveys – CAHPS Member Experience Survey

Objectives

ODM requires MCOs, MCOPs, and the OhioRISE plan to conduct quality measurement activities to ensure members have timely access to high-quality healthcare services. ODM requires the MCOs, MCOPs, and OhioRISE plan to contract with an NCQA-certified HEDIS survey vendor to conduct annual CAHPS Health Plan Surveys. The surveys assess topics such as quality of care, access to care, the communication skills of providers and administrative staff, as well as overall experience with health plans and providers. ODM contracted with IPRO to validate that the surveys were conducted in alignment with state requirements and to analyze the MCEs' 2023 survey year (MY 2022) data and report the results. Data from the MCO and MCOP CAHPS surveys have been analyzed, and OhioRISE will be added to next year's Annual Technical Report.

Technical Methods of Data Collection and Analysis

Managed Care Program

ODM requires the MCOs in the managed care program to use the CAHPS 5.1H Adult Medicaid Health Plan Survey and the CAHPS 5.1H Child Medicaid Health Plan Survey (with the chronic conditions measurement set). The CAHPS 5.1H Adult Medicaid Health Plan Survey includes 40 core questions that yield 12 measures. The CAHPS 5.1H Child Medicaid Health Plan Survey (with the CCC measurement set) includes 76 core questions that yield 14 measures. **Table 36** provides a summary of the measures used.

Table 36: MCO CAHPS Measures, MY 2022

Global Ratings	Composite Measures	Individual Items	MSC Measures[1]	CCC Composite Measures[2]	CCC Items[2]
Rating of Health Plan	Getting Needed Care	Coordination of Care	Advising Smokers and Tobacco Users to Quit	Access to Specialized Services	Access to Prescription Medicines
Rating of All Health Care	Getting Care Quickly	-	Discussing Cessation Medications	Family-Centered Care (FCC): Personal Doctor Who Knows Child	FCC: Getting Needed Information
Rating of Personal Doctor	How Well Doctors Communicate	-	Discussing Cessation Strategies	Coordination of Care for Children with Chronic Conditions	-
Rating of Specialist Seen Most Often	Customer Service	-	-	-	-

[1] The Medical Assistance with Smoking and Tobacco Use Cessation (MSC) measures are only present in the CAHPS 5.1H Adult Medicaid Health Plan Survey.
[2] The CCC composite measures/items are only present in the CAHPS 5.1H Child Medicaid Health Plan Survey (with the CCC measurement set).
CAHPS: Consumer Assessment of Healthcare Providers and Systems; MY: measurement year; CCC: children with chronic conditions.

HEDIS specifications require that the MCOs provide a list of all eligible members for the sampling frame. Following HEDIS requirements, the MCOs included members in the sample frame who were 18 years of age or older for adult members or 17 years of age or younger for child members as of December 31, 2022, continuously enrolled for at least five of the last six months of 2022, and currently enrolled in the MCO. **Table 37** provides a summary of the technical methods of data collection by MCO.

Table 37: Technical Methods of CAHPS Data Collection by MCO, MY 2022

CAHPS Methods	Buckeye	CareSource	Molina	Paramount	UHC
Adult CAHPS Survey					
Survey vendor	SPH Analytics	SPH Analytics	SPH Analytics	SPH Analytics	SPH Analytics
Survey tool	5.1H	5.1H	5.1H	5.1H	5.1H
Survey timeframe	February to May 2023	February to May 2023	February to May 2023	February to May 2023	February to May 2023
Method of collection	Mail, Internet, telephone	Mail, Internet, telephone	Mail, Internet, telephone	Mail, Internet, telephone	Mail, Internet, telephone
Sample size	1,755	2,700	2,025	1,755	1,890
Response rate	9.00%	11.17%	10.24%	11.60%	10.70%
Child CAHPS Survey					
Survey vendor	SPH Analytics	SPH Analytics	SPH Analytics	SPH Analytics	SPH Analytics
Survey tool	5.1H	5.1H	5.1H	5.1H	5.1H
Survey timeframe	February to May 2023	February to May 2023	February to May 2023	February to May 2023	February to May 2023
Method of collection	Mail, Internet, telephone	Mail, Internet, telephone	Mail, Internet, telephone	Mail, Internet, telephone	Mail, Internet, telephone
Sample size – general	2,145	4,950	7,425	2,145	1,982
Response rate	6.08%	7.50%	7.63%	9.99%	5.57%
CCC supplemental sample size	2,392	1,840	1,840	1,840	2,206

CAHPS: Consumer Assessment of Healthcare Providers and Systems; MCO: managed care organization; MY: measurement year; CCC: children with chronic conditions; UHC: UnitedHealthcare Community Plan.

For MY 2022, a total of 2,452 surveys were completed for Ohio's MMC program, including 1,063 adult surveys and 1,389 general child surveys (excluding members in the CCC supplemental sample). The survey response rates were 8.6% overall for Ohio's MMC program, 10.6% for the adult population, and 7.5% for the general child population.

A total of 2,232 parents or caretakers of child members returned a completed survey from both the general child and CCC supplemental samples. Of the 2,232 completed child surveys, 1062 were for children identified as having a chronic condition based on survey responses (CCC population), and 1,190 were for children who did not have a chronic condition (non-CCC population). This represents a response rate for the child population of 7.8%.[7]

In accordance with HEDIS specifications for survey measures,[8] results for the adult and child populations were reported separately, and no weighting or case-mix adjustment was performed on the results. However, IPRO did report all MCOs' CAHPS results differently than HEDIS specifications by including measures with fewer than 100 responses. These are noted with an asterisk (*).

[7] This includes all children sampled (both the general child sample and the CCC supplemental sample). According to NCQA protocol, children in the CCC supplemental sample are not included in NCQA's standard child response rate calculations. Therefore, the overall child response rates reported in this paragraph should not be compared to the NCQA response rates.

[8] National Committee for Quality Assurance. *HEDIS® MY 2022. Volume 3: Technical Specifications for Survey Measures*. Washington, DC: NCQA, 2022.

For the global ratings, composite measures, composite items, individual item measures, CCC composite measures, CCC composite items, and CCC items, the score was provided on a 100-point scale.[9] Responses were classified into response categories. Table 38 displays these categories and the measures for which these response categories are used.

Table 38: MCO CAHPS Response Categories, MY 2022

Measures	Response Categories
Global Ratings	• 0 to 4 (Dissatisfied) • 5 to 7 (Neutral) • 8 to 10 (Satisfied)
Getting Needed Care, Getting Care Quickly, How Well Doctors Communicate, and Customer Service composite measures and items; the Coordination of Care individual item measure; the Access to Specialized Services CCC composite measure; and the Access to Prescription Medicines and Family-Centered Care (FCC): Getting Needed Information CCC items	• Never (Dissatisfied) • Sometimes (Neutral) • Usually/Always (Satisfied)
FCC: Personal Doctor Who Knows Child and the Coordination of Care for Children with Chronic Conditions (CCC) composite measures, and the items within these CCC composites	• No • Yes
Smoking and Tobacco Use Cessation	• Never (No) • Sometimes/Usually/Always (Yes)

CAHPS: Consumer Assessment of Healthcare Providers and Systems; MY: measurement year; CCC: children with chronic conditions.

IPRO received de-identified member survey data from each of the MCOs to calculate results for the MY 2022 *Medicaid Managed Care program CAHPS Member Experience Survey* full report. Several different analyses were conducted to evaluate MCO performance.

To compare performance at the statewide level, two types of analyses were performed: 1) a comparison of each MCO's MY 2022 scores to the program's MY 2022 scores, and 2) a comparison of each MCO's and the program's MY 2022 scores to its MY 2021 scores. Additionally, child members with a chronic condition were compared to child members without a chronic condition for the CCC results analysis. Each population's MY 2022 scores were also compared to its MY 2021 scores.

For the adult and general child populations, hypothesis tests were conducted to determine: 1) whether the MCOs' response category percentages and scores were statistically significantly different from the program average, and 2) whether scores in MY 2022 were statistically significantly different from scores in MY 2021. For the CCC results analysis, hypothesis tests were conducted to determine: 1) whether the CCC population's score was statistically significantly different from the non-CCC population's score, and 2) whether scores in MY 2022 were statistically significantly different from scores in MY 2021.

The scores are annotated with ↑ or ↓ to indicate scores that are significantly higher or lower, respectively, than the Ohio Medicaid score for MY 2022 (for the CCC results analysis, these annotations indicate scores for one population that are significantly higher or lower, respectively, than scores for the other population). Additionally, the scores are annotated with ▲ or ▼ to indicate MY 2022 scores that are significantly higher or lower, respectively, than the same population's score for MY 2021.

[9] The CCC composite measures and CCC item measures are only included in the CAHPS 5.1H Child Medicaid Health Plan Survey (with CCC measurement set). Parents or caretakers of both general child members (those in the general child sample) and CCC members (those in the CCC supplemental sample) completed the CAHPS 5.1H Child Medicaid Health Plan Survey (with CCC measurement set), which includes the CCC composite measures and CCC items. The Statewide Comparisons section presents the CCC composite and CCC item results for general child members and children with chronic conditions.

The MY 2021 and MY 2022 NCQA national Medicaid averages are presented for measures, when available, for comparison.

Each year, NCQA releases the national benchmarks and thresholds for the HEDIS/CAHPS Survey results required for NCQA's accreditation of MCOs for the Medicaid population. NCQA requires MCOs to submit HEDIS and CAHPS data as part of the MCO accreditation process. Using these data submissions, NCQA recalculates the summary statistics annually for each HEDIS measure. These recalculated national results are compared to the prior year's accreditation benchmarks and thresholds. If there is minimal change to the national performance, accreditation benchmarks and thresholds are held constant. If performance changes, NCQA considers updating the benchmarks and thresholds. In addition, should changes to the measures impact trending, NCQA will recalculate the benchmarks and thresholds and update as necessary to avoid penalizing the plans.

For the Ohio MMC population, the four global ratings (Rating of Health Plan, Rating of All Health Care, Rating of Personal Doctor, and Rating of Specialist Seen Most Often), four composite measures (Getting Needed Care, Getting Care Quickly, How Well Doctors Communicate, and Customer Service), and one individual item measure (Coordination of Care) were scored on a 100-point scale using an NCQA-approved scoring methodology. The Ohio MMC program's and MCOs' scores were compared to NCQA's 2023 *Quality Compass* national percentiles.[10] Based on this comparison, ratings of one star (★) to five stars (★★★★★) were determined for each CAHPS measure, where one is the lowest possible rating (i.e., Poor) and five is the highest possible rating (i.e., Excellent; **Table 39**).

Table 39: MCO CAHPS Star Ratings, MY 2022

Stars	Percentiles
★ Poor	Below the 25th percentile
★★ Fair	At or between the 25th and 49th percentiles
★★★ Good	At or between the 50th and 74th percentiles
★★★★ Very Good	At or between the 75th and 89th percentiles
★★★★★ Excellent	At or above the 90th percentile

CAHPS: Consumer Assessment of Healthcare Providers and Systems; MY: measurement year.

MyCare Ohio

Plans participating in MyCare Ohio were required to use the 2022 Medicare Advantage and Prescription Drug Plan (MA & PDP) CAHPS Survey. ODM obtained the MCOPs' 2022 survey data (MY 2021) from CMS and contracted with IPRO to analyze the data and report individual MCOP results compared to the state average. At the time of writing, the MY 2022 MCOP results were not available. In addition to using Ohio-specific benchmarks, data analysis was conducted with minor differences in methodology; therefore, the results should not be compared to other reports presenting the same data (e.g., NCQA). The results presented in this report are not official survey results and are intended only for QI purposes.

In January 2022, CMS selected a random sample of eligible members from the Integrated Data Repository for each participating contract. CMS allowed oversampling at the contract level if there was sufficient eligible enrollee volume to support additional sampling after the required MA & PDP CAHPS Survey sample was drawn. MCOPs were required to request an increase in sample size for their contract by December 1, 2021. Following *MA & PDP Quality Assurance Protocols & Technical Specifications*, CMS selected a random sample of at least 800 MyCare Ohio members from each MCOP.[11] The MCOP sample sizes are outlined in **Table 40**.

[10] National Committee for Quality Assurance. *Quality Compass 2022*. Washington, DC: NCQA, 2022.

[11] Per CMS's sampling protocol, the targeted sample size is based on the type of contract. For MA contracts, with or without a PDP component, a targeted random sample of 800 members was selected for surveying.

Table 40: MCOP CAHPS Sample Sizes, MY 2021

MCOP	Targeted Sample Size	Oversample Size	Total Sample Size
Aetna	800	800	1,600
Buckeye	800	240	1,040
CareSource	800	1,200	2,000
Molina	800	0	800
UnitedHealthcare	800	4,200	5,000

MCOP: MyCare Ohio plan.

The MCOPs contracted with separate CMS-approved CAHPS survey vendors to perform the administration of the MA & PDP CAHPS Survey. The survey administration protocol employed by the MCOPs' vendors was the standardized CAHPS mixed-mode methodology, which allowed for two methods by which members could complete the surveys. The first phase, or mail phase, consisted of a prenotification letter being mailed to all sampled members, alerting them of the forthcoming questionnaire, and assuring the sampled members that the survey is sponsored by CMS. Following the prenotification letter, all sampled members received the first survey mailing. A second survey mailing was sent out to all nonrespondents. The second phase, or telephone phase, consisted of computer-assisted telephone interviewing (CATI) for sampled members who had not mailed in a completed survey in either of the two mailings. A series of at least five CATI calls was made to each nonrespondent.[12] It has been shown that the addition of the telephone phase aids in the reduction of nonresponse bias by increasing the number of respondents who are more demographically representative of a health plan's population.[13] The survey protocol allowed sampled members the option to use a proxy (i.e., another individual's assistance with completing the survey) during both the mail and telephone phases of survey administration. Additionally, sampled members had the option to complete the survey in other languages.[14] **Table 41** provides a summary of measures used.

Table 41: MCOP CAHPS Measures, MY 2021

Global Ratings	Composite Measures	Individual Items	Other Measures Reported to Contracts
Rating of Health Plan	Getting Needed Care	Annual Flu Vaccine	Contact from Doctor's Office, Pharmacy, or Drug Plan: Reminders to Fill Prescription
Rating of Health Care Quality	Getting Appointments and Care Quickly	Pneumonia Vaccine	Contact from Doctor's Office, Pharmacy, or Drug Plan: Reminders to Take Medications
Rating of Drug Plan	Doctors Who Communicate Well	-	-
Rating of Personal Doctor	Customer Service	-	-
Rating of Specialist	Getting Needed Prescription Drugs	-	-
-	Care Coordination	-	-

MCOP: MyCare Ohio plan; CAHPS: Consumer Assessment of Healthcare Providers and Systems.

[12] Centers for Medicare & Medicaid Services. *MA & PDP Quality Assurance Protocols & Technical Specifications, V12.0*. October 2021.
[13] Fowler FJ Jr., Gallagher PM, Stringfellow VL, et al. "Using Telephone Interviews to Reduce Nonresponse Bias to Mail Surveys of Health Plan Members." *Medical Care*. 2002. 40(3): 190−200.
[14] Survey vendors have the option to offer a Spanish, Chinese, Korean, Tagalog, or Vietnamese translation of the MA & PDP CAHPS Survey questionnaires.

For 2022, 1,884 surveys were completed for the MyCare Ohio program, for a response rate of 19.0%. **Table 42** presents the total completed surveys and response rates for the MyCare Ohio program and each MCOP.

Table 42: MCOP CAHPS Completed Surveys and Response Rates, MY 2021

Program/MyCare Ohio Plan	Total Completed Surveys	Total Response Rate
MyCare Ohio	1,884	19.0%
Aetna	332	21.0%
Buckeye	155	15.0%
CareSource	400	20.2%
Molina	146	18.4%
UnitedHealthcare	851	18.9%

MA & PDP: Medicare Advantage and Prescription Drug Plan; CAHPS: Consumer Assessment of Healthcare Providers and Systems.

In order to assess the overall performance of the MyCare Ohio program and each MCOP, IPRO calculated the linear means for the five global ratings (Rating of Health Plan, Rating of Health Care Quality, Rating of Drug Plan, Rating of Personal Doctor, and Rating of Specialist), six composite measures (Getting Needed Care, Getting Appointments and Care Quickly, Doctors Who Communicate Well, Customer Service, Getting Needed Prescription Drugs, and Care Coordination), and two other measures (Annual Flu Vaccine and Pneumonia Vaccine) using CMS's scoring methodology. IPRO compared the MCOPs' and MyCare Ohio program's overall mean scores to national Medicare-Medicaid Plan (MMP) percentiles from NCQA's 2022 *Quality Compass* national percentiles.[15]National MMP benchmarks provided by CMS were used for this analysis. The national MMP benchmarks were produced using a subset of all MMPs (n = 38); therefore, caution should be exercised when interpreting these results.

Based on this comparison, ratings of one star (★) to five star (★★★★★) were assigned for each CAHPS global rating, composite measure, and other measure, relative to national benchmarks, where one is the lowest possible rating (i.e., Poor) and five is the highest possible rating (i.e., Excellent), as shown in **Table 43**.[16]

Table 43: MCOP CAHPS Star Ratings, MY 2021

Stars	Percentiles
★ Poor	Below the 25th percentile
★★ Fair	At or between the 25th and 49th percentiles
★★★ Good	At or between the 50th and 74th percentiles
★★★★ Very Good	At or between the 75th and 89th percentiles
★★★★★ Excellent	At or above the 90th percentile

MCOP: MyCare Ohio plan; CAHPS: Consumer Assessment of Healthcare Providers and Systems; MY: measurement year.

[15] National Committee for Quality Assurance. *Quality Compass 2022*. Washington, DC: NCQA, 2022.

[16] IPRO used a different methodology to determine star ratings than is specified in the *MA & PDP Quality Assurance Protocols & Technical Specifications, V12.0*.

Conclusion and Comparative Findings

Managed Care Program - Adults

The Ohio MMC program demonstrated above average performance at the national level on all nine of the global ratings, composite measures, and individual item measure. The program's performance compared to the previous year were largely unchanged, with none of the differences between measures in MY 2022 and MY 2021 being statistically significant. The statewide comparisons analysis for the global ratings, composite measures, and individual item for the adult population revealed no statistically significant differences between any MCO's score when compared to the program average.

Table 44 provides the calculated scores for each MCO, as well as the program and the statewide comparisons findings for the adult population for MY 2021 and MY 2022.

Table 45 displays the scores for each measure. The stars represent overall adult member ratings when the scores were compared to NCQA's 2022 *Quality Compass* national percentiles. Although NCQA requires a minimum of 100 responses on each item to report the item as a CAHPS/HEDIS result, all MCOs' results are reported for each item in this report, regardless of the number of responses, to provide more information regarding MCO performance. Measures with fewer than 100 responses are noted with an asterisk (*).

Table 44: MCO Adult CAHPS Scores Compared to Previous Year, MY 2021 and MY 2022

Measure	Year	National Medicaid (%)	Ohio Medicaid (%)	Buckeye (%)	CareSource (%)	Molina (%)	Paramount (%)	UHC (%)
Global Ratings								
Rating of Health Plan	MY 2021	78.0	81.5	81.7	80.9	82.7	79.9	82.5
	MY 2022	77.7	78.1	76.7	80.6	81.8	69.6	80.1
Rating of All Health Care	MY 2021	75.4	75.9	77.0	73.4	79.2	77.7	72.7
	MY 2022	74.6	74.8	74.5	76.7	77.2	73.3	71.0
Rating of Personal Doctor	MY 2021	82.4	83.5	87.7	82.2	85.6	79.9	79.9
	MY 2022	82.4	83.6	85.1	87.2	82.3	81.2	80.9
Rating of Specialist Seen Most Often	MY 2021	83.5	83.3	79.9	86.7	81.2	84.2*	85.9*
	MY 2022	81.4	83.6	77.8*	86.6	88.6*	75.0*	85.7*
Composite Measures								
Getting Needed Care	MY 2021	81.9	85.4	82.2	85.3	86.1	87.1	88.5
	MY 2022	81.0	85.0	85.3	85.2	86.8	87.2	80.5
Getting Care Quickly	MY 2021	80.2	83.8	84.4	83.8	82.6	86.3	80.5
	MY 2022	80.4	84.4	89.2	83.9	84.6	81.9	83.8
How Well Doctors Communicate	MY 2021	92.5	93.1	92.9	94.5	92.7	93.8	91.1 ▼
	MY 2022	92.5	93.8	92.2	95.5	94.0	93.3	92.7
Customer Service	MY 2021	88.9	91.3	90.4	91.9	91.2	96.3	88.8
	MY 2022	89.2	91.3	90.8*	91.7	91.5	90.4	91.7
Individual Item Measure								
Coordination of Care	MY 2021	84.0	87.5	82.1	93.3	88.8*	88.1*	83.6*
	MY 2022	84.6	89.5	87.7*	88.6	91.7*	90.5*	89.0*

↑ Indicates the score for the plan is significantly higher than the Ohio Medicaid score for MY 2022.
↓ Indicates the score for the plan is significantly lower than the Ohio Medicaid score for MY 2022.
▲ Indicates the population's score for MY 2022 is significantly higher than the score for MY 2021.
▼ Indicates the population's score for MY 2022 is significantly lower than the score for MY 2021.
* Caution should be exercised when interpreting these results since scores were based on fewer than 100 respondents.

CAHPS: Consumer Assessment of Healthcare Providers and Systems; MY: measurement year; UHC: UnitedHealthcare Community Plan.

Table 45: MCO Adult CAHPS Scores Compared to Quality Compass National Percentiles, MY 2022

Measure	Ohio Medicaid (%)	Buckeye (%)	CareSource (%)	Molina (%)	Paramount (%)	UHC (%)
Global Ratings						
Rating of Health Plan	★★★ 78.1	★★ 76.7	★★★ 80.6	★★★★ 81.8	★ 69.6	★★★ 80.1
Rating of All Health Care	★★ 74.8	★★ 74.5	★★★ 76.7	★★★ 77.2	★★ 73.3	★ 71.0
Rating of Personal Doctor	★★★ 83.6	★★★★ 85.1	★★★★★ 87.2	★★ 82.3	★★ 81.2	★★ 80.9
Rating of Specialist Seen Most Often	★★★ 83.6	★ 77.8*	★★★★ 86.6	★★★★★ 88.6*	★ 75.0*	★★★★ 85.7*
Composite Measures						
Getting Needed Care	★★★★ 85.0	★★★★ 85.3	★★★★ 85.2	★★★★★ 86.8	★★★★★ 87.2	★★ 80.4
Getting Care Quickly	★★★ 84.4	★★★★★ 89.1	★★★ 83.8	★★★ 84.6	★★★ 81.9	★★★ 83.8
How Well Doctors Communicate	★★★ 93.8	★★ 92.2	★★★★★ 95.5	★★★ 94.0	★★★ 93.3	★★ 92.7
Customer Service	★★★★ 91.3	★★★ 90.8*	★★★★ 91.7	★★★★ 91.5	★★★ 90.4	★★★★ 91.7
Individual Item Measure						
Coordination of Care	★★★★★ 89.5	★★★★ 87.7*	★★★★ 88.6	★★★★★ 91.7*	★★★★★ 90.5*	★★★★★ 89.0*
Star assignments based on percentiles						
★★★★★ 90th or above	★★★★ 75th–89th	★★★ 50th–74th	★★ 25th–49th	★ Below 25th		

* Caution should be exercised when interpreting these results since scores were based on fewer than 100 respondents.
CAHPS: Consumer Assessment of Healthcare Providers and Systems; MY: measurement year; UHC: UnitedHealthcare Community Plan.

Managed Care Program – General Child Population

The Ohio Medicaid program demonstrated above average performance at the national level on six of the nine global ratings, composite measures, and individual item measures for which national data were available. The program's performance declined from the previous year on most of the measures (six of nine measures). However, none of the differences between measures in MY 2022 and MY 2021 are statistically significant.

The statewide comparisons analysis for the global ratings, composite measures, and individual item measure for the general child population revealed no statistically significant differences between any MCO's score when compared to the program average. The global ratings, composite measures, and individual item measure for the general child population did not show statistically significant differences between the MCOs' scores in MY 2022 and scores in MY 2021.

Table 46 provides the calculated scores for each MCO, as well as the program and the statewide comparisons findings for the general child population for MY 2022 and MY 2021.

Table 47 displays the scores for each measure. The stars represent overall child member ratings when the scores were compared to NCQA's 2022 *Quality Compass* national percentiles. Although NCQA requires a minimum of 100 responses

on each item to report the item as a CAHPS/HEDIS result, all MCOs' results are reported for each item in this report, regardless of the number of responses, to provide more information regarding MCO performance. Measures with fewer than 100 responses are noted with an asterisk (*).

Table 46: MCO Child CAHPS Scores Compared to Previous Year, MY 2021 and MY 2022

Measure	Year	National Medicaid (%)	Ohio Medicaid (%)	Buckeye (%)	CareSource (%)	Molina (%)	Paramount (%)	UHC (%)
Global Ratings								
Rating of Health Plan	MY 2021	83.6	84.7	85.8	84.2	85.2	85.4	82.0
	MY 2022	82.7	81.8	86.7	86.0	83.0	70.7	81.7
Rating of All Health Care	MY 2021	85.7	87.9	87.2	86.7	88.4	88.6	89.9
	MY 2022	83.3	85.4	85.3	88.9	86.8	79.9	83.2
Rating of Personal Doctor	MY 2021	89.3	90.2	89.8	90.1	89.5	93.0	90.2
	MY 2022	88.0	89.0	89.1	90.01	90.9	84.6	89.0
Rating of Specialist Seen Most Often	MY 2021	87.3	88.0	89.0	86.9	88.2	84.1*	91.4*
	MY 2022	86.4	84.8	89.7*	85.5	85.5	80.2	82.4*
Composite Measures								
Getting Needed Care	MY 2021	86.9	87.8	85.2	86.7	87.3	92.0	91.9
	MY 2022	84.6	87.0	86.8	89.6	85.6	87.6	84.2
Getting Care Quickly	MY 2021	90.2	89.9	89.4	89.7	88.5	90.5	93.7
	MY 2022	89.2	90.3	90.4	91.6	89.7	89.5	90.4
How Well Doctors Communicate	MY 2021	94.8	94.6	94.2	94.6	94.3	96.1	94.6
	MY 2022	93.5	95.3	94.0	94.1	97.3	94.6	94.8
Customer Service	MY 2021	NA	87.5	88.5	86.4	85.2	91.3	89.3*
	MY 2022	89.6	85.4	87.0	85.5	95.4	81.7	89.3
Individual Item Measure								
Coordination of Care	MY 2021	84.7	85.8	85.1	84.3	87.6	86.8*	84.9*
	MY 2022	83.6	85.8	81.6*	85.4	90.4	82.5	84.3*

↑ Indicates the score for the plan is significantly higher than the Ohio Medicaid score for MY 2022.
↓ Indicates the score for the plan is significantly lower than the Ohio Medicaid score for MY 2022.
▲ Indicates the population's score for MY 2022 is significantly higher than the score for MY 2021.
▼ Indicates the population's score for MY 2022 is significantly lower than the score for MY 2021.
* Caution should be exercised when interpreting these results since scores were based on fewer than 100 respondents.
NA: not available; CAHPS: Consumer Assessment of Healthcare Providers and Systems; MY: measurement year; UHC: UnitedHealthcare Community Plan.

Table 47: MCO Child CAHPS Scores Compared to Quality Compass National Percentiles, MY 2022

Measure	Ohio Medicaid (%)	Buckeye (%)	CareSource (%)	Molina (%)	Paramount (%)	UHC (%)
Global Ratings						
Rating of Health Plan	★ 82.0	★★★★ 90.4	★★ 84.7	★ 83.1	★ 71.1	★ 77.1
Rating of All Health Care	★★★ 86.8	★★★★ 89.9*	★★★ 88.0	★★★ 87.0	★ 84.0	★ 81.9*
Rating of Personal Doctor	★★ 89.5	★★ 88.4	★★★ 90.0	★★★★ 91.5	★ 85.8	★ 86.2*

Measure	Ohio Medicaid (%)	Buckeye (%)	CareSource (%)	Molina (%)	Paramount (%)	UHC (%)
Rating of Specialist Seen Most Often	★★ 85.5	★★★ 87.2*	★★ 84.8*	★★ 84.4	★★★★★ 94.0*	★ 71.4*
Composite Measures						
Getting Needed Care	★★★★ 86.5	★★★★ 89.1*	★★★★ 88.6	★★★ 84.3	★★★★ 88.9*	★ 79.2*
Getting Care Quickly	★★★★ 90.1	★★★★ 89.8*	★★★★★ 90.9	★★★ 89.0	★★★ 89.2*	★★★★★ 94.6*
How Well Doctors Communicate	★★★ 95.1	★★★ 94.1*	★★ 92.3	★★★★★ 97.2	★★★ 95.2	★★★ 95.0*
Customer Service	★ 83.8	★ 85.1*	★ 80.6*	★ 83.9	★ 83.9*	★★★★ 90.5*
Individual Item Measure						
Coordination of Care	★★★ 86.6	★ 79.5*	★★★ 86.8	★★★★★ 91.1	★★ 83.0*	★ 78.6*
Star assignments based on percentiles						
★★★★★ 90th or above	★★★★ 75th–89th	★★★ 50th–74th	★★ 25th–49th	★ Below 25th		

* Caution should be exercised when interpreting these results since scores were based on fewer than 100 respondents.
CAHPS: Consumer Assessment of Healthcare Providers and Systems; MY: measurement year; UHC: UnitedHealthcare Community Plan.

Managed Care Program - Children With Chronic Conditions Population

Table 48 provides the calculated scores for the CCC and non-CCC populations for the four global ratings, four composite measures, and individual item measure. The CCC population reported higher levels of satisfaction with plans and care than the non-CCC population on three out of nine measures. None of the differences were statistically significant. The CCC population's scores did not statistically significantly differ from MY 2021 to MY 2022 for any measures (data not shown).

Table 48: MCO CCC and Non-CCC CAHPS Scores, MY 2022

Measure	CCC Population (%)	Non-CCC Population (%)
Global Ratings		
Rating of Health Plan	79.4	84.0
Rating of All Health Care	82.8	88.7
Rating of Personal Doctor	88.7	89.3
Rating of Specialist Seen Most Often	84.1	86.8
Composite Measures		
Getting Needed Care	87.4	85.5
Getting Care Quickly	90.5	90.2
How Well Doctors Communicate	95.1	95.5
Customer Service	85.8	84.8
Individual Item Measure		
Coordination of Care	85.1	87.2

MyCare Ohio

The MyCare Ohio program demonstrated above average performance at the national level on 10 of 13 measures. The MyCare Ohio program's performance declined from the previous year on most of the measures (9 of 13 measures).

The statewide comparisons analysis for the global ratings, composite measures, and other measures revealed one MCOP score that was statistically significantly lower than the program average and five MCOP scores that were statistically significantly higher than the program average.

The trend analysis revealed five statistically significantly lower scores in MY 2021 than in MY 2020. None of the MCOPs had statistically significantly higher scores in MY 2021 than in MY 2020.

Table 49 presents the calculated mean scores for each MCOP and the program and the statewide comparisons findings for MY 2020 and MY 2021. MMP national averages are also included for comparative purposes.

Table 50 provides highlights of the national comparison findings for the MyCare Ohio program and each MCOP. The numbers in the table represent the linear mean score for each measure, while the stars represent overall member ratings when the linear mean scores were compared to national MMP percentiles.

Table 49: MCOP CAHPS Scores Compared to MyCare Ohio Program and National MMP, MY 2020 and MY 2021

Measure	MY	National MMP (%)	MyCare Ohio (%)	Aetna (%)	Buckeye (%)	CareSource (%)	Molina (%)	UHC (%)
Global Ratings								
Rating of Health Plan	2020	87.6	88.5	86.5	88.8	91.2	87.3	88.2
	2021	86.3	88.1	86.7	↓ 83.5 ▼	↑ 90.2	89.4	88.1
Rating of Health Care Quality	2020	86.9	84.9	85.0	84.1	85.1	84.7	85.0
	2021	85.0	84.8	82.7	82.6	↑ 86.7	86.2	84.7
Rating of Drug Plan	2020	87.6	90.3	88.8	91.6	90.9	91.1	90.2
	2021	86.9	89.0 ▼	89.2	84.7	90.2	89.7	89.0
Rating of Personal Doctor	2020	91.0	90.5	89.9	91.0	90.4	90.9	90.4
	2021	90.2	90.5	90.3	87.9	91.1	90.2	90.7
Rating of Specialist	2020	89.9	89.6	87.8	88.5	87.9	89.2	91.5
	2021	89.3	88.3	87.4	88.8	89.6	88.2	87.7 ▼
Composite Measures								
Getting Needed Care	2020	81.1	80.7	82.5	81.8	79.4	80.0	80.4
	2021	79.5	80.9	79.8	79.6	82.4	81.9	80.5
Getting Appointments and Care Quickly	2020	76.7	77.1	76.4	78.9	76.1	74.8	77.8
	2021	76.0	77.2	78.4	75.4	77.4	79.0	76.8
Doctors Who Communicate Well	2020	90.6	89.6	89.1	90.9	89.1	90.0	89.6
	2021	90.6	90.8	91.9	88.5	90.5	89.7	90.8
Customer Service	2020	89.5	89.8	89.0	89.2	91.2	89.8	89.7
	2021	89.5	89.7	88.4	89.1	↑ 91.7	89.2	89.4
Getting Needed Prescription Drugs	2020	90.4	90.9	88.3	93.2	90.6	91.2	91.5
	2021	89.3	90.2	88.3	88.6	↑ 91.5	88.6	90.5
Care Coordination	2020	84.7	85.1	84.4	86.0	83.6	85.6	85.5
	2021	84.0	84.5 ▼	85.2	81.7	85.2	84.8	84.2
Other Measures – Percent Who Responded Yes								
Annual Flu Vaccine	2020	67.2	64.9	66.2	67.4	61.9	64.7	65.1
	2021	68.9	64.7	66.2	63.9	62.0	63.8	65.7
Pneumonia Vaccine	2020	55.2	60.4	59.2	58.0	63.8	62.7	59.8
	2021	56.2	58.7	↑ 63.6	50.8	55.2 ▼	54.8	60.6

↑ Indicates the score for the plan is significantly higher than the MyCare Ohio score for 2021.

Measure	MY	National MMP (%)	MyCare Ohio (%)	Aetna (%)	Buckeye (%)	CareSource (%)	Molina (%)	UHC (%)

↓ Indicates the score for the plan is significantly lower than the MyCare Ohio score for 2021.
▲ Indicates the population's score for 2022 is significantly higher than the score for 2020.
▼ Indicates the population's score for 2022 is significantly lower than the score for 2020.
MMP: Medicare-Medicaid Plan; UHC: UnitedHealthcare Community Plan.

Table 50: MCOP CAHPS Scores Compared to National MMP Benchmarks, MY 2021

Measure	MyCare Ohio (%)	Aetna (%)	Buckeye (%)	CareSource (%)	Molina (%)	UHC (%)
Global Ratings						
Rating of Health Plan	★★★	★★★	★	★★★★★	★★★★	★★★
	88.1	86.7	83.5	90.2	89.4	88.1
Rating of Health Care Quality	★★★	★	★	★★★	★★★	★★
	84.8	82.7	82.6	86.7	86.2	84.7
Rating of Drug Plan	★★★★	★★★★	★	★★★★★	★★★★★	★★★★
	89.0	89.2	84.7	90.2	89.7	89.0
Rating of Personal Doctor	★★	★★	★	★★	★★	★★
	90.5	90.3	87.9	91.1	90.2	90.7
Rating of Specialist	★	★	★	★★	★	★
	88.3	87.4	88.8	89.6	88.2	87.7
Composite Measures						
Getting Needed Care	★★★	★★★	★★★	★★★★	★★★	★★★
	80.9	79.8	79.6	82.4	81.9	80.5
Getting Appointments and Care Quickly	★★★	★★★	★★	★★★	★★★★	★★★
	77.2	78.4	75.4	77.4	79.0	76.8
Doctors Who Communicate Well	★★	★★	★	★★	★	★★
	90.8	91.9	88.5	90.5	89.7	90.8
Customer Service	★★	★★	★★	★★★★	★★	★★
	89.7	88.4	89.1	91.7	89.2	89.4
Getting Needed Prescription Drugs	★★★	★★	★★	★★★★	★★	★★★
	90.2	88.3	88.6	91.5	88.6	90.5
Care Coordination	★★	★★★	★	★★★	★★	★★
	84.5	85.2	81.7	85.2	84.8	84.2
Other Measures – Percent Who Responded Yes						
Annual Flu Vaccine	★★	★★	★★	★	★	★★
	64.7	66.2	63.9	62.0	63.8	65.7
Pneumonia Vaccine	★★★	★★★★	★	★★	★★	★★★
	58.7	63.6	50.8	55.2	54.8	60.6

Star assignments based on percentiles

★★★★★	★★★★	★★★	★★	★
90th or above	75th–89th	50th–74th	25th–49th	Below 25th

MMP: Medicare-Medicaid Plan; UHC: UnitedHealthcare Community Plan.

VIII. Encounter Data Validation

Objectives

CMS encourages states to implement the voluntary EDV protocol due to the need for valid and reliable encounter data as part of state QI efforts, including programs tying payments to quality. Encounter data that are accurate and reliable support agencies in driving healthcare improvements that can positively affect the total Medicaid population and particularly members with high-risk health concerns.

EDV in Ohio is an ongoing process involving the MCEs, ODM's encounter data unit, and IPRO. EDV activities identify incomplete data, perform missing-data quality checks, and assess the frequency and impact of late encounter data submissions. The SFY 2023 EDV study compared MCO, MCOP, and OhioRISE dental, pharmacy, inpatient, and professional encounter data to the data housed in IPRO's DW that originated from the Ohio MITS and were received from Gainwell. In SFY 2023, the first SPBM study was launched to compare data from the SPBM to the data in IPRO's DW.

Technical Methods of Data Collection and Analysis

ODM collects encounter data from all MCEs, including all paid (original, corrected, and adjusted) encounter data and some partial paid or denied encounter data, and houses it in MITS. IPRO receives monthly data extracts of these encounter submissions to fulfill various projects and reporting needs and loads them into and maintains the data in a DW.

As in past years, this year's EDV studies used the following methodology:

- The MCEs submitted all data elements by claim type obtained from their adjudicated source claims that corresponded to the period specified by IPRO. To verify the source claims data, IPRO requested the MCEs include the internal control number (ICN), if available, obtained by the MCE when the encounter was submitted to MITS.
- IPRO imported the files into SAS® and stored the different encounter types separately.
- IPRO compared each data element in the source data to the encounter data received by ODM and Gainwell.
- IPRO identified the discrepancies by comparing the source data for each data element. IPRO identified differences between the data element values from the source data and the data element values included in IPRO's DW. Discrepancies were identified by data element.
- Data elements with less than a 90% match rate were reviewed. IPRO reviewed discrepancies and categorized them for each encounter type.
- IPRO selected a sample of 1,000 records for each encounter type and data element discrepancy category identified for each MCE. IPRO provided percentages of all discrepancies by discrepancy category to ODM and the MCEs.
- Following interviews with the MCOs/MCOPs, IPRO generated a separate report for each MCE on the omission, surplus, and discrepant data element findings of all variances found by encounter data type.

IPRO requested that the MCOs, MCOPs, and OhioRISE provide all encounters with dates of service from January 1 to September 30, 2022, and submitted to the state between January 1, 2022, and October 31, 2022. The SPBM timeframe was October 1, 2022, to December 31, 2022. The MCEs were requested to select all claims adjudicated by their vendors; the claims provided to IPRO included encounter submissions including all paid (original, corrected, adjusted/voided, and paid at $0) encounter data and partial payments denied at the line level and paid at the header level. IPRO provided the MCEs documentation identifying the logic to be utilized in the identification of the claims to be selected. The MCEs submitted the claims by claim type to IPRO. IPRO provided the MCEs the identifying data elements that IPRO used to compare to the claims IPRO receives and stores on the monthly vendor extracts. IPRO reviewed discrepant records.

Conclusions and Comparative Findings

MCO, MCOP, and OhioRISE

Based upon IPRO's review of the EDV study file values for the sampled records, identification and research of the discrepant values, review of the discrepant reason codes received from the MCEs, and discussions with the MCEs and

ODM during and following the teleconferences, there are no major encounter data issues. However, there are areas that require further research by encounter type by the MCO/MCOPs, as well as by ODM and IPRO.

Based on IPRO's discussion with ODM, data fields that were not validated for the fiscal year (FY) 2023 EDV study will be re-evaluated in future studies based on the new Medicaid Management Information System (MMIS).

Data elements highlighted in yellow in **Table 51** through **Table 60** were identified as plan reporting issues; for example, the claims files submitted to IPRO for this study contained missing, erroneous, or unexpected data for the fields requested. These claims files did not need to be resubmitted; however, they were flagged to indicate the error. Data elements with gray shading were actual discrepancies between data sources.

Professional Claims

Most of the issues were related to the extraction of data for this EDV study. For future studies, the RENDERING_PROV_NPI data field will be re-evaluated with the new MMIS. As an ODM requirement, the rendering provider NPI is not submitted when it matches the billing provider NPI.

Institutional Inpatient Claims

The majority of issues for this EDV study related to the extraction of data. Three MCEs had encounter data issues with a total of three elements affected. For the DRG data field, the DW has a leading zero in value and first three digits. For the REFERRING_PROV_NPI data field, if the operating and attending provider are the same, the information in the DW includes the attending provider NPI. For future studies, the REFERRING_PROV_NPI data field will be re-evaluated with the new MMIS.

Institutional Outpatient Claims

The majority of issues were related to the extraction of data for this EDV study. For the REFERRING_PROV_NPI data field, if the operating and attending provider are the same, information in the DW includes the attending provider NPI. For future studies, the REFERRING_PROV_NPI data field will be re-evaluated with the new MMIS.

Dental Claims

Two MCEs had encounter data issues with a total of two elements affected. For future studies, the RENDERING_PROV_NPI data field will be re-evaluated with the new MMIS. As an ODM requirement, the rendering provider NPI is not submitted when it matches the billing provider NPI.

Pharmacy Claims

Only data extraction issues were noted for this claim type.

Challenges Specific to Individual MCEs

Aetna MyCare

Professional

Aetna MyCare only had an EDV reporting study data extraction issue with the PAY_ARR_DTL data field.

Institutional Inpatient

Aetna had several data elements that were extracted incorrectly for this EDV study. Specifically, the data fields ranging from DIAGCD2 to DIAGCD14, as well as the DRG, DTE_ADMISSION, and PAY_ARR_HDR data fields had EDV reporting study data extraction issues.

Aetna had an encounter data issue with the DRG field. For future studies, for the DRG data field, Aetna must submit the All Patients Refined (APR) DRG field on the 837 extracts.

Institutional Outpatient

Aetna had a data extraction issue for the PAY_ARR_HDR data field.

Buckeye

Professional
Buckeye had an EDV reporting study data extraction issue with the DIAGCD5, NUM_ADJ_ICN, and PLACESVC data fields.

Institutional Inpatient
Buckeye had several data elements that were extracted incorrectly for this EDV study. Specifically, the ADMITTYP, ATTENDING_PROV_NPI, DIAGCD5, DTE_LAST_SVC_HDR, NUM_ADJ_ICN, PAY_ARR_HDR, SURG1, SURG2, and UNITS_BILLED data fields had EDV reporting study data extraction issues. Buckeye had an encounter data issue for the DIS_STAT data field. Buckeye reviewed the claim examples and advised that, for claims deemed outpatient, a discharge status code "01" was submitted to ODM on the 837I file instead of a "30," which was displayed on the claims screen.

Institutional Outpatient
Buckeye had an EDV reporting study data extraction issue with the ADMITTYP, ATTENDING_PROV_NPI, DIAGCD5, and NUM_ADJ_ICN data fields.

CareSource

Professional
CareSource had a data extraction issue for the AMT_PAID_MCO_DTL data field in this EDV study.

Institutional Inpatient
CareSource had several data elements that were extracted incorrectly for this EDV study, specifically PAY_ARR_HDR, TYPEBILL, and TCN. The DTE_LAST_SVC_DTL field was initially considered discrepant, but after further discussion with ODM, it is not required in the 837 submission and will be removed from future studies.

Dental
CareSource had several data elements that were extracted incorrectly for this EDV study. CareSource had an EDV reporting study data extraction issue with the NUM_ADJ_ICN, PAY_ARR_DTL, PAY_ARR_HDR, and TCN data fields.

Pharmacy
CareSource had several data elements that were extracted incorrectly for this EDV study. CareSource had an EDV reporting study data extraction issue with the DTE_FIRST_SVC_DTL, DTE_FIRST_SVC_HDR, and TCN data fields.

Molina

Institutional Inpatient
Molina had several data elements that were extracted incorrectly for this EDV study. Specifically, the data fields ranging from DIAGCD14 to DIAGCD25 had EDV reporting study data extraction issues.

Institutional Outpatient
Molina had an EDV reporting study data extraction issue with data elements ranging from DIAGCD14 to DIAGCD17.

Paramount

Institutional Inpatient
Paramount had an EDV reporting study data extraction issue with the PAID_DATE_DTL data field and with data fields ranging from SURGDTE1 to SURGDTE5.

Institutional Outpatient
Paramount had several data elements that were extracted incorrectly for this EDV study. Specifically, the CDE_NDC, DTE_FIRST_SVC_DTL, DTE_LAST_SVC_DTL, and PAID_DATE_DTL data fields had EDV reporting study data extraction issues.

Dental

Paramount had several data elements that were extracted incorrectly for this EDV study. Specifically, the PAID_DATE_HDR, PAY_ARR_DTL, PAY_ARR_HDR, and PLACESVC data fields had EDV reporting study data extraction issues. Paramount had an encounter data issue for TOOTHNUMBER. Paramount did not submit TOOTHNUMBER on the 837D extract; the DW had no value for this data element.

UnitedHealthcare

Institutional Inpatient

UnitedHealthcare had an encounter data issue with the Modifier3 data field. Modifier3 was not submitted, and this issue has been addressed for the Post-Adjudicated Claims Data Reporting (PACDR) submissions. UnitedHealthcare has applied this fix to systems as of 2/1/2023. This data field should be correct for future studies.

Dental

UnitedHealthcare had an encounter data issue with the PLACESVC data field. Place of service (POS) codes 31 and 32 when submitted as they appear on the claim were defaulting the value to POS of 11. As per UnitedHealthcare's response, the PACDR submission format went live on 2/1/2023 and should be correct for future studies.

Table 51: Aggregate Medicaid Professional Data Element Discrepancies and Findings by MCO/OhioRISE

Field Name	Aetna OhioRISE % Match	Buckeye Medicaid % Match	CareSource Medicaid % Match	Molina Medicaid % Match	Paramount Medicaid % Match	UHC Medicaid % Match
AMT_PAID_MCO_DTL	100	97.74	99.70	99.00	77.05	99.36
AMT_PAID_MCO_HDR	NV	NV	NV	NV	NV	NV
AMT_TPL_SUBM_DTL	99.79	98.71	98.70	98.59	98.71	99.34
BILLING_PROV_ID	NV	NV	NV	NV	NV	NV
BILLING_PROV_NPI	97.46	99.19	97.93	98.68	99.38	98.45
DIAGCD1	100	99.75	99.98	100	99.91	100
DIAGCD2	100	99.75	99.99	100	99.92	100
DIAGCD3	100	99.92	99.99	100	99.94	100
DIAGCD4	100	99.97	99.99	100	99.96	100
DIAGCD5	100	74.00	100	100	99.97	100
DIAGCD6	100	100	100	100	99.98	100
DIAGCD7	100	100	100	100	99.99	100
DIAGCD8	100	100	100	100	99.99	100
DIAGCD9	100	100	100	100	99.99	100
DIAGCD10	100	100	100	100	100	100
DIAGCD11	100	100	100	100	100	98.18
DIAGCD12	100	100	100	100	100	98.18
DTE_FIRST_SVC_DTL	100	100	99.96	100	97.87	100
DTE_LAST_SVC_DTL	99.37	99.71	99.63	100	97.68	99.72
ICN	100	100	100	100	100	100
LINE_NUMBER	100	100	100	100	100	100
MODIFIER1	100	99.97	99.94	100	90.69	100
MODIFIER2	100	99.71	99.97	100	97.81	100
MODIFIER3	100	99.98	100	100	99.81	100
MODIFIER4	100	100	100	100	100	100
NDC_Code	100	100	99.98	100	97.12	100
NUM_ADJ_ICN	100	97.76	99.98	100	98.81	99.92
NUM_CMS_ICN	NV	NV	NV	NV	NV	NV
NUM_HIC_SUB	NV	NV	NV	NV	NV	NV

Field Name	Aetna OhioRISE % Match	Buckeye Medicaid % Match	CareSource Medicaid % Match	Molina Medicaid % Match	Paramount Medicaid % Match	UHC Medicaid % Match
PAIDDATE_HDR	100	96.58	99.88	98.36	95.46	99.23
PAID_DATE_DTL	100	96.39	99.88	98.36	95.46	99.23
PAY_ARR_DTL	97.96	99.97	100	97.89	94.58	100
PAY_ARR_HDR	93.05	95.41	100	97.86	94.52	100
PLACESVC	100	2.90	99.78	99.88	99.99	99.81
PROCCODE1	100	100	99.78	100	70.23	100
QTY_UNITS_BILLED	99.93	94.61	99.96	0	96.45	100
RECIP_ID	96.75	99.85	99.98	100	99.99	100
REFERRING_PROV_ID	NV	NV	NV	NV	NV	NV
REFERRING_PROV_NPI	100	99.09	99.48	97.90	94.78	99.35
RENDERING_PROV_ID	NV	NV	NV	NV	NV	NV
RENDERING_PROV_NPI	0	11.22	0.28	30.32	11.08	20.46
TCN	100	100	100	100	100	99.92

MCO: managed care plan; OhioRISE: Ohio's Resilience through Integrated Systems and Excellence; UHC: UnitedHealthcare Community Plan; NV: not validated for the study; yellow shading: < 90% match and an MCO/MCOP reporting study data extraction issue; no shading and < 90% match is an IPRO/ODM/vendor data issue.

Table 52: Aggregate MyCare Professional Data Element Discrepancies and Findings

Field Name	Aetna MyCare % Match	Buckeye MyCare % Match	CareSource MyCare % Match	Molina MyCare % Match	UHC MyCare % Match
AMT_PAID_MCO_DTL	100	96.80	65.75	99.30	99.47
AMT_PAID_MCO_HDR	NV	NV	NV	NV	NV
AMT_TPL_SUBM_DTL	100	99.95	94.90	100	99.86
BILLING_PROV_ID	NV	NV	NV	NV	NV
BILLING_PROV_NPI	98.63	98.04	95.32	96.21	96.26
DIAGCD1	100	99.66	99.96	100	100
DIAGCD2	100	99.77	99.98	100	100
DIAGCD3	100	99.91	99.99	100	100
DIAGCD4	100	99.96	99.99	99.99	100
DIAGCD5	100	71.24	99.99	99.99	100
DIAGCD6	100	99.99	100	99.99	100
DIAGCD7	100	99.98	100	99.99	100
DIAGCD8	100	99.99	100	100	100
DIAGCD9	100	99.98	100	100	100
DIAGCD10	100	99.99	100	100	95.79
DIAGCD11	100	99.99	100	100	95.79
DIAGCD12	100	99.99	100	100	95.79
DTE_FIRST_SVC_DTL	100	99.95	99.63	99.90	100
DTE_LAST_SVC_DTL	99.45	99.16	97.85	99.84	99.24
ICN	100	100	100	100	100
LINE_NUMBER	100	100	100	100	100
MODIFIER1	100	99.86	99.95	100	100
MODIFIER2	100	99.69	99.99	100	99.99
MODIFIER3	100	99.96	100	100	99.99
MODIFIER4	100	99.99	100	100	99.99
NDC_Code	100	99.97	99.99	100	100

Field Name	Aetna MyCare % Match	Buckeye MyCare % Match	CareSource MyCare % Match	Molina MyCare % Match	UHC MyCare % Match
NUM_ADJ_ICN	100	77.04	99.91	100	100
NUM_CMS_ICN	NV	NV	NV	NV	NV
NUM_HIC_SUB	0	0	0	0	0
PAIDDATE_HDR	0	96.61	0	98.89	99.29
PAID_DATE_DTL	0	96.01	0	98.89	99.29
PAY_ARR_DTL	54.36	99.52	100	99.85	99.98
PAY_ARR_HDR	98.31	97.66	100	99.80	100
PLACESVC	100	0.31	99.46	99.95	99.20
PROCCODE1	100	99.53	99.86	100	100
QTY_UNITS_BILLED	99.84	97.48	99.88	99.98	100
RECIP_ID	100	99.99	99.99	99.99	100
REFERRING_PROV_ID	NV	NV	NV	NV	NV
REFERRING_PROV_NPI	99.46	98.94	99.40	95.71	99.64
RENDERING_PROV_ID	NV	NV	NV	NV	NV
RENDERING_PROV_NPI	1.54	14.70	60.32	58.95	63.28
TCN	99.46	100	100	100	100

UHC: UnitedHealthcare Community Plan; NV: not validated for the study; yellow shading: < 90% match and an MCO/MCOP reporting study data extraction issue; no shading and < 90% match is an IPRO/ODM/vendor data issue.

Table 53: Aggregate Medicaid Institutional Inpatient Data Element Discrepancies and Findings by MCO/OhioRISE

Field Name	Aetna OhioRISE % Match	Buckeye Medicaid % Match	CareSource Medicaid % Match	Molina Medicaid % Match	Paramount Medicaid % Match	UHC Medicaid % Match
ADMITTYP	100	0	100	100	99.93	100
AMT_CO_PAY_HDR	NV	NV	NV	NV	NV	NV
AMT_MCO_PAID_DTL	74.69	90.56	98.59	91.04	89.58	91.46
AMT_MCO_PAID_HDR	NV	NV	NV	NV	NV	NV
AMT_TPL_SUBM_DTL	99.61	99.77	99.85	100	99.71	99.88
AMT_TPL_SUBM_HDR	NV	NV	NV	NV	NV	NV
ATTENDING_PROV_ID	NV	NV	NV	NV	NV	NV
ATTENDING_PROV_NPI	100	0.02	99.02	99.30	98.89	98.49
BILLING_PROV_ID	NV	NV	NV	NV	NV	NV
BILLING_PROV_NPI	100	97.01	98.37	97.80	94.77	97.30
CDE_NDC	100	100	100	100	99.33	100
DIAGCD1	100	99.96	100	100	99.40	100
DIAGCD2	84.68	99.95	100	100	99.50	100
DIAGCD3	80.06	99.95	100	100	99.35	100
DIAGCD4	78.93	99.94	100	100	99.27	100
DIAGCD5	78.87	7.31	100	100	99.14	100
DIAGCD6	79.56	99.98	100	100	98.96	100
DIAGCD7	79.37	99.90	100	100	98.93	100
DIAGCD8	83.82	99.95	100	100	98.91	100
DIAGCD9	86.74	99.92	100	100	98.84	100
DIAGCD10	72.90	99.97	100	100	98.85	100
DIAGCD11	76.86	99.96	100	100	98.66	100

Field Name	Aetna OhioRISE % Match	Buckeye Medicaid % Match	CareSource Medicaid % Match	Molina Medicaid % Match	Paramount Medicaid % Match	UHC Medicaid % Match
DIAGCD12	80.22	99.97	100	100	98.65	100
DIAGCD13	84.81	99.96	100	100	98.75	100
DIAGCD14	88.17	99.95	100	48.53	98.71	100
DIAGCD15	91.36	99.97	100	52.78	98.57	100
DIAGCD16	93.29	99.95	100	56.66	98.69	100
DIAGCD17	96.81	99.94	100	60.27	98.74	100
DIAGCD18	97.94	99.98	100	63.65	98.76	100
DIAGCD19	98.29	99.96	100	67.07	98.97	100
DIAGCD20	98.35	99.98	100	70.00	98.98	100
DIAGCD21	99.09	99.95	100	72.67	99.00	100
DIAGCD22	99.31	99.95	100	75.07	99.01	100
DIAGCD23	99.50	99.98	100	77.44	99.23	100
DIAGCD24	100	99.94	100	79.73	99.26	100
DIAGCD25	100	99.98	100	89.02	99.24	100
DIS_STAT	100	99.74	100	100	99.87	100
DRG	1.38	4.70	4.17	4.96	1.66	5.18
DTE_ADMISSION	100	99.79	99.38	99.96	99.97	100
DTE_FIRST_SVC_HDR	100	100	99.99	100	99.83	99.83
DTE_LAST_SVC_HDR	100	96.99	99.59	100	99.82	98.75
ICN	100	100	100	100	100	100
IND_HDR_DTL	NV	NV	NV	NV	NV	NV
LINE_NUMBER	100	100	100	100	100	100
MODIFIER1	100	100	100	100	99.98	100
MODIFIER2	100	100	100	100	99.99	99.98
MODIFIER3	100	100	100	100	100	100
MODIFIER4	100	100	100	100	100	100
NUM_ADJ_ICN	100	97.21	99.90	100	93.70	100
NUM_CMS_ICN	NV	NV	NV	NV	NV	NV
NUM_HIC_SUB	NV	NV	NV	NV	NV	NV
OPERATING_PROV_ID	NV	NV	NV	NV	NV	NV
OPERATING_PROV_NPI	100	98.99	99.16	100	92.92	33.83
PAIDDATE_DTL	100	88.07	98.75	95.22	0.01	98.91
PAIDDATE_HDR	100	89.41	98.74	95.22	93.85	98.91
PAY_ARR_HDR	1.71	91.02	99.61	100	99.44	100
PROCCODE	100	99.94	99.51	99.92	99.96	99.88
RCC	100	98.80	99.96	100	67.89	100
RECIP_ID	96.97	99.72	99.93	99.98	99.99	100
REFERRING_PROV_ID	NV	NV	NV	NV	NV	NV
REFERRING_PROV_NPI	0	0.95	0.98	0.70	1.04	1.48
SURG1	100	33.85	99.99	100	99.88	100
SURG2	100	54.64	99.99	100	99.88	100
SURG3	100	99.74	99.99	100	99.91	100
SURG4	100	99.65	100	100	99.92	100
SURG5	100	99.60	100	100	99.90	100
SURG6	100	99.55	100	100	99.93	100
SURG7	100	99.58	100	100	99.96	100
SURGDTE1	100	100	99.99	100	38.19	100

Field Name	Aetna OhioRISE % Match	Buckeye Medicaid % Match	CareSource Medicaid % Match	Molina Medicaid % Match	Paramount Medicaid % Match	UHC Medicaid % Match
SURGDTE2	100	99.85	99.99	100	59.26	100
SURGDTE3	100	99.84	99.99	100	72.87	100
SURGDTE4	100	99.77	100	100	82.67	100
SURGDTE5	100	99.75	100	100	88.92	100
SURGDTE6	100	99.66	100	100	92.36	100
SURGDTE7	100	99.70	100	100	94.91	100
TCN	100	100	100	100	100	90.36
TYPEBILL	97.99	100	100	100	99.99	100
UNITS_BILLED	100	9.03	99.97	100	73.84	100

MCO: managed care plan; OhioRISE: Ohio's Resilience through Integrated Systems and Excellence; UHC: UnitedHealthcare Community Plan; NV: not validated for the study; yellow shading: < 90% match and an MCO/MCOP reporting study data extraction issue; no shading and < 90% match is an IPRO/ODM/vendor data issue.

Table 54: Aggregate MyCare Institutional Data Element Discrepancies and Findings

Field Name	Aetna MyCare % Match	Buckeye MyCare % Match	CareSource MyCare % Match	Molina MyCare % Match	UHC MyCare % Match
ADMITTYP	100	0	100	100	100
AMT_CO_PAY_HDR	NV	NV	NV	NV	NV
AMT_MCO_PAID_DTL	99.49	93.24	80.07	98.27	98.44
AMT_MCO_PAID_HDR	NV	NV	NV	NV	NV
AMT_TPL_SUBM_DTL	100	99.91	92.54	100	99.99
AMT_TPL_SUBM_HDR	NV	NV	NV	NV	NV
ATTENDING_PROV_ID	NV	NV	NV	NV	NV
ATTENDING_PROV_NPI	99.65	0.08	99.40	99.43	99.59
BILLING_PROV_ID	NV	NV	NV	NV	NV
BILLING_PROV_NPI	99.35	97.92	98.59	98.29	99.56
CDE_NDC	100	100	100	100	100
DIAGCD1	100	99.62	100	100	100
DIAGCD2	97.55	99.72	100	100	100
DIAGCD3	96.58	99.74	100	100	100
DIAGCD4	97.02	99.82	100	100	100
DIAGCD5	97.36	24.87	100	100	100
DIAGCD6	97.72	99.87	100	100	100
DIAGCD7	97.88	99.93	100	100	100
DIAGCD8	98.02	99.90	100	100	100
DIAGCD9	98.03	99.90	100	100	100
DIAGCD10	88.81	99.90	100	100	100
DIAGCD11	89.04	99.94	100	100	100
DIAGCD12	89.21	99.93	100	100	100
DIAGCD13	89.42	99.94	100	100	100
DIAGCD14	89.73	99.97	100	59.50	100
DIAGCD15	90.07	99.94	100	61.07	100
DIAGCD16	90.46	99.95	100	62.72	100
DIAGCD17	90.85	99.96	100	64.55	100
DIAGCD18	91.22	99.97	100	66.44	100
DIAGCD19	91.62	99.97	100	68.60	100

Field Name	Aetna MyCare % Match	Buckeye MyCare % Match	CareSource MyCare % Match	Molina MyCare % Match	UHC MyCare % Match
DIAGCD20	97.55	99.98	100	70.55	100
DIAGCD21	92.09	99.93	100	72.49	100
DIAGCD22	92.51	99.97	100	74.58	100
DIAGCD23	92.97	99.99	100	76.55	100
DIAGCD24	93.45	99.97	100	78.58	100
DIAGCD25	93.95	99.99	100	88.55	100
DIS_STAT	100	46.70	100	100	100
DRG	84.97	69.22	61.22	64.86	79.84
DTE_ADMISSION	61.96	44.64	93.11	98.29	100
DTE_FIRST_SVC_HDR	100	99.78	99.72	100	98.41
DTE_LAST_SVC_HDR	100	88.29	91.81	100	96.98
ICN	100	100	100	100	100
IND_HDR_DTL	NV	NV	NV	NV	NV
LINE_NUMBER	100	100	100	100	100
MODIFIER1	100	99.02	100	100	100
MODIFIER2	100	97.47	100	100	53.89
MODIFIER3	100	98.80	100	100	79.60
MODIFIER4	100	99.85	100	100	96.34
NUM_ADJ_ICN	100	54.26	99.86	100	100
NUM_CMS_ICN	NV	NV	NV	NV	NV
NUM_HIC_SUB	0	0	0	0	0
OPERATING_PROV_ID	NV	NV	NV	NV	NV
OPERATING_PROV_NPI	99.82	99.62	99.63	100	89.88
PAIDDATE_DTL	0	88.75	0	97.46	99.33
PAIDDATE_HDR	0	90.70	0	97.46	99.33
PAY_ARR_HDR	99.96	51.48	99.78	99.76	100
PROCCODE	99.35	96.27	98.96	99.32	97.96
RCC	100	97.42	99.96	100	100
RECIP_ID	99.98	99.99	100	100	100
REFERRING_PROV_ID	NV	NV	NV	NV	NV
REFERRING_PROV_NPI	0.36	0.45	0.63	0.57	0.41
SURG1	100	79.83	100	100	100
SURG2	100	86.75	100	100	100
SURG3	99.66	99.93	100	100	100
SURG4	99.57	99.89	100	100	100
SURG5	99.51	99.83	100	100	100
SURG6	99.52	99.83	100	100	100
SURG7	99.57	99.83	100	100	100
SURGDTE1	100	100	100	100	100
SURGDTE2	100	99.95	100	100	100
SURGDTE3	99.71	99.95	100	100	100
SURGDTE4	99.65	99.94	100	100	100
SURGDTE5	99.61	99.91	100	100	100
SURGDTE6	99.63	99.88	100	100	100
SURGDTE7	99.65	99.85	100	100	100
TCN	100	100	100	100	100
TYPEBILL	100	100	100	100	100

Field Name	Aetna MyCare % Match	Buckeye MyCare % Match	CareSource MyCare % Match	Molina MyCare % Match	UHC MyCare % Match
UNITS_BILLED	100	11.07	99.97	100	100

UHC: UnitedHealthcare Community Plan; NV: not validated for the study; gray shading: < 90% match and an MCO/MCOP discrepancy; yellow shading: < 90% match and an MCO/MCOP reporting study data extraction issue; no shading and < 90% match is an IPRO/ODM/vendor data issue.

Table 55: Aggregate Medicaid Institutional Outpatient Data Element Discrepancies and Findings by MCO/OhioRISE

Field Name	Aetna OhioRISE % Match	Buckeye Medicaid % Match	CareSource Medicaid % Match	Molina Medicaid % Match	Paramount Medicaid % Match	UHC Medicaid % Match
ADMITTYP	100	0	100	100	100	100
AMT_CO_PAY_HDR	NV	NV	NV	NV	NV	NV
AMT_MCO_PAID_DTL	100	96.27	99.29	98.62	62.09	99.62
AMT_MCO_PAID_HDR	NV	NV	NV	NV	NV	NV
AMT_TPL_SUBM_DTL	99.82	98.70	97.68	100	98.52	99.36
AMT_TPL_SUBM_HDR	NV	NV	NV	NV	NV	NV
ATTENDING_PROV_ID	NV	NV	NV	NV	NV	NV
ATTENDING_PROV_NPI	99.54	0.11	99.14	99.13	98.95	98.68
BILLING_PROV_ID	NV	NV	NV	NV	NV	NV
BILLING_PROV_NPI	100	96.90	99.25	97.71	96.2	97.77
CDE_NDC	100	100	99.91	99.99	82.19	99.98
DIAGCD1	100	99.99	100	100	99.72	100
DIAGCD2	99.95	99.99	100	100	80.32	100
DIAGCD3	99.95	100	100	100	79.18	100
DIAGCD4	99.77	99.99	100	100	74.19	100
DIAGCD5	99.91	49.43	100	100	78.99	100
DIAGCD6	99.77	100	100	100	79.37	100
DIAGCD7	99.91	99.99	100	100	84.88	100
DIAGCD8	98.71	100	100	100	89.01	100
DIAGCD9	99.26	100	100	100	91.89	100
DIAGCD10	99.49	100	100	100	94.01	100
DIAGCD11	99.54	99.99	100	100	95.45	100
DIAGCD12	100	100	100	100	96.53	100
DIAGCD13	100	100	100	100	97.25	100
DIAGCD14	100	100	100	92.01	97.79	100
DIAGCD15	100	100	100	93.22	98.29	100
DIAGCD16	100	100	100	94.28	98.62	100
DIAGCD17	100	100	100	95.15	98.89	100
DIAGCD18	100	100	100	95.97	99.09	100
DIAGCD19	100	100	100	96.56	99.22	100
DIAGCD20	100	100	100	97.13	99.33	100
DIAGCD21	100	100	100	97.59	99.44	100
DIAGCD22	100	100	100	97.95	99.60	100
DIAGCD23	100	100	100	98.30	99.65	100
DIAGCD24	100	100	100	98.59	99.77	100
DIAGCD25	100	100	100	99.45	99.70	100
DIS_STAT	100	98.90	100	100	100	100

Field Name	Aetna OhioRISE % Match	Buckeye Medicaid % Match	CareSource Medicaid % Match	Molina Medicaid % Match	Paramount Medicaid % Match	UHC Medicaid % Match
DRG	100	100	100	100	100	100
DTE_FIRST_SVC_DTL	100	100	99.95	100	0	100
DTE_FIRST_SVC_HDR	100	99.86	99.89	100	100	99.68
DTE_LAST_SVC_HDR	100	98.83	99.08	100	0	98.64
ICN	100	100	100	100	99.98	100
IND_HDR_DTL	NV	NV	NV	NV	NV	NV
LINE_NUMBER	100	100	100	100	100	100
MODIFIER1	100	100	99.93	100	81.24	100
MODIFIER2	100	99.96	99.99	100	98.54	98.03
MODIFIER3	100	100	100	100	99.91	99.82
MODIFIER4	100	100	100	100	100	100
NUM_ADJ_ICN	100	98.2	99.98	100	93.80	100
NUM_CMS_ICN	NV	NV	NV	NV	NV	NV
NUM_HIC_SUB	NV	NV	NV	NV	NV	NV
OPERATING_PROV_ID	NV	NV	NV	NV	NV	NV
OPERATING_PROV_NPI	99.91	99.79	99.81	100	95.75	99.44
PAIDDATE_DTL	100	90.39	99.96	96.58	0.01	99.13
PAIDDATE_HDR	100	92.38	99.96	96.58	95.09	99.13
PAY_ARR_HDR	10.73	99.82	94.93	100	96.71	100
PROCCODE	100	100	99.77	99.99	32.91	100
RCC	100	100	99.86	100	46.40	100
RECIP_ID	96.04	99.91	99.98	99.99	100	100
REFERRING_PROV_ID	NV	NV	NV	NV	NV	NV
REFERRING_PROV_NPI	0.18	0.8	0.83	0.84	1.04	1.29
TCN	100	100	100	100	100	100
TYPEBILL	100	100	100	100	100	100
UNITS_BILLED	100	94.55	99.92	100	81.92	100

MCO: managed care plan; OhioRISE: Ohio's Resilience through Integrated Systems and Excellence; UHC: UnitedHealthcare Community Plan; NV: not validated for the study; yellow shading: < 90% match and an MCO/MCOP reporting study data extraction issue; no shading and < 90% match is an IPRO/ODM/vendor data issue.

Table 56: Aggregate MyCare Institutional Data Element Discrepancies and Findings

Field Name	Aetna MyCare % Match	Buckeye MyCare % Match	CareSource MyCare % Match	Molina MyCare % Match	UHC MyCare % Match
ADMITTYP	100	0	100	100	100
AMT_CO_PAY_HDR	NV	NV	NV	NV	NV
AMT_MCO_PAID_DTL	99.96	97.42	81.61	99.68	99.59
AMT_MCO_PAID_HDR	NV	NV	NV	NV	NV
AMT_TPL_SUBM_DTL	100	99.72	89.52	100	99.83
AMT_TPL_SUBM_HDR	NV	NV	NV	NV	NV
ATTENDING_PROV_ID	NV	NV	NV	NV	NV
ATTENDING_PROV_NPI	98.99	0.18	99.30	99.19	99.14
BILLING_PROV_ID	NV	NV	NV	NV	NV
BILLING_PROV_NPI	97.29	97.18	99.27	98.28	99.01
CDE_NDC	99.93	98.82	99.84	100	100
DIAGCD1	99.99	99.98	100	100	100

Field Name	Aetna MyCare % Match	Buckeye MyCare % Match	CareSource MyCare % Match	Molina MyCare % Match	UHC MyCare % Match
DIAGCD2	98.35	99.98	100	100	100
DIAGCD3	97.11	99.96	100	100	100
DIAGCD4	96.76	99.97	100	100	100
DIAGCD5	96.59	25.79	100	100	100
DIAGCD6	97.00	99.98	100	100	100
DIAGCD7	97.06	99.97	100	100	100
DIAGCD8	97.23	99.99	100	100	100
DIAGCD9	97.42	99.99	100	100	100
DIAGCD10	92.41	99.99	100	100	100
DIAGCD11	92.84	99.97	100	100	100
DIAGCD12	93.19	99.98	100	100	100
DIAGCD13	93.50	99.99	100	100	100
DIAGCD14	93.70	99.97	100	83.76	100
DIAGCD15	94.36	99.97	100	85.44	100
DIAGCD16	94.69	99.99	100	86.98	100
DIAGCD17	95.13	99.99	100	88.44	100
DIAGCD18	95.64	99.99	100	90.02	100
DIAGCD19	96.01	100	100	91.41	100
DIAGCD20	96.40	100	100	92.49	100
DIAGCD21	96.70	99.99	100	93.51	100
DIAGCD22	97.29	100	100	94.35	100
DIAGCD23	97.52	99.99	100	95.15	100
DIAGCD24	97.99	100	100	95.93	100
DIAGCD25	96.24	100	100	98.18	100
DIS_STAT	100	94.26	100	100	100
DRG	100	100	99.91	100	100
DTE_FIRST_SVC_DTL	98.85	98.28	99.16	100	98.90
DTE_FIRST_SVC_HDR	100	98.03	99.03	100	99.92
DTE_LAST_SVC_HDR	100	96.92	97.36	100	99.68
ICN	100	100	100	100	100
IND_HDR_DTL	NV	NV	NV	NV	NV
LINE_NUMBER	100	100	100	100	100
MODIFIER1	99.95	99.07	99.89	100	100
MODIFIER2	100	99.43	99.97	100	90.25
MODIFIER3	100	99.98	100	100	99.46
MODIFIER4	100	100	100	100	99.97
NUM_ADJ_ICN	100	60.21	99.94	100	100
NUM_CMS_ICN	NV	NV	NV	NV	NV
NUM_HIC_SUB	0	0	0	0	0
OPERATING_PROV_ID	NV	NV	NV	NV	NV
OPERATING_PROV_NPI	99.69	99.78	99.88	100	99.78
PAIDDATE_DTL	0	92.85	0	98.47	97.88
PAIDDATE_HDR	0	94.34	0	98.47	97.88
PAY_ARR_HDR	99.79	99.93	99.95	99.96	100
PROCCODE	99.82	96.99	99.07	99.82	100
RCC	99.89	98.53	99.81	100	100
RECIP_ID	99.97	99.98	99.99	100	100

Field Name	Aetna MyCare % Match	Buckeye MyCare % Match	CareSource MyCare % Match	Molina MyCare % Match	UHC MyCare % Match
REFERRING_PROV_ID	NV	NV	NV	NV	NV
REFERRING_PROV_NPI	0.92	1.07	0.69	0.78	0.84
TCN	100	100	100	100	100
TYPEBILL	100	100	100	100	100
UNITS_BILLED	99.90	94.34	99.86	100	100

UHC: UnitedHealthcare Community Plan; NV: not validated for the study; yellow shading: < 90% match and an MCO/MCOP reporting study data extraction issue; no shading and < 90% match is an IPRO/ODM/vendor data issue.

Table 57: Aggregate Medicaid Dental Data Element Discrepancies and Findings by MCO

Field Name	Buckeye Medicaid % Match	CareSource Medicaid % Match	Molina Medicaid % Match	Paramount Medicaid % Match	UHC Medicaid % Match
AMT_PAID_MCO_DTL	98.25	92.72	99.96	100	99.93
AMT_PAID_MCO_HDR	NV	NV	NV	NV	NV
AMT_TPL_SUBM_DTL	99.16	100	100	100	100
BILLING_PROV_ID	NV	NV	NV	NV	NV
BILLING_PROV_NPI	98.84	94.35	97.48	91.73	99.96
DTE_FIRST_SVC_DTL	99.89	99.98	99.91	100	99.93
DTE_LAST_SVC_DTL	99.91	99.89	99.80	100	100
ICN	100	100	100	100	100
LINE_NUMBER	100	100	100	100	100
MODIFIER1	100	100	100	100	100
MODIFIER2	100	100	100	100	100
MODIFIER3	100	100	100	100	100
MODIFIER4	100	100	100	100	100
NUM_ADJ_ICN	99.81	0.41	100	100	100
NUM_CMS_ICN	NV	NV	NV	NV	NV
NUM_HIC_SUB	NV	NV	NV	NV	NV
PAIDDATE_HDR	100	99.85	99.95	0	99.92
PAID_DATE_DTL	100	99.85	0	100	99.23
PAY_ARR_DTL	100	100	100	0	100
PAY_ARR_HDR	100	100	100	0	100
PLACESVC	99.84	95.01	100	0	98.00
PROCCODE1	98.29	92.79	100	100	100
QTY_UNITS_BILLED	99.86	100	100	100	100
RECIP_ID	99.72	99.87	100	99.99	100
REFERRING_PROV_ID	NV	NV	NV	NV	NV
REFERRING_PROV_NPI	100	100	100	100	100
RENDERING_PROV_ID	NV	NV	NV	NV	NV
RENDERING_PROV_NPI	100	99.99	89.10	88.33	99.96
TCN	100	0	100	100	100
TOOTHNUMBER	98.66	90.73	91.74	67.93	90.80

MCO: managed care plan; UHC: UnitedHealthcare Community Plan; NV: not validated for the study; gray shading: < 90% match and an MCO/MCOP discrepancy; yellow shading: < 90% match and an MCO/MCOP reporting study data extraction issue; no shading and < 90% match is an IPRO/ODM/vendor data issue.

Table 58: Aggregate MyCare Dental Data Element Discrepancies and Findings

Field Name	Aetna MyCare % Match	Buckeye MyCare % Match	CareSource MyCare % Match	Molina MyCare % Match	UHC MyCare % Match
AMT_PAID_MCO_DTL	100	98.74	11.03	99.95	5.86
AMT_PAID_MCO_HDR	NV	NV	NV	NV	NV
AMT_TPL_SUBM_DTL	100	98.36	99.93	100	100
BILLING_PROV_ID	NV	NV	NV	NV	NV
BILLING_PROV_NPI	94.95	99.44	95.18	100	100
DTE_FIRST_SVC_DTL	99.67	99.76	100	100	99.86
DTE_LAST_SVC_DTL	100	99.81	99.79	100	100
ICN	100	100	100	100	100
LINE_NUMBER	100	100	100	100	100
MODIFIER1	100	100	100	100	100
MODIFIER2	100	100	100	100	100
MODIFIER3	100	100	100	100	100
MODIFIER4	100	100	100	100	100
NUM_ADJ_ICN	99.73	99.71	99.93	100	100
NUM_CMS_ICN	NV	NV	NV	NV	NV
NUM_HIC_SUB	0	99.91	0	0	0
PAIDDATE_HDR	100	100	0	99.93	99.92
PAID_DATE_DTL	100	100	0	0	99.91
PAY_ARR_DTL	100	100	0	100	100
PAY_ARR_HDR	100	100	0	100	100
PLACESVC	100	100	98.33	100	73.57
PROCCODE1	100	99.07	99.63	100	99.99
QTY_UNITS_BILLED	100	99.87	99.99	100	100
RECIP_ID	100	99.99	100	100	100
REFERRING_PROV_ID	NV	NV	NV	NV	NV
REFERRING_PROV_NPI	100	100	100	100	100
RENDERING_PROV_ID	NV	NV	NV	NV	NV
RENDERING_PROV_NPI	84.40	100	99.99	88.56	100
TCN	100	100	100	100	100
TOOTHNUMBER	100	99.28	99.89	100	90.26

UHC: UnitedHealthcare Community Plan; NV: not validated for the study; yellow shading: < 90% match and an MCO/MCOP reporting study data extraction issue; no shading and < 90% match is an IPRO/ODM/vendor data issue.

Table 59: Aggregate Medicaid Pharmacy Data Element Discrepancies and Findings by MCO

Field Name	Buckeye Medicaid % Match	CareSource Medicaid % Match	Molina Medicaid % Match	Paramount Medicaid % Match	UHC Medicaid % Match
AMT_NDC_PROFEE	98.86	99.40	99.15	98.64	99.70
AMT_PAID_MCO_HDR	98.22	99.34	NV	98.51	92.69
AMT_TPL_SUBM_HDR	NV	98.90	NV	98.91	NV
BILLING_PROV_ID	NV	NV	NV	NV	NV
BILLING_PROV_NPI	99.37	99.77	99.25	98.94	99.77
DISPENSE_DATE	100	100	99.96	99.99	99.78
DTE_FIRST_SVC_DTL	100	18.24	99.96	99.99	99.78

Field Name	Buckeye Medicaid % Match	CareSource Medicaid % Match	Molina Medicaid % Match	Paramount Medicaid % Match	UHC Medicaid % Match
DTE_FIRST_SVC_HDR	100	18.24	99.96	99.99	99.78
ICN	100	100	99.96	99.99	99.78
LINE_NUMBER	NV	NV	NV	NV	NV
NDC	99.75	99.87	99.54	99.59	99.57
NUM_ADJ_ICN	100	99.34	100	100	92.91
NUM_CMS_ICN	NV	NV	NV	NV	NV
NUM_DAY_SUPPLY	100	99.36	99.96	99.99	99.78
NUM_HIC_SUB	NV	NV	NV	NV	NV
NUM_PRESCRIPTION_ID	100	100	99.96	99.99	99.78
PAIDDATE_HDR	100	99.31	99.96	99.99	92.69
PRESC_DATE	100	100	99.96	99.99	99.78
PRESC_PROV_ID	NV	NV	NV	NV	NV
PRESC_PROV_NPI	97.71	97.86	97.85	96.90	99.15
QTY_DISPENSE_DTL	99.82	99.28	99.64	99.75	99.58
QTY_DISPENSE_HDR	99.83	99.26	99.80	99.86	99.56
RECIP_ID	100	100	99.96	99.99	99.78
TCN	100	0	99.96	99.99	92.69

MCO: managed care plan; UHC: UnitedHealthcare Community Plan; NV: not validated for the study; yellow shading: < 90% match and an MCO/MCOP reporting study data extraction issue; no shading and < 90% match is an IPRO/ODM/vendor data issue.

Table 60: Aggregate MyCare Pharmacy Data Element Discrepancies and Findings

Field Name	Aetna MyCare % Match	Buckeye MyCare % Match	CareSource MyCare % Match	Molina MyCare % Match	UHC MyCare % Match
AMT_NDC_PROFEE	97.05	98.62	96.58	98.11	99.23
AMT_PAID_MCO_HDR	96.02	98.11	94.59	NV	95.03
AMT_TPL_SUBM_HDR	100	NV	100	NV	NV
BILLING_PROV_ID	NV	NV	NV	NV	NV
BILLING_PROV_NPI	99.59	99.24	98.47	99.46	99.40
DISPENSE_DATE	100	99.62	100	100	99.40
DTE_FIRST_SVC_DTL	100	99.62	15.45	100	99.40
DTE_FIRST_SVC_HDR	100	99.62	15.45	100	99.40
ICN	100	99.62	100	100	99.40
LINE_NUMBER	NV	NV	NV	NV	NV
NDC	99.75	99.43	99.85	99.66	99.35
NUM_ADJ_ICN	100	100	94.57	100	95.62
NUM_CMS_ICN	NV	NV	NV	NV	NV
NUM_DAY_SUPPLY	100	99.62	94.58	100	99.40
NUM_HIC_SUB	0	0.19	0	0	0
NUM_PRESCRIPTION_ID	100	99.62	100	100	99.40
PAIDDATE_HDR	100	99.62	93.72	100	94.95
PRESC_DATE	100	99.62	100	100	99.40
PRESC_PROV_ID	NV	NV	NV	NV	NV
PRESC_PROV_NPI	98.43	97.76	98.90	98.71	98.84
QTY_DISPENSE_DTL	99.86	99.52	94.51	99.77	99.28
QTY_DISPENSE_HDR	99.86	99.52	94.45	99.86	99.20

Field Name	Aetna MyCare % Match	Buckeye MyCare % Match	CareSource MyCare % Match	Molina MyCare % Match	UHC MyCare % Match
RECIP_ID	100	99.62	100	100	99.40
TCN	100	99.25	0	99.97	93.09

UHC: UnitedHealthcare Community Plan; NV: not validated for the study; yellow shading: < 90% match and an MCO/MCOP reporting study data extraction issue; no shading and < 90% match is an IPRO/ODM/vendor data issue.

SPBM

IPRO requested SPBM claims data residing in its claims system for all members and for all service line items having a dispense date within the study period of October 1 to December 31, 2022. The SPBM submitted header and detail files combined in each file; therefore, the header record information was replicated for all claim service lines. The SPBM submitted data elements in **Table 61**.

IPRO identified the omitted ICNs and the encounters in the claim file that were not present in IPRO's DW. Percentages were identified by encounter type and month of service for the discrepant records (**Table 62**). Percentages were identified by encounter type and month of service for the discrepant records. For records that IPRO matched on ICN, IPRO identified the discrepancies by comparing the source data for each data element. IPRO identified differences between the data element values from the source data and the data element values included in IPRO's DW. Discrepancies were identified by data element (**Table 63**).

Table 61: Pharmacy Encounter Data Elements

Field Name	Type	Description
PLAN_ID	Char	SPBM provider Medicaid ID
RECIP_ID	Char	Unique number assigned to the recipient (12-digit Medicaid billing number)
NUM_HIC_SUB	Char	The recipient's health insurance claim (HIC) number (i.e., Medicare ID)
TCN	Char	This is the claims transaction number from the MCOs' system.
ICN	Char	Unique control number assigned by ODM to the original claim without any spaces or hyphens: the format is RRYYJJJBBBSSS where RR is the claim region; YY is the last two digits of the calendar year; JJJ is the Julian date of the claim receipt; BBB is the batch number, and SSS is the sequence number of the invoice within the batch.
NUM_ADJ_ICN	Char	This is the ICN of the original claim if the claim is an adjustment.
NUM_CMS_ICN	Char	Unique claim number assigned by CMS and present on MyCare encounters received from CMS
LINE_NUMBER	Num	Number of the detail on the claim
DTE_FIRST_SVC	Date	Date on which the statement period on the claim began (mm/dd/yyyy)
Payment information		
PAIDDATE_HDR	Date	The date on which the SPBM paid the provider for the claim (mm/dd/yyyy)
AMT_PAID_MCO_HDR	Num	This is the SPBM paid amount from the header (Number(11,2)).
AMT_TPL_SUBM_HDR	Num	This is the third party liability (TPL) submitted from the header (Number(15,2)).
AMT_NDC_PROFEE	Num	Amount that the provider receives for dispensing a prescription drug (Number(11,2))
Prescription/Provider/Prescribing date information		
PRESC_PROV_ID	Char	This is the prescribing provider Medicaid ID.
PRESC_PROV_NPI	Char	This is the prescribing provider NPI.
BILLING_PROV_ID	Char	This is the billing provider Medicaid ID.
BILLING_PROV_NPI	Char	This is the billing provider NPI.
PRESC_DATE	Date	Date on which prescription was prescribed (mm/dd/yyyy)
NUM_PRESCRIPTION_ID	Char	The number assigned to the prescription by the provider
DISPENSE_DATE	Date	Date on which prescription was filled (mm/dd/yyyy)

Field Name	Type	Description
NDC	Char	National drug code for the drug dispensed
QTY_DISPENSE_HDR	Num	This is the quantity dispensed at the header (Number(10,3)).
QTY_DISPENSE_DTL	Num	This is the quantity dispensed at the detail of the claim (Number(10,3)).
NUM_DAY_SUPPLY	Num	The number of days the prescription should last (Number(9)).

Char: characters; Num: numerals; SPBM: single pharmacy benefit manager; ID: identification; MCO: managed care organization; CMS: Centers for Medicare & Medicaid Services; ODM: Ohio Department of Medicaid; NPI: National Provider Identifier, ICN: internal control number; TPL: third party liability.

Table 62: Surplus and Omitted ICN Counts

Encounter Type	Counts Surplus	Counts Omitted
Pharmacy	0.25%	0.19%

ICN: internal control number.

Gainwell noted that a majority of the claims were for members with a deleted enrollment segment. For future submissions, Gainwell will incorporate SPBM claims data for all members who had a dispense date within the study period including members with a deleted enrollment segment. Gainwell reported that 891 of the 1,000 claims provided exist in Business Intelligence Analytical Reporting (BIAR) with a paid date after the study period, meaning 109 claims were not found in BIAR/MITS. Gainwell is aware that SPBM claims from a special mid-week financial cycle in December (paid date 12/27/2022) and were not sent to MITS.

Table 63: SPBM Pharmacy Data Element Discrepancies and Findings

Field Name	Gainwell % Match	Gainwell Findings for Fields with < 90% Match
AMT_NDC_PROFEE	99.84	N/A
AMT_PAID_MCO_HDR	NV	This field was not validated since the value is not populated in the data warehouse.
AMT_TPL_SUBM_HDR	96.89	N/A
BILLING_PROV_ID	95.86	N/A
BILLING_PROV_NPI	100	N/A
DISPENSE_DATE	100	N/A
DTE_FIRST_SVC_DTL	100	N/A
DTE_FIRST_SVC_HDR	100	N/A
LINE_NUMBER	100	Remote meeting discussion**:** For future EDV studies, Gainwell will be submitting line numbers submitted on the NCPDP.
NDC	99.50	N/A
NUM_DAY_SUPPLY	100	N/A
NUM_PRESCRIPTION_ID	100	N/A
PAIDDATE_HDR	0	Follow-up item**:** The data warehouse is null for this field. IPRO will re-evaluate this field comparison based on the new MMIS.
PRESC_DATE	100	N/A
PRESC_PROV_ID	99.78	N/A
PRESC_PROV_NPI	99.85	N/A
TY_DISPENSE_DTL	19.15	Remote meeting discussion: EDV study data extraction issue. Compound claims indicators and line number are not submitted on the EDV study. When Gainwell submits the line number on future studies, this field should then match.

Field Name	Gainwell % Match	Gainwell Findings for Fields with < 90% Match
QTY_DISPENSE_HDR	81.05	Remote meeting discussion**:** The header is populated with 0 in the data warehouse**.** Gainwell will ensure that denied and voided claims are not submitted for future studies.
RECIP_ID	100	N/A
TCN	100	N/A

SPBM: single pharmacy benefits manager; NV: not validated for this study; EDV: encounter data validation; NCPDP: National Council for Prescription Drug Programs; MMIS: Medicaid Management Information System; N/A: not applicable.

VIII. Strengths, Opportunities for Improvement, and EQR Recommendations

This section integrates findings from each activity in the preceding sections, highlights MCEs' strengths and opportunities for improvement, and provides IPRO's recommendations for approaches the MCEs could take to improve performance. Error! Reference source not found. through Error! Reference source not found. ar e organized by MCE and program. No EQR activities were fully complete for the SPBM and OhioRISE lines of business in SFY 2023, so there are no summary tables this year.

Most EQR activities assess MCE performance related to **quality, timeliness,** and **access** to care (the exception being the activities whose purpose is to assure data accuracy and completeness). The relevance of each activity to the domains of **quality, timeliness,** and **access** is noted with an "X." Activities without a specific link to the three foci but nonetheless important to achieving quality goals are shaded gray.

Table 64: EQR Summary of Strengths, Opportunities, and Recommendations for AmeriHealth MCO

EQR Activity	Strengths	Opportunity	Recommendation	Quality	Timeliness	Access
PIP	AmeriHealth collaborated with other MCOs to share information and strategies to improve quality and reduce disparities. AmeriHealth utilized lessons from previous projects to inform new tests of change.	AmeriHealth has not yet met the Diabetes PIP SMART Aim goal rates. AmeriHealth had the lowest percentage of members with diabetes who had a claim for CGM in the 12-month measurement period (11.1%) compared to the MCO median score of 17.0%.	Continue to test interventions to identify those that show qualitative and quantitative evidence that the change led to sustained improvement in the SMART Aims. Continue to update KDD to show how theory of improvement evolved. Plan for spread beyond the initial population.	**X**	**X**	**X**
Compliance with Medicaid Standards	Amerihealth met all requirements for: Enrollee Rights, Availability of Services, Assurances of Adequate Capacity and Service, Coordination and Continuity of Care, Coverage and	AmeriHealth did not meet all requirements of the Disenrollment: Requirements and Limitations, Emergency and Post-stabilization Services, Grievance and Appeal Systems, and Practice Guidelines standards.	Implement corrective action plans to meet federal and state standards for all unmet requirements.	**X**	**X**	**X**

EQR Activity	Strengths	Opportunity	Recommendation	Quality	Timeliness	Access
	Authorization of Services, Provider Selection, Confidentiality, Subcontractual Relationships and Delegation, Health Information Systems, and QAPI.					
Network Adequacy – PCP Access	AmeriHealth had a high provider directory accuracy rate of 88.2% compared to a median MCO score of 85.2%, for PCPs accepting new patients.	Of the PCPs who confirmed they were accepting new patients, 71.4% offered timely well-check appointments and 57.1% offered timely sick appointments. Established patients were offered access to timely, well-check appointments 75.0% of the time and access to timely, sick appointments 50.0% of the time.	Implement processes to validate the accuracy of provider data. Encourage practices to improve the availability of well-check and sick visit appointments and monitor progress.		**X**	**X**

Gray shading: activities without a specific link to the three foci but nonetheless important to achieving quality goals; EQR: external quality review; EQRO: external quality review organization; PIP: performance improvement project; MCO: managed care organization; QAPI: Quality Assessment and Performance Improvement Program; MCPN: managed care provider network; SMART: Specific, Measurable, Achievable, Realistic, and Timely; KDD: key driver diagram; PCP: primary care provider.

Table 65: EQR Summary of Strengths, Opportunities, and Recommendations for Anthem MCO

EQR Activity	Strengths	Opportunity	Recommendation	Quality	Timeliness	Access
PIP	Anthem had the highest percentage of members with diabetes who had a claim for CGM in the	Anthem has not yet met the SMART Aim goal rate for DSME.	Continue to test interventions to identify those that show qualitative and quantitative evidence that the change led to sustained improvement in the SMART Aims.	**X**	**X**	**X**

EQR Activity	Strengths	Opportunity	Recommendation	Quality	Timeliness	Access
	12-month measurement period (20.5%). Anthem's CGM claims' rate exceeded the SMART aim goal rate of 17.7%. The percentage of members with diabetes who had a claim for DSME in the 12-month measurement period was 1.3%, which approached the SMART Aim goal rate of 1.5%. Anthem collaborated with other plans to share information and strategies to improve quality and reduce disparities. Anthem utilized lessons from previous projects to inform new tests of change.		Continue to update KDD to show how theory of improvement evolved. Plan for spread beyond the initial population.			
Compliance with Medicaid Standards	Anthem met all the requirements of Enrollee Rights, Emergency and Post-Stabilization Services, Availability of Services, Assurances of Adequate Capacity	Anthem did not meet all requirements of the Disenrollment: Requirements and Limitations and Grievance and Appeal Systems standards.	Implement corrective action plans to meet federal and state standards for all unmet requirements.	**X**	**X**	**X**

EQR Activity	Strengths	Opportunity	Recommendation	Quality	Timeliness	Access
	and Services, Coordination and Continuity of Care, Coverage and Authorization of Services, Provider Selection, Confidentiality, Subcontractual Relationships and Delegation, Practice Guidelines, Health Information Systems, and QAPI.					
Network Adequacy – PCP Access	Anthem had a high provider directory accuracy rate of 88.2% for PCPs accepting new patients.	Of the PCPs who confirmed they were accepting new patients, 66.7% offered timely access to well-check appointments and 40.0% offered timely access to sick appointments. Established patients were offered timely access to well-check appointments 76.5% of the time and to sick appointments 52.9% of the time.	Implement processes to validate the accuracy of provider data. Encourage practices to improve availability of well-check and sick visit appointments and monitor progress.		X	X

Gray shading: activities without a specific link to the three foci, but nonetheless important to achieving quality goals; EQR: external quality review; EQRO: external quality review organization; PIP: performance improvement project; MCO: managed care organization; MCPN: managed care provider network; SMART: Specific, Measurable, Achievable, Realistic, and Timely; KDD: key-driver diagram; QAPI: Quality Assessment and Performance Improvement Program; PCP: primary care provider; CGM: continuous glucose monitoring; DSME: diabetes self-management education.

Table 66: EQR Summary of Strengths, Opportunities, and Recommendations for Buckeye MCO

EQR Activity	Strengths	Opportunity	Recommendation	Quality	Timeliness	Access
PIP	Buckeye collaborated with other MCOs to share information and strategies to improve quality and reduce disparities. Buckeye utilized lessons from previous projects to inform new tests of change.	Buckeye has not yet met the Diabetes PIP SMART Aim goal rates. The percentage of members with diabetes who had a claim for CGM in the 12-month measurement period was 15.3%. The SMART Aim goal rate is 17.7%. The percentage of members with diabetes who had a claim for DSME in the 12-month measurement period was 1.1%. The SMART Aim goal rate is 1.5%.	Continue to test interventions to identify those that show qualitative and quantitative evidence that the change led to sustained improvement in the SMART Aims. Continue to update KDD to show how theory of improvement evolved. Plan for spread beyond the initial population.	X	X	X
Performance Measures	Buckeye fully met five of six IS standards for reporting HEDIS data to NCQA and to ODM. Buckeye met 97.7% of MPSs for MY 2022.	Buckeye did not meet the minimum performance threshold for one measure in the Healthy Children category. Buckeye scored at or below the national average on 63.2% of quality measures. Of these, 26.3% of quality measures were scored below the 25th national Medicaid percentile.	Improve all performance measures that were below the 75th percentile.	X	X	X

EQR Activity	Strengths	Opportunity	Recommendation	Quality	Timeliness	Access
Compliance with Medicaid Standards	Buckeye met all the requirements of Emergency and Post-Stabilization Services, Availability of Services, Assurances of Adequate Capacity and Services, Coverage and Authorization of Services, Provider Selection, Confidentiality, Subcontractual Relationships and Delegation, Practice Guidelines, Health Information Systems, and QAPI.	Buckeye did not meet all requirements of the Disenrollment: Requirements and Limitations, Enrollee Rights, Coordination and Continuity of Care, and Grievance and Appeal Systems standards.	Implement corrective action plans to meet federal and state standards for all unmet requirements.	X	X	X
Network Adequacy – PCP Access	None.	Buckeye's provider directory accuracy rate for accepting new patients was the lowest (60.0%) compared to the median MCO score of 85.2%. Of the PCPs who confirmed they were accepting new patients, 66.7% offered timely well-check appointments to new patients and 25.0% offered timely	Implement processes to validate the accuracy of provider data. Encourage practices to improve the availability of well-check and sick visit appointments and to monitor their progress.		X	X

EQR Activity	Strengths	Opportunity	Recommendation	Quality	Timeliness	Access
		sick appointments. Established patients were offered timely access to well-check appointments 60.0% of the time and to sick appointments 50.0% of the time. Buckeye's rates for offering new patients timely access to sick appointments (25.0%) and existing patients access to well-check appointments (60.0%) were the lowest across MCOs.				
Network Adequacy – Oral Surgeon Access	Buckeye had the highest telephone number accuracy response rate for oral surgeons (76.7%).	Buckeye's provider directory accuracy rate was low. It was found that 8.3% of oral surgeons offered timely appointment access.	Improve contact information accuracy. Add oral surgeons to the provider network to increase access to timely appointments.		**X**	**X**
Quality-of-Care Survey – Adult Member Experience	Buckeye achieved one adult CAHPS score at or above the 90th national Medicaid percentile and four above the 75th percentile. Performance was highest on the composite measure Getting Care Quickly.	Buckeye had one adult CAHPS score below the 25th national Medicaid percentile. Performance was related to Rating of Specialist Seen Most Often.	Address CAHPS measures that fell below the statewide average.	**X**	**X**	**X**

EQR Activity	Strengths	Opportunity	Recommendation	Quality	Timeliness	Access
Quality-of-Care Survey – Child Member Experience	Buckeye achieved four child CAHPS scores between the 75th and 89th national Medicaid percentiles, up from two last year Performance was related to Rating of Health Plan, Rating of All Health Care, Getting Needed Care, and Getting Care Quickly.	Buckeye had two child CAHPS scores below the 25th national Medicaid percentiles. Performance was related to Customer Service and Coordination of Care.	Maintain corrections implemented following EDV studies.	X	X	X
EDV	None.	Buckeye had several data elements that were extracted incorrectly for the EDV study.				

Gray shading: activities without a specific link to the three foci but nonetheless important to achieving quality goals; EQR: external quality review; EQRO: external quality review organization; PIP: performance improvement project; IS: information systems; HEDIS: Healthcare Effectiveness Data and Information Set; NCQA: National Committee for Quality Assurance; ODM: Ohio Department of Medicaid; MPS: minimum performance standard; MY: measurement year; MCO: managed care organization; CAHPS: Consumer Assessment of Healthcare Providers and Systems; KDD: key-driver diagram; QAPI: Quality Assessment and Performance Improvement Program; PCP: primary care provider; SMART: Specific, Measurable, Achievable, Realistic, and Timely; CGM: continuous glucose monitoring; DSME: diabetes self-management education; EDV: encounter data validation.

Table 67: EQR Summary of Strengths, Opportunities, and Recommendations for CareSource MCO

EQR Activity	Strengths	Opportunity	Recommendation	Quality	Timeliness	Access
PIP	The percentage of members with diabetes who had a claim for CGM in the 12-month measurement period was 18.6%, which exceeded the SMART Aim goal rate of 17.7%.	CareSource can continue to test improvements to further increase diabetes performance.	Continue to test interventions to identify those that show qualitative and quantitative evidence that the change led to sustained improvement in the SMART Aims. Continue to update KDD to show how theory of improvement evolved. Plan for	X	X	X

EQR Activity	Strengths	Opportunity	Recommendation	Quality	Timeliness	Access
	The percentage of members with diabetes who had a claim for DSME in the 12-month measurement period was 1.5%, which met the SMART Aim goal rate of 1.5% and was the highest score for the DSME measure. CareSource collaborated with other MCOs to share information and strategies to improve quality and reduce disparities. CareSource utilized lessons from previous projects to inform new tests of change.		spread beyond the initial population.			
Performance Measures	CareSource met all IS standards for reporting HEDIS data to NCQA and to ODM. CareSource met 97.7% of the MPSs for MY 2021. CareSource scored the highest portion of quality measures above the 75th national Medicaid percentile (29.0%)	CareSource did not meet the minimum performance threshold for one measure in the Chronic Conditions category. CareSource scored at or below the national average on 39.47% of quality measures.	Improve all performance measures that were below the 75th percentile.	**X**	**X**	**X**

EQR Activity	Strengths	Opportunity	Recommendation	Quality	Timeliness	Access
	compared to the median score across MCOs and the statewide average (15.8%).					
Compliance with Medicaid Standards	CareSource met all the requirements of Emergency and Post-Stabilization Services, Availability of Services, Assurances of Adequate Capacity and Services, Coordination and Continuity of Care, Coverage and Authorization of Services, Provider Selection, Confidentiality, Subcontractual Relationships and Delegation, Health Information Systems, and QAPI.	CareSource did not meet all requirements of the Disenrollment: Requirements and Limitations, Enrollee Rights, Grievance and Appeal Systems, and Practice Guidelines standards.	Implement corrective action plans to meet federal and state standards for all unmet requirements.	X	X	X
Network Adequacy – PCP Access	CareSource had the highest rating for offering established patients' timely access to sick visit appointments (70.4%). Established patients were offered timely access to well-check appointments 77.8% of the time.	CareSource's provider directory accuracy rate for new patients was low. Of the PCPs who confirmed they were accepting new patients, 69.6% offered timely well-check appointments and 39.1% offered timely sick appointments.	Implement processes to validate the accuracy of provider data. Encourage practices to improve the availability of well-check and sick visit appointments and to monitor progress.		X	X

EQR Activity	Strengths	Opportunity	Recommendation	Quality	Timeliness	Access
Network Adequacy – Oral Surgeon Access	CareSource had a high rate for MCPN telephone number accuracy (75.4%) compared to other MCOs.	CareSource's provider directory accuracy rate was low. It was found that 11.1% of oral surgeons offered timely appointment access.	Add oral surgeons to the provider network to increase access to timely appointments. Improve contact information accuracy.		X	X
Quality-of-Care Survey – Adult Member Experience	CareSource achieved two adult CAHPS score at or above the 90th national Medicaid percentile for Rating of Personal Doctor and How Well Doctors Communicated. CareSource had four adult CAHPS measures between the 75th and 89th national Medicaid percentiles related to Rating of Specialist Seen Most Often, Getting Needed Care, Coordination of Care, and Customer Service.		Address priority areas noted in the full CAHPS report, including members' ability to get care, appointments, and treatment as soon as needed.	X	X	X
Quality-of-Care Survey – Child Member Experience	CareSource achieved one child CAHPS score at or above the 90th national Medicaid percentile for Getting Care Quickly. CareSource achieved one child CAHPS scores between the 75th and 89th national Medicaid percentiles	CareSource had one child CAHPS score below the 25th national Medicaid percentile. Performance was related to Customer Service. CareSource had three scores between the 25th and 49th percentiles for Rating of Health Plan,	Address priority areas noted in the full CAHPS report including assuring members' personal doctors spend enough time with them.	X	X	X

EQR Activity	Strengths	Opportunity	Recommendation	Quality	Timeliness	Access
	for Getting Needed Care.	Rating of Specialist Seen Most Often, and How Well Doctors Communicate.				
EDV	None.	CareSource had several data elements that were extracted incorrectly for the EDV study.	Maintain corrections implemented following EDV studies.			

Gray shading: activities without a specific link to the three foci but nonetheless important to achieving quality goals; EQR: external quality review; EQRO: external quality review organization; PIP: performance improvement project; IS: information systems; HEDIS: Healthcare Effectiveness Data and Information Set; NCQA: National Committee for Quality Assurance; ODM: Ohio Department of Medicaid; QAPI: Quality Assessment and Performance Improvement Program; MCO: managed care organization; CAHPS: Consumer Assessment of Healthcare Providers and Systems; PCP: primary care provider; MCPN: managed care provider network; KDD: key-driver diagram; SMART: Specific, Measurable, Achievable, Realistic, and Timely; CGM: continuous glucose monitoring; DSME: diabetes self-management education; EDV: encounter data validation.

Table 68: EQR Summary of Strengths, Opportunities, and Recommendations for Humana MCO

EQR Activity	Strengths	Opportunity	Recommendation	Quality	Timeliness	Access
PIP	The percentage of members with diabetes who had a claim for CGM in the 12-month measurement period was 18.8%, which exceeded the SMART Aim goal rate of 17.7%. Humana collaborated with other MCOs to share information and strategies to improve quality and reduce disparities. Humana utilized lessons from previous projects to inform new tests of change.	Humana has not yet met the Diabetes PIP SMART Aim goal rate for DSME.	Continue to test interventions to identify those that show qualitative and quantitative evidence that the change led to sustained improvement in the SMART Aims. Continue to update KDD to show how theory of improvement evolved. Plan for spread beyond the initial population.	**X**	**X**	**X**

EQR Activity	Strengths	Opportunity	Recommendation	Quality	Timeliness	Access
Compliance with Medicaid Standards	Humana met the requirements for Enrollee Rights, Availability of Services, Assurances of Adequate Capacity and Services, Coordination and Continuity of Care, Coverage and Authorization of Services, Provider Selection, Confidentiality, Subcontractual Relationships and Delegation, Practice Guidelines, Health Information Systems, and QAPI	Humana did not meet all requirements of the Disenrollment: Requirements and Limitations, Emergency and Post-stabilization Services, and Grievance and Appeal Systems standards.	Implement corrective action plans to meet federal and state standards for all unmet requirements.	X	X	X
Network Adequacy – PCP Access	None.	Of the PCPs who confirmed they were accepting new patients, 54.9% offered timely well-check appointments and 35% offered timely sick appointments. Established patients were offered access to timely well-check appointments 64.3% of the time and access to timely sick appointments 60.0% of the time.	Implement processes to validate the accuracy of provider data. Encourage practices to improve the availability of well-check and sick visit appointments and to monitor progress.		X	X

Gray shading: activities without a specific link to the three foci but nonetheless important to achieving quality goals; EQR: external quality review; EQRO: external quality review organization; PIP: performance improvement project; MCO: managed care organization; SMART: Specific, Measurable, Achievable, Realistic, and Timely; KDD: key-driver diagram; PCP: primary care provider; CGM: continuous glucose monitoring; DSME: diabetes self-management education; QAPI: Quality Assessment and Performance Improvement Program.

Table 69: EQR Summary of Strengths, Opportunities, and Recommendations for Molina MCO

EQR Activity	Strengths	Opportunity	Recommendation	Quality	Timeliness	Access
PIP	Molina collaborated with other MCOs to share information and strategies to improve quality and reduce disparities. Molina utilized lessons from previous projects to inform new tests of change.	Molina has not yet met the Diabetes PIP SMART Aim goal rates.	Continue to test interventions to identify those that show qualitative and quantitative evidence that the change led to sustained improvement in the SMART Aims. Continue to update KDD to show how theory of improvement evolved. Plan for spread beyond the initial population.	X	X	X
Performance Measures	Molina met all IS standards for reporting HEDIS data to NCQA and to ODM. Molina met 100% of the MPSs for MY 2021. Molina was the only MCO to score 100% on this measure.	None.	None.	X	X	X
Compliance with Medicaid Standards	Molina met all the requirements of for Enrollee Rights, Emergency and Post-Stabilization Services, Availability of Services, Assurances of Adequate Capacity and Services, Coordination and Continuity of Care, Coverage and Authorization of Services, Provider Selection, Confidentiality, Subcontractual	Molina did not meet all requirements of the Disenrollment: Requirements and Limitations, and Grievance and Appeal Systems standards.	Implement corrective action plans to meet federal and state standards for all unmet requirements.	X	X	X

EQR Activity	Strengths	Opportunity	Recommendation	Quality	Timeliness	Access
	Relationships and Delegation, Practice Guidelines, Health Information Systems, and QAPI.					
Network Adequacy – PCP Access	Molina's provider directory accuracy rates for timely access to well-check appointments for new patients (81.8%) and established patients (86.2%) were the highest compared to other MCOs. Established patients were offered timely access to sick appointments 65.5% of the time	Molina's provider directory accuracy rate was low. Of the PCPs who confirmed they were accepting new patients, 36.4% offered timely sick appointments.	Implement processes to validate the accuracy of provider data. Encourage practices to improve the availability of well-check and sick visit appointments and to monitor progress.		**X**	**X**
Network Adequacy – Oral Surgeon Access	None.	It was found that 21.4% of oral surgeons offered timely appointment access.	Add oral surgeons to the provider network to increase access to timely appointments. Improve contact information accuracy.		**X**	**X**
Quality-of-Care Survey – Adult Member Experience	Molina achieved adult CAHPS scores at the 90th percentile or above on three measures and between the 75th and 89th national Medicaid percentiles on two measures. Performance was highest for Rating of Specialist Seen Most Often, , Getting	Molina had one adult CAHPS scores between the 25th and 49th national Medicaid percentiles, which was Rating of Personal Doctor.	Address CAHPS measures identified in the full report as having the greatest room for improvement and likely impact on scores, which were assuring members get care as soon as needed, ease getting treatment, and getting an appointment with a specialist as soon as needed.	**X**	**X**	**X**

EQR Activity	Strengths	Opportunity	Recommendation	Quality	Timeliness	Access
	Needed Care, and Coordination of Care.					
Quality-of-Care Survey – Child Member Experience	Molina achieved two child CAHPS scores at the 90th percentile or above, and one between the 75th and 89th national Medicaid percentiles. Top performing areas were How Well Doctors Communicate, Coordination of Care, and Rating of Personal Doctor.	Molina had two child CAHPS scores below the 25th national Medicaid percentile which were for Rating of Health Plan and Customer Service.	Address CAHPS measures identified in the full report as having the greatest room for improvement and likely impact on scores, which were easy to get treatment needed, getting an appointment with a specialist as soon as needed, and receiving information or help from health plan customer service.	X	X	X
EDV	None.	Molina had several data elements that were extracted incorrectly for this EDV study.	Maintain corrections implemented following EDV studies.			

Gray shading: activities without a specific link to the three foci, but nonetheless important to achieving quality goals; EQR: external quality review; EQRO: external quality review organization; PIP: performance improvement project; IS: information systems; HEDIS: Healthcare Effectiveness Data and Information Set; NCQA: National Committee for Quality Assurance; ODM: Ohio Department of Medicaid; MCO: managed care organization; MPS: minimum performance standard; PCP: primary care provider; CAHPS: Consumer Assessment of Healthcare Providers and Systems; SMART: Specific, Measurable, Achievable, Realistic, and Timely; MY: measurement year; KDD: key-driver diagram; EDV: encounter data validation; QAPI: Quality Assessment and Performance Improvement Program.

Table 70: EQR Summary of Strengths, Opportunities, and Recommendations for UnitedHealthcare MCO

EQR Activity	Strengths	Opportunity	Recommendation	Quality	Timeliness	Access
PIP	The percentage of members with diabetes who had a claim for DSME in the 12-month measurement period was	UnitedHealthcare has not yet met the Diabetes PIP SMART Aim goal rates for CGM.	Continue to test interventions to identify those that show qualitative and quantitative evidence that	X	X	X

EQR Activity	Strengths	Opportunity	Recommendation	Quality	Timeliness	Access
	1.2%, which approached the SMART Aim goal rate of 1.5%. UnitedHealthcare collaborated with other MCOs to share information and strategies to improve quality and reduce disparities. UnitedHealthcare utilized lessons from previous projects to inform new tests of change.		the change led to sustained improvement in the SMART Aims. Continue to update KDD to show how theory of improvement evolved. Plan for spread beyond the initial population.			
Performance Measures	UnitedHealthcare met all IS standards required for the successful reporting of HEDIS data to NCQA and to ODM. UnitedHealthcare met 97.7% of the MPSs for MY 2021.	UnitedHealthcare did not meet the minimum performance threshold for one measure in the Behavioral Health category. UnitedHealthcare scored at or below the national average on 50% of quality measures.	Improve performance measures that were below the 75th percentile.	**X**	**X**	**X**
Compliance with Medicaid Standards	UnitedHealthcare met all the requirements of for Emergency and Post-Stabilization Services, Availability of Services, Assurances of Adequate Capacity and Services, Coordination and Continuity of Care, Coverage and Authorization of Services, Confidentiality, Subcontractual Relationships and	UnitedHealthcare did not meet all requirements for the Disenrollment: Requirements and Limitations, Enrollee Rights, Provider Selection, and Grievance and Appeal Systems standards.	Implement corrective action plans to meet federal and state standards for all unmet requirements.	**X**	**X**	**X**

EQR Activity	Strengths	Opportunity	Recommendation	Quality	Timeliness	Access
	Delegation, Practice Guidelines, Health Information Systems, and QAPI.					
Network Adequacy – PCP Access	UnitedHealthcare reported the highest provider directory accuracy rate (94.7%) for accepting new patients compared to the median MCO score of 85.2%.	Of the PCPs who confirmed they were accepting new patients, 50.0% offered timely well-check appointments and 33.3% offered timely sick appointments. Established patients were offered access to timely well-check appointments 68.4% of the time and access to timely sick appointments 52.6% of the time.	Implement processes to validate the accuracy of provider data submitted to the MCPN. Encourage practices to improve the availability of well-check and sick visit appointments and to monitor progress.		X	X
Network Adequacy – Oral Surgeons Access	None.	UnitedHealthcare's provider directory telephone number accuracy rate for oral surgeons was 72.6%. It was found that 6.7% of oral surgeons offered timely appointment access.	Increase the number of oral surgeons in the network to improve access to timely dental care. Improve contact information accuracy.		X	X
Quality-of-Care Survey – Adult Member Experience	UnitedHealthcare achieved one adult CAHPS score at or above the 90th national Medicaid percentile. Performance was related to Coordination of Care. UnitedHealthcare achieved two adult CAHPS score at or between the 75th and 89th national Medicaid percentiles.	UnitedHealthcare achieved one adult CAHPS score at or below the 25th national Medicaid percentile. Performance was related to Rating of Health Plan. Three adult scores were between the 25th and 49th percentiles. Performance was related to Rating of Personal Doctor, Getting Needed Care, and How Well Doctors Communicate.	Address CAHPS measures that fell below the 50th percentile compared to national benchmarks.	X	X	X

EQR Activity	Strengths	Opportunity	Recommendation	Quality	Timeliness	Access
	Performance was related to Rating of Specialist Seen Most Often and Customer Service.					
Quality-of-Care Survey – Child Member Experience	UnitedHealthcare achieved one child CAHPS scores that performed at or above the 90th national Medicaid percentile. Performance was related to Getting Care Quickly. UnitedHealthcare achieved one child CAHPS score between the 75th and 89th national Medicaid percentiles. Performance was related to Customer Service.	UnitedHealthcare achieved six child CAHPS score at or below the 25th national Medicaid percentile. Performance was related to Rating of Health Plan, Rating of All Health Care, Rating of Personal Doctor, Rating of Personal Doctor, Getting Needed Care, and Coordination of Care.	Address CAHPS measures that fell below the 25th percentile compared to national benchmarks.	**X**	**X**	**X**
EDV	None.	UnitedHealthcare had several data elements that were extracted incorrectly for the EDV study.	Maintain corrections implemented following EDV studies.			

Gray shading: activities without a specific link to the three foci but nonetheless important to achieving quality goals; EQR: external quality review; EQRO: external quality review organization; PIP: performance improvement project; MCO: managed care organization; IS: information systems; HEDIS: Healthcare Effectiveness Data and Information Set; NCQA: National Committee for Quality Assurance; ODM: Ohio Department of Medicaid; MPS: minimum performance standard; MCPN: managed care provider network; CAHPS: Consumer Assessment of Healthcare Providers and Systems; QAPI: Quality Assessment and Performance Improvement Program; PCP: primary care provider; SMART: Specific, Measurable, Achievable, Realistic, and Timely; MY: measurement year; KDD: key driver diagram; EDV: encounter data validation.

Table 71: EQR Summary of Strengths, Opportunities, and Recommendations for Aetna MCOP

EQR Activity	Strengths	Opportunity	Recommendation	Quality	Timeliness	Access
PIP	Aetna collaborated with other plans to share information and strategies to improve quality and reduce	Aetna has not yet met the Diabetes PIP SMART Aim goal rates.	Continue to test interventions to identify those that show qualitative and quantitative evidence that the change led to sustained improvement in	**X**	**X**	**X**

EQR Activity	Strengths	Opportunity	Recommendation	Quality	Timeliness	Access
	disparities. Aetna utilized lessons from previous projects to inform new tests of change.		the SMART Aims. Continue to update KDD to show how theory of improvement evolved. Plan for spread beyond the initial population.			
Performance Measures	Aetna met all IS standards for reporting HEDIS data to NCQA and to ODM. Aetna met 100% of the MPSs for MY 2021.	Aetna scored 80% of quality measures below the 25th national Medicaid percentile.	Improve performance measures that were below the 75th percentile.	X	X	X
Compliance with Medicaid Standards	Aetna met all the requirements for: Disenrollment: Requirements and Limitations, Enrollee Rights, Emergency and Post-stabilization Services, Availability of Services, Assurances of Capacity and Services, Coordination and Continuity of Care, Coverage and Authorization of Services, Confidentiality, Subcontractual Relationships and Delegation, Practice Guidelines, Health Information Services and QAPI.	Aetna did not meet all requirements for the Provider Selection, Grievance and Appeal System, and Subcontractual Relationships and Delegation standards.	Implement corrective action plans to meet federal and state standards for all unmet requirements.	X	X	X
Network Adequacy – PCP Access	None.	Aetna's provider directory accuracy rate was low. Of the PCPs who confirmed they	Implement processes to validate the accuracy of provider data. Encourage practices to improve the		X	X

EQR Activity	Strengths	Opportunity	Recommendation	Quality	Timeliness	Access
		were accepting new patients, 62.5% offered timely access to well-check appointments and 43.8% offered access to sick appointments. Established patients were offered timely access to well-check appointments and sick appointments 72.0% of the time.	availability of well-check and sick visit appointments and monitor progress.			
Quality-of-Care Survey – Adult Member Experience	None.	None.	None.	**X**	**X**	**X**
EDV	None.	Aetna had several data elements that were extracted incorrectly for this EDV study.	Maintain corrections implemented following EDV studies.			

Gray shading: activities without a specific link to the three foci but nonetheless important to achieving quality goals; EQR: external quality review; EQRO: external quality review organization; PIP: performance improvement project; IS: information systems; HEDIS: Healthcare Effectiveness Data and Information Set; NCQA: National Committee for Quality Assurance; ODM: Ohio Department of Medicaid; MPS: minimum performance standard; QAPI: Quality Assessment and Performance Improvement Program; SMART: Specific, Measurable, Achievable, Realistic, and Timely; MY: measurement year; KDD: key-driver diagram; EDV: encounter data validation; CGM: continuous glucose monitoring; DSME: diabetes self-management education.

Table 72: EQR Summary of Strengths, Opportunities, and Recommendations for Buckeye MCOP

EQR Activity	Strengths	Opportunity	Recommendation	Quality	Timeliness	Access
PIP	Buckeye collaborated with other MCOPs to share information and strategies to improve quality and reduce disparities. Buckeye utilized lessons from previous projects to inform new tests of change.	Buckeye has not yet met the Diabetes PIP SMART Aim goal rates. Buckeye had the lowest percentage of members with diabetes who had a claim for CGM in the 12-month measurement	Continue to test interventions to identify those that show qualitative and quantitative evidence that the change led to sustained improvement in the SMART Aims. Continue to update KDD to show how theory of improvement evolved. Plan for	**X**	**X**	**X**

EQR Activity	Strengths	Opportunity	Recommendation	Quality	Timeliness	Access
		period (4.1%) across MCOPs. The SMART Aim goal rate is 12.4%.	spread beyond the initial population.			
Performance Measures	Buckeye met all IS standards for reporting HEDIS data to NCQA and ODM. Buckeye met 100% of the MPSs for MY 2021.	Buckeye scored between the 10th and 25th national Medicaid percentiles for 60.0% of quality measures.	Improve performance measures that were below the 75th percentile.	X	X	X
Compliance with Medicaid Standards	Buckeye met all requirements for: Emergency and Post-stabilization Services, Availability of Services, Assurances of Adequate Capacity and Services, Coordination and Continuity of Care, Coverage and Authorization of Services, Provider Selection, Confidentiality, Subcontractual Relationships and Delegation, Practice Guidelines, Health Information Services, and QAPI.	Buckeye did not meet all requirements of the Disenrollment: Requirements and Limitations, Enrollee Rights, and Grievance and Appeal System standards.	Implement corrective action plans to meet federal and state standards for all unmet requirements.	X	X	X
Network Adequacy – PCP Access	Buckeye's provider directory accuracy rate for accepting new patients (78%) was high compared to other MCOPs. Of the PCPs who confirmed they were accepting new patients, 78% offered timely access to well-check appointments.	Buckeye's rate for offering new patients timely access to sick appointments (27.8%) and rates for offering established patients timely access to well-check (69.6%) and/or sick appointments (52.2%) were the lowest compared to other MCOPs.	Implement processes to validate the accuracy of provider data that appears in the provider directory. Encourage practices to improve the availability of well-check and sick visit appointments and monitor progress.		X	X
Network Adequacy – Oral Surgeon Access	Buckeye had the highest response rate for telephone number accuracy for oral surgeons (76.7%).	It was found that 8.3% of oral surgeons offered timely appointment access.	Add oral surgeons to the provider network to increase access to timely appointments. Improve contact information accuracy.		X	X
Quality-of-Care Survey – Adult Member Experience	None.	Buckeye had the highest number of scores at or below the 25th national Medicaid percentile (8 scores). Buckeye CAHPS measures below the 25th percentile related to Rating of Health Plan, Rating of	None.	X	X	X

EQR Activity	Strengths	Opportunity	Recommendation	Quality	Timeliness	Access
		Health Care Quality, Rating of Drug Plan, Rating of Personal Doctor, Rating of Specialist, Doctors Who Communicate Well, Care Coordination, and Pneumonia Vaccine.				
EDV	None.	Buckeye had several data elements that were extracted incorrectly for this EDV study.	Maintain corrections implemented following EDV studies.			

Gray shading: activities without a specific link to the three foci but nonetheless important to achieving quality goals; EQR: external quality review; EQRO: external quality review organization; PIP: performance improvement project; IS: information systems; HEDIS: Healthcare Effectiveness Data and Information Set; NCQA: National Committee for Quality Assurance; ODM: Ohio Department of Medicaid; MPS: minimum performance standard; QAPI: Quality Assessment and Performance Improvement Program; MY: measurement year; MCOP: MyCare Ohio plan; PCP: primary care provider; SMART: Specific, Measurable, Achievable, Realistic, and Timely; KDD: key-driver diagram; CGM: continuous glucose monitoring; EDV: encounter data validation.

Table 73: EQR Summary of Strengths, Opportunities, and Recommendations for CareSource MCOP

EQR Activity	Strengths	Opportunity	Recommendation	Quality	Timeliness	Access
PIP	CareSource had the highest percentage of members with diabetes who had a claim for CGM in the 12-month measurement period (19.5%) and exceeded the SMART Aim goal rate of 12.4%. CareSource had the highest percentage of members with diabetes who had a claim for DSME in the 12-month measurement period (1.9%). This rate is approaching the SMART Aim goal rate of 3.1%.	CareSource has not yet met the Diabetes PIP SMART Aim goal rates for DSME.	Continue to test interventions to identify those that show qualitative and quantitative evidence that the change led to sustained improvement in the SMART Aims. Continue to update KDD to show how theory of improvement evolved. Plan for spread beyond the initial population.	X	X	X

EQR Activity	Strengths	Opportunity	Recommendation	Quality	Timeliness	Access
	CareSource collaborated with other MCOPs to share information and strategies to improve quality and reduce disparities. CareSource utilized lessons from previous projects to inform new tests of change.					
Performance Measures	CareSource met all IS standards for reporting HEDIS data to NCQA and to ODM. CareSource met 100% of the MPSs for MY 2021.	CareSource scored below the 10th national Medicaid percentile for 40.0% of quality measures.	Improve performance measures that were below the 75th percentile.	X	X	X
Compliance with Medicaid Standards	CareSource met all requirements for: Emergency and Post-stabilization Services, Availability of Services, Assurances of Adequate Capacity and Services, Coordination and Continuity of Care, Coverage and Authorization of Services, Provider Selection, Confidentiality, Practice Guidelines, Health Information Systems, and QAPI.	CareSource did not meet all requirements for the Disenrollment: Requirements and Limitations, Enrollee Rights, Grievance and Appeal System, and Subcontractual Relationships and Delegation standards.	Implement corrective action plans to meet all federal and state standards for all unmet requirements.	X	X	X
Network Adequacy – PCP Access	CareSource had the highest provider	CareSource had the lowest rate for PCPs	Implement processes to validate the accuracy of		X	X

EQR Activity	Strengths	Opportunity	Recommendation	Quality	Timeliness	Access
	directory accuracy rate for accepting new patients (85.0%) and highest rate among MCOPs for offering new patients timely access to sick appointments (47.1%). Established patients were offered timely access to sick appointments 70.0% of the time.	who confirmed they were accepting new patients and offered timely access to well-check appointments (52.9%). Established patients were offered timely access to well-check appointments 70.0% of the time.	provider directory information. Encourage practices to improve availability of well-check and sick visit appointments and monitor progress.			
Network Adequacy –Oral Surgeons Access	CareSource had a high rate for provider directory telephone number accuracy (75.4%) compared to other MCOPs.	CareSource's provider directory telephone number accuracy rate for oral surgeons was 72.6%. This was the lowest across MCOPs. It was found that 11.1% of oral surgeons offered timely appointment access.	Add oral surgeons to the provider network to increase access to timely appointments. Improve contact information accuracy.		X	X
Quality-of-Care Survey – Adult Member Experience	CareSource scored the highest number of CAHPS measures at or above the 90th national Medicaid percentile (2 measures) related to Rating of Health Plan and Rating of Drug Plan.	CareSource scored at or below the 25th national Medicaid percentile for the CAHPS measure related to Annual Flu Vaccine.	None.	X	X	X
EDV	None.	CareSource had several data elements that were extracted incorrectly for the EDV study.	Maintain corrections implemented following EDV studies.			

Gray shading: activities without a specific link to the three foci but nonetheless important to achieving quality goals; EQR: external quality review; EQRO: external quality review organization; PIP: performance improvement project; IS: information systems; HEDIS: Healthcare Effectiveness Data and Information Set; NCQA: National Committee for Quality Assurance; ODM: Ohio Department of Medicaid; MCOP: MyCare Ohio plan; PCP: primary care provider; SMART: Specific, Measurable, Achievable, Realistic, and

Timely; KDD: key-driver diagram; CGM: continuous glucose monitoring; DSME: diabetes self-management education; QAPI: Quality Assessment and Performance Improvement Program; EDV: encounter data validation.

Table 74: EQR Summary of Strengths, Opportunities, and Recommendations for Molina MCOP

EQR Activity	Strengths	Opportunity	Recommendation	Quality	Timeliness	Access
PIP	Molina collaborated with other MCOPs to share information and strategies to improve quality and reduce disparities. Molina utilized lessons from previous projects to inform new tests of change.	Molina has not yet met the Diabetes PIP SMART Aim goal rates. Molina had the lowest percentage of members with diabetes who had a claim for DSME in the 12-month measurement period (1.1%). The SMART Aim goal rate is 3.1%.	Continue to test interventions to identify those that show qualitative and quantitative evidence that the change led to sustained improvement in the SMART Aims. Continue to update KDD to show how theory of improvement evolved. Plan for spread beyond the initial population.	X	X	X
Performance Measures	Molina met all IS standards for reporting HEDIS data to NCQA and to ODM. Molina met 100% of the MPSs for MY 2021.	Molina has the most (80%) measures below the 25th national Medicaid percentile compared to the median MCOP score of 45%.	Improve performance measures that were below the 75th percentile.	X	X	X
Compliance with Medicaid Standards	Molina met all the requirements of for Enrollee Rights, Emergency and Post-Stabilization Services, Availability of Services, Assurances of Adequate Capacity and Services, Coordination and Continuity of Care, Coverage and Authorization of	Molina did not meet all requirements for the Disenrollment: Requirements and Limitations and Grievance and Appeal System standards.	Implement corrective action plans to meet all federal and state standards for unmet requirements.	X	X	X

EQR Activity	Strengths	Opportunity	Recommendation	Quality	Timeliness	Access
	Services, Provider Selection, Confidentiality, Subcontractual Relationships and Delegation, Practice Guidelines, Health Information Systems, and QAPI.					
Network Adequacy – PCP Access	Molina's provider directory accuracy rate for offering new patients timely access to well-check appointments (82.8%) was the highest compared to other MCOPs.	Of the PCPs who confirmed they were accepting new patients, 44.8% offered timely access to sick appointments. Established patients were offered timely access to well-check appointments 76.5% of the time and to sick appointments 62.2% of the time.	Implement processes to validate the accuracy of provider data prior to submitting it for the provider directory. Encourage practices to improve the availability of well-check and sick visit appointments and to monitor progress.		**X**	**X**
Network Adequacy – Oral Surgeon Access	None.	Molina's provider directory telephone number accuracy rate for oral surgeons was 74.6%. It was found that 21.4% of oral surgeons offered timely appointment access.	Add oral surgeons to the provider network to increase access to timely appointments. Improve contact information accuracy.		**X**	**X**
Quality-of-Care Survey – Adult Member Experience	Molina achieved one CAHPS score at or above the 90th national Medicaid percentile for Rating of Drug Plan.	Molina had three CAHPS scores at or below the 25th national Medicaid percentile related to Rating of Specialist,	None.	**X**	**X**	**X**

EQR Activity	Strengths	Opportunity	Recommendation	Quality	Timeliness	Access
	Molina scored between the 75th and 89th national Medicaid percentiles for two CAHPS measures related to Rating of Health Plan and Getting Appointments and Care Quickly.	Doctors Who Communicate Well, and Annual Flu Vaccine.				
EDV	None.	Molina had several data elements that were extracted incorrectly for this EDV study.	Maintain corrections implemented following EDV studies.			

Gray shading: activities without a specific link to the three foci but nonetheless important to achieving quality goals; EQR: external quality review; EQRO: external quality review organization; PIP: performance improvement project; IS: information systems; HEDIS: Healthcare Effectiveness Data and Information Set; NCQA: National Committee for Quality Assurance; ODM: Ohio Department of Medicaid; MCOP: MyCare Ohio plan; MPS: minimum performance standard; PCP: primary care provider; SMART: Specific, Measurable, Achievable, Realistic, and Timely; MY: measurement year; KDD: key-driver diagram; DSME: diabetes self-management education; EDV: encounter data validation; QAPI: Quality Assessment and Performance Improvement Program.

Table 75: EQR Summary of Strengths, Opportunities, and Recommendations for UnitedHealthcare MCOP

EQR Activity	Strengths	Opportunity	EQRO Assessment/Recommendation	Quality	Timeliness	Access
PIP	UnitedHealthcare collaborated with other MCOPs to share information and strategies to improve quality and reduce disparities. UnitedHealthcare utilized lessons from previous projects to inform new tests of change.	UnitedHealthcare has not yet met the Diabetes PIP SMART Aim goal rates.	Continue to test interventions to identify those that show qualitative and quantitative evidence that the change led to sustained improvement in the SMART Aims. Continue to update KDD to show how theory of improvement evolved. Plan for spread beyond the initial population.	X	X	X
Performance Measures	UnitedHealthcare met all IS standards for	UnitedHealthcare had 80% of performance	Improve performance measures that were below the 75th percentile.	X	X	X

EQR Activity	Strengths	Opportunity	EQRO Assessment/Recommendation	Quality	Timeliness	Access
	reporting HEDIS data to NCQA and to ODM. UnitedHealthcare met 100% of the MPSs for MY 2021.	measures below the 25th national Medicaid percentile.				
Compliance with Medicaid Standards	UnitedHealthcare met all requirements for: Emergency and Post-stabilization Services, Availability of Services, Assurances of Adequate Capacity and Services, Coordination and Continuity of Care, Coverage and Authorization of Services, Confidentiality, Subcontractual Relationships and Delegation, Practice Guidelines, Health Information Systems and QAPI.	UnitedHealthcare did not meet all requirements for the Disenrollment: Requirements and Limitations, Enrollee Rights, Provider Selection, and Grievance and Appeal System standards.	Implement corrective action plans to meet federal and state standards for all unmet requirements.	X	X	X
Network Adequacy – PCP Access	UnitedHealthcare had the highest provider directory accuracy rate for accepting new patients (85.0%) and offering established patients timely access to well-check appointments (76.5%) compared to other MCOPs.	Of the PCPs who confirmed they were accepting new patients, 76.9% offered timely access to well-check appointments and 46.2% offered access to sick appointments. Established patients were offered timely access to sick appointments 58.8% of the time.	Implement processes to validate the accuracy of provider data. Encourage practices to improve the availability of well-check and sick visit appointments and monitor progress.		X	X

EQR Activity	Strengths	Opportunity	EQRO Assessment/Recommendation	Quality	Timeliness	Access
Network Adequacy – Oral Surgeons Access	None.	UnitedHealthcare reported the lowest provider directory telephone number accuracy rate for oral surgeons (72.6%). It was found that 6.7% of oral surgeons offered timely appointment access.	Add oral surgeons to the provider network to increase access to timely appointments. Improve contact information accuracy.		X	X
Quality-of-Care Survey – Adult Member Experience	UnitedHealthcare achieved one CAHPS score between the 75th and 89th national Medicaid percentiles for Rating of Drug Plan.	UnitedHealthcare scored between the 25th and 49th national Medicaid percentiles for CAHPS measures related to Rating of Health Care Quality, Rating of Personal Doctor, Doctors Who Communicate Well, Customer Service, Care Coordination, and Annual Flu Vaccine. UnitedHealthcare had the highest number of scores in this percentile (6 scores). UnitedHealthcare scored at or below the 25th national Medicaid percentile for CAHPS measures related to Rating of Specialist.	None.		X	X
EDV	None.	UnitedHealthcare had several data elements that were extracted	Maintain corrections implemented following EDV studies.			

EQR Activity	Strengths	Opportunity	EQRO Assessment/Recommendation	Quality	Timeliness	Access
		incorrectly for the EDV study.				

Gray shading: activities without a specific link to the three foci but nonetheless important to achieving quality goals; EQR: external quality review; EQRO: external quality review organization; PIP: performance improvement project; MCOP: MyCare Ohio plan; IS: information systems; HEDIS: Healthcare Effectiveness Data and Information Set; NCQA: National Committee for Quality Assurance; ODM: Ohio Department of Medicaid; QAPI: Quality Assessment and Performance Improvement Program; MPS: minimum performance standard; SMART: Specific, Measurable, Achievable, Realistic, and Timely; MY: measurement year; KDD: key-driver diagram; EDV: encounter data validation.

Overall, findings from SFY 2023-2024 EQR activities highlight the MCEs' continued commitment to achieving the goals of the Ohio Medicaid quality strategy. Strengths related to **quality**, **timeliness**, and **access** were observed across all covered populations. For example:

- More members living with diabetes are engaged in monitoring their blood glucose levels than were previously.
- Plans met 100% of their contractual requirements in most areas during the comprehensive administrative review, demonstrating both documentation and knowledge of the many program standards that ODM and CMS have prioritized.
- Members' satisfaction with their care, particularly adult members, meets or exceeds national benchmarks in many CAHPS domains.
- Ohio Medicaid achieved high scores for behavioral health care HEDIS measures, including scoring at or above the 75th percentile on:
  - Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics,
  - Follow-up After Emergency Department Visit for Substance Use, 7-Day Follow-up, and
  - Follow-up After Emergency Department Visit for Substance Use, 30-Day Follow-up.

However, numerous quality measures showed room for improvement either compared to national benchmarks or to other Medicaid MCOs and MCOPs. For example:

- Participation in diabetes self-management education lags behind goals, but plans still have time to ensure members get this valuable disease management resource.
- Compliance with contractual requirements for handling grievances and appeals and handling disenrollments showed some shortfalls.
- Provider directories include outdated contact and participation information for a high proportion of providers, challenging members' ability to get needed care.
- Many providers cannot meet access standards, particularly for patients new to their practices.
- Parents of Medicaid-enrolled children rate their plans poorly overall, and in particular, they rate customer service poorly.

MCOs and MCOPs will be required to take action to address the opportunities identified in this report, and those actions will be summarized in the SFY 2024 EQR technical report.

IX. Appendix A: IPRO's Assessment of MCO Responses to the SFY 2022 EQR Recommendations

Title 42 CFR § 438.364 External quality review results (a)(6) requires each annual technical report to include "an assessment of the degree to which each MCO, PIHP, PAHP, or PCCM[17] entity has effectively addressed the recommendations for quality improvement made by the EQRO during the previous year's EQR." To achieve full compliance with this federal regulation, IPRO requested each MCO provide a written summary of actions taken in response to recommendations provided in the *Ohio External Quality Review Annual Technical Report, SFY 2022*. Using this information, IPRO determined the extent to which each MCO addressed recommendations. The SFY 2022 Annual Technical Report did not include the MCOPs, PIHP, or PAHP, so there are no responses from those plans.

IPRO provided each MCO with a standardized response form to describe current and planned QI interventions aimed at addressing the SFY 2022 EQR recommendations. For each recommendation, the MCOs were asked to answer the following questions:

- What has the MCO done or planned to do to address the recommendation?
- When and how will this be accomplished?
- What are the expected outcomes or goals of the actions to be taken?
- What is the MCO's process for monitoring the actions to determine their effectiveness?

Table 76 displays the determination categories used by IPRO for this assessment, while **Table 77** through **Table 80** display MCO responses to the recommendations and IPRO's assessment of the response.

Table 76: Assessment Determinations and Definitions

Assessment Determinations and Definitions
Addressed
MCO's QI response addressed the recommendation.
Partially addressed
MCO's QI response addressed most but not all recommendations.
Remains an opportunity for improvement
MCO's QI response did not address the recommendations.

MCO: managed care organization; QI: quality improvement.

[17] Primary care case management.

Table 77: Buckeye's Response to the SFY 2022 EQR Recommendations

Topic Area	Recommendation	MCO's Response	IPRO's Assessment
PIP	While all goals were met, to achieve the higher standards set by ODM for FY 2023, 1) increase attendance in the DSME program, 2) convert members to 90-day insulin supply, 3) enroll members on CGM in remote monitoring, and 4) remove prior authorization requirement for selected providers.	1) The Diabetes Self-Management Education (DSME) program continues to be worked by the care managers and care coordinators. If current members are diagnosed with diabetes, then the care managers and care coordinators work with the Buckeye Health Plan (BHP) members so they can help to self-regulate their diabetes. This increases the number of BHP members that are working with the DSME program. 2) In 2024, Buckeye Health Plan (BHP) will implement a quarterly fax outreach to our top providers to encourage up to 102-day supply of insulin based on current SPBM formulary restrictions. Prescriptions written for insulin have wide variability in days' supply submitted by pharmacies. Buckeye would consider anything over 60-days' supply as an extended days' supply and a success. We will start this in Q1 of 2024 via faxes to our top providers to encourage the writing of extended day supplies. Buckeye will monitor days' supply throughout the calendar year for percentage of members with extended days' supply. We will need to establish a baseline for the first 6 months of the year and then establish a goal based on our experience in the first 6 months. Buckeye will review SPBM claims and track percentage of 30-day prescriptions vs extended days' supply. The quality of this data is contingent on accurate and complete claims received from the SPBM. 3) For the continuous glucose monitor (CGM) the Buckeye Health Plan has removed prior authorizations for pharmacy benefits. This will allow more members with diabetes to monitor their glucose levels. Follow-up will be made by BHP care managers to ensure the members are properly utilizing this service. 4) Effective April 1, 2023, Buckeye removed prior authorization (PA) requirements for CGMs and associated testing supplies for the Medicaid line of business for participating (PAR) providers. Moving forward, Buckeye only requires a PA if providers/members request over the Medicaid fee-for-service (FFS) fee schedule limits for these items.	Addressed.
PIP	Apply the learnings from the KDD, intervention testing, process mapping and run charts to carry out future quality improvement initiatives aimed at members with diabetes.	BHP reviews member information on diabetes monthly. BHP uses multiple sources of data to monitor current processes and procedures and create new initiatives. BHP is leveraging the care managers and care guides to assist members with diabetes to ensure they are properly following care instructions. BHP is also ensuring that all members have a primary care physician designated to help try to schedule annual visits to better manage members health outcomes, including diabetes.	Addressed.

Topic Area	Recommendation	MCO's Response	IPRO's Assessment
PIP	Ensure continued medication adherence for members.	In 2024, Buckeye Health Plan will implement a quarterly text outreach to our non-adherent members who have not had recent refills to encourage adherence to diabetic medications (all diabetic medications excluding insulin) based on current adherence levels and lack of recent refills. BHP will monitor adherence levels throughout the calendar year for the percentage of members that are 80% adherent. We will need to establish a baseline for the first 6 months of the year and then establish a goal based on our experience in the next 6 months. BHP will review Single Pharmacy Benefit Manager (SPBM) claims and track the percentage of members who are 80% adherent. The quality of this data is contingent on accurate and complete claims received from the SPBM.	Addressed.
Performance Measures	Improve performance measures that were below the statewide average and those that did not meet the minimum performance standards noted in the SFY 22 report. • Well-Child Visits for Ages 15 Months— 30 Months • Child and Adolescent Well-Care Visits for all ages • WCC BMI Percentile, Counseling for Nutrition, Counseling for Physical Activity • Annual Dental Visit • CIS Combination 10 • IMA HPV Vaccine IMA Combination 2 • Postpartum Care • UOP Multiple Prescribers	Buckeye Health Plan is continuously working on performance measures to make improvements to quality scores. BHP places more emphasis on the underperforming performance measures, but we are always looking for ways to improve all performance measures. Buckeye Health Plan monitors all measures monthly and shares the results with cross-functional teams and senior leadership. Buckeye Health Plan uses month over month and year over year trends to improve access and timeliness of all measures. Success is determined by meeting or exceeding the established metrics, both internally and set by the Ohio Department of Medicaid, Centers for Medicare and Medicaid Services, and the National Committee for Quality Assurance. In addition to other performance items mentioned in this response, some of the other performance measures BHP is also working on include: (1) BHP is working on connecting members to a dentist and getting appointments. This involves partnering with Envolve Dental to get members a dentist and an appointment and having care guides outreach to get members an appointment and any needed transportation they may need. Based on these extra steps, BHP is trying to ensure its members will go to regular dental visits. BHP is monitoring all gap closure on our quality path to 4 dossier, Care Guide dossier, and manual tracking. (2) BHP is working on connecting members to their primary care physicians for them to provide proper Immunizations. BHP is performing the following items: a. Q3 Member Outreach Campaign to active members – primary care physician engagement, appointment reminders, and facilitation. b. Care guides outreach to members who need both a well child visit and IMA Combo 2. c. Member incentives for receiving certain immunizations. d. Well-visit/vaccination messaging in target areas on social media, streaming services, billboards, etc.	Addressed.

Topic Area	Recommendation	MCO's Response	IPRO's Assessment
		e. Partnering with local health departments to drive members to their immunization events. f. Partnering with Partners For Kids (PFK). g. Reviewing HealthChek forms for family identified gaps. h. Partnering with providers. All items noted below are actions currently occurring with BHP. a. Weekly tracking to ensure on track to meet measure. b. Outreach changed to focus on primarily members who have not had a PCP visit in the past 12 months. c. Text approved - deployment expected week of 12/11/23. d. Due to cost, focusing on well visits - Final approvals received. Messaging to 70k members in target zip codes using digital ads, Facebook, Instagram, and Tik Tok to launch 11/9/23. e. Making members aware of Health Department immunization events in their area. f. Collaboration with PFK for members needing immunizations. g. Attempted additional outreach for HealthChek forms for families indicating need for Immunization, Visits, etc. h. Giving providers gap lists for their members to make them aware of their patients that need immunizations. Expected outcome is to meet the MPSO goal: To get the members the needed vaccinations. IMA: Gaps: 728 CIS: Combo 3 Gaps: 89 BHP is monitoring all gap closure on our "Quality Path to 4" dossier, Care Guide dossier, and manual tracking. (3) Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET) Engagement 18+ -- to Utilize peer supporters to help members get follow up treatment. a. Utilize Thrive supporters to meet with members before leaving the hospital/ED. b. The members engaged will get the outpatient care that is needed. c. BHP is monitoring all gap closure on our "Quality Path to 4" dossier. We are already meeting MPSO for this measure.	

Topic Area	Recommendation	MCO's Response	IPRO's Assessment
		(4) Follow-Up After Hospitalization for Mental Illness (FUH) 7-day 6-17 years of age a. Utilize peer supporters to help members get follow up treatment. b. Complete BH HEDIS Assessments with members post discharge to create a pseudo claim. c. Increasing member engagement with Care Managers. All below actions are currently being performed by BHP: a. Utilize Thrive supporters to meet with members before leaving the hospital/ED. b. Care coordination team is reaching out to members to engage them in CM and to complete the BH HEDIS assessment. The expected outcome is for members to get the outpatient care that is needed. Gaps to close: 23. To determine effectiveness, BHP will monitor all gap closure on our "Quality Path to 4" dossier and through manual tracking.	
Compliance with Medicaid Standards	None.	Not applicable.	Not applicable.
Network Adequacy – PCP Access	Implement processes to validate the accuracy of provider data prior to submitting to the MCPN. Encourage practices to improve availability of well visit appointments.	Buckeye Health Plan is continually reminding providers of the importance of providing timely and accurate data to the Provider Network Management module. We do this through electronic newsletters, provider meetings, and regular interactions with providers. Our value-based contracts now include well visit appointments as a measurable quality metric, which in turn helps reiterate the importance of these exams to our contracted providers.	Addressed.
Network Adequacy – Dental and BH Access	Add dentists and BH providers to the provider network to increase access to timely appointments. Improve contact information accuracy for BH providers.	Buckeye Health Plan's dental contracting team regularly identifies when additional/new dentists are contracted with ODM. Once they are contracted, they are recruited to join our dental network. Buckeye Health Plan now has automated queries that identify when new BH provides are contracted with ODM. Once they are, they are recruited to join our BH provider network.	Partially addressed.
Quality-of-Care Survey – Child	Address CAHPS measures that fell below the statewide average, noted in the SFY 22 report.	Buckeye Health Plan has taken a comprehensive approach to look at Consumer Assessment of Healthcare Providers and Systems (CAHPS) and outcomes within the survey to identify opportunities for improvement across the board since the time of this	Addressed.

Topic Area	Recommendation	MCO's Response	IPRO's Assessment
Member Experience	• Rating of Specialist Seen Most Often (Adult and Child) • Getting Needed Care (Adult and Child) • How Well Doctors Communicate (Adult and Child) • Coordination of Care (Child) • Rating of Health Plan (Child) • Rating of All Health Care (Child) • Rating of Personal Doctor (Child) • Getting Care Quickly (Child)	survey and moving into the future. The MY2020 CAHPS results showed opportunities in the listed composites and ratings for the period: • Rating of All Healthcare • Rating of Personal Doctor • Care Coordination Taking an aggressive approach to increase access to services, encourage care coordination during the public health emergency (PHE), and to remove barriers to equitable care, Buckeye Health Plan considered trends in utilization in medical and pharmacy, related grievances in access to care, and took steps to create operational efficiencies to reduce barriers to care. Some of the initiatives included: • Allowing transportation access to moms and children on an unlimited basis for preventative health services. • Modifications to our PCP attribution process to ensure members were assigned to providers of choice. • Enhanced member outreach campaigns for preventative health and chronic conditions. • Establishment of workstreams dedicated to enhancing the member experience. • Provider collaboration to increase understanding around CAHPS, culturally and linguistically appropriate services (CLAS), and member experience principles. These initiatives were implemented during the PHE and have continued to move through continual process improvement using quality improvement (QI) science protocols under the Service workstream. To ensure members and providers were aware of the changes, BHP utilized the listed tactics and forums: • Interdepartmental workstreams • Member communication of enhanced offerings • Provider communications – face to face engagement, newsletters, and joint operating committee (JOC) meetings As member experience tactics generally take considerable time for the effects to be realized, Buckeye Health Plan did see some increase in metrics identified to monitor outcomes (grievances, call volume on related interventions, provider satisfaction, member experience surveys) immediately – within the next survey timeframe. Additional tactics continue to positively affect the member experience and journey throughout the next two survey cycles.	

Topic Area	Recommendation	MCO's Response	IPRO's Assessment
		Buckeye continues to monitor survey outcomes on an annual basis (as they become available via CAHPS) and identified metrics related to grievances, disenrollment trends, and utilization monthly.	
Encounter Data Validation	None.	Not applicable.	Not applicable.
Quality Rating	Buckeye should work on well-child quality metrics.	For Q3 2023, BHP began a Member Outreach Campaign to active members – primary care physician (PCP) engagement: appointment reminders and facilitation. We also started Well-visit messaging in target areas on social media, streaming services, billboards, etc. BHP staff targeted care guide outreach for well-visit scheduling, including all members in household: 1) Collaboration with HUB. 2) Partnering with Partners For Kids (PFK). 3) Reviewing HealthChek forms for family identified gaps. This will be accomplished as noted with activities that are currently occurring through Buckeye Health Plan: 1) Weekly monitoring of outcomes to decide whether additional interventions required. 2) Messaging to 70k members in target zip codes utilizing digital ads, Facebook, Instagram, and Tik Tok to launched on 11/9/23. 3) Tracking on Care guides (CG) dossier. Care Guides working from dossier as well as comprehensive primary care (CPC) supplied lists. 4) HUB partnership includes an incentive. Started in August. Collaboration with PFK for members needing Well Child Visits. Attempted additional outreach for HealthChek forms for families indicating need for immunization, visits, etc. The expected outcomes are to meet the MPSO: To get the children to the provider for well child visits (WCV). WCV 3-11 Gaps: 9001 WCV 12-17 Gaps: 6011 WCV First 15 months: Already meeting minimum performance standards outliers (MPSO) WCV 15-30 months Gaps: 223	Addressed.

Topic Area	Recommendation	MCO's Response	IPRO's Assessment
		BHP is monitoring all gap closures on our "Quality Path to 4" dossier, Care Guide dossier, and manual tracking.	

SFY: state fiscal year; EQR: external quality review; MCO: managed care organization; PIP: performance improvement project; IS: information systems; HEDIS: Healthcare Effectiveness Data and Information Set; ODM: Ohio Department of Medicaid; MPSO: minimum performance standard outlier; MY: measurement year; MCP: managed care plan; CAHPS: Consumer Assessment of Healthcare Providers and Systems; PCP: primary care provider; MCPN: managed care provider network; FY: fiscal year; SPBM: single pharmacy benefit manager; Q: quarter; KDD: key-driver diagram; BMI: body mass index; HPV: human papillomavirus; ED: emergency department; CM: care management; BH: behavioral health.

Table 78: CareSource's Response to the SFY 2022 EQR Recommendations

Topic Area	Recommendation	MCO's Response	IPRO's Assessment
PIP	Continue to engage members in their health and provide diabetes services (e.g., care coordination, DSME, in-home HbA1c testing, etc.) to achieve diabetes management objectives.	CareSource has continued to provide case management outreach and care coordination to achieve diabetes management objectives. This is being accomplished by improvements in our diabetes care planning and member outreach.	Addressed.
PIP	Continue to identify member and provider preferences for various initiatives to reduce HbA1c levels.	Voice of the Customer is continuously collected as part of the Quality Improvement process from both the member and provider point of view as well as any vendors, community-based organizations or other partners to ensure it is incorporated into interventions. CareSource has continued and will continue to collect and document any feedback within the PIP IHI documentation. The feedback has and will be used to make adjustments to interventions where needed to become more impactful. This recommendation will be an ongoing process to ensure that access remains and that provider and/or member preferences are accounted for and taken into consideration for ongoing and new initiatives. CareSource expects to see adjustments to PDSA testing, improvements in member satisfaction and reductions in complications due to uncontrolled diabetes for members who have participated in the intervention. Additionally, we anticipate additional members utilizing the benefits as they are communicated to members and providers. CareSource continues to identify member and provider preferences based on feedback from our consumer experience "voice of the customer" collaborations.	Addressed.
PIP	Continue applying the learnings from KDDs, PDSA testing, process mapping, and run charts to refine and carry out future	As part of the PIP, CareSource has continued to adapt testing and apply learnings to applicable QI tools and making decisions on adapting, adopting, or abandoning interventions based on refreshing data and run charts. CareSource has also committed to evaluating the success of the interventions throughout 2024 and to sustain or improve	Addressed.

Topic Area	Recommendation	MCO's Response	IPRO's Assessment
	quality improvement initiatives aimed at members with diabetes.	upon gains in DSME and CGM utilization as well as mitigate any reduction in utilization through additional intervention testing via PDSAs. The evaluation will be completed through ongoing refresh of run charts, data, and any other applicable QI tools. Through the continued evaluation of the success of the interventions implemented in the PIP, CareSource will determine if interventions will be successful in the long term, and if there are changes in utilization, address them by completing further QI testing with the other Ohio Medicaid Plans. To monitor the effectiveness, CareSource has committed to rerunning data on a quarterly basis to review and make decisions on the success of the interventions. We have also committed to continuing to collect Voice of the Customer for our members, providers, community-based organizations and other partners to determine if the adopted interventions are still meeting the needs of the population. CareSource continues to apply the learnings from PDSA testing, member and provider feedback, process mapping, run charts, and KDDs. Some of these learnings are: Outreaching members at their normal schedules to avoid abrasion and offering transportation or providing home testing for those with transportation challenges and working with Pulsewrx to provide phones for members needing CGM.	
PIP	Update KDD as PDSA cycle worksheets are updated and tests are either adopted, adapted, or abandoned.	Throughout the end of 2023, CareSource updated the KDD in accordance with determinations of whether tests were effective. The determinations of test effectiveness was evaluated through both qualitative and quantitative feedback. CareSource will continue to use this method, both in this PIP and in other QI initiatives that are completed in 2024. Through these updates to the KDD and PDSA cycle worksheets, CareSource will be able to stay organized and ensure that the documentation is completed to accurately show the evolution of key drivers and interventions over the course of the project. CareSource's process is to regularly review qualitative and quantitative data with stakeholders and to make informed decisions about the success of interventions and necessary changes to the KDD. CareSource also has a designated team responsible for updating KDD and PDSA cycle worksheets.	Addressed.
Performance Measures	Improve upon performance measures, focusing on those that were below the statewide average and those that did not meet the minimum performance	CareSource has continuously reviewed HEDIS data, including presenting the information to applicable stakeholders and leadership to determine which metrics need to be prioritized for improvement. These presentations will continue throughout 2024 as HEDIS for MY2023 closes to identify areas of opportunity. CareSource has also developed robust Population Health Management Strategy which includes Quality Improvement activity to focus on throughout 2024 and beyond. This strategy includes a look at our	Addressed.

Topic Area	Recommendation	MCO's Response	IPRO's Assessment
	standards, noted in the SFY 22 report. • WCC Counseling for Nutrition-Ages 3-11 • WCC Counseling for Physical Activity for all ages • IMA HPV Vaccine • IMA Combination 2 • Postpartum Care • AMM Effective Acute Phase Treatment, Effective Continuation Phase • PEC Systemic Corticosteroid, Bronchodilator	provider network, our membership, health disparities (geographic, racial, ethnic, etc.), and a plan to address any gaps that we are able to identify. Additionally, CareSource is working with ODM to determine where CareSource is an outlier for poor performance in Ohio Medicaid for HEDIS metrics in MY2022 to determine areas of improvement. Through this strategy, CareSource anticipates continuously evaluating areas of necessary improvement as well as building upon current areas of meeting benchmarks for continuous improvement. Additionally, the strategy lays the foundation for QI activities and projects to improve HEDIS metrics for coming years.	
Compliance with Medicaid Standards	None.	Not applicable.	Not applicable.
Network Adequacy – PCP Access	Implement processes to validate the accuracy of provider data prior to submitting to the MCPN. Encourage practices to improve availability of well visit appointments.	The Network Strategy and Contracting team met with inter-departmental teams including Network Operations, Network Adequacy and Health Partner Life Cycle/Provider Information Management and will be bringing forward a recommendation at the January 17th Network Development and Management Plan (NDMP) Committee to vote on an intervention and establish a workgroup that will look at all sources of MCPN data (internal and shared response data from ODM) to align and improve accuracy.	Partially addressed.
Network Adequacy – Dental and BH Access	Add dentists and BH providers to the provider network to increase access to timely appointments for needed care.	We expect DentaQuest to continue their process of looking at non-par provider claims monthly and targeting the highest non-par utilizers to see if they can recruit them into the network. For Behavioral Health: • discuss monthly during the NDMP Committee • built a Provider map for contracted and non-contracted Opioid Treatment Program (OTP) providers to work on increasing access • are building a Provider map for contracted and non-contracted applied behavior analysis (ABA) providers to work on increasing access • Identify and implement innovative programming to enhance access and availability	Addressed.

Topic Area	Recommendation	MCO's Response	IPRO's Assessment
		• Support workforce to increase access and availability • Increase efficiencies for Providers to reduce / avoid Provider abrasion • Ongoing access and availability assessments • Voice of the customer from Providers and members	
Quality-of-Care Survey – Adult/ Child Member Experience	Address CAHPS measures that fell below the statewide average, noted earlier in this report. • Rating of All Health Plan (Adult and Child) • Rating of Personal Doctor (Adult and Child) • Rating of All Health Care (Child) • How Well Doctors Communicate (Child) • Customer Service (Child) • Coordination of Care (Child)	To improve areas where CareSource's CAHPS measures fell below the statewide average, CareSource has developed a CareSource Quality Patient Experience Guide which has been presented to providers over the course of 2023. The guide has a lot of interactive information for providers to use to be able to help providers guide members through our benefits. Additionally, CareSource developed a Coordination of Care Release of Information Form for providers who are making referrals to other providers which aim to improve member and provider satisfaction by telling the provider receiving the referral why the patient is there and what the referring provider wants that provider to address. CareSource expects through the implementation and spreading of this information, providers will be able to more easily help members navigate benefits as well as allow the providers to get information more effectively to reduce frustration on coordination of care. CareSource will gather Voice of the Customer from providers and members and implement necessary changes to improve the coordination of care and overall experience of providers and members.	Addressed.
Encounter Data Validation	None.	Not applicable.	Not applicable.
Quality Rating	CareSource should work on quality measures related to Living With Illness.	CareSource has continued to implement strategies and initiatives to attempt to improve programs surrounding Chronic Conditions. We have partnered with community-based organizations, providers, and other organizations to connect members with their appropriate providers. CareSource has continued to work on the all-plan DSME and CGM work. We have also implemented some new interventions in hypertension, diabetes, and obesity to address food insecurity (e.g., YMCA in Dayton, value-added benefit of Weight Watchers, Food as Medicine interventions, home test kits, etc.)	Addressed.

SFY: state fiscal year; EQR: external quality review; PIP: performance improvement project; MCO: managed care organization; DSME: diabetes self-management education; HbA1c: hemoglobin A1c; PDSA: plan-do-study-act; IHI: Institute for Healthcare Improvement; KDD: key-driver diagram; QI: quality improvement; CGM: continuous glucose monitoring; HPV: human papillomavirus; HEDIS: Healthcare Effectiveness Data and Information Set; MY: measurement year; ODM: Ohio Department of Medicaid; CAHPS: Consumer Assessment of Healthcare Providers and Systems; PCP: primary care provider; MCPN: managed care provider network; BH: behavioral health; OPT: Opioid Treatment Program; NDMP: Network Development and Management Plan; ABA: applied behavioral analysis.

Table 79: Molina's Response to the SFY 2022 EQR Recommendations

Topic Area	Recommendation	MCO's Response	IPRO's Assessment
PIP	Tailor interventions specifically to disparate populations (e.g., take into consideration language and culture).	Quantitative and qualitative data collected regarding disparate populations. Higher rates of Continuous Glucose Monitoring (CGM) use occur in suburban counties compared to urban counties. Higher rates for CGM are also found in White members when compared to Black or Asian. Older members are less likely to use CGM compared to younger members. For Diabetes Self-Management Education (DSME), older members are less likely to complete compared to younger members. No disparities have been identified among Caucasian, Black/African American, and Asian members for DSME completion. Interventions have been created and tailored to address these disparities and include Community Based Organization (CBO) collaboration for increased targeting of minority populations; partnering with DME and Retail pharmacies to increase access to CGM supplies and compatible phones in all geographical areas; and increasing the member/provider linkage to additional education and support. This learning will continue to be used to develop interventions as the project continues into CY 2024. Improvement in the management of diabetes to improve HbA1C control for MyCare members. Ongoing monitoring of project SMART Aim and intervention specific process measure data and targets.	Addressed.
PIP	Work with members to understand barriers to monitoring blood sugar at home and participating in care management.	Interventions to date include Case Management (CM) and Utilization Management Collaboration for approved member CGM. CM provides individual member support and education specific to member needs. CM outreach also included assisting in the member facilitation of DSME. New interventions are currently in early testing and include Transition of Care (TOC) team outreach to hospitalized members prior to discharge and CM outreach to members with new diagnosis of diabetes to facilitate enrollment in DSME. Learnings, intervention development, and testing will continue with the PIP into CY 2024. SMART Aims and intervention specific process measures will continue to be developed and monitored into CY 2024.	Addressed.
PIP	Consider seeking member feedback for the Quality Resource Guide (QRG) during	The Quick Reference Guide (QRG) is a provider facing reference guide designed to provide the Provider with information needed successfully enroll the member in DSME and CGM. Included in the QRG includes how to determine CGM and DSME member	Addressed.

Topic Area	Recommendation	MCO's Response	IPRO's Assessment
	face-to-face encounters, given lack of participation in group setting or through telephonic outreach.	benefit information, MyCare vs. Medicaid benefit comparison guide, information on how to start a Prior Authorization, locate a DSME Provider or CGM supplier, and connect the member with transportation and the member's Case Manager. Provider Voice of the Customer was gathered during the production and implementation of the QRG. Feedback was obtained by the clinical teams and included physicians, medical assistants, office staff, and back-office staff. Based on the intervention learnings, Molina expects the QRG to be a valuable tool for Providers and assist offices increase the facilitation of CGM and DSME in members Periodic review of the QRG for needed updates and changes. Ongoing monitoring of SMART Aim, run charts, and process measure data.	
PIP	Implement some of the PDSA cycles that have gained traction, phasing in change to operate with existing systems.	Molina and the collaborative PIP Team continues to work through PDSA cycles for interventions to identify opportunities for spread. Adopted interventions include development and distribution of the Ohio MCE MyCare DSME and CGM Provider Quick Reference Guides, Member mailings to provide information on the benefits of DSME, and MCO education regarding DSME, CGM and compatible phones for the member facing teams. Interventions currently in PDSA testing include TOC team outreach to hospitalized members prior to discharge and Case Management outreach to member with new diagnosis of diabetes to facilitate enrollment in DSME. Testing also continues with Case Management collaboration with LifeCare Alliance DSME program. Molina uses the ODM approved QI templates, including KDD, PDSA Ramp Planning and Readiness for Spread. Learnings, intervention development, testing, and readiness for spread will continue with the PIP into CY 2024. SMART Aims and intervention specific process measures will continue to be developed and monitored into CY 2024.	Addressed.
Performance Measures	Improve performance measures, focusing on those that were below the statewide average and	For Performance Measures below HEDIS statewide averages, Molina consistently establishes multi-disciplinary, cross functional Improvement Teams by Population Stream focused on improving quality of, access to and timeliness of care. These teams	Addressed.

Topic Area	Recommendation	MCO's Response	IPRO's Assessment
	those that did not meet the minimum performance standards, noted earlier in the report. • WCC Counseling for Nutrition, Counseling for Physical Activity for All Ages • Cervical Cancer Screening • AMM Effective Acute Phase Treatment, Continuation Phase	are led by QI SMEs who ensure the application of QI science in the execution of improvement efforts. Pointing to our efforts to improve performance on deficient Healthy Children's, BH Adults and Women's Health measures as an example, Molina has tested and or implemented several improvement interventions including but not limit to: o Including some these measures in our Achieve Provider Incentive program since the program's inception and working with enrolled providers to focus practice-level improvements on these Measures. o Launching Mass Text Message Reminders Campaigns to increase child and adolescent well care visits and cervical cancer screenings. o Targeted Cervical Cancer Screening reminder campaign for women ages 55+ o Testing In-home Childhood Immunizations for 0–2-year-olds in Hamilton and Montgomery Counties o Incorporating the use of HIE ADT data in our outreach process to increase 7 day follow up visits for members with a discharge from a hospitalization for mental illness. This is a needs-based, ongoing process whereby our theories of change, to address performance opportunities are developed based on the key drivers of performance identified. Interventions to improve performance, the member experience, member supports and achieve our overarching performance goals are tested, implemented and spread where applicable. Related to Healthy Children improvement initiatives: o These improvements will be accomplished by testing a series of targeted interventions and implementing/spreading those which show measurable, positive impact on our improvement goals. Molina targets the completion of improvement efforts for the end of the Measurement Year. Molina fully expects to drive sustainable improvements in our performance based on the interventions identified, tested, implemented and spread across all targeted populations throughout the state. Testing on a small scale then broadening our tests, under different conditions will ensure countermeasures implemented and spread continue to have an appreciable impact on Performance Measures	

Topic Area	Recommendation	MCO's Response	IPRO's Assessment
		Related to Health Children improvement initiatives: ○ Molina expects our performance, on all related measures to meet and or exceed the Minimum Performance Standards (MPS) for all applicable measures. Molina uses outcome, process and balancing measures and the associated data for those measures to gage the effectiveness and vitality of our interventions to improve performance. These data are reviewed at regular intervals in different meeting settings to ensure broad communication and collaboration. Shared decision-making, by the teams, regarding the need to modify and or adapt strategies is a key component of our monitoring process. Related to Health Children improvement initiatives: ○ Existing annotated run charts, showing our performance over time, will be used to measure and monitor the impact of our interventions. ○ Our performance is consistently shared with the Improvement Team and key stakeholders in other meeting settings. ○ As a result of our performance review of the related measures, decisions are made regarding additional improvements effort needed to reach performance goals.	
Compliance with Medicaid Standards	None.	Not applicable.	Not applicable.
Network Adequacy – PCP Access	Implement processes to validate the accuracy of provider data prior to submitting to the MCPN. Encourage practices to improve availability of well visit appointments.	Molina has engaged in various activities to validate provider data accuracy on an ongoing basis, including outreach to providers to verify information, confirmation of provider data during interactions with providers, reminders via provider bulletins to update data, a provider data validation survey through Survey Monkey, and use of CAQH® Solutions Provider Data Portal. These activities improve the accuracy of information stored within Molina systems and shared via MCPN and provider directories. Ohio Medicaid moved to centralized provider data via PNM in 2023, Molina has operationalized this change and utilizes PNM data.	Partially addressed.
Network Adequacy – Dental and BH Access	Add dentists and BH providers to the provider network to increase access to timely appointments.	Molina continues to maintain open panels for these provider types to not limit contracting with new providers. For dental and BH providers with specialties, in regions, and/or rendering services with limited access, Molina continues to negotiate unique contract terms to ensure access and maximize the size of the provider network. Molina leverages county and time and distance-based monitoring of the network to ensure	Addressed.

Topic Area	Recommendation	MCO's Response	IPRO's Assessment
		adequacy along with provider recommendations, non-network paid claims, and access grievances. Molina promotes, to members and providers, telehealth as an available covered service in many instances. Community BH providers have been particularly successful in leveraging telehealth visits to ensure timely access to care. Additionally, Molina has expanded the relationship with Teladoc to add telehealth behavioral services which has been especially successful with member needs during evenings and weekends.	
Quality-of-Care Survey – Adult/ Child Member Experience	Use the results of the 2021-star ratings to guide efforts to improve quality, accessibility, and timeliness of care. • How Well Doctors Communicate (Adult) • Rating of Health Plan (Child) • Rating of Personal Doctor (Child) • Customer Service (Child) • Getting Needed Care (Child)	Molina leverages a member/provider satisfaction workgroup to oversee and initiate action in response to concerns and negative experiences raised by members. This workgroup addresses access issues and provider experience concerns, along with any specific or general feedback raised by our members. Molina has enhanced the reporting used to inform this process making it easier for member feedback collected from various touch points to be appropriately channeled through to the provider services team for action. Molina has also supplemented a traditional top view approach to network adequacy with member feedback monitoring through its member experience communication channel. Themes or trends raised in access are identified through this workgroup and directly through Contracting for action to enhance the network. Molina has developed structured Member Concierge and Member Care 4 Care program, to provide additional support to those that need it and gather robust member experience feedback. Molina's goal is to raise its scores in the areas of access, member provider facing experience and overall rating of health plan to four stars in 2025. Molina's objective is to provide a top tier service network and experience for its members. Molina seeks to supplement the CAHPS survey process with other more targeted sources of information. Molina's Member and Provider Advisory Council leverages A&G data, along with direct input from members and community providers to help inform its approach and validate that it is going the right direction. Molina establishes SMART goals for its QI and CAHPS based performance objectives to ensure that a target result is set and monitored to achievement.	Addressed.
Encounter Data Validation	None.	Not applicable.	Not applicable.

Topic Area	Recommendation	MCO's Response	IPRO's Assessment
Quality Rating	Work on low scoring quality measures related to Women's Health.	Molina continues to engage providers across women's health measures including regular provider meetings, sharing of quality performance including gaps in care and value-based payment programs. These activities have often resulted in improved performance across the measures. Additionally, Molina has been an active participant in quality withhold activities associated with the reporting of pregnancy initiated by the Ohio Department of Medicaid for 2023.	Addressed.

SFY: state fiscal year; EQR: external quality review; MCO: managed care organization; PIP: performance improvement project; CY: calendar year; HbA1C: hemoglobin A1c; SMART: Specific, Measurable, Achievable, Realistic, and Timely; PDSA: plan-do-study-act; MCE: managed care entity; QI: quality improvement; KDD: key-driver diagram; HEDIS: Healthcare Effectiveness Data and Information Set; ODM: Ohio Department of Medicaid; CAHPS: Consumer Assessment of Healthcare Providers and Systems; PCP: primary care provider; MCPN: managed care provider network; BH: behavioral health; HIE: health information exchange; ADT: admission; discharge, and transfer; SME: subject matter expert; PNM: Provider Network Management; DME: durable medical equipment.

Table 80: UnitedHealthcare's Response to the SFY 2022 EQR Recommendations

Topic Area	Recommendation	MCO's Response	IPRO's Assessment
PIP	Validate the results from externally reported sources, when possible, to confirm the information being received aligns with UHC's data collection results. Further, this will allow UHC to internally calculate and trend data related to their improvement efforts.	UHC has defined an internal process to create and maintain a comprehensive data dictionary for all data requested and received from external sources. This data dictionary also defines processes and procedures to overlay data onto internal data sources, with the goal to create a common data set that will aid in comprehensive evaluation of performance. The structure for this approach has been drafted and will be applied to all current and future performance improvement activities. The expected outcome is a data set representing both internal and external data with built-in checks and balances to ensure that all data aligns with UHC's data collection results. UHC will be performing ongoing audits of data analysis and evaluation to ensure the newly defined process is meeting the expectation defined above.	Addressed.
PIP	Additional, repeated outreach efforts are needed to garner engagement (for instance, in initiatives such as Ready, Set, Begin). UHC should continue to test what outreach efforts work best for their membership.	UHC plans to deploy a comprehensive initiative to better understand how to effectively reach and engage our members. Projects and pilots that rely on internal resources to perform outreach, such as our care management teams, will seek to gather data in the form of drop-down choices that represent the most common barriers: inaccurate phone number, no phone number listed, unable to reach (x minimum 3 attempts), voicemail left, and member disconnected call. These results will be analyzed on an ongoing basis and QI tools applied to findings: process mapping, systems Failure Modes and Effects Analysis (sFMEA), fishbone diagram, root cause analysis. UHC will continue to pursue	Addressed.

Topic Area	Recommendation	MCO's Response	IPRO's Assessment
		testing solutions that are identified through the QI process and will document findings to share more broadly across our organization. We will also be working to analyze the efficacy of provider and vendor outreach as potential alternate strategies in reaching and engaging members. UHC has started the process outlined above and will continue to pursue collection of data and analysis of opportunity throughout the coming measurement year. The goal of these actions is twofold: first, to identify a process by which to improve member engagement and ensure accuracy of contact information; second, to identify a process by which UHC can improve member engagement once a member is successfully reached. UHC Quality, Population Health, Care Management and Data teams will work collaboratively to monitor performance of the actions defined above to determine effectiveness. Each outreach campaign and pilot are unique; as such, each evaluation will require input from functional leaders across teams to define success and operationalize next steps based on findings. Standardized data collection tools will be used throughout all opportunities to aid in effective evaluation of performance.	
PIP	Continue applying the learnings from KDDs, PDSA testing, process mapping, and run charts to refine and conduct future quality improvement initiatives aimed at diabetic members.	UHC has implemented a comprehensive evaluation strategy to apply learnings from KDDs, PDSA testing, process mapping and run charts to support improved outcomes among our Diabetic members. We have developed a bi-weekly review process among Quality and Population Health teams to analyze and evaluate the effectiveness of our QAPI program, with emphasis on diabetic initiatives. Results from this analysis and the EQR recommendations, NCQA Population Health Management Evaluation findings, local Population Health Strategy coupled with prior Population Health Evaluation documents, provider performance dashboards, and ongoing Quality Withhold learnings all combine to provide a comprehensive overview of opportunities for improvement. UHC uses this foundational knowledge to drive improvement for our diabetic members through development of living KDDs, targeted PDSA testing, process and journey mapping, and annotated run charts. UHC has implemented this process and will continue to support bi-weekly collaborative performance reviews. The expected outcomes of this approach are the development of an intervention portfolio tailored to the needs of our members, clearly annotated run	Addressed.

Topic Area	Recommendation	MCO's Response	IPRO's Assessment
		charts and QI documentation, and achievement of all SMART aims defined for our diabetic population by 12/31/24. Quality and Population Health leaders and team members evaluate the effectiveness of all interventions during bi-weekly performance review meetings. Run charts, process measures, and QI documentation are reviewed across all interventions. Stakeholders contribute feedback and offer suggestions for improvement based on data to date.	
PIP	Continue educational programs for members in monitoring and controlling their HbA1c.	UHC will continue to apply a comprehensive plan to link members to educational opportunities to manage diabetes and controlling HbA1c values. Internally, our care management team is educated semiannually, at minimum, on the principles of diabetes management, motivational interviewing techniques, and assessment skills to identify opportunities to link members to diabetes education. This training is conducted during formal weekly all staff call, Learnsource modules and live training. Externally, UHC collaborates with providers to share updates on covered Medicaid benefits including DSME, medical nutrition therapy (MNT), and the National Diabetes Prevention Program. UHC provides technical assistance targeted toward improving member uptake of educational opportunities, offering practice support, and sharing quality data to drive improvement. Ongoing work continues to gather Voice of the Customer data to better understand the needs and preferences of our members in interacting with educational opportunities in a culturally and linguistically humble manner. The above outlined strategy is implemented and ongoing. Annual training dates will be published internally every January, provider communications occur as our Clinical Transformation team meets with individual practices, and member feedback is elicited at every scheduled Member Advisory Committee (MAC) meeting, community event and member interaction. The expected outcomes of this strategy include improved uptake of DSME, MNT, and DPP. We also anticipate a greater uptake of CGM use as members become educated on appropriate diabetes management, as well as an overall improvement in HbA1c control. UHC monitors claims activity on a regular and ongoing basis to evaluate the efficacy of this approach. Our Diabetes Dashboard allows us to analyze the methodology on a member-level. At the population level, this will allow us to understand member interest in diabetes education, utilization trends, primary care engagement, and other contributing factors such as tobacco use. Routine analysis of performance utilizing this	Addressed.

Topic Area	Recommendation	MCO's Response	IPRO's Assessment
		dashboard allows UHC to identify trends and emerging correlations, and act on those findings quickly to promote improved outcomes and improved diabetes management.	
PIP	Continue working to develop tests of change targeting the disparate population and ensuring that the voice of the consumer is represented.	UHC has performed a literature search – focused on diabetes management - to develop tests of change from evidence-based findings; results underscore evidence that supports increasing access and utilization of CGM devices within communities that are significantly underserved and historically experience health disparity. Information was incorporated from the American Diabetes Association (ADA), Abbott®, and the National Center for Urban Solutions (NCUS). We apply a similar approach across all population streams – developing rapid-cycle tests of change that are supported by current evidence. UHC also takes every opportunity to capture voice of the customer to ensure that the voice of our members and communities are represented in our work. Member advisory councils, call center interactions, care management engagement, and community engagement activities all present ongoing opportunities to capture this vital voice. UHC strives to understand and act on all feedback received. UHCCP is participating in the all-MCO CGM and DSME quality withhold (QW) methodology and a key intervention is collaborating with CBOs. Tests of change were conducted in 2023: • Q1 with NCUS to refer members to CBO partner/providers for connection to CGM devices. • Q3 Based on measured improvement in CGM utilization, the all-MCE collaborative has moved to adapt and spread the CBO Collaboration to CBO partners to refer patients to providers to connect members to CGM devices. • Q4 with El Centro pilot testing starts to spread the previous model from NCUS intervention testing. Providing CLAS support to members to connect to CBO/providers. We are also testing various strategies across population streams to impact broader population health goals outside of diabetes management. This is iterative work that is ongoing throughout the year. The expected outcomes of this work are improved population health outcomes that can be linked to testing and analysis of performance via annotated SMART aim run charts. We would also expect to see year over year reduction in the index of disparity analysis that is applied to all quality metrics retrospectively on an annual basis. UHC has developed dashboards, SMART Aim run charts, and biweekly data review processes to analyze the performance of all QI activities and disparity reduction efforts.	Addressed.

Topic Area	Recommendation	MCO's Response	IPRO's Assessment
		Leadership participates in these regular reviews, with the goal of offering recommendations to cross-system workgroups that have been created to support this work. As part of the workgroup process, voice of the customer is routinely documented, analyzed, and incorporated into future intervention development and testing strategies.	
Performance Measures	Improve performance measures that were below the statewide average and those that did not meet the minimum performance standards, noted earlier in the report. • Annual Dental Visit • CIS Combination 10 • IMA HPV Vaccine, Combination 2 • UOP Multiple Prescribers	UHC met all MPS standards for the measurement period defined in the report. For Performance Measures below HEDIS statewide averages, UHC has developed multi-disciplinary, cross functional workgroups focused on improving quality of, access to and timeliness of care. These workgroups are led by Population Health Leads for each respective population stream and utilize the IHI Model for Improvement methodology in the execution of improvement efforts. UHC has initiated deployment of these workgroups and meetings are ongoing throughout the year. Measures that have been identified as below state average have defined SMART Aims and associated QI documentation to support structured learning as we strive to improve performance. The expected outcomes of this approach are primarily improvement in measures that fall below Statewide averages. UHC also strives to follow the QI process, structuring all documentation to support maximum learning as the work develops. A key goal that is monitored consistently is appropriate use of QI tools and documentation and how those learnings translate into improvements. UHC has a robust data structure that allows for ongoing evaluation of all metrics at the aggregate level, and at the member level. Tracking and trending our performance month over month, and year over year – by measure – with associated member-level detail defined allows us to evaluate performance, identify new opportunities, and quickly shift strategies in a data informed manner.	Addressed.
Compliance with Medicaid Standards	None.	Not applicable.	Not applicable.
Network Adequacy – PCP Access	Implement processes to validate the accuracy of provider data submitted to the MCPN. Encourage practices to improve availability of well visit appointments.	UHC is currently auditing MCPN files to ensure it includes Providers specified by ODM. This file validation process is conducted daily. At present, UHC is capturing Primary Care Providers. We are actively working to identify a process to include all Providers specified by ODM.	Addressed.

Topic Area	Recommendation	MCO's Response	IPRO's Assessment
		UHC audits all Providers to ensure registration is completed with ODM via the PNM portal. UHC audits Network providers registration based on ODM guidance. UHC then works to Determine if data is accurate. Encourage practices to improve availability of well visit appointments. UHC has engaged an external vendor to conduct an appointment availability survey on providers specified in ODM's Provider Agreement. The survey questions are designed to ascertain the next available appointments, aligning with the standards in the Provider agreement. Currently, Provider Advocates reinforce the need for practices to improve availability during Ohio State Medical Association (OSMA) meetings as well as publish content in Provider Manuals and Monthly Provider Network News Articles. Additionally, United Health Network and Provider Advocates reinforce via JOC and Operational meetings. UHC anticipates improved awareness of appointment availability standards and subsequent improved access to needed appointments for members. UHC will continue to analyze our appointment availability results through ongoing surveys, The principles of quality improvement science will be applied to develop a comprehensive improvement plan built from findings in our root cause analysis. UHC's Quality Department and Provider Network Team are collaboratively establishing internal benchmarks since there is not a currently defined performance goal for appointment availability standards.	
Network Adequacy – Dental Access	Increase the number of dentists in the network to improve access to timely dental care.	UHC recognizes the importance of dental access to all its members. While UHC continually monitors provider availability and access by way of various reporting, UHC's Population Health team, Clinical representation, and Vendor Oversight Manger hold a monthly JOC with Its broker DentaQuest. Provider access and network availability are a regularly scheduled topic. UHC recognizes the need for a more creative approach to improve provider accessibility and overall network development, particularly for our pediatric members. UHC's Population Health dept. has been actively identifying dental care opportunities in Medicaid child members through use of member level data Scorecards, Child Opportunity Index, HEDIS and Claims data to identify children in need of dental services.	Addressed.

Topic Area	Recommendation	MCO's Response	IPRO's Assessment
		UHC did a targeted outreach to 18–21-year-olds in Franklin County who have care gaps for annual dental visits in specified zip codes. UHC provided culturally specific outreach to members who primarily speak Nepali, Somali, or Spanish. Targeted outreach was done to members with access to designated School Based Dental Care for school aged children. UHC is partnering with local providers who operate mobile health and/or dental units (i.e., NEON, Nationwide). We are also partnering with Third Street Family Health Services on a Mobile Health Unit to provide mobile well-child visits and oral health care in care shortage areas. UnitedHealthcare is supporting Third Street Family Health Services mobile healthcare unit to provide medical, dental, and MAT services in Central Ohio through community reinvestment and community engagement partnership. This partnership will support increased well-child visits, PCP engagement, and annual dental visits, as well as support for members with OUD. UHC is Aligning with School based Health and/or dental centers to close gaps in care. UHC collaborated with the school Nurse to promote dental van visit to Gahanna Jefferson Public Schools for child members who needed dental care and attend GJPS schools. UHC and DentaQuest, have identified dental offices that may not meet the minimal panel required hours of availability but are willing to contract DentaQuest and accept Ohio Medicaid rates. Recruitment efforts are underway. UHC and DentaQuest have collaborated with individual dental providers to be available at local community centers on prescheduled dates. MedWorks dental event (Nov 2022): UHC mailed copies of the flyer to the MedWorks community event in downtown Cleveland to advise members of a walk-in dental care opportunity. UHC does accessibility validation through Dial America, as well as outreach to outlying providers by way of email or a phone call for feedback and opportunities. UHC expects to increase annual dental visits for children 2-20 years old by 3.5% by 6/30/24. UHC expects to see an increased overall dental service accessibility as demonstrated by the time and distance reporting.	

Topic Area	Recommendation	MCO's Response	IPRO's Assessment
		UHC is hopeful that it will close accessibility gaps in areas that may not meet panel requirements due to lack of providers in Nobel, Putman, and Mercer County by providing alternative dental accessibility. Continue UHC's secrete shopper through Dial America to validate provider accessibility. UHC will continue monthly and quarterly monitoring of Member Level Data Scorecards, Child Opportunity Index, HEDIS and Claims data to monitor effectiveness. UHC will continue to monitor quarterly red/green and time and distance reports.	
Quality-of-Care Survey – Adult/ Child Member Experience	Address CAHPS measures that fell below the statewide average, noted earlier in this report. • Rating of Health Plan (Child) • Rating of All Health Care (Adult and Child) • Rating of Personal Doctor (Adult and Child) • How Well Doctors Communicate (Adult) • Customer Service (Adult) • Coordination of Care (Adult and Child)	All CAHPS Adult and Child measure performance has been analyzed by plan executive and functional leaders. Measures that fell below statewide average have been defined and assigned to focused multi-disciplinary and cross functional workgroups for strategy development and execution. UnitedHealthcare holds routine Member Advisory Committee meetings to obtain direct feedback from members in the community. Our community engagement team works to engage members and other stakeholders in the communities they live, work and play; they elicit feedback at the member and community level to help provide context to the work we do and ensure that all interventions developed incorporate the voice of our members and the unique needs of our communities. All UHC staff are Health Equity certified and trained in how to facilitate culturally and linguistically humble conversations. Leveraging this strength, we strive to actively listen to members' needs and identify unique solutions to enhance their experience. Monthly Joint Operating Committees within our Call Center, Operations, Quality, Population Health, and Care Management teams put the member experience at the center of our work. We use these forums to identify opportunities for improvement and review updates to improvement plans. UHC has implemented this approach as defined above. Cross functional workgroups and JOCs meet monthly. The goal of these actions is improved member experience as evidenced by improvement in all Adult and Child CAHPS scores, particularly in lagging measures. UHC strives to support an ecosystem that contributes to excellent member experience. UHC strives to monitor member experience using more proximal measures in between CAHPS surveys in the form evaluation of Appeals and Grievances, Authorization Denials, Call Center encounters, care management feedback/satisfaction, NPS feedback, and ongoing voice of the member. The ability to act quickly on identified opportunities is a vital consideration when working to improve the member experience. UHC also	Addressed.

Topic Area	Recommendation	MCO's Response	IPRO's Assessment
		leverages national survey feedback in the form of member verbatims that allows for ongoing analysis of qualitative member feedback.	
Quality Rating	Utilize the results of the 2021 star ratings to drive the direction of activities aimed at improving the quality of access to and timeliness of care.	UnitedHealthcare will utilize these star ratings to drive improvement in the timeliness, access to and quality of care across all domains, with the goal to exceed average rating status. As part of our comprehensive Quality / Population Health strategy, a primary focus will remain promoting PCP engagement and wellness exam completion. Aligning data and geo-analysis with provider partnership, we strive to reduce barriers to access, promote timely engagement with preventive and wellness care, and promote improved quality through APMs, VBC and collaborative intervention testing. UnitedHealthcare also commits to incorporating voice of the member, voice of the provider, and voice of the community into all improvement planning activities. Utilization of predictive models to engage members with chronic conditions earlier is expected to improve timeliness of care. Looking beyond HEDIS denominators, custom disease registries have been developed to provide comprehensive insight into quality of care for members diagnosed with a chronic condition; these data will inform improvements needed to promote better quality outcomes. Emphasis on the power of data, with a structure in development to overlay population health data with contextual sources such as Opportunity Indices, school data, and other validated external data sources can assist UHC in quickly identifying and addressing root cause factors impacting health. Women's Health remains a priority focus at UnitedHealthcare. Our data driven strategy seeks to promote improved quality across the lifespan – from reproductive health to preventive screenings. We are working to improve quality through deployment of evidence-based strategies to promote improved timeliness of prenatal and postpartum care, improved birth outcomes, and improved wellness screenings. Our women's health workgroup has identified specific areas of the state where we are lagging in performance and are developing targeted strategies to meet members where they are and engage them in care. This strategy has been deployed at UHC and is ongoing. Workgroups meet biweekly or monthly, and regular Quality and Population health committees analyze performance on a routine basis. The expected outcome of this work is a star rating at or above 3.5 stars across all domains. UHC has a robust evaluation structure in place to gauge the effectiveness of our work across multiple domains within our organization. As we work as a collaborative	Addressed.

Topic Area	Recommendation	MCO's Response	IPRO's Assessment
		team to evaluate interventions and outcomes, we leverage the focus and expertise of all internal departments to create a culture and organizational environment with exceptional member experience at the core. We will continue to strive as an organization to act on evaluation findings and strive for improvement across all domains.	

UHC/UHCCP: UnitedHealthcare Community Plan; SFY: state fiscal year; EQR: external quality review; MCO: managed care organization; PIP: performance improvement project; QI: quality improvement; KDD: key driver diagram; PDSA: plan-do-study-act; QAPI: Quality Assessment and Performance Improvement; NCQA: National Committee for Quality Assurance; SMART: Specific, Measurable, Achievable, Realistic, and Timely; HbA1C: hemoglobin A1c; DSME: diabetes self-management education; CGM: continuous glucose monitoring; CBO: community-based organization; MCE: managed care entity; Q: quarter; HPV: human papillomavirus; MPS: minimum performance standard; HEDIS: Healthcare Effectiveness Data and Information Set; IHI: Institute for Healthcare Improvement; PCP: primary care provider; MCPN: managed care provider network; ODM: Ohio Department of Medicaid; MAT: medication-assisted treatment; OUD: opioid use disorder; CAHPS: Consumer Assessment of Healthcare Providers and Systems; PNM: Provider Network Management; JOC: joint operating committee; CLAS: culturally and linguistically appropriate services; APM: alternative payment model; VBC: value-based care; ADA: American Diabetes Association; NCUS: National Center for Urban Solutions; QW: quality withhold; sFMEA: systems Failure Modes and Effects Analysis.