

THE STATE OF OHIO 1915(b)

Project Name: PremierCare

Originally Approved: 7/1/01

Most Recently Renewed: 7/1/03

Current Expiration Date: 6/30/05

PROGRAM SUMMARY: The State of Ohio submitted a request under Section 1915(b) of the Social Security Act (the Act) to renew their managed care system, entitled PremierCare. The authority for PremierCare is sought under Sections 1915(b)(2) and (4) of the Act. This authority would permit the State to waive the following sections of Title XIX of the Act: 1902(a)(1) Statewide; 1902(a)(10)(B) Comparability of Services; and 1902(a)(23) Freedom of Choice.

Ohio has been contracting with managed care organizations (MCOs) since 1978 and has operated a mandatory enrollment program since 1989 when the state implemented a 1915(b) waiver program. In 1996, Ohio implemented a section 1115 demonstration, "OhioCare". With the authority of the section 1115 expiring in July 2001, Ohio Medicaid assessed the managed care program objectives and decided to transition the 1115 authority to a 1915(b) authority.

As of July, 2003, mandatory enrollment exists in 4 counties with voluntary enrollment in 5 counties. In selected counties, known as Preferred Option counties, with only one MCO, eligible beneficiaries can choose between Medicaid fee-for-service and the MCO. Beneficiaries who do not make a choice would be enrolled in the MCO. Beneficiaries in Preferred Option counties can disenroll at any time without cause and choose the fee-for-service option. Prior to the county being designated as a Preferred Option county, the participating MCO would have to meet additional access and capacity requirements as well as comply with MCO program requirements. As July, 2003, 6 counties were designated as Preferred Option counties (Butler, Clark, Franklin, Hamilton, Lorain, and Montgomery).

POPULATIONS SERVED: There are approximately 443,000 beneficiaries enrolled in PremierCare. Mandatory county enrollment is 260,000; 181,000 are enrolled in Preferred Option Counties. This waiver includes the following populations:

- a) Section 1931 children and related poverty level population (TANF/AFDC)
- b) Section 1931 adults and related poverty level population (TANF/AFDC)
- c) Foster Care Children
- d) Title XXI CHIP

Individuals with special needs are covered if included in one of the above eligibility groups.

The waiver excludes those who:

- have Medicare coverage, except for purposes of Medicaid only services. are residing in a nursing home.
- are residing in an Intermediate Care Facility for the Mentally Retarded.
- participate in a home and community based program.
- have an eligibility period that is only retroactive.

HEALTH CARE DELIVERY: Ohio utilizes MCOs to provide all medical services to Medicaid beneficiaries. As of July, 2003, 6 plans participate in the program in 15 counties. They are: CareSource (formerly Dayton Area Health Plan), QualChoice, Family Health Plan, Paramount, MediPlan, and SummaCare.

BENEFIT PACKAGE: The waiver will cover most Medicaid services offered under the State Plan. Services not included in the capitation rate will be covered by the state fee-for-service arrangements. The State ensures that beneficiaries have access to emergency services including emergency transportation and family planning services without pre-authorization. MCOs are responsible for ensuring that beneficiaries receive any medically necessary mental health and substance abuse services and for coordinating those services with all other medical and support services. MCOs must advise beneficiaries of the ability to self-refer for those services. In addition, beneficiaries are allowed to self-refer within the MCO panel for obstetricians and gynecologists for covered obstetric and gynecological services and certified midwives for prenatal care, delivery and postpartum care.

LOCK-IN PROVISION: Beneficiaries are locked-in with an MCO for one year, with the ability to change MCOs without cause during the first 90 days of each enrollment period. Beneficiaries in Preferred Option counties are not subject to lock-in provisions.

ENROLLMENT BROKER: The State utilizes an enrollment broker, Automated Health Systems, to assist the beneficiaries in their choice of an MCO and in their choice of a Primary Care Provider, to conduct outreach activities, to provide assistance in resolving complaints and to conduct screenings to determine health care needs. The enrollment broker does not perform eligibility or verification tasks.

COST EFFECTIVENESS: The State anticipates a 20.7% annualized increase in member months from the Base Year to Year 1. This increase is due to an expected expansion of mandated care into Mahoning and Trumbull counties, as well as an increase in the number of eligibles due to economic factors. An additional 13.5% increase is expected in the second year. The State anticipates a 2.7% benefit reduction in the first year due to legislative changes. There is an anticipated 8.7% and 4.5% inflation adjustment to administrative costs in Year 1 and Year 2, respectively. Incentive costs are expected to rise 4.5% in Year 2. (The State maintains a two-tiered incentive program to reward MCOs for performance excellence. The costs for the performance incentive program are derived from penalties levied against poor performers.)

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