Ohio External Quality Review Organization

June 2020

State Fiscal Year 2019

Annual EQRO Technical Report

For Review Period July 1, 2018–June 30, 2019

Ohio | Department of Medicaid

Qsource

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List of Tables and Figures

Acknowledgements, Acronyms, and Initialisms[1]

ABD ..... Aged, Blind, and Disabled
ADHD ..... Attention Deficit Hyperactivity Disorder
AHRQ ..... Agency for Healthcare Research and Quality
API ..... Associates in Process Improvement
APM ..... Alternative Payment Model
BH ..... Behavioral Health
BMI ..... Body Mass Index
Buckeye ..... Buckeye Health Plan®, administered in Ohio by Centene Corporation
CAP ..... Corrective Action Plan
CareSource® ..... CareSource Management Group, administered in Ohio by Humana Inc.
CASS ..... Coding Accuracy Support System
CATI ..... Computer Assisted Telephone Interviewing
CFC/MAGI ..... Covered Families and Children/ Modified Adjusted Gross Income
CFR ..... *Code of Federal Regulations*
CHIP ..... Children's Health Insurance Program
CHIPRA .... *Children's Health Insurance Program Reauthorization Act*
CI ..... Confidence Intervals
COPD ..... Chronic Obstructive Pulmonary Disease
CPC ..... Comprehensive Primary Care
CY ..... Calendar Year
DME ..... Durable Medical Equipment
DRG ..... Diagnosis-Related Group
EDV ..... Encounter Data Validation
EHR ..... Electronic Health Record
EQR/EQRO ..... External Quality Review/EQR Organization
FAR ..... Final Audit Report
FMEA ..... Failure Modes and Effects Analysis
FTP ..... File Transfer Protocol
GDM ..... Gestational Diabetes Mellitus
HCBS ..... Home- and Community-Based Services
HEDIS® ..... Healthcare Effectiveness Data and Information Set, a registered trademark of NCQA
HSAG ..... Health Services Advisory Group, Inc.
ICN ..... Internal Control Number
IS ..... Information System
KDD ..... Key Driver Diagram
LO ..... Licensed Organization
MCOP ..... MyCare Ohio Plan
MCP ..... Managed Care Plan
MCPN ..... Managed Care Provider Network
MI ..... Myocardial Infarction
MITS ..... Medicaid Information Technology System
Molina® ..... Molina Healthcare of Ohio, Inc.
MOMS+ ..... Maternal Opiate Medical Supports Plus
MPS ..... Minimum Performance Standard
MRR ..... Medical Record Review
N ..... No
NAS ..... Neonatal Abstinence Syndrome
NCQA ..... National Committee for Quality Assurance
NCQA HEDIS Compliance Audit™ ..... a trademark of NCQA
NPI ..... National Provider Identification
ODH ..... Ohio Department of Health

[1] *Other company and product names may be trademarks of the respective companies with which they are associated. The mention of such companies and product names is with due recognition and without intent to misappropriate such names or marks.*

ODM ..... Ohio Department of Medicaid
OHCIDS ..... Ohio Comprehensive Home Visiting Integrated Data System
PAP ..... Principal Accountable Provider
P4P ..... Pay for Performance
Paramount® ..... Paramount Advantage, administered in Ohio by ProMedica
PCMH ..... Patient-Centered Medical Home
PCP ..... Primary Care Provider
PDSA ..... Plan-Do-Study-Act
PIP ..... Performance Improvement Project
PMV ..... Performance Measure Validation
PQI ..... Prevention Quality Indicator
PRAF ..... Pregnancy Risk Assessment Form
QBA ..... Quality-Based Assignment
QI ..... Quality Improvement
Qsource® ..... a registered trademark
SAS® ..... a registered trademark of SAS Institute, Inc.[2]
SFY ..... State Fiscal Year
SMART ..... Specific, Measurable, Attainable, Relevant and Time-Bound
T2DM ..... Type 2 Diabetes Mellitus
TPL ..... Third-Party Liability
UnitedHealthcare ..... UnitedHealthcare Community Plan of Ohio, administered in Ohio by UnitedHealth Group, Inc.
Y ..... Yes

[2] *SAS and all other SAS Institute Inc. product or service names are registered trademarks of SAS Institute Inc. in the United States and other countries.*

Executive Summary

Overview

In accordance with Title 42 *Code of Federal Regulations* (CFR) §438.364, Qsource has produced this *2019 Annual EQRO Technical Report* to summarize the quality, timeliness, and accessibility of care furnished to members of Ohio's Medicaid program by the managed care plans (MCPs) contracted by the Ohio Department of Medicaid (ODM). Results were determined by aggregating and analyzing the findings of several federally mandatory and optional external quality review (EQR) activities, as defined in 42 CFR §438.358:

- **Mandatory**: Performance Improvement Projects (PIPs), Comprehensive Administrative Review, Performance Measure Validation (PMV), and Network Adequacy Validation
- **Optional**: Encounter Data Validation (EDV) and Quality Ratings of MCPs
- **Other Activities**: Provider Satisfaction Survey

During the period under review, State Fiscal Year (SFY) 2019 (July 1, 2018–June 30, 2019), ODM's MCPs included Buckeye Health Plan (Buckeye); CareSource; Molina Healthcare of Ohio, Inc. (Molina); Paramount *Advantage* (Paramount); and UnitedHealthcare Community Plan of Ohio, Inc. (United-Healthcare).

EQR Activities and Technical Report

The EQR activities summarized in this report were conducted by Health Services Advisory Group, Inc. (HSAG), through an EQRO contract with ODM. As the state's newly contracted EQRO in SFY 2020, Qsource has compiled and prepared this detailed report of results, which—in addition to this Executive Summary and the Overview and Background section—includes the following activity sections:

- Performance Improvement Projects (PIPs)
- Comprehensive Administrative Review
- Performance Measures
- Network Adequacy Validation
- Encounter Data Validation (EDV)
- Provider Satisfaction Survey
- MCP Report Card
- Plan-Level Summaries and Conclusion

Each of the activity sections includes information on data collection and analysis methodologies, comparative findings, a discussion of the findings, and, where applicable, the MCPs' performance strengths and opportunities for improvement. As mandated by 42 CFR § 438.364, the data included in this report make it possible to benchmark performance statewide and nationally. The data also depict the healthcare landscape for the state's Medicaid population, which assists ODM in its collaborations with other state agencies to

address common health issues—particularly those that are prevalent, chronic, and preventable. ODM can use these data to measure progress toward goals and objectives of its Quality Strategy, identify areas where targeted quality improvement interventions could be beneficial, and determine if new or restated goals are needed.

High-Level Program Findings and Recommendations

Qsource used the analyses and evaluations of EQR activity findings from the review period of July 1, 2018–June 30, 2019 to assess the performance of Ohio Medicaid MCPs in providing quality, timely, and accessible healthcare services to Medicaid members. The individual MCPs were evaluated against State and national benchmarks for measures related to the quality, access, and timeliness domains, and results were compared to previous years for trending when possible.

The following provides a high-level summary of these findings for the Ohio Medicaid Managed Care Program. The overall findings for MCPs were also compared and analyzed to develop overarching conclusions and recommendations for each MCP. These plan-level findings are discussed in each EQR activity section as well as the Plan-Level Summaries and Conclusion section.

Strengths

The EQR activities conducted in SFY 2019 demonstrated that the ODM and the MCPs share a commitment to State and federal compliance and to providing high-quality, timely, and accessible care for members. Program strengths included the following:

Member Satisfaction

When CAHPS results for the adult and general child population were compared to 2018 national Medicaid percentiles, the Ohio Medicaid Managed Care Program's performance was good to excellent, with none of the program's means below the 50th percentile. Areas of excellent performance (at or above the 90th percentile) included Rating of All Health Care (general child), Rating of Personal Doctor (adult and general child), Rating of Specialist Seen Most Often (general child), Getting Care Quickly (general child), How Well Doctors Communicate (adult and general child), Customer Service (adult and general child), and Coordination of Care (general child).

Administrative Compliance

The Comprehensive Administrative Review activity is conducted once every three years, with the most recent review having occurred in SFY 2017. Nine of the 13 program standards evaluated during the Comprehensive Administrative Review received MCP aggregated scores of 95% or higher, demonstrating strength in adherence to program requirements. Additionally, in SFY 2018, all MCPs demonstrated compliance with the corrective action plan (CAP) submission for the deficiencies that were identified in the SFY 2017 review.

Encounter Data Completeness

The EDV comparative analysis and medical record review (MRR) showed that the program's level of data completeness among all encounters (dental, professional, the institutional claim type categories, and pharmacy) is high, with very low encounter surplus and omission rates. For all claim types, both the encounter omission and surplus findings suggest relatively complete submission of claims by the MCPs to ODM. Payment error rates also overwhelmingly met the performance standards for all encounter types. Furthermore, more third-party liability (TPL) payments were being captured and populated in ODM's vendor data compared to the prior year's study.

Performance Improvement Project

Each MCP has shown dedication to the statewide PIP by successfully completing Modules 3 and 4 for SFY 2019, during which the MCPs tested interventions using QI science tools and conducted PDSA cycles to address key drivers and prioritized failure modes.

Opportunities for Improvement

Performance Measures

Although the majority of MCPs demonstrated an increase in the percentage of HEDIS measure indicators that met the minimum performance standard (MPS), statewide performance rates were below the national Medicaid 25th percentile for three measures: Use of Multiple Concurrent Antipsychotics in Children and Adolescents—Total; Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%); and the Adult Body Mass Index (BMI) Assessment measure indicator Although none of the statewide averages were below the national Medicaid 10th percentile, these results suggest that chronic conditions and preventive healthcare and treatment remain an opportunity for improvement.

Provider Data Accuracy

Network Adequacy activities revealed that inaccurate provider data is a continued weakness, particularly regarding MCPs' published telephone number and address information for primary care providers (PCPs) as well as durable medical equipment (DME) suppliers (the information was relatively accurate for BH agencies). DME suppliers were also shown to have limited availability. These results point to a program opportunity to improve accuracy and, thereby, Ohio Medicaid members' access to and availability of care.

Provider Satisfaction

SFY 2019 Provider Satisfaction Survey results showed that over half of providers were not satisfied with the Medicaid plans (approximately 51%), which indicates that improving provider satisfaction is a priority for the program. Enhancing MCP-provider partnerships to support better healthcare outcomes for members should be a particular focus. Providers' satisfaction was particularly low regarding the Prior Authorization Process (32%), Assistance in Meeting Social Service Needs (37%), and Provider Relations (38%). The only measure that exceeded 50% was Ability to Obtain Member-Level Information (54%).

Recommendations

- ODM should continue to work with MCPs to address low performance measure rates, particularly in the areas of Behavioral Health and Chronic Conditions. As in prior years, ODM should continue to review MCPs' annual QAPI submissions for clearly delineated, outcomes-driven strategies for improvement that measure, analyze, and track specific performance indicators and continuously monitor them for effectiveness.
- Complete, accurate healthcare provider data are necessary for members to have adequate information that facilitates provider selection and access to care in a timely manner. Since the MCPs' combined Managed Care Provider Network (MCPN) survey results demonstrated low PCP and DME supplier address and phone number accuracy rates, HSAG recommended that ODM consider expanding the scope of existing provider data validations to align with the Centers for Medicare & Medicaid Services' (CMS') Medicare Advantage Organizations online provider directory recommendations.
- HSAG recommended that ODM leverage the CAHPS Health Plan Survey data and report findings to support the development of relevant initiatives, quality improvement strategies and interventions, and performance monitoring and evaluation activities. For example, CAHPS data may be analyzed to identify potential health disparities among key demographics. Supplemental items may be used to recognize issues related to cultural competence. This type of information could inform initiatives such as infant mortality, CPC, behavioral healthcare coordination, and school-based healthcare.
- Based on the EDV MRR findings, HSAG recommended that ODM consider requiring MCPs to audit provider encounter submissions for completeness and accuracy. The audit should include a review of both State and national coding requirements and standards, especially for new providers contracted with the MCPs. ODM might also consider requiring MCPs to perform periodic reviews of submitted claims to verify appropriate coding and completeness to ensure encounter data quality. Results from these reviews may be submitted to ODM and used in its ongoing encounter data monitoring.
- As provider satisfaction continues to be a program weakness, ODM could continue efforts toward optimizing MCP-provider partnerships. As HSAG previously recommended, ODM could request each MCP to perform an assessment of provider-facing roles and responsibilities with a goal to ensure more streamlined, efficient, and seamless provider services, applying Institute for Healthcare Improvement concepts of patient care efficiency to provider services.

Overview and Background

States that provide Medicaid services through contracts with MCPs are required by federal mandate (42 CFR §438.310–438.370) to conduct EQR activities and ensure that the results of those activities are used to perform an external, independent assessment and produce an annual report. The annual assessment evaluates each MCP's performance related to the quality, timeliness, and accessibility of the care and services it provides. The EQR activities summarized in this report were conducted by Ohio's former EQRO, HSAG. As the state's current contracted EQRO, Qsource has compiled this detailed report of results. This section describes the history of Medicaid managed care in Ohio, and highlights the State's Quality Strategy and Medicaid initiatives.

Managed Care in Ohio

Launched in July 2013, ODM is Ohio's first executive-level Medicaid agency. ODM is responsible for the implementation and administration of Ohio's combined Medical Assistance Program authorized under Title XIX of the Social Security Act (also referred to as Medicaid) and Title XXI of the Social Security Act (also referred to as the State Children's Health Insurance Program [CHIP]), implemented in Ohio as a Medicaid expansion program. As of September 2019, Ohio has enrolled more than 2.7 million individuals in Medicaid and CHIP. Working closely with stakeholders, advocates, medical professionals, and fellow state agencies, ODM continues to modernize the Medicaid program and improve Ohio's healthcare landscape. High-level priorities of ODM include

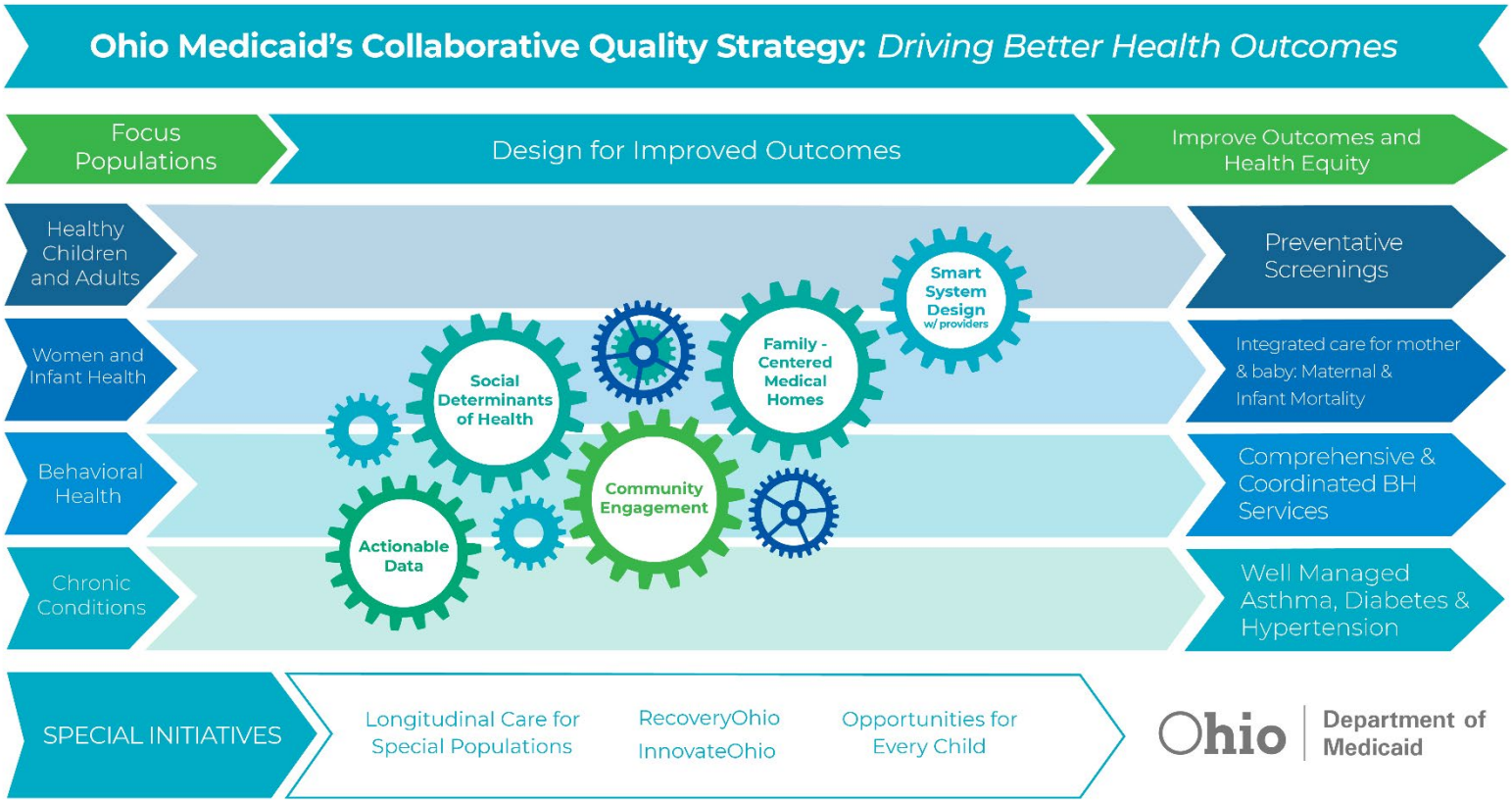
- assuring sustainability, quality, and access;
- investing in kids; and
- investing in recovery.

The risk-based, comprehensive Ohio Medicaid managed care program was introduced in 2005 and is mandatory for certain Medicaid beneficiaries in Ohio. In 2013, Ohio changed the Medicaid managed care program to make all MCPs available statewide. In January 2014, ODM expanded Medicaid coverage availability to all individuals with incomes up to 138% of the federal poverty level. By August 2016, these adult extension members, including those in need of a home and community-based services (HCBS) waiver, received their Medicaid coverage through one of the five MCPs. By January 2017, ODM also mandated that individuals enrolled in the Bureau of Children with Medical Handicaps program, Children in Custody and Children Receiving Adoption Assistance, and Breast and Cervical Cancer Project recipients receive their Medicaid benefits through one of the five MCPs.

Ohio Medicaid Quality Strategy

In its continued effort to improve health outcomes for Ohio's citizens enrolled in the Medicaid program, the Ohio Department of Medicaid (ODM)'s Quality Strategy (see **Figure 1**) serves as a framework for communicating Ohio's approach to ensuring that individuals have timely access to high quality services in a coordinated, cost-effective manner that ultimately contributes to the improved health of our population. ODM's strategy delineates the complexity of the populations served and utilizes a person-centered approach to meet health needs within the context of community, supporting sustainability through actionable data linked to Value-Based Purchasing (VBP).

Figure 1. Ohio Medicaid Quality Strategy

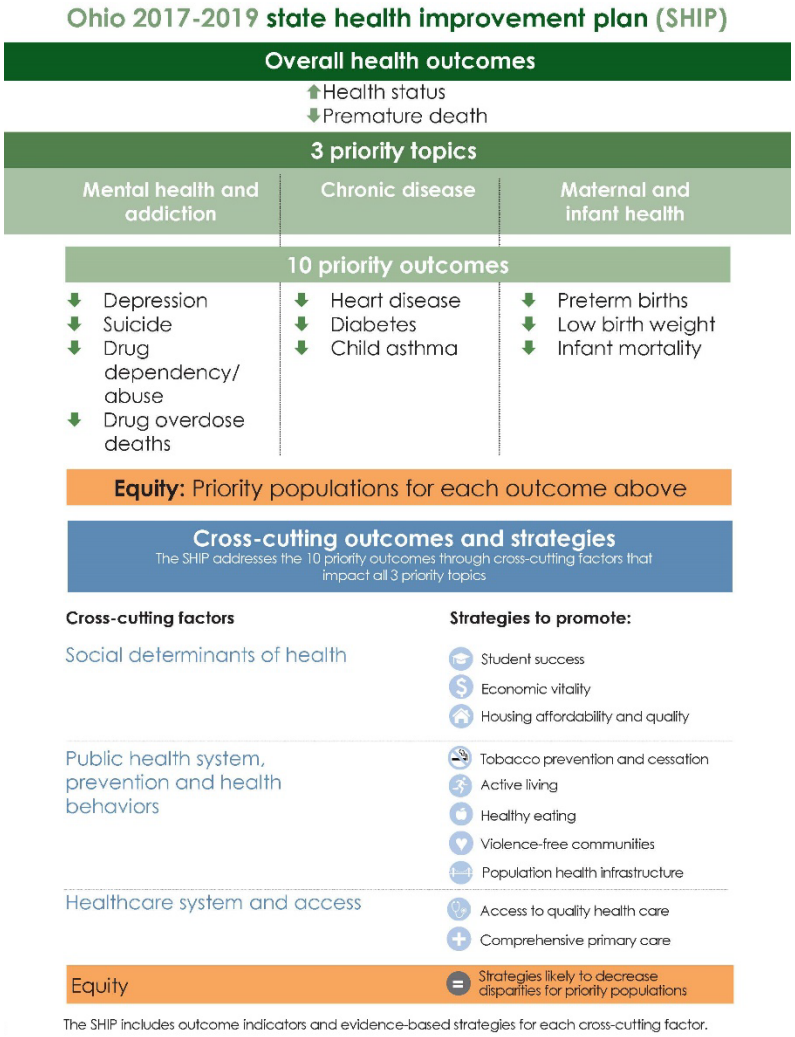


The five Medicaid MCPs have a central role in the improvement of population health outcomes, and are expected to participate in efforts to achieve the outcomes established in the Quality Strategy and to improve the quality of care for and health of the Ohio Medicaid population. ODM has created an accountability system to ensure that MCPs are working within the framework of the Quality Strategy to assess and improve the quality of care provided to members.

Medicaid's collaborative partnerships with providers and provider associations, private insurers, other state agencies, academic medical centers, and state-level quality improvement (QI) collaboratives also contribute to the success of achieving outcomes by ensuring coordinated planning and facilitating alignment across complementary initiatives. These partnerships are strengthened by the alignment of the Ohio Medicaid Quality Strategy and the State Health Improvement Plan, supporting ODM's and the MCPs' work with other state agencies on improvement goals.

Figure 2 illustrates the 2017-2019 State Health Improvement Plan.

Figure 2. Ohio State Health Improvement Plan



In 2017, ODM refined the MCP QI program to better align with the population-based health approach and ODM's delivery system reforms. The intentional shift to a value-based purchasing role recognizes that MCPs are required to play a different role (purchaser of value vs. a payer of claims) and focus efforts in a new way (effective programs versus compliance-oriented programs). ODM removed many of the MCPs' detailed care management requirements with the expectation that MCPs will shift resources to proven QI strategies and support ODM's value-based purchasing initiatives. Three components of the MCPs' QI program were revised in January 2018: population health management program, MCP QI programs, and incentives to promote MCP performance.

Population Health Management

To achieve its quality strategy goals, ODM takes a population health approach, grouping the Medicaid population into population streams. The MCPs are accountable for assigning each Medicaid managed care member to one of these population streams, which include:

- Healthy Children and Adults
- Women and Infant Health
- Behavioral Health
- Chronic Conditions

Components of the population health program are as follows:

- *Identification*—Use of assessments, claims, and supplemental data sources to identify clinical cohorts that align with ODM's population streams.
- *Prioritization*—Assign a risk level considering clinical conditions, social determinants of health, geography, etc. for the purpose of targeting interventions and allocating resources based on member's needs.
- *Programming*—Comprehensive offering of services tailored to population stream and risk level. Examples include medical homes, disease management, health and wellness programs, enhanced maternal care, care management, community workers, etc.
- *Continuous QI*—Assessment and improvement of outcomes for each group identified by the MCP's population health management strategy using improvement science.

ODM's goals and associated initiatives focus on pursuing positive health outcomes for its Medicaid recipients by preventing disease through early detection, reducing preterm birth and infant mortality, integrating physical and behavioral health, and optimally managing chronic conditions. ODM has coordinated efforts to address disparities that occur within each of ODM's population streams. For each of these, data are used to identify and target areas in priority regions where disparities in optimal outcomes are greatest. Current health equity efforts are focused on reducing infant mortality through increasing pre-term birth interventions, capitalizing on MCP partnerships with community-

based organizations to address additional contributors to infant mortality, and reducing disparities in hypertension control between African-American and Caucasian Medicaid members.

ODM requires MCPs to actively participate in both federally-required improvement projects and initiatives reflecting State efforts to improve quality of care and outcomes. The topic choice for ODM's required improvement projects ties to the Ohio Medicaid Quality Strategy and focuses on one of the population health streams. Topics addressing disparities in health outcomes are prioritized. Additional efforts involve active collaboration with other State agencies and quality collaborative groups. These initiatives include the following:

- *Medicaid Pre-Release Enrollment Program*—The Ohio Department of Rehabilitation and Correction and ODM established a program to facilitate Medicaid enrollment and MCP selection 90 days prior to the release of an incarcerated individual. MCP care managers assist individuals with complex healthcare needs with a transition plan to assure successful community integration. The program is active at all 28 state prisons.
- *Comprehensive Primary Care (CPC)* and *Comprehensive Primary Care for Kids Support*—ODM's investment in Ohio's primary care infrastructure is accompanied by a financing methodology intended to support improved population health outcomes by attributing members to specific providers. CPC is anchored in team-based care with transparency in healthcare data that allows for population risk-tiering to guide more effective, holistic care. MCPs support CPC practices in several ways to increase the use of the patient-centered medical home (PCMH) model and increase the percentage of high-risk patients receiving preventive care.
- *School-Based Healthcare (SBHC) Initiative*—Through a partnership between Ohio Medicaid and the Ohio Department of Education, the SBHC Initiative aims to create an accessible, connected community of caring adults around each student to keep them in class and learning. Preparing the whole child for future success requires each student to be supported by teachers and administration so health issues do not interfere with learning; families have convenient, consistent way for their children to receive needed care; each student can have greater access to external clinicians; and more students can be treated in an efficient manner. The two departments collaborated to launch a nationally recognized School-Based Healthcare Support toolkit in the spring of 2018. With leadership from the Governor's Office of Children's Initiatives in 2019, Ohio Medicaid began a new collaborative effort with the education and mental health systems to expand access to behavioral health in schools using telehealth technologies. This work will continue in 2020.

Maternal Health and Infant Mortality Reduction Initiatives

- *Sustaining and Spreading the Progesterone Initiation PIP*. Begun in SFY 2017, the PIP within the Women and Infant

Health population stream focuses on preventing preterm birth. The web-based standardized pregnancy risk assessment form (the PRAF 2.0), which streamlines communication among partners, is integrated into Ohio's Medicaid eligibility system and interfaces with the Ohio Department of Health's (ODH's) Ohio Comprehensive Home Visiting Integrated Data System (OHCIDS). This integration reduces the risk of Medicaid coverage loss during pregnancy while increasing efficiencies in communicating education and follow-up needs with Ohio's Home Visiting program.

- *Smoke Free Families Perinatal Improvement Project*. ODM and ODH have partnered to reduce tobacco use among Medicaid women during pregnancy in order to improve birth outcomes. Using a QI learning collaborative, participating sites receive training on the Ohio Smoke Free Families provider toolkit, "5 A's" (Ask, Advise, Assess, Assist, and Arrange), "5 R's" (Relevance, Risks, Rewards, Roadblocks, and Repetition), and motivational interviewing while implementing tools and interventions at their site.
- *Smoke Free Families Pediatric Improvement Project*. This project aims to reduce the use of tobacco among postpartum women and the exposure to secondhand smoke of their infants and other family members though PCP screening and support in quitting smoking through implementation of the "5 A's" plan.
- *Efforts in Ohio's Equity Institute Communities*. ODM has dedicated funds to support community-driven interventions with proven track records to help reduce infant mortality locally. These interventions are focused on outreach and connection for the highest risk mothers. ODM has contracted with the Government Resource Center (GRC) to evaluate these activities and complete periodic reviews of the barriers faced by Medicaid recipients in gaining full access to interventions intended to reduce tobacco use, prevent prematurity, and promote optimal birth spacing. The information will assist ODM in determining how to further infant mortality reduction policy and programs.

Initiatives Targeting Opioid Use Disorder

- *Neonatal Abstinence Syndrome (NAS) Improvement Project*. This statewide improvement initiative for the Women's Health and Behavioral Health population streams is sustaining efforts, refining protocols, and continuing support for sites that have implemented interventions focused on compassionate care, community outreach, and delivery of high-calorie formula.
- *Maternal Opiate Medical Supports Plus (MOMS+) Improvement Project*. Key learnings from the MOMs and NAS projects have helped shape the next phase of the project, MOMS+. Using an obstetrical specialty model, MOMS+ offers MAT induction by a specialized obstetrician who assists in helping local obstetricians maintain MAT and provide access to needed psychological services. Goals of the project include: increasing the percentage of women with opioid use disorder during pregnancy who receive prenatal

care, MAT, and behavioral health counseling each month; decreasing the percentage of full-term infants with neonatal abstinence syndrome requiring pharmacological treatment; and increasing the percentage of babies who go home with mother after delivery.

Chronic Condition Interventions

- *Hypertension Control Improvement Project.* This project is aimed at the Medicaid population of adults with chronic conditions, specifically cardiovascular disease as exhibited by uncontrolled hypertension. This project focuses on health disparities informed by data demonstrating much higher rates of uncontrolled hypertension among African-American patients as compared to Caucasian patients. To begin closing this disparity, the project SMART (specific, measurable, achievable, relevant, time-bound) aims include improving the control of hypertension by 15% in the overall study population and 20% in the African-American population. The effort involves MCP support of clinical efforts to implement clinical best practices shown to be effective in controlling hypertension and reducing disparities. The project's key drivers and interventions include: accurate blood pressure measurement, timely follow-up for high blood pressure, the tailoring of outreach and communication in a culturally appropriate manner, and adherence to a medication treatment algorithm. MCP support activities include standardization of home blood pressure monitor ordering and coverage of 90-day prescriptions.
- *Gestational Diabetes Mellitus (GDM)*. ODM and ODH are partnering to increase the number of women with a history of GDM who receive recommended screening and education for type 2 diabetes (T2DM). Participating practices test interventions and the 29 original Ohio Obstetrics/Gynecology (OB/GYN) and Maternal Fetal Medicine practices are now focused on sustaining successful processes developed as part of quality improvement interventions to improve the rates of: timely screenings of pregnant women for GDM; postpartum visits; and postpartum T2DM screenings within recommended time frames. Fifteen Ohio PCPs are engaged in testing interventions to improve rates for: the assessment of women for a history of GDM or at risk for T2DM; and the improvement of T2DM screening rates throughout the life course.

Promoting Effective Behavioral Healthcare

- *Behavioral Health Benefit Package*. Over the past six years, Ohio has redesigned the Medicaid behavioral health services delivery system and benefit package. The new behavioral health benefit package became available on January 1, 2018. Behavioral health services were integrated into Ohio's current Medicaid managed care plan contracts on July 1, 2018 (making the services "carved-in" to managed care). Provider organizations in the new network include community behavioral health organizations, inpatient hospitals, clinics, and specialty practitioners. This carve-in of behavioral health services supports ODM's commitment to developing a healthcare market where payment is

consistently and increasingly designed to reflect and improve the effectiveness and efficiency of care delivery and where Medicaid insured individuals are actively engaged in managing their own health, including selection of providers and value-based services.

Patient, Family, and Community Centered Approaches

- *Social Determinants of Health.* Much of what impacts the health of individuals is outside the purview of the medical setting. Social determinants of health, such as a safe living environment and neighborhood, stable housing, the availability of transportation, adequate and healthful food, and quality childcare all have an impact on the ability of Medicaid recipients to be actively engaged in their own health and well-being and to take ownership of their healthcare. In July of 2017, ODM required each MCP to devote at least one full-time position to community engagement activities. These positions are intended to bolster MCP-community relations, increase MCP understanding of community needs, and increase community trust of MCPs, with the desired outcome being increased ability to address social determinants of health.

Alternative Payment Models (APMs)

ODM's goal is to have at least 80% of Ohio's population receiving services through a value-based payment model (combination of episode- and population-based payments) within five years. Several strategies are currently being implemented to assist with this goal, including Episodes of Care (EOC), an APM with specific clinical areas of focus designed to improve systems of care for both fee-for-service (FFS) and managed care populations.

Regarding episode-based payments, a principal accountable provider (PAP) is identified and is eligible to benefit financially by keeping the cost of care low and the quality of care high. For each episode, patients seek care as usual and providers continue to submit claims as they have in the past. The difference is that, after the performance year, the expenditures attributed to the PAP are compared to target levels. PAPs are then eligible to participate in shared savings based on how they compare to their peers. After 12 months of quarterly reporting, incentive payments based on the previous 12-month period of outcomes began. Since 2015, Ohio has launched 43 episodes, eighteen of which are currently tied to financial incentives. The MCPs are currently reporting on a large number of episodes of care that address multiple population streams including Healthy Children, Healthy Adults, Women's Health, and Chronic Conditions.

At the provider level, Ohio's Comprehensive Primary Care (CPC) Program is a PCMH program—a team-based care delivery model led by a primary care practice that comprehensively manages a patient's health needs. The goal of the program is to empower practices to deliver the best care possible to their patients, improving quality of care and lowering costs. Although most medical costs occur outside of a primary care practice, primary care practitioners are able to guide many decisions that impact those broader costs, improving cost efficiency and care quality.

Incentivizing MCP Performance

For SFY 2019 and SFY 2020, ODM designated specific measures for use in the Quality Withhold Incentive System that will provide the MCPs with financial incentives to improve the quality of care delivered to their members, emphasizing the effectiveness of each MCP's population health management strategy and programs to impact population health outcomes.

This new structure will withhold 2.0% of the calendar year capitation and delivery payments for each MCP for use in the Quality Withhold (QW) Program. ODM will use Quality Indices to measure the effectiveness of the MCP's population health management strategy and QI program in impacting population health outcomes. Quality indices will be comprised of multiple performance measures related to the index topic and a separate score will be calculated for each Quality Index. Index scores will be used to determine the MCP's annual Quality Withhold Payout.

The Quality Indices used in the QW program for SFY 2019 (measurement year CY 2018) are:

- Chronic Condition: Cardiovascular Disease;
- Chronic Condition: Diabetes;
- Behavioral Health; and
- Healthy Children.

ODM implemented Quality-Based Assignments (QBA) as part of the MCP assignment process for consumers who do not have a prior history with specific providers on an MCP's provider panel or have not chosen an MCP. The QBA algorithm aggregates results for measures related to women's health and infant mortality to calculate a Women's Health Index comparing MCP performance as a means to assign members to an MCP on a quarterly basis. Plans with higher performance on these measures have a greater percentage of new Medicaid enrollees assigned to them.

Performance Improvement Projects (PIPs)

Background

ODM requires its contracted MCPs to conduct PIPs in accordance with 42 CFR §438.330(b)(1), and to report results monthly. PIPs are studies that aim to improve MCP performance in relevant areas of clinical care and non-clinical services, and are intended to promote actual, significant, and sustained improvement in Medicaid member health status (via improving both clinical and non-clinical services), quality of life, and provider and member satisfaction. PIP study topics must reflect Medicaid enrollment in terms of demographic characteristics and, if applicable, in terms of the prevalence and potential consequences (risks) of disease.

In SFY 2018, ODM initiated a new PIP topic across all MCPs that focuses on improving hypertension control for targeted Medicaid members and reducing disparities for the African American population. ODM recognized that hypertension is more prevalent among African American Medicaid members, has an earlier onset, is harder to control, and is responsible for half of the cardiovascular mortality disparity between whites and African Americans. The state-level *Hypertension Control and Disparity Reduction* PIP aligns with the State's Quality Strategy by addressing a prevalent chronic condition with disproportionately negative health outcomes.

The PIP's objectives include the following:

- Promote evidence-based interventions for hypertension management to improve blood pressure control.
- Identify, implement, and share best practices for hypertension management across the State, beginning with the selected high-volume provider practices.
- Establish a data collection methodology and provider practice site-specific reporting system for electronic health record (EHR) data.
- Develop processes and outcome measures to track PIP progress and sustainability.
- Engage MCPs and provider practice sites in QI activities to identify, modify, and adapt best practice interventions into provider and MCP systems and sustain activities over time.

ODM requires its MCPs to use a rapid-cycle PIP framework that includes the following components: forming a PIP team (consisting of internal and external members); setting aims; establishing outcome, process, and balancing measures;, determining interventions; rapid-cycle testing of interventions using a series of Plan-Do-Study-Act (PDSA) cycles; and sustaining and spreading successful changes.

The following outlines the rapid-cycle PIP validation framework established by HSAG:

- *Module 1—PIP Initiation*: Outlines the framework for the project following the Associates in Process Improvement's (API's) Model for Improvement, which was popularized by the Institute for Healthcare Improvement, by:
  - Clearly stating the desired accomplishment through articulating how the project fits into ODM's larger Global Aim (reducing deaths due to myocardial infarction and stroke from cardiovascular disease and reducing disparities for African Americans).
  - Precisely stating a project-specific SMART Aim (specific, measurable, attainable, relevant and time-bound) including the topic rationale and supporting data so that alignment with larger initiatives and feasibility are clear.
  - Building a PIP team consisting of internal and external stakeholders.
  - Completing a key driver diagram (KDD) that summarizes the changes that are agreed upon by the team as having sufficient evidence to lead to improvement.
- *Module 2—SMART Aim Data Collection*: The SMART Aim measure is operationalized, and the data collection methodology is described. SMART Aim data are displayed in a run chart.
- *Module 3—Intervention Determination*: Involves a deeper dive into the QI activities reasonably thought to impact the SMART Aim. Interventions, in addition to those in the original KDD, are identified using tools such as process mapping, failure modes and effects analysis (FMEA), Pareto charts, and failure mode priority ranking, for testing using PDSA cycles in Module 4.
- *Module 4—PDSA*: The interventions selected in Module 3 are tested and evaluated through a thoughtful and incremental series of PDSA cycles.
- *Module 5—PIP Conclusions*: Summarizes key findings and presents comparisons of successful and unsuccessful interventions, outcomes achieved, and lessons learned.

Technical Methods of Data Collection and Analysis

The PIP targets Medicaid members 18 to 85 years of age with a diagnosis of hypertension. Members excluded from the denominator are those with evidence of end-stage renal disease on or prior to the end of the measurement period, those who have been diagnosed with pregnancy during the measurement period, and those with an admission to a non-acute inpatient setting during the measurement period. The Global Aim for this PIP is to "Reduce deaths due to myocardial infarction (MI) and stroke from cardiovascular disease and reduce disparities for African Americans." The SMART Aim is to increase the percentage of members with controlled hypertension by 15% and, for African American members, increase the percentage of controlled hypertension by 20%. Controlled hypertension is defined as both systolic and diastolic blood pressure of less than 140/90.

- Numerator—Total number of hypertensive members whose average blood pressure is less than 140/90

- Denominator—Total number of hypertensive members in the reporting period
- Baseline—10/1/2016–11/30/2017
- Measurement Intervals—Twice per month

The MCPs used their National Committee for Quality Assurance (NCQA) HEDIS Compliance Audit™ measure data for the most recent year for the baseline rate; however, HEDIS data collection specifications were not used for the PIP. The baseline percentage for the SMART Aim was adjusted to reflect the actual baseline percentage for the targeted population (the MCP's members with hypertension at the participating practice sites as extracted from the EHR submission). The data are collected by the ODM-contracted Ohio Colleges of Medicine Government Resource Center and its subcontractor, Duet Health.

While the PIP is in progress, an evaluation tool is used to assess whether each MCP has met criteria throughout each module and is therefore proceeding toward methodologically sound and credible results. Once the MCPs complete and submit Module 5—PIP Conclusions, expected in SFY 2020, ODM's EQRO Island Peer Review Organization (IPRO) will use a standardized scoring methodology to determine the overall validity and reliability of the PIP and report a level of confidence for the PIP results. The confidence levels are as follows:

- High confidence—the PIP was methodologically sound, achieved the SMART Aim goal, and the demonstrated improvement was clearly linked to the QI processes conducted.
- Confidence—the PIP was methodologically sound, achieved the SMART Aim goal, and some of the QI processes were linked to the demonstrated improvement; however, there was not a clear link to all of the QI processes and the demonstrated improvement.
- Low confidence—(A) the PIP was methodologically sound; however, the SMART Aim goal was not achieved; or (B) the SMART Aim goal was achieved; however, the QI processes and interventions were poorly executed and could not be linked to the improvement.
- Reported PIP results were not credible—the PIP methodology was not executed as approved.

Description of Data Obtained

Each of the five MCPs completed Modules 3 and 4 during SFY 2019. HSAG validated each MCP's modules using an evaluation tool to determine whether specific criteria were met.

Comparative Findings

In SFY 2019, all MCPs met each of the criteria for Modules 3 and 4. The components of all four completed modules are outlined in **Table 1**.

Table 1. PIP Module Validation Results

Criteria	Buckeye	CareSource	Molina	Paramount	UnitedHealth-care
Module 1: PIP Initiation (evaluated in SFY 2018)					
1. The topic and narrowed focus were supported by data.	✓	✓	✓	✓	✓
2. The team members were identified for both internal MCP staff members and external partners, including representation for the narrowed focus.	✓	✓	✓	✓	✓
3. The SMART Aim included all required components (narrowed focus, baseline rate, goal, and date) and was developed based on literature review, MCP data, and/or experience.	✓	✓	✓	✓	✓
4. The Global Aim, SMART Aim, drivers, and potential interventions were aligned and stated accurately.	✓	✓	✓	✓	✓
Module 2: SMART Aim Data Collection (evaluated in SFY 2018)					
1. The SMART Aim measure included all the following components: a. The numerator and denominator were well-defined to measure outcomes for the SMART Aim. b. The baseline measurement period and rate were appropriate. c. The measurement intervals were appropriate for the SMART Aim. d. The SMART Aim goal was appropriate based on the baseline rate and denominator size.	✓	✓	✓	✓	✓
2. The SMART Aim data collection methodology supported the rapid-cycle process and included: a. Data sources(s). b. A step-by-step process that aligned with the baseline data collection methodology. c. Team members collecting data.	✓	✓	✓	✓	✓
3. If a data collection tool was used, the tool(s) was appropriate and captured all required data elements.	✓	✓	✓	✓	✓
4. The run/control chart included the titles, SMART Aim goal, baseline percentage, and data collection interval.	✓	✓	✓	✓	✓

Criteria	Buckeye	CareSource	Molina	Paramount	UnitedHealth-care
Module 3: Intervention Determination (evaluated in SFY 2019)					
1. The documentation included the team members responsible for completing the process map and failure mode and effects analysis (FMEA).	✓	✓	✓	✓	✓
2. The documentation included a process map illustrating the step-by-step flow of the current overall process. The subprocesses identified in the process map as opportunities for improvement were numbered and clearly referenced in the FMEA table.	✓	✓	✓	✓	✓
3. The MCP included a description and rationale used for the selection of subprocesses for the FMEA table.	✓	✓	✓	✓	✓
4. The FMEA table included: subprocesses that aligned with the opportunities for improvement identified in the process map, failure modes, failure causes, and failure effects for each subprocess listed in the table.	✓	✓	✓	✓	✓
5. The MCP described its failure mode priority ranking process.	✓	✓	✓	✓	✓
6. The interventions listed in the Intervention Determination Table were appropriate based on the ranked failure modes.	✓	✓	✓	✓	✓
7. The MCP considered the intervention's reliability and sustainability as part of its selection process.	✓	✓	✓	✓	✓
Module 4: PDSA (evaluated in SFY 2019)					
1. The intervention tested addressed at least one or more of the key drivers or identified failures. The MCP explained how the intervention fits into the theory of change.	✓	✓	✓	✓	✓
2. The MCP documented an appropriate *Intervention Plan* (who, what, where, and how).	✓	✓	✓	✓	✓
3. The *Intervention Effectiveness Measure* was methodologically sound and appropriate for the intervention tested.	✓	✓	✓	✓	✓
4. The MCP provided a complete and accurate summary of the intervention testing results.	✓	✓	✓	✓	✓
5. The MCP's decision to adopt, adapt, or abandon the intervention was supported by appropriate rationale and intervention testing results.	✓	✓	✓	✓	✓

Findings and Recommendations

The PIP validation findings indicated that all five MCPs were successful in prioritizing interventions to test using QI science tools such as process mapping and failure modes and effects analysis. Each MCP was also successful in testing interventions using PDSA cycles. HSAG offered the following recommendations for improvement for each MCP:

- As the MCP progresses to testing additional interventions through a series of incremental PDSA cycles, the MCP should ensure clear communication of the rationale for revising intervention strategies and how specified changes will lead to improvement. A common understanding and agreement about the drivers of improvement will allow the MCP's team to properly direct resources and improvement activities toward appropriate change.
- When planning a test of change, the MCP should think proactively (i.e., scaling/ramping up to build confidence in the change and eventually implementing policy to sustain changes).
- When planning intervention testing methodology, the MCP should articulate the best method for identifying the intended effect of an intervention prior to testing. The intended effect should be known beforehand to help determine a sound data collection plan for the intervention evaluation measure(s).
- The MCP should submit its Intervention Plan to ODM for review prior to testing to ensure the methodology for determining the effectiveness of the intervention is sound.

Comprehensive Administrative Review

Background

According to 42 CFR §438.358, a review must be conducted within the previous three-year period that determines MCPs' 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 Medicaid Managed Care Provider Agreement with the MCPs. The most recent comprehensive review of the MCPs covered the SFY 2017 review period of July 1, 2016, through December 31, 2016. In follow-up to the SFY 2017 Comprehensive Administrative Review, ODM required corrective action plans (CAPs) from each MCP for program areas with deficiencies.

Technical Methods of Data Collection and Analysis

The MCPs cited supporting evidence and uploaded the related source documents in an online Comprehensive Administrative Review tool. Two weeks prior to each MCP's onsite review, HSAG provided cases selected for the file reviews to ensure they were available during the audit. The case and member selections were uploaded to a folder specific to each MCP via a secure FTP. Additionally, each MCP was given the opportunity to provide additional documentation before the close of business on the last day of its onsite review.

The onsite review consisted of a five-day review at each MCP's location. The HSAG review team completed key staff member interviews, which focused on each of the program areas, and conducted case file reviews for the *Coordination and Continuity of Care* standard. The team also requested that each MCP provide a system demonstration of its processes for loading *Health Insurance Portability and Accountability Act of 1996* (HIPAA) 834 enrollment files.

HSAG used a two-point scoring methodology, and elements were scored based on *Met* and *Not Met* criteria. These scores indicate the degree to which the MCPs' performance met the requirements. If a requirement was not relevant, the element was neither evaluated nor scored and was identified as *Not Applicable*. Scores of *Met* and *Not Met* indicate the degree to which the MCPs' performance met the requirements. This scoring methodology is consistent with CMS' final protocol, set forth in its *EQR Protocol 1: Assessment of Compliance with Medicaid Managed Care Regulations: A Mandatory Protocol for External Quality Review (EQR)* (Version 2.0, September 2012.)

Met indicates that the plan achieved *one* of the following criteria:

- All documentation and data sources reviewed (including MCP and ODM data and documentation, file reviews, and systems demonstrations for a regulatory provision, or component thereof) were present and provided supportive evidence of congruence, and staff members were able to provide

responses to reviewers that were consistent with each other, with the data and documentation reviewed, and with the regulatory provision.

- The MCP achieved deemed status on standards eligible for this designation according to ODM's methodology.

Not Met indicates *any* of the following:

- Documentation and data sources were not present and/or did not provide supportive evidence of congruence with the regulatory provision.
- Staff members had little or no knowledge of processes or issues addressed by the regulatory provisions.
- Key components of the provision could not be identified and/or did not provide sufficient evidence of congruence with the regulatory provision. Any findings of *Not Met* for these components resulted in an overall provisional finding of *Not Met* for the standard, regardless of the findings noted for the remaining components.

For a standard to have been exempt from the Comprehensive Administrative Review (i.e., deemed), the MCP's score on the accreditation standard/element must have been 100% of the point value during the most recent accreditation survey. The most current accreditation report for the MCP was reviewed prior to the assessment and determined which standards were eligible to be deemed based on the MCP's score on the related accreditation standard. Prior to deeming an element within a standard, HSAG consulted with ODM to determine final deeming status for each element for the MCP. Deemed standards were assigned a finding of *Met*.

HSAG calculated a total administrative performance score for each of the 13 standards and an overall administrative performance score across the 13 standards. HSAG calculated the total and overall scores by adding the score for each requirement in the standard receiving a score of *Met* (value: 1 point) or *Not Met* (value: 0 points) and dividing the summed score by the total number of applicable requirements for that standard. Any *Not Applicable* elements were removed from the calculation.

Description of Data Obtained

HSAG gathered documentation and data from multiple sources prior to conducting the evaluation. The MCPs' noncompliance logs provided by ODM aided in directing to areas needing focused review. The MCPs' Model of Care submissions to ODM were used to assess performance with the *Coordination and Continuity of Care* standard and components of the care management file review. The MCPs' QAPI program descriptions were used to assess the *Quality Assessment and Performance Improvement* standard. Data from the Utilization Management Tracking Database was used when evaluating the *Coverage and Authorization of Services* standard, and data from ODM's Athena database was used to review elements within the *Grievance System* standard. ODM's oversight processes and the associated monitoring reports were additional evidence of overall MCP performance.

Comparative Findings

Table 2 presents an overview of the MCPs' scores from the SFY 2017 Comprehensive Administrative Review.

Table 2. SFY 2017 Comprehensive Administrative Review Scores Summary

Standard		Buckeye	CareSource	Molina	Paramount	United-Healthcare
I.	Availability of Services	100%	100%	100%	100%	100%
II.	Assurance of Adequate Capacity and Services	100%	67%	100%	100%	67%
III.	Coordination and Continuity of Care	97%	93%	83%	83%	90%
IV.	Coverage and Authorization of Services	93%	96%	100%	93%	93%
V.	Credentialing and Recredentialing	89%	100%	78%	89%	78%
VI.	Subcontractual Relationships and Delegation	100%	100%	100%	100%	100%
VII.	Member Information and Member Rights	92%	100%	100%	100%	88%
VIII.	Confidentiality of Health Information	80%	100%	100%	100%	100%
IX.	Enrollment and Disenrollment	100%	100%	100%	100%	100%
X.	Grievance System	97%	90%	94%	97%	87%
XI.	Practice Guidelines	100%	100%	100%	100%	83%
XII.	Quality Assessment and Performance Improvement	100%	100%	93%	100%	93%
XIII.	Health Information Systems	100%	100%	100%	100%	100%
Total Score		**96%**	**96%**	**94%**	**95%**	**91%**

Findings and Recommendations

Buckeye

Buckeye received an administrative performance score of 100% in seven of the 13 standards reviewed for the Medicaid program, while deficiencies requiring corrective action plans were identified for the remaining six standards. The MCP received a total administrative performance score of 96% for its Medicaid line of business.

CareSource

CareSource received an administrative performance score of 100% in nine of the 13 standards reviewed for the Medicaid program, while deficiencies requiring corrective action plans were identified for the remaining four standards. The MCP received a total administrative performance score of 96% for its Medicaid line of business.

Molina

Molina received an administrative performance score of 100% in nine of the 13 standards reviewed for the Medicaid program, while deficiencies requiring corrective action plans were identified for the remaining four standards. The MCP received a total administrative performance score of 94% for its Medicaid line of business.

Paramount

Paramount received an administrative performance score of 100% in nine of the 13 standards reviewed for the Medicaid program, while deficiencies requiring corrective action plans were identified for the remaining four standards. Overall, the MCP received an administrative performance score of 95%.

UnitedHealthcare

UnitedHealthcare received an administrative performance score of 100% in five of the 13 standards reviewed for the Medicaid program, while deficiencies requiring corrective action plans identified for the remaining eight standards. The MCP received a total administrative performance score of 91% for its Medicaid line of business.

Performance Measures

Assessment Background

In accordance with 42 CFR §438.358, ODM has established quality measures and standards to evaluate MCP performance in key program areas. The selected measures align with specific priorities, goals, and/or focus areas of the Ohio Medicaid Quality Strategy and include HEDIS measures. All measures used by ODM for performance evaluation are derived from national measurement sets, widely used for evaluation of Medicaid and/or managed care industry data. ODM contracted with HSAG, its former EQRO, during SFY 2019 to validate the HEDIS measures.

For SFY 2019, ODM required each contracted MCP to collect and report on 56 measure indicators for HEDIS 2019 (measurement year CY 2018) specified in the provider agreement as well as in the SFY 2019 *ODM Specifications for the Submission of Managed Care Plan Self-Reported, Audited HEDIS Results*. For SFY 2019 and SFY 2020, specific measures are designated for use in the Quality Based Assignment and Quality Withhold Incentive Systems. For these measures, results will be used in determining the award of incentives for participating MCPs. For the measures that include a Minimum Performance Standard, failure to meet a standard will result in the assessment of a noncompliance penalty. The measurement set also includes reporting-only measures, some of which have multiple indicators. Measures were grouped into the following population streams: Healthy Children/Adults; Women's Health; Behavioral Health; and Chronic Conditions.

In addition to the HEDIS measures, HSAG calculated means for the CAHPS child and adult survey responses, which were then compared to NCQA HEDIS Benchmarks and Thresholds for Accreditation and assigned ratings.

HEDIS Measure Validation

Technical Methods of Data Collection and Analysis

For the HEDIS measures, federal requirements allow states, agents that are not managed care organizations, or an EQRO to conduct the PMV to ascertain the validity of the reported rates. Beginning in SFY 2013, ODM required MCPs to self-report performance measure results for HEDIS measures selected for required reporting and to undergo an independent NCQA HEDIS Compliance Audit™ by a licensed organization (LO). The LO documented findings associated with the MCPs' compliance with NCQA's Information System (IS) standards and the audit results associated with each measure. As Ohio's former EQRO, HSAG received the HEDIS measure results and the final audit reports (FARs) and conducted verification to determine that the audit process was consistent with NCQA's audit methodology. After the verification, the HEDIS measure results were used to calculate the statewide results and conduct MCP comparisons. HSAG also used NCQA's national benchmarks to assess the MCPs' performance.

Description of Data Obtained

Validation was performed on MCP self-reported, audited HEDIS rates for the CY 2018 measurement period (i.e., January 1, 2018–December 31, 2018).

Comparative Findings

Table 3 presents the overall number of measure indicators that met or exceeded the MPS by MCP for each population stream. The total number of measure indicators with established MPS for each population stream is presented for comparison. CareSource, Molina, Paramount, and UnitedHealthcare met all 15 MPS that could be compared to national Medicaid benchmarks, and all MCPs met all of the MPS in the Women's Health, Behavioral Health, and Chronic Conditions population streams.

In contrast, Buckeye did not meet the MPS for the Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years measure indicator in the Healthy Children/Adults population stream.

Table 3. HEDIS: Number of Measure Performance Standards Met by Population Stream

Population Stream	Buckeye	CareSource	Molina	Paramount	United-Healthcare	Measures with an MPS
Healthy Children/Adults	6	7	7	7	7	7
Women's Health	4	4	4	4	4	4
Behavioral Health	2	2	2	2	2	2
Chronic Conditions	2	2	2	2	2	2
Total	**14**	**15**	**15**	**15**	**15**	**15**

The HEDIS 2019 measure results for each MCP and the statewide weighted averages are shown in **Table 4**. Measures included in the index scores are footnoted.

Table 4. HEDIS Results: MCP Comparative and Statewide Weighted Average Measure Results

Performance Measures	Buckeye	CareSource	Molina	Paramount	United-Healthcare	Statewide Average
Healthy Children/Adults						
Adolescent Well-Care Visits[2,3]	56.4%	49.9%	50.1%	48.2%	51.7%	50.8%
Annual Dental Visits						
Total	46.0%	53.7%	51.5%	45.0%	46.2%	50.8%
Appropriate Testing for Children with Pharyngitis						
Total	78.3%	81.3%	80.2%	83.0%	80.7%	81.0%
Childhood Immunization Status						
Combination 2	64.7%	67.4%	65.5%	70.6%	64.2%	66.8%
Combination 3	61.8%	64.7%	63.3%	66.9%	60.6%	63.9%
Combination 10	27.5%	26.5%	31.1%	35.0%	28.7%	28.2%
Children and Adolescents' Access to Primary Care Practitioners						
12–24 Months	93.4%	94.7%	94.5%	94.8%	94.1%	94.4%
25 Months–6 Years	84.8%	86.3%	88.0%	87.1%	86.9%	86.4%
7–11 Years	88.1%	89.2%	91.7%	89.4%	88.9%	89.4%
12–19 Years	88.0%	89.3%	91.0%	89.6%	88.5%	89.2%
Immunizations for Adolescents						
Combination 1 (Meningococcal, Tdap)	74.0%	81.0%	76.4%	77.6%	80.0%	79.3%
HPV	22.9%	32.8%	28.2%	26.5%	28.7%	30.1%
Inpatient Utilization, General Hospital/Acute Care						
Discharges Per 1,000 Member Months	6.8%	7.8%	7.4%	8.3%	6.2%	7.4%
Average Length of Stay	4.9%	4.8%	5.0%	4.3%	4.8%	4.8%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents						
BMI Percentile Documentation—Total	71.3%	63.7%	67.9%	74.0%	68.1%	66.5%
Counseling for Nutrition—Total	63.5%	56.7%	59.6%	66.7%	62.5%	59.4%
Counseling for Physical Activity—Total	62.8%	49.6%	51.6%	63.7%	54.5%	53.2%

Performance Measures	Buckeye	CareSource	Molina	Paramount	United-Healthcare	Statewide Average
Well-Child Visits in the First 15 Months of Life[3]						
Six or More Well-Child Visits	65.9%	56.9%	58.4%	62.8%	59.5%	59.1%
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life[3]	67.9%	74.7%	69.6%	71.0%	68.9%	72.2%
Adults' Access to Preventive/Ambulatory Health Services						
Total	82.0%	86.0%	82.0%	80.7%	82.3%	84.0%
Ambulatory Care—Total (per 1,000 Member Months)[1]						
ED Visits—Total	84.6%	88.6%	85.7%	90.9%	80.0%	86.8%
Women's Health						
Breast Cancer Screening[3]	56.2%	54.1%	50.2%	54.6%	52.8%	53.7%
Cervical Cancer Screening[3]	54.7%	68.1%	59.9%	61.1%	57.9%	63.6%
Chlamydia Screening in Women						
Total	54%	58.3%	56.8%	56.8%	55.7%	57.2%
Prenatal and Postpartum Care[2,3]						
Timeliness of Prenatal Care	79.1%	83.7%	83.0%	86.4%	85.5%	83.4%
Postpartum Care	59.4%	66.4%	67.4%	70.3%	65.5%	65.8%
Behavioral Health						
Antidepressant Medication Management						
Effective Acute Phase Treatment	52.6%	50.2%	53.5%	49.9%	50.4%	50.9%
Effective Continuation Phase Treatment	37.2%	34.5%	38.3%	34.6%	35.1%	35.4%
Follow-Up After Emergency Department Visit for AOD Abuse or Dependence						
7-Day Follow-Up	13.0%	15.0%	17.0%	13.2%	30.8%	17.0%
30-Day Follow-Up	22.6%	24.6%	25.5%	22.4%	40.9%	26.4%
Follow-Up After Emergency Department Visit for Mental Illness						
7-Day Follow-Up	47.4%	52.8%	47.0%	45.4%	47.1%	49.8%
30-Day Follow-Up	60.6%	65.5%	62.6%	59.2%	61.6	63.4%
Follow-Up After Hospitalization for Mental Illness						
7-Day Follow-Up[2,3]	42.0%	43.4%	43.3%	42.4%	37.5%	42.3%
30-Day Follow-Up	63.2%	65.2%	64.9%	63.7%	61.1%	64.2%

Performance Measures	Buckeye	CareSource	Molina	Paramount	United-Healthcare	Statewide Average
Follow-Up Care for Children Prescribed ADHD Medication						
Initiation Phase	59.2%	59.9%	49.9%	52.4%	33.4%	55.2%
Continuation and Maintenance Phase	67.6%	69.9%	57.9%	65.8%	40.3%	64.6%
Initiation and Engagement of AOD Abuse or Dependence Treatment						
Initiation of AOD Treatment—Total[3]	45.8%	49.1%	54.6%	50.3%	69.5%	51.7%
Engagement of AOD Treatment—Total	17.6%	21.6%	24.9%	20.9%	24.5%	21.8%
Mental Health Utilization						
Any Service—Total	14.4%	19.5%	16.9%	20.2%	16.1%	18.1%
Inpatient—Total	1.1%	1.3%	1.4%	1.6%	1.3%	1.3%
Intensive Outpatient or Partial Hospitalization—Total	0.2%	1.8%	1.1%	2.2%	1.2%	1.4%
Outpatient—Total	14.2%	19.3%	16.2%	19.8%	15.6%	17.8%
ED—Total	0.2%	1.6%	1.9%	2.1%	1.3%	1.5%
Telehealth—Total	0.1%	0.1%	0.1%	0.9%	0.1%	0.2%
Risk of Continued Opioid Use						
At Least 15 Days Covered	3.9%	4.4%	3.4%	4.2%	4.7%	4.2%
At Least 31 Days Covered	1.9%	2.4%	2.2%	2.3%	2.4%	2.3%
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics						
1-5 Years	NA	59.3%	53.3%	NA	NA	60.2%
6-11 Years	79.7%	78.8%	79.4%	78.5%	84.7%	79.7%
12-17 Years	78.3%	79.5%	74.7%	84.5%	73.0%	78.4%
Total	78.7%	78.4%	75.9%	81.0%	77.7%	78.3%
Use of Multiple Concurrent Antipsychotics in Children and Adolescents[1,3]						
1-5 Years	NA	0.7%	NA	NA	NA	1.0%
6-11 Years	1.3%	3.6%	3.6%	2.2%	0.8%	2.9%
12-17 Years	2.9%	4.2%	3.2%	4.1%	2.3%	3.7%
Total	2.2%	3.9%	3.3%	3.2%	1.8%	3.3%
Use of Opioids at High Dosage	1.7%	1.8%	2.6%	2.4%	1.7%	1.9%
Use of Opioids From Multiple Providers						
Multiple Prescribers	25.0%	23.9%	23.1%	24.6%	23.8%	24.0%

Performance Measures	Buckeye	CareSource	Molina	Paramount	United-Healthcare	Statewide Average
Multiple Pharmacies	4.6%	7.8%	4.9%	6.9%	4.0%	6.5%
Multiple Prescribers and Multiple Pharmacies	3.0%	4.1%	2.6%	4.1%	2.3%	3.6%
Chronic Conditions						
Adult BMI Assessment	87.1%	81.0%	80.5%	86.9%	88.0%	83.1%
Annual Monitoring for Patients on Persistent Medications						
Total	87.8%	88.4%	88.9%	86.3%	87.6%	88.1%
Comprehensive Diabetes Care						
HbA1c Testing[3]	88.3%	86.1%	88.1%	85.9%	85.9%	86.6%
HbA1c Control (<8.0%)	47.2%	43.5%	45.7%	51.3%	43.6%	45.0%
HbA1c Poor Control (>9.0)[1,2,3]	41.6%	47.5%	43.3%	37.2%	43.6%	44.8%
Blood Pressure Control (<140/90 mm Hg)[3]	64.5%	63.7%	64.0%	71.0%	65.5%	64.7%
Eye Exam (Retinal) Performed[3]	63.3%	64.4%	61.6%	61.8%	56.4%	62.6%
Medical Attention for Nephropathy	90.0%	88.1%	89.5%	88.8%	87.3%	88.5%
Controlling High Blood Pressure[2,3]	63.5%	56.9%	56.7%	69.8%	58.4%	59.1%
Medication Management for People With Asthma						
Medication Compliance 50%—Total	68.2%	63.2%	66.0%	63.7%	62.3%	64.0%
Medication Compliance 75%—Total	46.0%	40.5%	40.9%	42.4%	39.3%	41.2%
Pharmacotherapy Management of COPD Exacerbation						
Systemic Corticosteroid	76.6%	75.3%	76.5%	75.2%	75.3%	75.6%
Bronchodilator	84.9%	86.0%	85.5%	84.6%	84.2%	85.5%
Statin Therapy for Patients With Cardiovascular Disease[3]						
Received Statin Therapy—Total	80.9%	81.5%	81.8%	81.1%	77.8%	80.9%
Statin Therapy for Patients With Diabetes						
Received Statin Therapy—Total	66.1%	67.3%	67.4%	63.9%	61.9%	66.2%

[1] *A lower rate indicates better performance for this measure.*
[2] *Indicates a pay-for-performance measure/indicator.*
[3] *Indicates the measure indicator was included in the index score calculation.*

Table 5 displays the percentage of star ratings for each measure by MCP and the statewide weighted average for HEDIS 2018 and HEDIS 2019.

Table 5. HEDIS Results: Percentage of Star Ratings by MCP and Statewide Weighted Average

MCP	★	★★	★★★	★★★★	★★★★★
HEDIS 2018 (CY 2017)					
Buckeye	5.7%	15.1%	41.5%	20.8%	17.0%
CareSource	7.5%	17.0%	22.6%	28.3%	24.5%
Molina	5.7%	15.1%	45.3%	13.2%	20.8%
Paramount	5.7%	17.0%	39.6%	22.6%	15.1%
UnitedHealthcare	5.7%	24.5%	41.5%	18.9%	9.4%
Statewide	**1.9%**	**20.8%**	**30.2%**	**30.2%**	**17.0%**
HEDIS 2019 (CY 2018)					
Buckeye	0.0%	13.3%	53.3%	13.3%	20.0%
CareSource	0.0%	13.3%	40.0%	20.0%	26.7%
Molina	0.0%	13.3%	26.7%	46.7%	13.3%
Paramount	0.0%	0.0%	53.3%	33.3%	13.3%
UnitedHealthcare	0.0%	0.0%	66.7%	26.7%	6.7%
Statewide	**0.0%**	**6.7%**	**46.7%**	**33.3%**	**13.3%**

HEDIS star ratings represent the following percentile comparisons:

★★★★★	★★★★	★★★	★★	★
At or above national Medicaid 75th percentile	At or above 50th, below 75th	At or above 25th, below 50th	At or above 10th, below 25th	Below 10th percentile

CAHPS Measures

Technical Methods of Data Collection and Analysis

ODM required the MCPs to contract with an NCQA-certified HEDIS survey vendor to conduct annual CAHPS Health Plan Surveys. These standardized CAHPS surveys are used to produce several measures of patient experience and include global measures (single-item measures sometimes referred to as an "overall" rating), composite measures (a combination of two or more related survey items), and single-item measures. The standardized survey instruments administered in 2018 were the CAHPS 5.0H Adult Medicaid Health Plan Survey and the CAHPS 5.0H Child Medicaid Health Plan Survey (including the children with chronic conditions measurement set). HSAG aggregated and analyzed the survey data to measure members' experiences with regard to quality of care, access to care, communication with providers and administrative staff members, and overall experience with the MCPs and providers.

To assess the overall consumer-experience rating of the Ohio Medicaid managed care program and MCPs, ODM focused on a set of core measures composed of 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 three-point scale using an NCQA-approved scoring methodology. The three-point means were calculated in accordance with HEDIS specifications for survey measures. According to HEDIS specifications, results for the adult and child populations were reported separately, and no weighting or case-mix adjustment was performed on the results. However, all survey items in the MCPs' CAHPS/HEDIS results were reported to the plans and made available on the ODM website, regardless of the number of responses. Measures with fewer than 100 responses are noted with an asterisk (*).

The MCPs' three-point mean scores were compared to NCQA's 2018 Benchmarks and Thresholds for Accreditation. Based on this comparison, ratings of one (★) to five (★★★★★) stars were determined for each CAHPS measure, where one is the lowest possible rating (i.e., Poor) and five is the highest (i.e., Excellent).

Description of Data Obtained

Adult members and the parents or caretakers of child members from each MCP completed the 2018 CAHPS surveys from February to May 2018. The members eligible for sampling included those who were MCP members at the time the sample was drawn and who were continuously enrolled in the MCP for at least five of the last six months (July–December) of 2017. Adult members eligible for sampling included those who were 18 years of age or older (as of December 31, 2017). Child members eligible for sampling included those who were 17 years of age or younger (as of December 31, 2017). The MCPs were responsible for obtaining an NCQA-certified CAHPS survey vendor to administer the CAHPS surveys to the adult and child Medicaid populations. Survey vendors submitted the CAHPS data to HSAG and ODM.

Comparative Findings

Summaries of the MCPs' adult and child CAHPS performance results are presented in **Table 6** and Table 7, respectively. For the adult survey, the Ohio Medicaid Managed Care program scored at or above the 90th percentile for Rating of Personal Doctor, How Well Doctors Communicate, and Customer Service. The program scored at or between the 75th and 89th percentiles for Getting Needed Care and Getting Care Quickly. In addition, Ohio Medicaid scored at or between the 50th and 74th percentiles for Rating of Health Plan, Rating of All Health Care, Rating of Specialist Seen Most Often, and Coordination of Care. The Ohio Medicaid Managed Care program did not score at or below the 49th percentile on any measures on the adult survey.

Table 6. CAHPS Adult Survey Results: Overall MCP Means Compared to National Benchmarks

	Ohio Medicaid	Buckeye	CareSource	Molina	Paramount	United-Healthcare
Global Ratings						
Rating of Health Plan	2.49	2.47	2.52	2.46	2.49	2.50
Rating of All Health Care	2.40	2.46	2.37	2.32	2.42	2.44
Rating of Personal Doctor	2.57	2.64	2.56	2.52	2.57	2.53
Rating of Specialist Seen Most Often	2.55	2.58	2.45	2.54	2.58	2.61
Composite Measures						
Getting Needed Care	2.44	2.46	2.38	2.43	2.43	2.47
Getting Care Quickly	2.50	2.52	2.47	2.50	2.50	2.53
How Well Doctors Communicate	2.70	2.76	2.67	2.69	2.72	2.67
Customer Service	2.64	2.68	2.61	2.58*	2.71*	2.57
Individual Item Measure						
Coordination of Care	2.47	2.56	2.36	2.52	2.48	2.44

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.*

For the child survey, summarized in **Table 7**, the Ohio Medicaid Managed Care Program scored at or above the 90th percentile for Rating of All Health Care, Rating of Personal Doctor, Rating of Specialist Seen Most Often, Getting Care Quickly, How Well Doctors Communicate, Customer Service, and Coordination of Care. In addition, the program scored at or between the 75th and 89th percentiles for Rating of Health Plan and Getting Needed Care. The Ohio Medicaid Managed Care Program did not score at or below the 74th percentile on any measures of the child survey.

Table 7. CAHPS Child Survey Results: Overall MCP Means Compared to National Benchmarks

	Ohio Medicaid	Buckeye	CareSource	Molina	Paramount	United-Healthcare
Global Ratings						
Rating of Health Plan	2.63	2.59	2.74	2.60	2.60	2.56
Rating of All Health Care	2.67	2.65	2.72	2.67	2.61	2.62
Rating of Personal Doctor	2.73	2.74	2.75	2.70	2.72	2.71
Rating of Specialist Seen Most Often	2.70	2.66*	2.72	2.65	2.80*	2.71*
Composite Measures						
Getting Needed Care	2.58	2.57	2.61	2.53	2.63	2.62
Getting Care Quickly	2.71	2.75	2.75	2.66	2.71	2.69
How Well Doctors Communicate	2.77	2.79	2.79	2.75	2.72	2.74
Customer Service	2.65	2.63	2.64	2.62	2.64*	2.82*
Individual Item Measure						
Coordination of Care	2.54	2.50	2.59	2.51	2.58*	2.49*

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.*

Findings and Recommendations

HEDIS

Based on a review of the FARs issued by each MCP's independent auditor, HSAG found that the MCPs were determined to be Fully Compliant with all seven of the applicable NCQA Information System (IS) standards. The MCPs' independent auditors determined that the rates reported by the MCPs were calculated in accordance with NCQA's defined specifications and there were no data collection or reporting issues identified by the MCPs' independent auditors.

Rates for the following two measure indicators with an MPS ranked at or above the national Medicaid 50th percentile for all five MCPs and the statewide average:

- Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics—Total
- Medication Management for People With Asthma—Medication Compliance 75%—Total

Compared to the other MCPs, Molina had the highest percentage of rates (60.0%) ranking at or above the national Medicaid 50th percentile, but also had two rates (13.3%) fall below the national Medicaid 25th percentile. Conversely, Buckeye, CareSource, Paramount, and UnitedHealthcare each had more than half of their rates fall below the 50th percentile for HEDIS 2019.

Although none of the statewide averages were below the national Medicaid 10th percentile, statewide performance was below the national Medicaid 25th percentile for the Adult Body Mass Index (BMI) Assessment measure indicator.

CAHPS

When CAHPS results for the adult and general child population were compared to 2018 national Medicaid percentiles, the Ohio Medicaid Managed Care Program's performance was good to excellent (i.e., none of the program's means were below the 50th percentile). Areas of excellent performance (i.e., at or above the 90th percentile) included: Rating of All Health Care (general child), Rating of Personal Doctor (adult and general child), Rating of Specialist Seen Most Often (general child), Getting Care Quickly (general child), How Well Doctors Communicate (adult and general child), Customer Service (adult and general child), and Coordination of Care (general child).

For the adult population, Buckeye had the highest results when compared to national percentiles (i.e., eight measures were at or above the 75th percentile), while CareSource had the lowest results (i.e., one measure was below the 25th percentile and three measures were at or between the 25th and 49th percentiles). For the general child population, CareSource had the highest results when compared to national percentiles (i.e., all nine measures were at or above the 75th percentile), while UnitedHealthcare had the lowest results (i.e., one measure was at or between the 25th and 49th percentiles and one measure was at or between the 50th and 74th percentiles).

In a priority analysis of the CAHPS results, HSAG identified the following as measures for focus at the overall population level: Rating of Health Plan, Rating of All Health Care, and Rating of Personal Doctor global ratings. For the adult population, top priority items for the program included getting care as soon as needed; ease of getting care, tests, or treatment; getting an appointment as soon as needed; getting an appointment to see a specialist as soon as needed; receiving information or help from health plan customer service; and doctor asking the member what they thought was best for them. For the general child population, top priority items for the program included amount of time a child's personal doctor spends with the child; getting an appointment as soon as needed; getting an appointment to see a specialist as soon as needed; ease of getting treatment; and receiving information or help from the health plan's customer service.

HSAG recommended that ODM leverage the CAHPS Health Plan Survey data and report findings to support the development of relevant initiatives, quality improvement strategies and interventions, and performance monitoring and evaluation activities. For example, CAHPS data may be analyzed to identify potential health disparities among key demographics. Supplemental items may be used to recognize issues related to cultural competence. This type of information could inform initiatives such as infant mortality, CPC, behavioral healthcare coordination, and school-based healthcare. A review of the CAHPS measure results (e.g., customer service, smoking cessation) may impact the development of related quality improvement strategies, performance measurement and accountability systems, and program monitoring activities. In these and other ways, CAHPS data are valuable resources for patient-centered approaches to population health management and improving health outcomes.

Network Adequacy Validation

Background

The Ohio Medicaid Managed Care Provider Agreement specifies provider panel requirements that must be met by each MCP. MCPs' provider directories must include all contracted providers as well as certain non-contracted providers as specified by ODM. The MCPN is the tool ODM uses to monitor the MCPs' provider networks, and MCPs are required to submit all network provider information data into the MCPN.

To validate the accuracy of the information in the MCPN and to provide insights on members' access to providers, ODM contracted with HSAG to conduct two non-secret (i.e., revealed caller) PCP Access telephone surveys of PCPs contracted with at least one of the MCPs, as well as a secret shopper telephone survey of PCPs. A secret shopper is a person employed to pose as a shopper, client, or patient in order to evaluate the quality of customer service or the validity of information (e.g., accurate prices or location information). The secret shopper telephone survey allows for objective data collection from healthcare providers without potential biases introduced by knowing the identity of the surveyor.

In addition to the PCP Access Surveys, ODM also contracted with HSAG to conduct revealed-caller telephone surveys of durable medical equipment (DME) providers and behavioral health (BH) agencies in each MCP region during SFY 2019. The survey objectives were to determine the availability of DME supplies and the availability of counseling services, respectively, for Medicaid members. HSAG validated select MCPN data elements as a secondary objective for both surveys.

PCP Access Surveys

The primary objectives for the PCP surveys were to evaluate the accuracy of the information in the MCPN database and assess appointment and service availability. To accomplish these objectives, the SFY 2019 surveys were conducted as follows:

Technical Methods of Data Collection and Analysis

Revealed-Caller Surveys

The Fall 2018 revealed-caller survey was conducted for Medicaid PCP providers enrolled with any of the five MCPs as of the September 2018 MCPN files, while the Spring 2019 survey was conducted for providers enrolled as of the March 2019 MCPN files.

The sample frame for both surveys excluded obstetricians/ gynecologists. Out-of-state PCPs were included in the sample frame and attributed to the nearest MCP region. To facilitate the grouping of providers for survey calls, HSAG standardized MCPN address fields in the sample frame to align with the United States Postal Service Coding Accuracy Support System (CASS). Address standardization did not affect the sample frame; provider locations requiring address standardization remained in the sample frame, and standardization changes were rejected if they resulted in a

different address (e.g., potential misspellings in street names were retained for verification during the survey calls).

For each MCP, HSAG selected a statistically valid sample from the list of unique providers based on a 95% confidence level and ±5% margin of error. A 30% oversample for each MCP was added to the sample size to increase the probability of capturing appointment availability information from a statistically valid number of providers.

Before conducting the survey calls, HSAG identified all MCP-contracted locations for each sampled PCP and grouped the providers by location based on address and telephone number. This location-based deduplication enabled HSAG to ask about all sampled providers at a given location during the same call, with the intent of minimizing the burden of the survey on the providers' office staff.

During the survey, callers used an ODM-approved script while making up to two telephone calls on different days and times of day to each selected provider office during standard operating hours. A location was considered unreachable if the telephone number did not connect to a medical provider's office, or if the caller was unable to speak with office personnel during either call attempt (e.g., placed on hold for five minutes or longer). If a call attempt was answered by an answering service or voicemail, a subsequent call was attempted on another day, at another time; if the caller reached an answering service or voicemail on the second call attempt, a message was left requesting a return call to complete the survey. If a return call was received, the telephone script was completed; otherwise, the location was listed as "unreachable." HSAG allowed up to one week for a return call from the provider location. Callers underwent project-specific training with a dedicated analytics manager to standardize how calls were placed and how data were collected during the calls. For each caller, the analytics manager reviewed 100% of calls placed during the first week after the training period and a minimum of 10% of calls for the remainder of the survey period.

Responses from sampled provider locations were entered into an electronic data collection tool. The survey was conducted between October and November 2018. Prior to calculating study indicators, HSAG reviewed the survey responses to ensure complete and accurate data entry.

Data elements collected at the location level (e.g., telephone number accuracy, appointment availability, and address accuracy) were attributed to each sampled provider affiliated with the unique location. While appointment availability was assessed at the practice location level, validation of MCPN elements such as MCP affiliation and acceptance of new patients were assessed for the selected provider.

Secret Shopper Survey

For SFY 2019, ODM also directed HSAG to conduct a secret shopper telephone survey of PCPs to fulfill the following study objectives related to provider network adequacy and data validation:

- Verify the results of the revealed caller PCP Access Surveys
- Evaluate members' access to PCPs
- Validate selected elements from the MCPN data files

The survey was conducted for Medicaid PCP providers enrolled with any of the five MCPs as of the September 2018 MCPN files. To prevent overlap with the concurrent revealed-caller PCP Access Survey, PCPs not selected for the PCP Access Survey were eligible for inclusion in the secret shopper survey. The data collection, sampling, and analysis methodologies for the secret shopper survey were the same as those used for the revealed-caller surveys.

Description of Data Obtained

Providers' survey responses were used to assess access to providers and the validity of MCPN data across three domains:

- Provider access: information on whether the provider could be contacted via telephone, was still contracted with the specified MCP, and whether the provider was accepting new patients.
- Appointment availability: information on the soonest-available appointment with any provider at the location for sick and well-check visits among new and existing Medicaid members, including the availability of after-hours and walk-in appointments.
- MCPN data accuracy: the degree to which survey responses aligned with MCPN data for providers' telephone number, location, MCP contract status, and new patient acceptance status.

Due to the nature of the survey script, data may have been unavailable for some providers. For example, if the MCPN telephone number was incorrect for the location and a corrected telephone number could not be obtained from the person responding to the survey, the survey script would end and data would be missing for remaining survey elements.

Comparative Findings

Table 8 provides a summary of results of the Fall and Spring surveys for appointments with wait times of 30 days or less, by appointment type, for each MCP.

Table 8. Revealed-Caller PCP Access Survey Results: PCPs with ≤30 Days Wait Time

	Fall 2018 Survey								Spring 2019 Survey							
	New Patient Routine Well Check		Existing Patient Routine Well Check		New Patient Sick Visit		Existing Patient Sick Visit		New Patient Routine Well Check		Existing Patient Routine Well Check		New Patient Sick Visit		Existing Patient Sick Visit	
MCPs	#	%	#	%	#	%	#	%	#	%	#	%	#	%	#	%
Buckeye	193	82.1	264	89.8	194	89.0	319	99.4	203	81.2	282	95.6	222	89.2	300	100.0
CareSource	208	84.2	267	90.5	214	93.4	321	99.4	212	83.5	301	96.5	231	91.3	315	100.0
Molina	211	82.1	277	90.5	216	88.5	322	99.4	197	82.1	258	94.9	213	89.5	282	99.6
Paramount	180	79.6	256	92.1	197	91.2	302	100.0	208	87.4	276	96.2	232	96.3	295	100.0
UnitedHealthcare	171	79.9	240	88.6	181	91.4	281	98.6	144	80.0	202	94.4	165	92.2	219	99.5
All MCPs	**963**	**81.7%**	**1,304**	**90.3%**	**1,002**	**90.7%**	**1,545**	**99.4%**	**964**	**83.0%**	**1,319**	**95.6%**	**1,063**	**91.6%**	**1,411**	**99.9%**

Table 9 illustrates the results of the Secret Shopper survey for appointments with wait times of 30 days or less, by appointment type, for each MCP.

Table 9. Secret Shopper PCP Access Survey Results: PCPs with ≤30 Days Wait Time

	SFY 2019 Secret Shopper PCP Access Survey			
	New Patient Routine Well-Check Visit		New Patient Sick Visit	
MCPs	#	%	#	%
Buckeye	40	67.8	48	78.7
CareSource	34	69.4	30	68.2
Molina	49	75.4	54	80.6
Paramount	30	61.2	34	70.8
UnitedHealthcare	25	73.5	30	73.2
All MCPs	**178**	**69.5%**	**196**	**75.1%**

Durable Medical Equipment Survey

In SFY 2019, ODM directed HSAG to survey durable medical equipment (DME) suppliers to determine the availability of 16 specific DME supplies for Medicaid members, and to validate selected MCPN data elements as a secondary objective. HSAG contracted with Issues & Answers to conduct a non-secret (i.e., revealed caller) telephone survey for all DME suppliers contracted with at least one of the MCPs as of the February 2019 MCPN file. Out-of-state DME suppliers were included in the case list.

Technical Methods of Data Collection and Analysis

To facilitate the grouping of providers for survey calls, the MCPN address data was standardized to align with the United States Postal Service CASS. Address standardization did not affect the case list; provider locations requiring address standardization remained in the case list, and standardization changes were rejected if they resulted in a different address (e.g., potential misspellings in street names were retained for verification during the survey calls). Before conducting the survey calls, HSAG grouped the DME suppliers by telephone number. This deduplication enabled asking about all potential plans at a given DME supplier during the same call, with the intent of minimizing the survey burden on the office staff.

During the survey, Issues & Answers' interviewers used an ODM-approved script within its computer assisted telephone interviewing (CATI) system to place no more than two telephone calls to each selected unique telephone number ("case") during standard operating hours. A case was considered nonresponsive if any of the following criteria were met: The telephone number was invalid (i.e., disconnected) or did not connect to a DME supplier office; office personnel refused to complete the survey; office personnel failed to respond to voicemail requests to complete the survey; the interviewer was unable to speak with office personnel during either call attempt (e.g., an automated answering service that prevented the interviewer from speaking with office staff or leaving a voicemail).

If a call attempt was answered by an answering service or voicemail, a message was left requesting a return call to complete the survey. A subsequent call was attempted on another day if a return call was not received. If a return call was received following either call attempt, the telephone script was completed; otherwise, the location was listed as "unreachable."

Interviewers underwent project-specific training with a dedicated survey manager to standardize how calls were placed and how data were collected during the calls. At least 10% of all interviews and calls attempted were reviewed by Issues & Answers' call staff.

Description of Data Obtained

Issues & Answers' interviewers entered survey responses into the CATI system, using transcribed audio recordings for open-ended responses. All survey calls were conducted in March 2019. Prior to analyzing the results, HSAG reviewed the responses from Issues & Answers to ensure complete and logical data entry. Results from the surveyed cases were aggregated by plan for analysis and reporting.

Comparative Findings

The survey responses were compared to the data contained in the MCPN files to calculate the accuracy of selected MCPN data elements. **Table 10** reports whether survey respondents were still participating with the plan and program(s) indicated in the MCPN file. Overall, 43.3% of DME survey cases were determined by survey responses to be DME suppliers, consistent with the specialty information in the MCPN file.

Table 10. DME Survey: MCPN Accuracy Rate for Plan and Program Participation

MCPN-Reported Plan	Denom[1]	DME Supplier[2]	Not a DME Supplier	Not Reached[3]	DME Supplier Accuracy Rate
Buckeye	26	12	0	14	46.2%
CareSource	446	172	25	249	38.6%
Molina	339	168	13	158	49.6%
Paramount	534	221	18	295	41.4%
UnitedHealthcare	240	127	6	107	52.9%
All Plans	**650**	**267**	**31**	**352**	**41.1%**

[1] The denominator includes the DME suppliers identified from the MCPN file.
[2] While some respondents did not answer all survey questions and may have been counted as an overall refusal, a record was validated as a DME supplier if the respondent answered the initial question confirming that the phone number connected to a DME supplier.
[3] A record's status as a DME supplier could not be confirmed if the DME supplier was not reached. DME suppliers not reached are a subset of the 1,268 non-respondents identified in Table 1.

Behavioral Health Survey

Survey responses were used to assess members' access to BH agencies and the validity of MCPN data across two domains:

- MCPN data accuracy: information on whether the BH agency could be contacted via telephone, was still contracted with the specified plan and serving Medicaid members, and had accurate MCPN address information.
- Appointment availability: information on the soonest-available appointment with any provider at the location for individual and family counseling services among new and existing adult and pediatric Medicaid members.

Technical Methods of Data Collection and Analysis

The survey was conducted among all BH agencies contracted with one of the MCPs as of the March 2019 MCPN file. Out-of-state BH agencies located in states adjacent to Ohio were included in the case list.

Before conducting the survey calls, the BH agencies were grouped by telephone number, creating survey cases based on the combination of unique telephone number and address. This deduplication enabled HSAG to ask about all potential MCPN addresses associated with a given BH agency's telephone number

during the same call, with the intent of minimizing the survey burden on the office staff.

During the survey, interviewers used an ODM-approved script while making no more than two telephone call attempts to each selected unique telephone number ("case") during standard operating hours. A case was considered nonresponsive if any of the following criteria were met:

- The telephone number was invalid (i.e., disconnected) or connected to an individual or business unrelated to a BH agency
- Office personnel refused to complete the survey
- Office personnel failed to respond to voicemail requests to complete the survey
- The interviewer was unable to speak with office personnel during either call attempt (e.g., an automated answering service prevented the interviewer from speaking with office staff or leaving a voicemail).
- If a call attempt was answered by an answering service or voicemail, a message was left requesting a return call to complete the survey. A subsequent call was attempted on another day if a return call was not received.

Interviewers underwent project-specific training with a dedicated analytics manager to standardize how calls were placed and how data were collected during the calls. For each caller, the analytics manager reviewed 100% of calls placed during the first week after the training period and a minimum of 10% of calls for the remainder of the survey period.

Description of Data Obtained

Responses from surveyed cases were entered into an electronic data collection tool. Survey calls were conducted between April and May 2019. Prior to calculating study indicator results, the survey responses were reviewed to ensure complete and accurate data entry.

Data elements collected at the case level (e.g., telephone number accuracy) were attributed to each BH agency affiliated with the unique telephone number. Results from the surveyed cases were aggregated by plan for analysis and reporting.

Comparative Findings

Table 11 summarizes appointment availability results from the BH survey. In general, BH agencies offered appointments to new and established patients for individual and family counseling within seven calendar days, and a limited number of agencies offered same-day appointments.

Table 11. BH Survey: Summary of Median Appointment Wait Times in Calendar Days by Appointment Scenario and Plan

MCP	Individual Counseling – Median Wait Time (Calendar Days)				Family Counseling – Median Wait Time (Calendar Days)	
	New Pediatric Patient	Established Pediatric Patient	New Adult Patient	Established Adult Patient	New Patients	Established Patients
Buckeye	6.0	6.0	6.0	4.0	7.0	7.0
CareSource	3.5	5.0	3.0	2.0	2.5	3.0
Molina	6.0	6.0	5.0	4.0	7.0	7.0
Paramount	6.0	5.0	6.0	4.0	7.0	7.0
UnitedHealthcare	3.0	3.0	3.0	3.0	4.0	4.0
All Plans	**6.0**	**6.0**	**5.0**	**4.0**	**7.0**	**7.0**

Findings and Recommendations

PCP Access Surveys

Each of the three PCP surveys achieved higher-than-average response rates, and in general, results of the three surveys showed that PCP offices offered appointments to new and existing patients for routine well-checks or illnesses within 30 calendar days.

All three surveys also suggested significant inaccuracies within the MCPN data. The Fall and Spring revealed-caller surveys showed that 26.4% and 25.3%, respectively, of sampled provider locations did not match the telephone number listed in the MCPN data files, and 63.6% and 64.7%, respectively, did not match the MCPN address information. In the Secret Shopper survey, 33.1% of sampled provider locations could not be reached at the telephone number listed in the MCPN data files.

In the revealed-caller surveys, appointments for both well-checks and illnesses were available sooner for existing patients than for new patients, with the Fall survey finding an average wait time of 8.9 days until an illness-related visit for a new patient versus an average of 1.3 days for an existing patient, and the Spring survey finding an average wait time of 9.0 days for new patients versus 0.6 days for existing patients. The Secret Shopper survey revealed that PCP offices offered appointments to new Medicaid patients requesting sick visits sooner (an average of 20.9 days' wait time)

than to new Medicaid patients requesting routine well-checks (an average of 26.6 days' wait time). The surveys also found the following:

- Fall PCP Access Survey—among providers that could be reached and were still contracted with the sampled MCP, 66.9% were accepting new patients, with a range of 61.8% for UnitedHealthcare to 73.7% for Molina across the MCPs.
- Spring PCP Access Survey—among the providers that could be reached and were still contracted with the sampled MCP, 69.1% were accepting new patients, with a range of 65.4% for CareSource to 71.7% for Buckeye across the MCPs.
- Secret Shopper Survey—among the providers that could be reached and were still contracted with the sampled MCP, 63.4% were accepting new Medicaid patients, with a range of 57.4% for CareSource to 69.3% for Buckeye. Only 7.9% of Paramount's PCP provider locations reported accepting new patients without limitations. Among those locations, 45.0% required callers to pre-register with the practice or provide personal information before an appointment could be scheduled.

DME Survey

The DME survey results are summarized as follows:

- MCPN data for DME suppliers showed substantial variability across plans for the same DME supplier. A single DME supplier may contract with all plans and be reflected in the MCPN data differently for each plan (e.g., variations in the agency name, address(es), and/or telephone number[s]). To validate the MCPN data for DME suppliers, the survey administration vendor attempted to contact each of the 1,183 unique telephone numbers shown for the 2,235 MCPN records for DME suppliers.
- Of the DME suppliers that reported contracting with an MCP and accepting Medicaid, HSAG noted low availability rates for the 16 DME products included in the survey. Overall availability rates varied by product, ranging from 9.1% of respondents offering the Tolerex nutritional formula to 33.5% of respondents offering portable oxygen concentrators.
- Product availability varied within product category (e.g., airway management devices, feeding supplies). While respondents reported higher availability rates of invasive ventilators and portable oxygen concentrators, low availability rates were reported for other airway management devices (e.g., apnea monitors).
- Most DME suppliers (85.3%) responding to the survey indicated that they were contracted with the plan(s) specified in the MCPN files, with MCPN accuracy ranging from 74.2% for UnitedHealthcare to 91.3% for Buckeye.
- Overall MCPN accuracy for program acceptance was 51.0% and this relatively low rate can be attributed primarily to Paramount and UnitedHealthcare. Respondents for these plans reported accepting both Medicaid and MyCare, while the corresponding MCPN records noted only Medicaid

acceptance. For example, Paramount is contracted to serve only MCP consumers and Aetna is contracted to serve only MyCare Ohio consumers, but survey respondents reported accepting consumers with both the Medicaid and MyCare Ohio programs for these plans.

- In conjunction with high self-reported rates of overall program acceptance, MCPN program accuracy findings suggest that MCPN program data for Paramount and UnitedHealthcare reflect a concern that DME suppliers may not clearly differentiate whether products are available to Medicaid consumers.

BH Survey

The results of the BH Survey are summarized as follows:

- The study had a response rate of 58.1%. Plan-level response rates ranged from 86.7% for UnitedHealthcare to 56.0% for Buckeye. UnitedHealthcare's high response rate resulted from the small number of BH agencies attributed to UnitedHealthcare in the MCPN data, suggesting potential concerns with the plan's definition of BH agencies.
- Among the agencies that could be reached, were still contracted with the sampled MCP and Medicaid, and offered outpatient BH services, 95.8% offered individual counseling services, 78.7% offered group counseling services, and 67.5% offered family counseling services.
- Survey findings suggest that the MCPN data for address and telephone numbers for BH agencies were accurate, as 72.0% of sampled provider locations matched the telephone number listed in the MCPN data files, and 89.7% matched the MCPN address information.

Based on the findings of all the network adequacy surveys, Qsource makes the following recommendations:

- All MCPs should work to improve the accuracy of PCP telephone numbers and addresses listed in MCPN data files.
- Paramount should work to increase its number of PCPs accepting new patients without limitations.
- All MCPs should address their DME suppliers' low availability rates for DME products.
- Paramount and UnitedHealthcare should ensure that their DME suppliers can clearly differentiate whether products are available to Medicaid consumers.
- Due to the small number of BH agencies attributed to the MCP in the MCPN data, UnitedHealthcare should review and, if needed, revise its definition of BH agencies to ensure that it accurately captures all organizations/facilities that provide BH services.

Encounter Data Validation (EDV)

Background

EDV determines the accuracy and completeness of encounter data to inform policy and operational decision-making, assess quality, monitor program integrity, and determine capitation payment rates.

ODM's Medicaid Managed Care Provider Agreement requires MCPs to collect data on services furnished to members through a claims system, and the encounter data must be reported to ODM electronically according to the specified schedule following ODM Encounter Data Submission Guidelines and the Quality Measure Methodology document. The MCP must submit a letter of certification, using the form required by ODM, with each encounter data file. In SFY 2019, ODM contracted with HSAG to conduct an administrative comparative data analysis of the MCPs' submitted data for all encounter types (dental, professional, institutional, and pharmacy). The primary objectives for the validation were to verify that MCPs submitted encounter data accurately and that payment was made appropriately.

To align with CMS's *EQR Protocol 4 Validation of Encounter Data* (Version 2.0; September 2012), HSAG also conducted a review of medical records to verify the completeness and accuracy of the professional encounter data submitted to ODM by the MCPs.

Administrative Comparative Data Analysis

Technical Methods of Data Collection and Analysis

The administrative comparative data analysis component for MCPs focused on encounters for the Covered Families and Children/Modified Adjusted Gross Income (CFC/MAGI) and aged, blind, and disabled (ABD) populations with dates of service during calendar year 2017. The analysis consisted of the following key activities:

- *Collecting data and conducting preliminary file review*. MCPs submitted fully adjudicated dental, professional, institutional, and pharmacy claims and encounters with dates of service during the study period (i.e., January 1, 2017–December 31, 2017) with a final paid status in the MCPs' data systems as of September 30, 2018. All data submitted by the MCPs underwent a preliminary file review to ensure that the submitted files were generally comparable to the encounters extracted from ODM's vendor data. Preliminary file acceptance reports summarized the results of the reviews as well as any notable data issues. After the MCPs reviewed their preliminary file acceptance reports, they had an opportunity to resubmit their files.
- *Validating payment information*. The first step examined omissions identified in each comparison pair—i.e., ODM to MCP and MCP to ODM. Omissions from ODM's encounter

file were identified as *encounter omissions*, and omissions from the MCPs' files were defined as *encounter surpluses*. To assess omissions and surpluses, HSAG used a matching algorithm to conduct the evaluation of omitted claims and encounters. Data fields used for institutional record-level matching may have included but were not limited to the following fields: recipient identification number, ICN, revenue center code, procedure code, and units billed. These data elements were concatenated to create a unique MATCHKEY, a distinct identifier for each detail record in ODM's and the MCP's data.

- *Validating completeness of third-party liability (TPL) information on claims*. MCPs are required to submit TPL information on claims submitted to Medicaid Information Technology System (MITS). The accuracy of the MCPs' population of TPL information on claims submitted to MITS was evaluated by comparing it to what was populated in the MCPs' claims processing systems.
- *Validating completeness of provider information of claims/encounters*. The accuracy of MCPs' population of provider information on claims/encounters submitted to MITS was evaluated by comparing it to what was populated in the MCPs' claims processing systems. HSAG focused on the National Provider Identification (NPI) number field associated with each provider field specific to the claim/encounter type. For dental and professional claims/encounters, the provider fields included in the validation were rendering and billing providers; for institutional claims/encounters, the fields were attending and billing providers; for pharmacy claims/encounters, the fields were billing and prescribing providers.

Description of Data Obtained

Claims were excluded from the analyses in which one or more of the service lines had dates of service beyond the study period. Prior to data collection, HSAG collaborated with ODM to draft a data requirements document to assist the MCPs with submitting claims data. Following distribution of the documentation to the MCPs, HSAG and ODM conducted conference calls with the MCPs to review the documentation and answer any questions related to data submission.

For the submitted files to be accepted, at least 90% of the MCP's claims/encounters had to match those in ODM's vendor data. At least 95% of the payment amounts in the MCP's header records had to match the sum of the payment amounts in the detail line item records, where applicable, for the MCPs' dental, professional, and outpatient files. The quality of each submitted file was also evaluated, including the volume of the MCP's claims/encounter files compared to ODM's encounter file; the MCP's compliance with payment reporting requirements for diagnosis-related group (DRG) claims and capitated claims; and the completeness and reasonableness of critical data fields.

Comparative Findings

Table 12 through Table 14 display individual MCPs' performance in complying with the performance standards as stipulated in the provider agreements for encounter omission, encounter surplus, and payment error. As **Table 13** shows, all MCPs were in compliance with the dental, professional, institutional (Inpatient, Outpatient, and Other categories), and pharmacy encounter omission performance standards. The statewide MCP encounter omission rates were below 2% for all encounter types, with rates ranging from 0.6% (Dental and Outpatient category) to 1.2% (Inpatient category).

Table 12. EDV: Omission Rates by MCP

Ohio MCPs	Dental	Professional	Institutional			Pharmacy
			Inpatient	Outpatient	Other	
Performance Standards	**≤10%**	**≤10%**	**≤10%**	**≤10%**	**≤10%**	**≤10%**
Buckeye	0.4%	0.6%	2.6%	0.6%	0.6%	1.4%
CareSource	0.8%	0.9%	1.4%	0.7%	1.1%	0.5%
Molina	0.1%	0.3%	0.3%	0.3%	0.8%	0.3%
Paramount	0.5%	0.4%	0.6%	0.6%	0.5%	4.5%
UnitedHealthcare	0.1%	0.1%	0.3%	0.3%	0.4%	0.1%
MCP Statewide	**0.6%**	**0.7%**	**1.2%**	**0.6%**	**1.0%**	**0.9%**

Table 13 shows that all MCPs were in compliance with the dental, professional, institutional (Inpatient, Outpatient, and Other categories), and pharmacy encounter surplus performance standards. The MCPs' encounter surplus rates had mixed performance across all encounter types, with statewide rates ranging from 1.0% (dental) to 5.7% (Other category).

Table 13. EDV: Surplus Rates by MCP

Ohio MCPs	Dental	Professional	Institutional			Pharmacy
			Inpatient	Outpatient	Other	
Performance Standards	**≤10%**	**≤10%**	**≤10%**	**≤10%**	**≤10%**	**≤10%**
Buckeye	0.2%	7.3%	4.1%	1.5%	4.5%	1.3%
CareSource	1.0%	1.0%	4.3%	3.9%	6.0%	3.1%
Molina	2.2%	0.8%	0.8%	0.8%	4.6%	0.7%
Paramount	0.7%	0.8%	1.9%	0.4%	7.2%	6.2%
UnitedHealthcare	0.1%	0.5%	2.5%	0.4%	4.5%	0.7%
MCP Statewide	**1.0%**	**1.7%**	**3.4%**	**2.5%**	**5.7%**	**2.6%**

Table 14 illustrates that MCP payment error rates varied minimally across all encounter types, with statewide rates ranging from less than 0.1% (dental, professional, and Other category) to 4.0% (pharmacy). Two MCPs (Buckeye and Paramount) had payment error rates meeting the performance standards for all encounter types. CareSource, Molina, and UnitedHealthcare had payment error rates (i.e., 4.1%, 6.9%, and 4.3%, respectively) exceeding the 4% performance standard for pharmacy claims.

Table 14. EDV: Payment Error Rates by MCP

Ohio MCPs	Dental	Professional	Institutional			Pharmacy
			Inpatient	Outpatient	Other	
Performance Standards	**≤4%**	**≤4%**	**≤4%**	**≤4%**	**≤4%**	**≤4%**
Buckeye	<0.1%	0.1%	1.0%	0.4%	<0.1%	2.0%
CareSource	0.1%	<0.1%	1.4%	0.1%	<0.1%	4.1%
Molina	0.0%	<0.1%	0.0%	<0.1%	0.0%	6.9%
Paramount	0.0%	<0.1%	0.2%	0.1%	<0.1%	1.8%
UnitedHealthcare	0.0%	0.0%	3.4%	0.0%	0.0%	4.3%
MCP Statewide	**<0.1%**	**<0.1%**	**1.2%**	**0.1%**	**<0.1%**	**4.0%**

Medical Record Review

Technical Methods of Data Collection and Analysis

Encounter data completeness and accuracy were also evaluated through a review of medical records for physician services rendered between January 1, 2017, and December 31, 2017. The MRR was conducted to verify that four data elements—date of service, diagnosis code, procedure code, and procedure code modifier—found in the professional encounter data were complete and accurate when compared to information contained within the medical records. The MRR involved the following key steps:

- *Identifying the eligible population*. A recipient had to have been continuously enrolled in the same MCP and had to have at least one professional visit during the study period. Recipients with Medicare or other insurance coverage were excluded from the eligible population since ODM does not have complete encounter data for all services they received.
- *Generating sample cases from ODM's vendor data*. First, all recipients who met the study population eligibility criteria were identified. Second, a total of 411 recipients were randomly selected from the eligible population for each of the five MCPs. Then, for each selected sample recipient, the SURVEYSELECT procedure in SAS was used to randomly select one professional visit that occurred in the study period.
- *Assisting MCPs to procure medical records from providers, as appropriate.* Upon receiving the final sample list, MCPs were responsible for procuring the sampled recipients' medical records from their contracted providers and for submitting the documentation. To improve the procurement rate, HSAG conducted a one-hour technical assistance call with participating MCPs to introduce the procurement protocols. MCPs were instructed to submit medical records electronically via a secure file transfer protocol (FTP) site to ensure the protection of personal health information.
- *Reviewing medical records against ODM's encounter data*. This involved a two-way approach in which encounters were chosen from both the electronic encounter data and from medical records and were subsequently compared with one another. This process allowed the study to identify encounters present in ODM's vendor data but not documented in the recipients' medical records (medical record omission), as well as to identify services documented in the recipients' medical records that were missing from ODM's data (encounter data omission). For services in both data sources, an analysis of coding accuracy was completed. Information that existed in both data sources but whose values did not match were considered discrepant.
- *Calculating study indicators based on the reviewed/abstracted data*. Once the trained reviewers completed the MRR, analysts exported the information collected from the electronic tool, reviewed the data, and conducted the analysis. Four study indicators were used to report the MRR results:

- *Medical record omission rate*: the percentage of dates of service identified in the electronic encounter data that were not found in the recipients' medical records.
- *Encounter data omission rate*: the percentage of dates of service from the recipients' medical records that were not found in the electronic encounter data.
- *Accuracy rate of coding*: the percentage of diagnosis codes, procedure codes, and procedure code modifiers associated with validated dates of service from the electronic encounter data that were correctly coded based on the recipients' medical records.
- *Overall accuracy rate*: the percentage of dates of service with all data elements coded correctly among all validated dates of service from the electronic encounter data.

Description of Data Obtained

The final sample included in the MRR evaluation consisted of 411 cases randomly selected for each MCP. Additionally, to evaluate whether any dates of service were omitted from ODM's data, HSAG reviewed a second date of service rendered by the same provider office during the review period. The providers were requested to submit all medical record documentation pertaining to an additional date of service occurring closest to the sampled recipients' selected date of service, if available. If a sampled recipient did not have a second visit with the same provider office during the review period, HSAG evaluated only one date of service for that recipient. As such, the final number of cases reviewed was between 411 and 822 cases total for each MCP.

Comparative Findings

Table 15 displays the medical record and encounter data omission rates for each key data element. Based on the cases sampled for MRR, the documentation in the recipients' medical records supported the key data elements in the electronic encounter data at different rates. For example, the *Date of Service* data element was relatively supported by the medical records as evidenced by the 10.3% medical record omission rate. However, the Diagnosis Code (28.8%), Procedure Code (26.5%), and Procedure Code Modifier (38.1%) data elements within the electronic encounter data were moderately supported by the medical records.

The encounter data omission rates reveal that the key data elements—Date of Service, Diagnosis Code, Procedure Code, and Procedure Code Modifier—found in the medical records were well supported by the data found in the electronic encounter data. For instance, only 4.1% of the dates of service documented in the recipients' medical records were absent from the electronic encounter data and 2.4% of the procedure code modifiers documented in the recipients' medical records were absent from the electronic encounter data.

Table 15. EDV: Statewide Encounter Data Completeness Summary

Key Data Elements	Medical Record Omission		Encounter Data Omission	
	Statewide Rate	MCP Range	Statewide Rate	MCP Range
Date of Service	10.3%	6.8%–20.0%	4.1%	1.4%–5.2%
Diagnosis Code	28.8%	25.1%–35.9%	4.8%	2.4%–6.1%
Procedure Code	26.5%	22.5%–38.9%	5.0%	1.6%–7.2%
Procedure Code Modifier	38.1%	31.1%–44.1%	2.4%	1.1%–3.6%

Table 16 displays the element accuracy rates for each key data element and the all-element accuracy rates.

Table 16. EDV: Statewide Encounter Data Accuracy Summary

Key Data Elements	Statewide Rate	MCP Range	Main Error Type
Diagnosis Code	99.1%	98.0%–99.4%	Inaccurate Code (77.5%) Specificity Error (22.5%)
Procedure Code	95.6%	94.5%–96.6%	Lower Level of Services in Medical Records (57.4%) Inaccurate Code (40.1%) Higher Level of Services in Medical Records (2.5%)
Procedure Code Modifier	99.9%	99.6%–100%	—
All-Element Accuracy	53.3%	52.2%–57.4%	—

Findings and Recommendations

Comparative Analysis

The analysis showed that the level of data completeness among all encounters (i.e., dental, professional, the institutional claim type categories, and pharmacy) was high, with very low encounter surplus and omission rates. For all claim types, both the encounter omission and surplus findings suggest relatively complete submission of claims by the MCPs to ODM and for the study. Payment error rates also overwhelmingly met the performance standards for all encounter types, with two MCPs meeting the performance standards for all claim types, and three meeting the performance standards for all types except pharmacy. Furthermore, more TPL payments were being captured and populated in ODM's vendor data in comparison to the prior year's study.

MRR

Overall, ODM's encounter data were either relatively or moderately complete for the key data elements when compared to the recipients' medical records. Among the four data elements assessed for the study, the Date of Service data element had a medical record omission rate (services located in the encounter data but not supported in the medical records) of less than 11%. For the remaining three data elements, ODM's encounters were moderately supported by the documentation in the recipients' medical records (i.e., 28.8% of the diagnosis codes, 26.5% of the procedure codes, and 38.1% of the procedure code modifiers identified in the electronic encounter data were not found in the corresponding medical records). All four key data elements (Date of Service, Diagnosis Code, Procedure Code, and Procedure Code Modifier) each had an encounter data omission rate of less than 6%.

When key data elements were present in both ODM's encounter data and the medical records and were evaluated independently, the data elements were found to be accurate. Among the data elements evaluated, 99.1% of diagnosis codes, 95.6% of procedure codes, and 99.9% of procedure code modifiers present in both sources were accurate.

Overall EDV

Based on the results of both the comparative analysis and MRR, HSAG offered the following recommendations:

- The payment error rates for the pharmacy encounters were found to be slightly higher for three of the MCPs (CareSource, Molina, and UnitedHealthcare). Based on additional investigation efforts from all three MCPs, it was determined that the discrepancies were related to payments paid to the pharmacy versus payments paid to the PBM. ODM could continue to work with the MCPs to ensure data submissions are in alignment with ODM's expectations.
- Since TPL discrepancies were identified in the SFY 2017 study, ODM and the MCPs have been collaborating to address the discrepancies. The current study has shown improvement in the collection of the TPL information for a few MCPs, while others continued to show discrepancies related to TPL information. As such, HSAG recommends that ODM continue to work with the MCPs to improve TPL information completeness and accuracy.
- Based on the MRR findings, ODM could consider requiring MCPs to audit provider encounter submissions for completeness and accuracy. The audit should include a review of both State and national coding requirements and standards, especially for new providers contracted with the MCPs. ODM might also consider requiring MCPs to perform periodic reviews of submitted claims to verify appropriate coding and completeness to ensure encounter data quality. Results from these reviews may be submitted to ODM and used in its ongoing encounter data monitoring.

Provider Satisfaction Survey

Background

SFY 2019 was the second year that ODM administered a Provider Satisfaction Survey to PCPs who were contracted with one or more of Ohio Medicaid's MCPs. ODM contracted with HSAG to administer the survey, analyze the data, and report the survey findings. The goal of the Provider Satisfaction Survey is to provide feedback to ODM as it relates to PCPs' perceptions of the MCPs and to evaluate differences in satisfaction between CPC and non-CPC providers. This survey was initially administered in 2018 to establish baseline PCP satisfaction results for MCPs.

Technical Methods of Data Collection and Analysis

A total of 6,252 potential PCPs were identified as eligible to complete a survey. Eligibility criteria requirements consisted of the following:

- Being flagged as a valid PCP based on ODM's PCP definition.
- Having at least 30 attributed Medicaid plan members.
- Having submitted at least one claim for each of those members during the measurement period (July 1, 2017–June 30, 2018).

Between January and March 2019, outreach to all eligible PCPs consisted of: 1) a pre-mailing campaign to notify PCPs that they had been identified to complete the survey; 2) mailing of the survey. as well as a cover letter explaining that PCPs could choose between completing the paper-based or web-based survey; 3) mailing of a reminder postcard to all non-respondents; and 4) making a telephone call to all PCPs who had not completed a survey.

The customized Provider Satisfaction Survey instrument was developed in collaboration with ODM. The questions modeled Likert scale questions and included both closed- and open-ended response options. The final instrument contained 16 questions that included six demographic questions and captured 10 core indicators. All questions included the following response categories: Very dissatisfied, Dissatisfied, Neutral, Satisfied, Very satisfied, and Not Applicable.

The Provider Satisfaction Survey yielded results for the following measures:

- *Medicaid Plans*—presents PCPs' level of satisfaction with the Medicaid plans.
- *Network of Medical Sub-Specialists*—presents PCPs' level of satisfaction with the health plans' network of medical sub-specialists.
- *Care Management Programs*—presents PCPs' level of satisfaction with the Medicaid plans' care management programs.

- *Assistance in Meeting Social Service Needs*—presents PCPs' level of satisfaction with the Medicaid plans' assistance with meeting their social service needs.
- *Ability to Obtain Member-Level Information*—presents PCPs' satisfaction with their ability to obtain member-level information from the Medicaid plans.
- *Prior-Authorization Process*—presents PCPs' level of satisfaction with the Medicaid plans' prior authorization process, including referrals and pre-certifications.
- *Claims Processing*—presents PCPs' level of satisfaction with the Medicaid plans' claims processing.
- *Provider Relations*—presents PCPs' satisfaction with the Medicaid plans' provider relations.
- *Provider Portal*—presents PCPs' satisfaction with the Medicaid plans' provider portal.
- *Assistance in Improving Health Outcomes*—presents PCPs' level of satisfaction with the extent the Medicaid plans assist with improving health outcomes.

For each question, a mean was calculated on a three-point scale at the plan and program levels. In addition, the proportion (or percentage) of respondents that fell into each response category was calculated. Response category proportion rates were calculated for each measure at the plan and program levels. Responses were classified into three categories: Satisfied (Very Satisfied/Satisfied); Neutral (Neutral); and Dissatisfied (Dissatisfied/Very Dissatisfied). Medicaid MCP survey responses were limited to PCPs who indicated they contracted with one or more Medicaid MCPs in Question 1 (e.g., responses for UnitedHealthcare were only evaluated for providers that indicated in Question 1 they were contracted with UnitedHealthcare). A PCP's responses were evaluated for each MCP with which he or she was contracted.

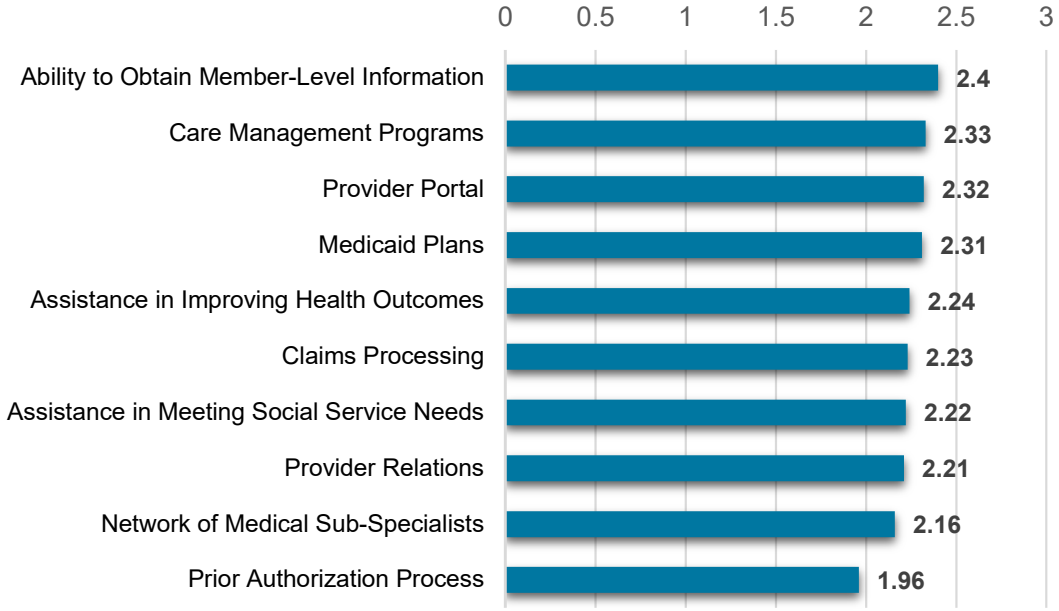
Description of Data Obtained

From January to March 2019, surveys were received from 471 PCPs, of which 140 were CPC providers. The response rate is calculated as the total number of completed surveys divided by all eligible providers. A survey was assigned a disposition code of "completed" if at least one question was answered within the survey and the surveyed provider was not deemed ineligible. A provider was deemed ineligible if he or she met at least one of the following criteria: deceased, not currently contracted with a Medicaid plan, or not a PCP. The response rate for the SFY 2019 survey was 7.6%.

Two sets of comparative analyses were performed: 1) a statewide comparison of the Medicaid plans' results to the statewide program and 2) a statewide comparison of CPC providers' results to non-CPC providers' results. In addition, results were trended from 2018 to 2019.

Figure 3 provides the mean scores of PCPs at the statewide program-level for each of the core measures evaluated in the Provider Satisfaction Survey. The statewide program is defined as the aggregate results of the Medicaid plans (MCPs and MyCare Ohio Plans [MCOPs]), although only the findings for MCPs are discussed in this report.

Figure 3. Provider Satisfaction Survey: Program-Level Mean Scores



Comparative Findings

The following is a summary of the MCPs' performance on the 10 core indicators and the differences between the plan-level mean scores and the statewide program-level mean scores:

- UnitedHealthcare's performance was not statistically different from the statewide program on any measure.
- Paramount's performance was *statistically significantly* higher than the statewide program on two measures: Medicaid Plans and Claims Processing.
- Molina's performance was *statistically significantly* higher than the statewide program on one measure, Claims Processing. Also, Molina's performance was *statistically significantly* lower than the statewide program on two

measures: Network of Medical Sub-Specialists and Prior-Authorization Process.

- CareSource's performance was *statistically significantly* higher than the statewide program on six measures: Network of Medical Sub-Specialists, Assistance in Meeting Social Service Needs, Ability to Obtain Member-Level Information, Prior-Authorization Process, Provider Portal, and Assistance in Improving Health Outcomes.
- Buckeye's performance was *statistically significantly* lower than the statewide program on seven measures: Medicaid Plans, Network of Medical Sub-Specialists, Care Management Programs, Ability to Obtain Member-Level Information, Prior-Authorization Process, Claims Processing, and Assistance in Improving Health Outcomes.

These results are illustrated in **Table 17.**

Table 17. Provider Satisfaction Survey: Statewide Program and Medicaid Plan Comparison

Measure (Satisfaction With…)	United-Healthcare	Paramount	Molina	CareSource	Buckeye
Medicaid Plans	—	Higher	—	—	Lower
Network of Medical Sub-Specialists	—	—	Lower	Higher	Lower
Care Management Programs	—	—	—	—	Lower
Assistance in Meeting Social Service Needs	—	—	—	Higher	—
Ability to Obtain Member-Level Information	—	—	—	Higher	Lower
Prior-Authorization Process	—	—	Lower	Higher	Lower
Claims Processing	—	Higher	Higher	—	Lower
Provider Relations	—	—	—	—	—
Provider Portal	—	—	—	Higher	—
Assistance in Improving Health Outcomes	—	—	—	Higher	Lower

Higher *= the Medicaid plan's mean was statistically significantly higher than the statewide program*
Lower *= the Medicaid plan's mean was statistically significantly lower than the statewide program*
A line (—) indicates the Medicaid plan's mean score was not statistically significantly different from the statewide program

Table 18 presents a summary of the trend analysis of the three measures where statistically significant differences were observed. The analysis of 2018 and 2019 mean scores showed the following:

- The statewide program's performance was *statistically significantly* higher in 2019 than in 2018 on two measures: Care Management Programs and Assistance in Improving Health Outcomes.
- Molina's performance was *statistically significantly* higher in 2019 than in 2018 on two measures: Care Management Programs and Assistance in Improving Health Outcomes.
- CareSource's performance was *statistically significantly* higher in 2019 than in 2018 on two measures: Provider Relations and Assistance in Improving Health Outcomes.
- There were no statistically significant differences between years for UnitedHealthcare, Paramount, or Buckeye.

Table 18. Provider Satisfaction Survey: Summary of Statewide Program and Medicaid Trend Results

Measure (Satisfaction With…)	Statewide Program	United-Healthcare	Paramount	Molina	CareSource	Buckeye
Care Management Programs	Higher	—	—	Higher	—	—
Provider Relations	—	—	—	—	Higher	—
Assistance in Improving Health Outcomes	Higher	—	—	Higher	Higher	—

Higher = the Statewide Program's or Medicaid plan's mean was statistically significantly higher in 2019 than in 2018
Lower = the Statewide Program's or Medicaid plan's mean was statistically significantly lower in 2019 than in 2018
A line (—) indicates the Statewide Program's or Medicaid plan's 2019 mean score was not statistically significantly different than the 2018 mean score.

Table 19 presents the statistically significant findings from the CPC and non-CPC comparison analysis for the two measures where statistically significant differences were observed. Statistically significant results were not identified for the other eight measures among CPC and non-CPC providers.

Table 19. Provider Satisfaction Survey: Statewide CPC and Non-CPC Comparison Results

Measure (Satisfaction With…)	CPC	Non-CPC
Prior-Authorization Process	Lower	Higher
Provider Portal	Lower	Higher

Higher = the population's mean was statistically significantly higher than the other population
Lower = the population's mean was statistically significantly lower than the other population

Table 20 summarizes the trend analysis for the one measure where statistically significant differences were observed. HSAG did not identify any statistically significant trends among CPC providers for the other nine measures or identify any statistically significant trends among non-CPC providers for any of the 10 measures.

Table 20. Provider Satisfaction Survey: Statewide CPC Trend Results

Measure (Satisfaction With…)	2019
Assistance in Improving Health Outcomes	Higher

Higher *= the population's mean was statistically significantly higher in 2019 than in 2018*

Findings and Recommendations

Results of the 2019 Provider Satisfaction Survey revealed that respondents' satisfaction with nine of the 10 core measures was below 50%. Over half of providers were not satisfied with the Medicaid plans (approximately 51%). Respondents' satisfaction was the lowest for the following three measures: Prior Authorization Process (approximately 32%), Assistance in Meeting Social Service Needs (approximately 37%), and Provider Relations (approximately 38%). The only measure that exceeded 50% was Ability to Obtain Member-Level Information (approximately 54%).

The low level of satisfaction with the prior authorization process is also consistent with the open-ended comments provided. The highest percentage of open-ended comments (almost 28%) were related to PCPs' dissatisfaction with the prior-authorization process, which they said is cumbersome and takes providers away from patient care.

The comparative analysis of the statewide program and plan-level mean scores revealed statistically significant differences between the Medicaid plans and the statewide program. CareSource's mean scores were more frequently statistically significantly higher than the statewide program than any other Medicaid plan (six of the 10 measures). Buckeye's mean scores were more frequently statistically significantly lower than the statewide program than any other Medicaid plan (seven of the 10 measures).

Satisfaction rates from 2018 to 2019 improved for seven measures, with Care Management Programs and Assistance in Improving Health Outcomes having statistically significantly higher rates in 2019 than in 2018. CareSource's means were statistically significantly higher in 2019 than in 2018 for two measures: Provider Relations and Assistance in Improving Health Outcomes. Molina's means were also statistically significantly higher in 2019 than in 2018 for two measures: Care Management Programs and Assistance in Improving Health Outcomes. No other Medicaid

plans had statistically significantly higher or lower means in 2019 than in 2018.

The trend analysis of the CPC and non-CPC providers' mean scores revealed one statistically significant difference in 2019 over 2018 for one measure: Assistance in Improving Health Outcomes.

Based on these results, Qsource recommends the following:

- Provider satisfaction should continue to be a priority for the Ohio Medicaid program, which should focus on facilitating MCP-provider partnerships to augment provider engagement and align with the State Quality Strategy.
- MCPs should continue to focus improvement efforts on streamlining their prior authorization processes,, expanding their networks of medical sub-specialists, providing assistance in meeting social service needs, and improving provider relations.

MCP Quality Ratings

Background

ODM contracted with HSAG to produce the 2019 MCP Report Card using Ohio Medicaid MCPs' performance measure data. Specifically, 2019 HEDIS results and 2019 CAHPS data were combined and analyzed to assess MCPs' performance as related to certain areas of interest to members.

The MCP Report Card was developed to support ODM's public reporting of MCP performance information to be used by members to make informed decisions about their healthcare. Because the MCP Report Card evaluated individual MCP performance in specific areas (e.g., how well doctors involved members in decisions about their care, if children regularly received checkups and important shots that helped protect them against serious illness), members had the opportunity to be better informed in certain areas of interest. Additionally, the MCP Report Card provided a five-level rating scale with an easy-to-read "picture" of quality performance across MCPs, and it presented data in a manner that clearly emphasized meaningful differences between MCPs (i.e., one- to five-star rating) to assist members when selecting an MCP. The finalized MCP Report Card included an overview, description of the performance areas, and MCP-specific results, as well as background information for assisting members in choosing a Medicaid MCP, including MCP contact information.

Technical Methods of Data Collection and Analysis

HSAG received the MCPs' CAHPS member-level data files and HEDIS data from ODM. The CAHPS 5.0H Adult Medicaid Health Plan Survey and the CAHPS 5.0H Child Medicaid Health Plan Survey (with the Children with Chronic Conditions [CCC] measurement set) were used for the adult and child populations, respectively. The CAHPS survey most recently administered in 2019 was used. The *HEDIS 2019 Specifications for Survey Measures, Volume 3* was used to collect and report on the CAHPS measures. The *HEDIS 2019 Technical Specifications for Health Plans, Volume 2* was used to collect and report on the HEDIS measures.

MCPs' performance was evaluated in five separate reporting categories identified as important to consumers. Each reporting category consists of a set of measures that were evaluated together to form a category summary score. The reporting categories and descriptions of the measures they contain are:

- *Getting Care*: Includes adult and child CAHPS composites on consumer perceptions regarding the ease of obtaining needed care and how quickly they received that care. This category includes HEDIS measures that assess adults' and children's access to care, as well as appropriate follow-up for mental illness and if adults had a body mass index (BMI) assessment.
- *Doctors' Communication and Service*: Includes adult and child CAHPS composites and items on consumer perceptions

about how well their doctors communicate, and shared decision making. This category includes overall ratings of personal doctors and specialists seen most often. In addition, this category includes a CAHPS measure related to medical assistance with smoking and tobacco use cessation.

- *Keeping Kids Healthy*: Includes HEDIS measures that assess how often preventative services are provided (e.g., child and adolescent immunizations, well-child visits, well-care visits for adolescents, annual dental visits, and weight assessment and counseling for children/adolescents). Further, this category also includes HEDIS measures related to follow-up care for attention deficit/hyperactivity disorder (ADHD) as well as children and adolescents use of antipsychotics.
- *Living With Illness*: Includes HEDIS measures that assess how well MCPs take care of people who have chronic conditions, such as asthma, diabetes, and high blood pressure. This category also includes HEDIS measures that assess medication and pharmacotherapy management for people living with depression, asthma, or chronic obstructive pulmonary disease (COPD). HEDIS measures related to initiation and engagement of treatment for addiction are also included.
- *Women's Health*: Includes HEDIS measures that assess how often women-specific services are provided (e.g., prenatal and postpartum care, and breast cancer, cervical cancer, and chlamydia screenings).

Five summary scores were calculated for each MCP, as well as the summary mean values for the MCPs as a group. Each score is a standardized score where higher values represent more favorable performance. Summary scores for the five reporting categories were calculated from MCP scores on selected HEDIS measures and CAHPS questions and composites.

Description of Data Obtained

The 2019 Report Card was based on 58 measures, 14 CAHPS and 44 HEDIS, and their associated weights. Weights were applied when calculating the category summary scores and the 95% confidence intervals (CIs) to ensure that all measures contributed equally in the derivation of the final results.

Comparative Findings

The MCP Report Card uses the star rating system defined in **Table 21**.

Table 21. MCP Report Card Star Rating Definitions

Rating	Level	Definition	Rating	Level	Definition
★★★★★	Highest Performance	The MCP's performance is 2 or more standard deviations above the Ohio Medicaid Managed Care Plan average.	★★	Low Performance	The MCP's performance is between 1 and 2 standard deviations below the Ohio Medicaid Managed Care Plan average.
★★★★	High Performance	The MCP's performance is between 1 and 2 standard deviations above the Ohio Medicaid Managed Care Plan average.	★	Lowest Performance	The MCP's performance is 2 or more standard deviations below the Ohio Medicaid Managed Care Plan average.
★★★	Average Performance	The MCP's performance is within one standard deviation of the Ohio Medicaid Managed Care Plan average.			

The quality rating results for each MCP are shown in **Table 22**.

Table 22. 2019 MCP Report Card Results

Performance Areas	Buckeye	CareSource	Molina	Paramount	United-Healthcare
Getting Care	★★★	★★★	★★	★★★	★★★
Doctor's Communication and Service	★★★★★	★★★	★★★	★★★	★★★
Keeping Kids Healthy	★★★★★	★★★★	★★★	★★	★★
Living with Illness	★★★★	★	★★★	★★★	★★★
Women's Health	★★★	★★★	★★	★★★★★	★★

Findings

Doctor's Communication and Service was the measure with the highest overall ratings across MCPs, while performance on the other measures varied widely among plans.

Buckeye

Buckeye excelled in the Doctor's Communication and Service and Keeping Kids Healthy performance areas, and performed above average in Living with Illness. The MCP performed at the state average for Getting Care and Women's Health.

CareSource

CareSource exhibited above-average performance in the area of Keeping Kids Healthy, and average performance in Getting Care, Doctor's Communication and Service, and Women's Health. CareSource had the lowest performance of any MCP for Living with Illness.

Molina

Molina exhibited average performance in the areas of Doctor's Communication and Service, Keeping Kids Healthy, and Living with Illness. Molina's performance was below average in the areas of Getting Care and Women's Health.

Paramount

Paramount excelled in the performance area of Women's Health and exhibited average performance in the areas of Getting Care, Doctor's Communication and Service, and Living with Illness. The MCP's performance was below average in the Keeping Kids Healthy performance area.

UnitedHealthcare

UnitedHealthcare earned average performance ratings in the areas of Getting Care, Doctor's Communication and Service, and Living with Illness, and performed below average in the areas of Keeping Kids Healthy and Women's Health.

Plan-Level Summaries and Conclusion

Plan-Level Findings, Follow-Up, and Recommendations

The following tables highlight each MCP's performance strengths and weaknesses, follow-up on prior EQRO recommendations, and this year's recommendations based on the aggregated results of SFY 2019 EQR activities.

Buckeye

SFY 2019 Findings and Recommendations: Buckeye	
SFY 2019 Strengths	
Comprehensive Administrative Review	Buckeye received an administrative performance score of 100% in seven of the 13 standards reviewed for the Medicaid program.
Performance Measures	Buckeye's CAHPS mean scores were statistically significantly higher than the program mean scores more frequently than any other MCP, and its 2018 mean scores were statistically significantly higher than the 2017 mean scores for five measures. For the adult population, Buckeye had the highest results when compared to national percentiles, with eight measures at or above the 75th percentile.
SFY 2019 Areas for Improvement	
Performance Measures	Buckeye did not meet the MPS for the Children and Adolescents' Access to Primary Care Practitioners—25 Months to 6 Years measure indicator in the Healthy Children/Adults population stream. The MCP also had more than half of its rates fall below the 50th percentile for HEDIS 2019.
Provider Satisfaction Survey	Buckeye's performance was statistically significantly lower than the statewide program than any other MCP on seven of 10 measures: Medicaid Plans, Network of Medical Sub-Specialists, Care Management Programs, Ability to Obtain Member-Level Information, Prior-Authorization Process, Claims Processing, and Assistance in Improving Health Outcomes.
SFY 2019 Recommendations	
Performance Measures	Buckeye should prioritize improving primary care access for children and adolescents, and work toward increasing its rates for all measures that fell below the statewide average for HEDIS 2019. In its next QAPI submission, Buckeye could include an analysis that identifies root causes for low performance and interventions considered or implemented to improve rates for each identified measure.
Provider Satisfaction Survey	Given that its performance was statistically significantly lower than the statewide program on seven measures, Buckeye should focus on improving provider relations and partnerships by working to streamline the prior authorization process; provide more resources to assist in improving health outcomes; expand its network of medical sub-specialists; and provide clear and efficient resources regarding care management programs, member-level information, and claims processing. As in previous years, Buckeye could consider HSAG's recommendation that each MCP perform an assessment of provider-facing roles and responsibilities to ensure provider services are more streamlined, efficient, and seamless to the providers.

Follow-Up on Prior EQRO Recommendations: Buckeye	
QAPI and Work Plan	In the *SFY 2018 EQRO Technical Report*, HSAG recommended that Buckeye prioritize three areas in its QAPI: child, adolescent, and adult access to preventive services; timely and adequate prenatal care to improve birth outcomes; and prevention and management of chronic conditions. HSAG recommended that Buckeye include specific information related to these goals in its QI Work Plan. Since each annual QAPI submission must include a clearly delineated outcomes-driven strategy for improvement that measures, analyzes, and tracks performance indicators reflecting the Ohio Medicaid Quality Strategy population health focus, Buckeye's QAPI program continues to align with the SFY 2018 recommendations. The requirement for each MCP to evaluate the impact and effectiveness of each effort within the QAPI program and to submit these evaluation results annually to ODM further demonstrates alignment with prior EQR recommendations to identify impactful quality improvement interventions, and to continuously monitor them for effectiveness. Additionally, each MCP now must include how these results will be incorporated within its quality strategy, which also demonstrates MCP progress toward the prior year recommendations.
Performance Measures	HSAG recommended that Buckeye include analyses in its QAPI of several specific HEDIS, CHIPRA, and non-HEDIS measures in the Healthy Children/Adults, Women's Health, and Chronic Conditions focus areas. Buckeye's most recent QAPI submission included QI project analyses and plans related to these measures.

CareSource

SFY 2019 Findings and Recommendations: CareSource	
SFY 2019 Strengths	
Comprehensive Administrative Review	CareSource received an administrative performance score of 100% in nine of the 13 standards reviewed for the Medicaid program, and received a total administrative performance score of 96% for its Medicaid line of business.
Performance Measures	CareSource met all 15 MPS that could be compared to national Medicaid benchmarks, and all of the MPS in the Women's Health, Behavioral Health, and Chronic Conditions population streams for HEDIS 2019.
	CareSource's CAHPs mean scores were statistically significantly higher than the program mean scores more frequently than any other MCP, and its 2018 mean scores were statistically significantly higher than the 2017 mean scores for seven measures. For the general child population, CareSource had the highest results when compared to national percentiles, with all nine measures at or above the 75th percentile.
Provider Satisfaction Survey	CareSource's mean scores were more frequently statistically significantly higher than the statewide program than any other Medicaid plan (six of the 10 measures). CareSource's means were statistically significantly higher in SFY 2019 than in SFY 2018 for two measures: Provider Relations and Assistance in Improving Health Outcomes.
SFY 2019 Areas for Improvement	
Performance Measures	CareSource had more than half of its rates fall below the 50th percentile for HEDIS 2019. CareSource's 2018 CAHPS mean scores were also statistically significantly lower than the 2017 mean scores on eight measures.
	For the CAHPS adult population, CareSource had the lowest results, with one measure below the 25th percentile and three measures at or between the 25th and 49th percentiles.
EDV	CareSource had a payment error rate of 4.1% for pharmacy claims, exceeding the 4% performance standard. The discrepancies were related to payments paid to the pharmacy versus payments paid to the PBM.
SFY 2019 Recommendations	
Performance Measures	CareSource should work toward improving its HEDIS rates that fell below the statewide average for HEDIS 2019, and increasing its low CAHPS adult ratings for Rating of All Health Care, Rating of Specialist Seen Most Often, Getting Needed Care, and Coordination of Care. In its next QAPI submission, CareSource could include an analysis that identifies root causes for low performance and interventions it has considered or implemented to improve rates for each identified measure.
EDV	CareSource should continue to work with ODM to ensure data submissions align with ODM's expectations.
Provider Satisfaction Survey	Given the low rates of provider satisfaction statewide, CareSource should focus on improving provider relations and partnerships by streamlining the prior authorization process and expand its network of medical sub-specialists. As in previous years, CareSource could consider HSAG's prior recommendation that each MCP perform an assessment of provider-facing roles and responsibilities to ensure provider services are more streamlined, efficient, and seamless to the providers.

Follow-Up on Prior EQRO Recommendations: CareSource	
QAPI and Work Plan	In the *SFY 2018 EQRO Technical Report*, HSAG recommended that CareSource prioritize four areas in its QAPI: young children's access to preventive services; timely and adequate prenatal care to improve birth outcomes; decreasing the prevalence of multiple concurrent antipsychotic prescriptions for children; and assisting members in managing diabetes and high blood pressure. HSAG recommended that CareSource include specific information related to these goals in its QI Work Plan. Since each annual QAPI submission must include a clearly delineated outcomes-driven strategy for improvement that measures, analyzes, and tracks performance indicators reflecting the Ohio Medicaid Quality Strategy population health focus, CareSource's QAPI program continues to align with the SFY 2018 recommendations. The requirement for each MCP to evaluate the impact and effectiveness of each effort within the QAPI program and to submit these evaluation results annually to ODM further demonstrates alignment with prior EQR recommendations to identify impactful quality improvement interventions, and to continuously monitor them for effectiveness. Additionally, each MCP now must include how these results will be incorporated within its quality strategy, which also demonstrates MCP progress toward the prior year recommendations.
Performance Measures	HSAG recommended that CareSource include analyses in its QAPI of several specific HEDIS, CHIPRA, and non-HEDIS measures in the Healthy Children/Adults, Women's Health, Behavioral Health, and Chronic Conditions focus areas. CareSource's most recent QAPI submission included QI project analyses and plans related to these measures.

Molina

SFY 2019 Findings and Recommendations: Molina	
SFY 2019 Strengths	
Comprehensive Administrative Review	Molina received an administrative performance score of 100% in nine of the 13 standards reviewed, and received a total administrative performance score of 94% for Medicaid.
Performance Measures	Molina met all 15 MPS that could be compared to national Medicaid benchmarks, and all of the MPS in the Women's Health, Behavioral Health, and Chronic Conditions population streams for HEDIS 2019.
	Compared to the other MCPs, Molina had the highest percentage of HEDIS rates (60.0%) ranking at or above the national Medicaid 50th percentile, and its 2018 CAHPS mean scores were statistically significantly higher than the 2017 mean scores for two measures.
Provider Satisfaction Survey	Molina's performance was statistically significantly higher than the statewide program on one measure, Claims Processing. Its performance was statistically significantly higher in SFY 2019 than in SFY 2018 on two measures: Care Management Programs and Assistance in Improving Health Outcomes.
SFY 2019 Areas for Improvement	
Performance Measures	Molina had two HEDIS rates fall below the national Medicaid 25th percentile.
EDV	Molina had a payment error rate of 6.9% for pharmacy claims, exceeding the 4% performance standard. The discrepancies were related to payments paid to the pharmacy versus payments paid to the PBM.
Provider Satisfaction Survey	Molina's performance was statistically significantly lower than the statewide program on two measures: Network of Medical Sub-Specialists and Prior-Authorization Process.
SFY 2019 Recommendations	
Performance Measures	Molina should work toward improving its HEDIS rates that fell below the statewide average for HEDIS 2019. In its next QAPI submission, Molina could include an analysis that identifies root causes for low performance and interventions it has considered or implemented to improve rates for each identified measure.
EDV	Molina should continue to work with ODM to ensure data submissions align with ODM's expectations.
Provider Satisfaction Survey	Molina should focus on improving provider relations and partnerships by working to streamline the prior authorization process and expand its network of medical sub-specialists. As in previous years, Molina could consider HSAG's prior recommendation that each MCP perform an assessment of provider-facing roles and responsibilities to ensure provider services are more streamlined, efficient, and seamless to the providers.

Follow-Up on Prior EQRO Recommendations: Molina	
QAPI and Work Plan	In the *SFY 2018 EQRO Technical Report*, HSAG recommended that Molina prioritize four areas in its QAPI: child, adolescent, and adult access to preventive services; timely and adequate prenatal and postpartum care to improve birth outcomes; decreasing the prevalence of multiple concurrent antipsychotic prescriptions for children; and assisting members in managing diabetes and high blood pressure. HSAG recommended that Molina include specific information related to these goals in its QI Work Plan. Since each annual QAPI submission must include a clearly delineated outcomes-driven strategy for improvement that measures, analyzes, and tracks performance indicators reflecting the Ohio Medicaid Quality Strategy population health focus, Molina's QAPI program continues to align with the SFY 2018 recommendations. The requirement for each MCP to evaluate the impact and effectiveness of each effort within the QAPI program and to submit these evaluation results annually to ODM further demonstrates alignment with prior EQR recommendations to identify impactful quality improvement interventions, and to continuously monitor them for effectiveness. Additionally, each MCP now must include how these results will be incorporated within its quality strategy, which also demonstrates MCP progress toward the prior year recommendations.
Performance Measures	HSAG recommended that Molina include analyses in its QAPI of several specific HEDIS, CHIPRA, and non-HEDIS measures in the Healthy Children/Adults, Women's Health, Behavioral Health, and Chronic Conditions focus areas. Molina's most recent QAPI submission included QI project analyses and plans related to these measures.

Paramount

SFY 2019 Findings and Recommendations: Paramount	
SFY 2019 Strengths	
Comprehensive Administrative Review	Paramount received an administrative performance score of 100% in nine of the 13 standards reviewed, and received an administrative performance score of 95%.
Performance Measures	Paramount met all 15 MPS that could be compared to national Medicaid benchmarks, and all of the MPS in the Women's Health, Behavioral Health, and Chronic Conditions population streams for HEDIS 2019.
EDV	Paramount met performance standards for all encounter types.
Provider Satisfaction Survey	Paramount's performance was statistically significantly higher than the statewide program on two measures: Medicaid Plans and Claims Processing.
SFY 2019 Areas for Improvement	
Performance Measures	Paramount's 2018 CAHPS mean scores were statistically significantly lower than the 2017 mean scores on three measures. The MCP also had more than half of its rates fall below the 50th percentile for HEDIS 2019.
Network Adequacy	The secret shopper survey found that only 7.9% of Paramount's PCP provider locations reported accepting new patients without limitations. Among those locations, 45.0% required callers to pre-register with the practice or provide personal information before an appointment could be scheduled.
	MCPN program accuracy findings reflected a concern that Paramount DME suppliers may not clearly differentiate whether products are available to Medicaid consumers. Paramount's DME suppliers expressed confusion regarding Medicaid and MyCare contracts.
SFY 2019 Recommendations	
Performance Measures	Paramount should work toward improving its rates that fell below the statewide average for HEDIS 2019. In its next QAPI submission, Paramount could include an analysis that identifies root causes for low performance and interventions it has considered or implemented to improve rates for each identified measure.
Network Adequacy	Paramount should ensure that its DME suppliers can clearly differentiate whether products are available to Medicaid consumers.
	Paramount should work to increase its number of PCPs accepting new patients without limitations.
	All MCPs should work to improve the accuracy of PCP and DME supplier telephone numbers and addresses listed in MCPN data files, and address their DME suppliers' low availability rates for DME products.
Provider Satisfaction Survey	Given the low rates of provider satisfaction statewide, Paramount should focus on improving provider relations and partnerships by streamlining the prior authorization process and expand its network of medical sub-specialists. As in previous years, Paramount could consider HSAG's prior recommendation that each MCP perform an assessment of provider-facing roles and responsibilities to ensure provider services are more streamlined, efficient, and seamless to the providers.

Follow-Up on Prior EQRO Recommendations: Paramount	
QAPI and Work Plan	In the *SFY 2018 EQRO Technical Report*, HSAG recommended that Paramount prioritize four areas in its QAPI: child, adolescent, and adult access to preventive services; timely and adequate prenatal care to improve birth outcomes; decreasing the prevalence of multiple concurrent antipsychotic prescriptions for children; and assisting members in managing diabetes and high blood pressure. HSAG recommended that Paramount include specific information related to these goals in its QI Work Plan. Since each annual QAPI submission must include a clearly delineated outcomes-driven strategy for improvement that measures, analyzes, and tracks performance indicators reflecting the Ohio Medicaid Quality Strategy population health focus, Paramount's QAPI program continues to align with the SFY 2018 recommendations. The requirement for each MCP to evaluate the impact and effectiveness of each effort within the QAPI program and to submit these evaluation results annually to ODM further demonstrates alignment with prior EQR recommendations to identify impactful quality improvement interventions, and to continuously monitor them for effectiveness. Additionally, each MCP now must include how these results will be incorporated within its quality strategy, which also demonstrates MCP progress toward the prior year recommendations.
Performance Measures	HSAG recommended that Paramount include analyses in its QAPI of several specific HEDIS, CHIPRA, and non-HEDIS measures in the Healthy Children/Adults, Women's Health, Behavioral Health, and Chronic Conditions focus areas. Paramount's most recent QAPI submission included QI project analyses and plans related to these measures.

UnitedHealthcare

SFY 2019 Findings and Recommendations: UnitedHealthcare	
SFY 2019 Strengths	
Performance Measures	UnitedHealthcare met all 15 MPS that could be compared to national Medicaid benchmarks, and all of the MPS in the Women's Health, Behavioral Health, and Chronic Conditions population streams for HEDIS 2019.
	UnitedHealthcare's 2018 CAHPS mean scores were statistically significantly higher than the 2017 mean scores on three measures.
SFY 2019 Areas for Improvement	
Performance Measures	UnitedHealthcare had more than half of its rates fall below the 50th percentile for HEDIS 2019.
EDV	UnitedHealthcare had a payment error rate of 4.3% for pharmacy claims, exceeding the 4% performance standard. The discrepancies were related to payments paid to the pharmacy versus payments paid to the PBM.
Network Adequacy	MCPN program accuracy findings reflected a concern that UnitedHealthcare DME suppliers may not clearly differentiate whether products are available to Medicaid consumers, and expressed confusion regarding Medicaid and MyCare contracts.
	UnitedHealthcare's high response rate in the BH Survey resulted from the small number of BH agencies attributed to the MCP in the MCPN data, which suggests potential concerns with the plan's definition of BH agencies.
SFY 2019 Recommendations	
Performance Measures	UnitedHealthcare should work toward improving its rates that fell below the statewide average for HEDIS 2019. In its next QAPI submission, UnitedHealthcare could include an analysis that identifies root causes for low performance and interventions it has considered or implemented to improve rates for each identified measure.
EDV	UnitedHealthcare should continue to work with ODM to ensure data submissions align with ODM's expectations.
Network Adequacy	Due to the small number of BH agencies attributed to the MCP in the MCPN data, UnitedHealthcare should review and, if needed, revise its definition of BH agencies to ensure that it accurately captures all organizations/facilities that provide BH services.
	UnitedHealthcare should ensure that its DME suppliers can clearly differentiate whether products are available to Medicaid consumers.
	All MCPs should work to improve the accuracy of PCP and DME supplier telephone numbers and addresses listed in MCPN data files, and address their DME suppliers' low availability rates for DME products.
Provider Satisfaction Survey	Given the low rates of provider satisfaction statewide, UnitedHealthcare should focus on improving provider relations and partnerships by streamlining the prior authorization process and expanding its network of medical sub-specialists. As in previous years, UnitedHealthcare could consider HSAG's prior recommendation that each MCP perform an assessment of provider-facing roles and responsibilities to ensure provider services are more streamlined, efficient, and seamless to the providers.

Follow-Up on Prior EQRO Recommendations: UnitedHealthcare	
QAPI and Work Plan	In the *SFY 2018 EQRO Technical Report*, HSAG recommended that UnitedHealthcare prioritize four areas in its QAPI: child, adolescent, and adult access to preventive services; timely postpartum care to increase access to and education about contraception; timely follow-up care after hospitalization for members diagnosed with mental illness; and assisting members in managing diabetes and high blood pressure. HSAG recommended that UnitedHealthcare include specific information related to these goals in its QI Work Plan. Since each annual QAPI submission must include a clearly delineated outcomes-driven strategy for improvement that measures, analyzes, and tracks performance indicators reflecting the Ohio Medicaid Quality Strategy population health focus, UnitedHealthcare's QAPI program continues to align with the SFY 2018 recommendations. The requirement for each MCP to evaluate the impact and effectiveness of each effort within the QAPI program and to submit these evaluation results annually to ODM further demonstrates alignment with prior EQR recommendations to identify impactful quality improvement interventions, and to continuously monitor them for effectiveness. Additionally, each MCP now must include how these results will be incorporated within its quality strategy, which also demonstrates MCP progress toward the prior year recommendations.
Performance Measures	HSAG recommended that UnitedHealthcare include analyses in its QAPI of several specific HEDIS, CHIPRA, and non-HEDIS measures in the Healthy Children/Adults, Women's Health, Behavioral Health, and Chronic Conditions focus areas. Paramount's most recent QAPI submission included QI project analyses and plans related to these measures.

Conclusion

Overall, findings from SFY 2019 EQR activities showed that Ohio MCPs are committed to delivering quality, timely, and accessible care to members. Although weaknesses persisted in performance measures, MCPN data accuracy, and provider satisfaction, MCPs continued to earn high ratings for performance improvement projects, comprehensive administrative review standards, CAHPS surveys, and encounter data completeness. As ODM and the MCPs use comprehensive QI strategies to target and continuously monitor low-performing areas—in particular, performance measures within the Behavioral Health and Chronic Conditions population streams, provider and encounter data accuracy, and MCP-provider partnerships—they should achieve further alignment with the State Quality Strategy and sustained improvement in health outcomes for Ohio Medicaid members.