

Managed Care Plan Progress Report

Statewide

January - June 1998

**Ohio Department of Human Services
Bureau of Managed Health Care**

STATEWIDE PROGRESS REPORT

TABLE OF CONTENTS

<u>SUBJECT</u>	<u>PAGE</u>
OVERVIEW.....	1
PURPOSE.....	1
VOLUNTARY DISENROLLMENTS.....	2
VOLUNTARY DISENROLLMENT REASONS.....	3
JUST CAUSE DISENROLLMENTS.....	3
ENROLLMENT STATUS.....	4
UTILIZATION OF HEALTH CARE SERVICES.....	5
COMPLAINTS.....	5
GRIEVANCES.....	6
PHYSICIAN ENCOUNTER CLAIMS VOLUME.....	7
MCP NET WORTH PER MEMBER.....	7
POINT COMPLIANCE SYSTEM.....	10
STATE HEARINGS.....	10
CONSUMER SATISFACTION SURVEY.....	11

Ohio Medicaid Managed Care Program

Overview

The Ohio Department of Human Services (ODHS) is the single state agency responsible for the implementation and administration of the Ohio Medicaid program. As a value purchaser of health care, Medicaid has expanded the use of managed care for assuring system accountability for access and quality while providing an opportunity for more effective cost predictability and control.

As of January 1998, Ohio's Medicaid managed care program consists of 13 managed care plans (MCPs) serving enrollees in 16 of Ohio's 88 counties. In seven counties enrollment is mandatory for participants in the Ohio Works First, or OWF (formerly Aid to Dependent Children [ADC]) and Healthy Start programs. Nine other counties have voluntary MCP enrollment available for participants.

Managed care plans (MCPs) selected to participate in the Ohio Medicaid managed care program are monitored to assure access to necessary and appropriate services and quality of care delivered to Medicaid enrollees. The Bureau of Managed Health Care (BMHC), in its capacity of managed care plan contract monitor, has the lead responsibility to evaluate MCP performance.

Statewide Progress Report
BMHC December 22, 1998

Purpose of Progress Reports

ODHS' focus on performance and information, such as the data found in the managed care progress reports, is a key component to a value purchasing strategy. The progress reports were developed to increase the amount of information available about Ohio's Medicaid managed care program and to provide performance information on Medicaid-serving MCPs.

County-specific progress reports have been produced since January 1997. This is the first statewide report. The progress report is divided into two sections: a statewide narrative, and a data section. The narrative provides an explanation of each data report, actions which have been taken to improve quality of service, and information on trends in the county. Information is presented for each MCP with enrollment combined for all counties.

The data reports provide statistics on key indicators, such as voluntary disenrollment reasons, grievances, utilization reports, and net worth. While the progress report is produced on a semi-annual basis, it should be noted that the information for the data reports may be collected monthly, semi-annually, or annually.

In utilizing this progress report to evaluate an MCP's performance, it is important not to assess performance on one indicator alone, but as a combination of indicators.

Statewide Summary

During the reporting period 13 MCPs were operating in 16 counties. In 9 counties asset transfers occurred which involved one MCP acquiring the Medicaid enrollee membership of another MCP. This resulted in a particular MCP leaving a county, moving into a county for the first time, or increasing its current membership in a county. (See Addendum at the end of this report).

Prior to approving an asset transfer, the MCPs involved must document at least a 90% match between the two provider panels to ensure continuity of care for the enrollees. Once approved by ODHS and the Ohio Department of Insurance, enrollees are notified by mail of the transfer and are offered the option of choosing another MCP prior to the effective date of transfer. They may also change MCPs, or return to Medicaid fee-for-service in voluntary counties, during the initial month of enrollment in the new plan or during open enrollment months.

The addendum provides a chart outlining all asset transfers that were approved during the reporting period.

Voluntary Disenrollments (January - June 1998)

Voluntary disenrollments are those disenrollments initiated by the enrollee. Involuntary disenrollments are those disenrollments that occur when an enrollee loses eligibility for MCP enrollment because of loss of Medicaid or a change to a non MCP-eligible Medicaid category. The rate of voluntary disenrollments is a comparison of an MCP's average monthly enrollment to the MCP's average monthly voluntary disenrollments.

- **MCP enrollees may change from one MCP to another, or in voluntary counties, back to fee-for-service during their initial month of enrollment in an MCP or during the designated open enrollment months.**
- **The Voluntary Disenrollments data report provides average disenrollment rates for use as a tool in measuring specific MCP performance.**
- **The voluntary disenrollment rate among all MCPs is much less than 1%, with individual MCP rates varying from a low of .01% to a high of 0.85%.**
- **Overall, the statewide disenrollment rate decreased from 0.5% during the period July-December 1997 to 0.36% for this period.**

- **As of June 1998, Dayton Area Health Plan had the highest enrollment and the lowest disenrollment rate.**
- **The accompanying chart and graph in the data section provides disenrollment information by MCP.**

Voluntary Disenrollment Reasons (January - June 1998)

The BMHC reviews reasons for voluntary disenrollment in conjunction with its monitoring of voluntary disenrollment rates.

MCP members indicate a primary reason for disenrolling from the MCP when completing an enrollment change form. ODHS collects and monitors each MCP's voluntary disenrollments by county and reason for disenrollment. The report presents each MCP's rate of disenrollment by primary reason as a percentage of its voluntary disenrollments.

- **By a substantial margin, "Provider not in plan" was the number one reason for disenrollment. This is consistent with past reports as well. Caution must be used, however, since this reason may be selected by enrollees because it is the first reason presented on the MCP change form. Also, as only one reason can be recorded in the ODHS system, when an enrollee chooses this reason in addition to others, this**

category is selected by Bureau staff. Approaches are being considered to confirm the accuracy of this information.

The data chart provides disenrollment information by MCP and reason.

Just Cause Disenrollments (January - June 1998)

Enrollees who wish to leave their current MCP at any time other than within the initial month they are enrolled in an MCP or during their county's Open Enrollment months, can request disenrollment with good cause. This type of disenrollment is called Just Cause.

There are designated reason criteria that are utilized by the ODHS in evaluating a Just Cause request for disenrollment. The five reasons for Just Cause disenrollments are:

1. The PCP of an enrollee leaves the MCP panel/ is no longer available or accessible and there is *no other* PCP within the MCP that is available or accessible.
2. The only PCP who spoke an enrollee's primary language has left the MCP panel; a PCP who speaks the enrollee's primary language is available and accessible in another MCP.
3. The onset of illness, an accident, or an assistance group (AG) addition requires a special PCP that is only accessible and available through another MCP.

4. The AG moves within the county; there is no PCP on the MCP's panel that is available and accessible; a PCP is available and accessible in another MCP.
5. A situation exists, which in the judgement of ODHS, makes continued enrollment in the current MCP harmful to the interests of the enrollee.

- **The total number of requests per 1000 member months decreased from 0.33 during the period July-December 1997 to 0.23 during the reporting period.**
- **Many Just Cause requests arise from a specific situation that affects a large number of enrollees, such as the restructuring or loss of an MCP's major medical provider.**
- **A total of 230 requests were denied during the reporting period. This number may be attributed to the fact that enrollees have the right to file for Just Cause even though they may not have an appropriate Just Cause reason. These applications did not meet Just Cause reason criteria.**
- **An additional 56 Just Cause requests were denied but the enrollment change form was processed. Even though they did not meet Just Cause requirements, the accompanying enrollment change form was honored because it was completed during**

an enrollee's initial month of enrollment in an MCP or during an open enrollment month.

- **The accompanying chart provides additional information**

Enrollment Status (Graph) (June 1998)

Minimum enrollment requirements for MCPs in mandatory counties have been established for each county. MCPs must have enrolled a county-specific percentage of the eligible population in a county by June 1998 in order to continue serving that county.

At the same time, a minimum number of MCPs has been identified in each mandatory county as necessary to ensure adequate consumer choice. If the number of MCPs in any mandatory county falls below the county-specific minimum number of MCPs, the MCP(s) with the enrollment percentage(s) nearest to the required minimum would continue to serve the county.

The presence of any MCP within a voluntary county after December 1998 will be dependent upon the acceptability of its submission to ODHS' April 1998 RFP.

- **As of June 1, 1998 the MCP enrollment number in managed care counties was 300,308 with an enrollment rate of 71.64%. Among all 88 counties the enrollment rate was 49%. These lower enrollment percentage rates reflect the impact of the Children's Health Insurance**

Program (CHIP). Individuals eligible to participate in CHIP are included in the total number of eligibles, however, they were not eligible for MCP enrollment until July 1, 1998. The rate is expected to increase gradually as these children are enrolled.

- **The data graph provides MCP specific enrollment as of June 1998.**

Utilization of Health Care Services (July - December 1997)

The ODHS collects data on an annual and semi-annual basis for a variety of utilization indicators. Included in this report are: primary care, specialty care, and emergency room visits, and inpatient hospital days indicators. Reports that track data across time periods are available from ODHS. Utilization data is submitted retroactively (several months after the date services are rendered); first half of SFY 1998 is the most current period of data.

- **The ODHS is working with those MCPs that fall significantly above/below county and statewide averages to identify possible causes, to develop ways to improve where appropriate and, in some cases, to increase the accuracy of utilization data reported.**

- **Variations in the data may be partly due to differences in the way each MCP allows members to access services (i.e., self-referral to specialists as opposed to requiring referral by PCP).**
- **ODHS compares utilization information with other indicators (such as encounter data, grievances, disenrollment reasons) to detect consistent patterns of problem areas.**
- **The data chart provides MCP specific information.**

Complaints (January - June 1998)

ODHS receives and addresses managed care program complaints through Enrollment Information Centers, from consumers directly or through the Medicaid Consumer Hotline, providers, and others. All complaints to the ODHS are logged and categorized. Only consumer complaints are included here.

Some of the most frequent concerns are related to access, member services, and denied claims. Resolutions are also tracked in the system.

- **When the ODHS receives a complaint, individual follow-up occurs including the contacting of the MCP and the enrollee to facilitate a resolution.**

- **The number of complaints per 1000 member months increased slightly from 0.03 for the period July-December 1997 to 0.04 for the current period.**
- **Out of a total of 83 complaints, 26 required remedial action by an MCP. Remedial action occurs when an MCP either takes or should have taken action to resolve the problem for which they or their provider is culpable. Remedial action is not required when the MCP is not directly responsible for the problem. An example is an enrollee not receiving her member card or other materials due to their loss in the mail.**
- **The data chart provides information by MCP and complaint.**

Grievances (January - June 1998)

MCPs are required to operate an internal grievance process in accordance with ODHS requirements and submit monthly grievance information to the ODHS. Grievances are problems and/or concerns identified by an enrollee and relayed to the MCP verbally or in writing. The same categories used for complaints are also used in categorizing grievance data.

The ODHS reviews MCP-submitted reports for number of grievances, category and length of time to resolve; ODHS also tracks data across time periods to identify trends.

- **The number of grievances per 1,000 member months increased from 2.29 for the period July-December 1997 to 3.93 for the reporting period. This increase may reflect ODHS' efforts to ensure appropriate and complete MCP reporting.**
- **Statewide data indicates that claims related, member services, and access issues remain the three most frequently reported grievances. Personal Physician Care and Family Health Plan had higher rates of grievances compared to other MCPs. ODHS closely monitors quality and access related grievances to ensure that members are receiving care.**
- **Seventy-four percent of the grievances required remedial action. Remedial action occurs when an MCP either takes or should have taken action to resolve the problem for which they or their provider is culpable. Remedial action is not required when the MCP is not directly responsible for the problem.**
- **The data chart provides information by MCP and grievance.**

Physician Encounter Claims Volume Report (Date of Service January-December 1997)

ODHS uses encounter data to evaluate access to health services and the quality of care delivered to Medicaid recipients enrolled in MCPs. Encounter data is submitted by the plans to ODHS and includes all claims paid by the MCPs. Utilization rates derived from these data can indicate the availability of providers. Clinical care can be compared to practice guidelines for assessing the quality of care. For state fiscal year 1997 and 1998, ODHS focused on care for children and perinatal care, two crucial aspects of care for the Ohio Works First / Healthy Start population enrolled in MCPs.

As reflected in this report, encounter data must be timely, complete and accurate. If a plan's encounter data submissions are delayed or not complete, their encounter data volume will be low. In these situations ODHS will request a corrective action plan (CAP) to bring the volume up by identifying and correcting data problems (e.g., incorrect coding, delayed submissions or incomplete submissions).

The State Fiscal Year 1997 Managed Care Performance Measurement Report was released in May 1998. The report represents the first phase in the use of encounter data to obtain comparative performance information and provides a starting point for the ongoing assessment of managed care plans in

priority areas. The priority areas for the encounter data reporting requirements are perinatal and pediatric care.

A copy of the performance measurement report or components of the report can be obtained by contacting the Bureau of Managed Health Care.

- **This report shows that there were four plans working under CAPs due to low volume.**
- **The accompanying chart provides quarterly information.**

MCP Net Worth Per Member (Periods Ending 12/31/97 and 3/31/98)

Oversight of the financial stability of all MCPs in the state is the statutory responsibility of the Ohio Department of Insurance. As a partial indicator of financial solvency, ODHS established a measure of \$50 net worth per member (NWPM) for Medicaid contracting plans. Any plan found to be below this standard is assessed and monitored for any indication of compromised quality or access. It must be emphasized that NWPM is a point in-time calculation subject to numerous variations and multiple interpretations.

Following is a brief description of the NWPM data reported for each participating MCP. On the data report, negative Net Worth is shown in parentheses.

- **DayMed Health Maintenance Plan**

DayMed Health Maintenance Plan's NWPM decreased from -\$72 per enrollee to -\$112 per enrollee (about a 69% decrease) for the periods ending 12 /31/97 and 3/31/98 respectively. This plan remained under scrutiny as the reporting period ended.

- **Dayton Area Health Plan**

Dayton Area Health Plan's NWPM increased from \$106 per enrollee to \$123 per enrollee (about a 16% increase) for the periods ending 12 /31/97 and 3/31/98 respectively.

- **Emerald**

Emerald's NWPM increased from \$0 per enrollee to \$48 per enrollee for the periods ending 12/31 /97 and 3/31/98 respectively. The final NWPM put the MCP at 96% of the required standard of \$50.

- **Family Health Plan**

Family Health Plan's NWPM decreased from \$43 per enrollee to \$34 per enrollee (about a 21% decrease) for the periods ending 12 /31/97 and 3/31/98 respectively. Family Health Plan's NWPM of \$34 is 68% of the NWPM standard of \$50.

- **Genesis**

Genesis's NWPM decreased from \$448 per enrollee to \$403 per enrollee (about a 10% decrease) for the periods ending 12 /31/97 and 3/31/98 respectively. Genesis is still well above the required NWPM standard of \$50.

- **Health Power HMO**

Health Power's NWPM decreased from \$18 per enrollee to \$5 per enrollee (about a 72% decrease) for the periods ending 12 /31/97 and 3/31/98 respectively. Health Power's NWPM of \$5 is 10% of the NWPM standard of \$50. The plan is being closely monitored.

- **Medical Mutual of Ohio (including HMO Health Ohio)**

HMO Health Ohio was a line of business of Blue Cross and Blue Shield Mutual of Ohio, now Medical Mutual of Ohio. The total enrollment was derived from the consolidated financial statements of the parent company. HMO Health Ohio's NWPM of \$91 per enrollee stayed the same for the periods ending 12 /31/97 and 3/31/98 respectively.

- **Paramount Care Inc**

Paramount Care Inc's NWPM decreased from \$58 per enrollee to \$42 per enrollee (about a 21% decrease) for the periods ending 12 /31/97 and 3/31/98 respectively. Paramount Care Inc's NWPM of \$42 is 84% of the NWPM standard of \$50.

- **Personal Physician Care**

Personal Physician Care's NWPM for the period ending 12/31/97 is -\$244. Their net worth figure came from their Independent Audit for the period ending 1997. As the reporting period ended, PPC had not yet submitted its quarterly statement for the period ending 03/31/98. Both ODI and ODHS were involved in active oversight of this plan throughout the reporting period. (ODHS terminated the PPC provider agreement effective August 31, 1998).

- **QualChoice Health Plan**

QualChoice HMO is a line of business of QualChoice Health Plan Inc. which is a subsidiary of University Health Systems Inc. QualChoice Health Plan Inc. operates several lines of business including QualChoice HMO. The total net worth and total enrollment of QualChoice Health Plan Inc. are from the consolidated statement which includes all lines of business. In addition, QualChoice Health Plan Inc has a

guarantee from UHHS to fund any deficits below the minimum statutory net worth requirement. QualChoice's NWPM decreased from \$189 per enrollee to \$163 per enrollee (about a 14% decrease) for the periods ending 12 /31/97 and 3/31/98 respectively. QualChoice is still well above the required NWPM standard of \$50.

- **SummaCare**

SummaCare's NWPM decreased from \$47 per enrollee to \$34 per enrollee (about a 28% decrease) for the periods ending 12 /31/97 and 3/31/98 respectively. SummaCare's NWPM of \$34 is 68% of the NWPM standard of \$50.

- **Medical Insurance Company of Ohio (including SuperMed HMO)**

SuperMed HMO is a line of business of Medical Insurance Company of Ohio. The net worth and total enrollment are combined from the consolidated financial statements of the parent company for the periods under review. SuperMed HMO's NWPM of \$91 per enrollee stayed the same for the periods ending 12 /31/97 and 3/31/98 respectively.

- **Total Health Care Plan**

Total Health Care Plan's NWPM decreased from \$480 per enrollee to \$457 per enrollee (about a 5% decrease) for the

periods ending 12 /31/97 and 3/31/98 respectively. Total Health Care Plan is still well above the required NWPM standard of \$50.

- **The net worth chart provides information for calendar year 1997 and the first quarter of calendar year 1998.**

Point Compliance System (January-June 1998)

One of the tools used by ODHS to monitor MCP contracts is a compliance assessment system. Under this system, specified point values are assessed when an MCP fails to meet certain designated program requirements. The purpose of such a point system is to improve the MCP's performance through a progressive series of actions to correct deficiencies in meeting program requirements.

The remedies attached to each point assessed are progressive based on the severity of the violation, or a repeated pattern of violations. Remedies can consist of corrective action plans (CAPs), fines, enrollment freezes, and termination of an MCP's provider agreement.

- **Five of Ohio's thirteen MCPs were assessed points under the compliance assessment system during this reporting period. Health Power HMO Inc. and**

SummaCare Health Plan each received 10 points and fines of \$2500.

- **The BMHC approves and monitors all CAPs in order to assure future compliance in these areas.**
- **The data chart lists which MCPs received points and fines.**

State Hearings (January-June 1998)

MCPs' providers are required to notify an individual of the right to a state hearing if they bill an enrollee due to a MCP's denial of payment of a Medicaid-covered service. If the provider does not notify the individual the MCP must do so if they are aware of the bill. MCPs must also notify an enrollee of a MCP's decision to deny, reduce, or terminate a service. The notice sent to members includes a "Right to a State Hearing Form". This form allows a MCP member to contest the action that is proposed or has been taken by the MCP. State Hearings are conducted at the County Department of Human Services by a hearing office from the appropriate ODHS District Office. Hearing decisions are generally made within 30 days of the hearing request. ODHS collects data on the number and type of state hearing forms sent out by each MCP as well as the number of State Hearings that are requested. Hearing outcomes are also tracked.

- **The chart included with this progress report represents the number of state hearing forms that have been sent by MCPs and the number of hearings that have been requested during the report period.**
- **Of the 13 hearings requested during the report period all of the hearings except one were either abandoned (individual did not show) or withdrawn.**
- **The number one reason for a hearing form being sent by a MCP was for non-payment of “Emergency room (ER)/non-emergency.” ODHS is closely monitoring the denial of payment as a result of ER use to ensure that appropriate standards are being considered.**
- **ODHS is specifically assessing those plans that submitted few or no state hearing forms to ensure that the MCP is notifying affected individuals of their right to a state hearing.**
- **The data chart provides more specific information.**

Consumer Satisfaction Survey (Graphs)

An important way to evaluate the quality of the Ohio Medicaid Managed Care Program is to survey enrollees about satisfaction

with the care and services they have received. Information from survey results may be used to:

- improve care and services;
- provide comparative data to members for selecting a managed care plan;
- provide comparative data among counties, managed care plans and other states;
- identify excellence; and
- assure minimum performance by managed care plans (plans must achieve a minimum score of at least 70%).

A telephone survey was done during the 1997/1998 winter season by a contracted company. The sample was selected from consumers who were in the same managed care plan for at least six months (from 6/97 to 11/97). The survey response rate was 74%: 4,795 consumers were interviewed. The Consumer Assessment of Health Plans Survey, designed for Medicaid Managed Care enrollees by the Agency for Health Care Policy and Research, was selected for baseline and future annual studies.

Topics of satisfaction measured include:

- general satisfaction with the managed care plan;
- satisfaction with clinical care; and
- satisfaction with access to care.

All contracting MCPs met the performance requirement.

The final survey report is available by mail. For information contact the Bureau of Consumer and Program Support at (614) 728-8476.

- The accompanying three graphs provide information on the three topics mentioned above.

Managed Care Initiatives: January - June 1998

The following information summarizes initiatives by ODHS for this report period:

- **Bureau status:** The Managed Health Care Section (MHCS) was reorganized into the Bureau of Managed Health Care. The Bureau consists of the following sections: Contract Administration, Performance Monitoring, Program Development, and Enrollment Administration.
- **MCP Site Visit:** MCP site visits were conducted during the time period. In addition to the standard review of MCP utilization and enrollee grievances, special attention was given to the provider termination process and, for those MCPs that were part of the external quality review organization (EQRO) survey, a discussion of their quality

improvement plans based on their EQRO survey results.

- **CHIP:** On January 1, 1998, through the Children's Health Insurance Program (CHIP), the State of Ohio expanded Medicaid coverage to Ohio children up to age 19, in families at or below 150% of the federal poverty level. Newly eligible children were not eligible for MCP enrollment until July 1998.
- **RFP:** On April 1, 1998, ODHS issued a Request for Proposals (RFP) for MCPs to provide Medicaid-covered services to Ohio Works First participants and Healthy Start eligibles in the nine voluntary managed care counties. Eleven MCPs responded to operate in one or more of the counties. ODHS Provider Agreements with the successful respondents will become effective December 1, 1998.

Statewide
January - June 1998

VOLUNTARY DISENROLLMENTS

ODHS enrollment data reports the actual number of individuals enrolled or disenrolled. Voluntary disenrollments are initiated by the enrollee. Involuntary disenrollments occur when an enrollee loses MCP eligibility. ODHS monitors rates to assess quality and satisfaction.

MCP	Enrollment as of June 1998	Avg. Monthly Enrollment	Avg. Monthly Voluntary Disenrollments	Avg. Monthly Voluntary Disenrollment Rate
DAYMED HMP INC	15,879	3,080	11.67	0.06 %
DAYTON AREA HEALTH PLAN	56,554	7,779	5.90	0.01 %
EMERALD HMO INC	15,082	5,123	38.50	0.38 %
FAMILY HEALTH PLAN	10,773	5,614	9.75	0.09 %
GENESIS HEALTH PLAN	191	790	15.61	0.85 %
HEALTH POWER HMO INC	25,629	5,345	17.25	0.06 %
HMO HEALTH OHIO	19,749	2,742	11.69	0.05 %
PARAMOUNT HEALTH CARE	15,070	15,628	16.50	0.11 %
PERSONAL PHYSICIAN CARE	35,593	7,221	36.64	0.08 %
QUALCHOICE	21,446	21,591	31.17	0.14 %
SUMMACARE	16,920	9,174	40.58	0.33 %
SUPERMED HMO	38,739	6,759	20.19	0.05 %
TOTAL HEALTH CARE	28,683	7,015	45.42	0.16 %
STATEWIDE TOTALS	300,308	314,707	21.64	0.36 %

Average monthly enrollment = Sum of monthly enrollment for the report period divided by the number of active months with enrollment.

Average voluntary disenrollment = Sum of monthly voluntary disenrollments for the report period divided by the number of months with enrollment.

Average voluntary disenrollment rate = Average monthly voluntary disenrollments divided by average monthly enrollment.

Statewide totals disenrollments for January - June 1998: 188,316

Statewide voluntary disenrollments for January- June 1998: 6,839

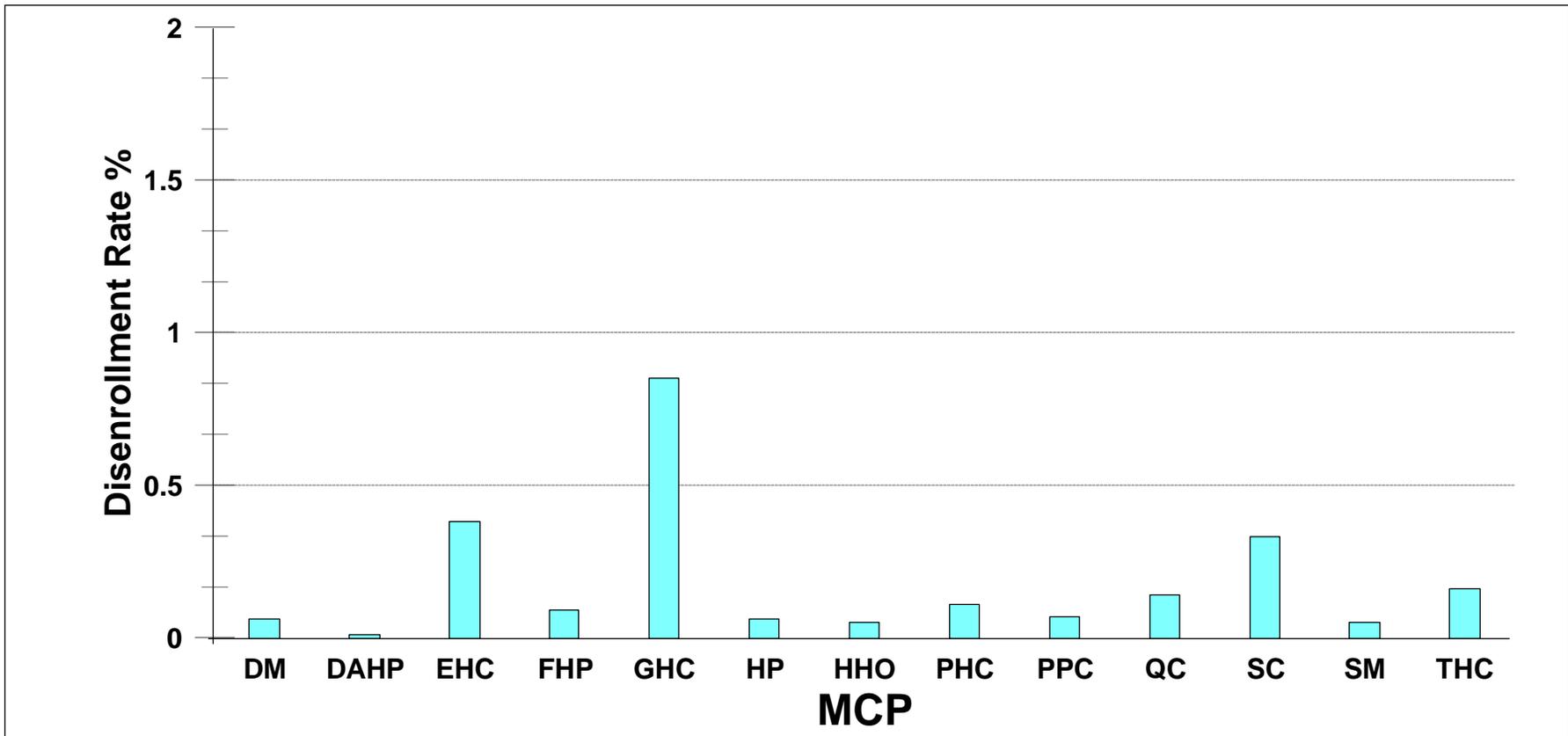
Please refer to the text for further information.

Statewide

January- June 1998

VOLUNTARY DISENROLLMENT RATE

The graph represents each managed care plan's average monthly voluntary disenrollment as a percentage of each managed care plan's average monthly enrollment.

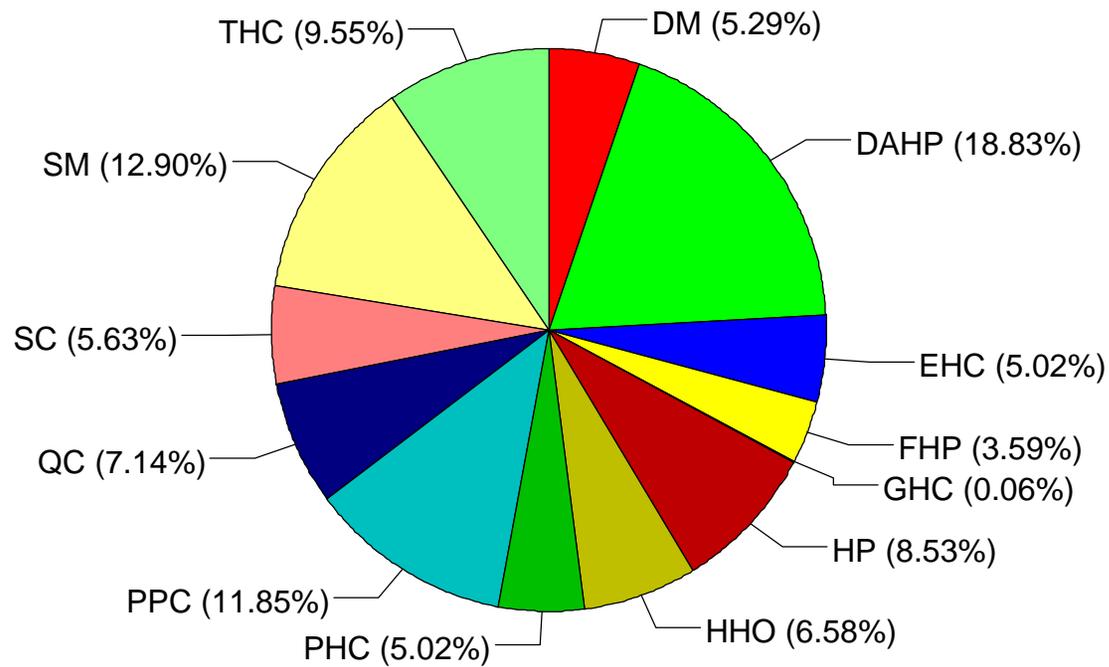


Please refer to the text for further information.

Source: ODHS, Bureau of Managed Care
11/16/98 MHS

Statewide June 1998 Enrollment Status

The graph represents the eligible enrollment percentage for each MCP statewide as of June 1998.



Please refer to the text for further information.

Source: ODHS, Bureau of Managed Health Care
11/16/98 MHS

STATEWIDE

July- December 1997

UTILIZATION OF HEALTH CARE SERVICES

ODHS collects county-specific and statewide data, by MCP, on an annual and semi- annual basis for a variety of utilization indicators. This ODHS data represents SFY 1998 member month totals, primary care provider, specialist, and emergency room visits, and inpatient hospital days per 1000 member months. Reports that trend data across time are also available from ODHS.

MCP	Member Months	PCP Visits per 1000 MM	Specialist Visits per 1000 MM	Inpatient Days per 1000 MM	ER Visits per 1000 MM
DAYMED HMP INC	21,515	174.31	124.70	30.11	50.85
DAYTON AREA HEALTH PLAN	86,185	221.28	287.18	51.36	45.71
EMERALD HMO INC	3,952	107.65	78.80	39.99	25.06
FAMILY HEALTH PLAN	24,012	337.99	205.64	29.59	84.34
GENESIS HEALTH PLAN	1,708	110.06	211.55	38.08	74.49
HEALTH POWER HMO INC	34,257	174.29	116.68	36.34	35.48
HMO HEALTH OHIO	22,501	221.14	72.84	45.68	91.71
PARAMOUNT HEALTH CARE	23,520	230.35	164.88	62.35	60.42
PERSONAL PHYSICIAN CARE	31,203	92.78	55.93	60.31	28.59
QUALCHOICE	21,345	165.71	270.96	30.39	15.38
SUMMACARE	9,967	176.13	586.54	43.44	24.23
SUPERMED HMO	34,389	144.36	56.50	41.00	58.77
TOTAL HEALTH CARE	44,910	244.42	175.86	32.12	19.83

Statewide Totals

1.980.271

181.52

165.58

44.62

43.04

PCP: Primary Care Provider

ER: Emergency Room

Member Months (MM) totals as reported by MCPs

"PCP Visits" through "ER Visits" = total visits x 1000 divided by the member months

Source: ODHS, Bureau of Managed Health Care

12/23/1998 MHS

Statewide

January - June 1998

COMPLAINTS

ODHS receives complaints via a 1-800 consumer hotline, the Enrollment Information Centers, providers and other interested parties.

MCP	Access	Quality	Transportation	Marketing	Covered Services	Authorization	Member Services	Claims Related	Other	Total*	Remedial Action**	Complaints per 1,000 MM***
DAYMED HMP INC	1	0	0	0	0	0	0	0	0	1	0	0.01
DAYTON AREA HEALTH PLAN	2	0	0	0	0	1	0	3	1	5	2	0.01
EMERALD HMO INC	0	0	0	0	0	0	3	3	1	5	0	0.08
FAMILY HEALTH PLAN	0	0	0	0	0	0	1	0	0	1	1	0.01
GENESIS HEALTH PLAN	0	0	0	0	0	0	0	0	1	1	0	0.09
HEALTH POWER HMO INC	1	0	0	0	1	0	2	6	3	10	2	0.06
HMO HEALTH OHIO	4	0	0	0	0	2	1	0	2	7	2	0.05
PARAMOUNT HEALTH CARE	0	0	0	0	0	0	1	1	0	2	0	0.02
PERSONAL PHYSICIAN CARE	7	0	0	0	3	3	0	22	9	31	8	0.11
QUALCHOICE	0	0	0	0	0	0	0	1	0	1	1	0.01
SUMMACARE	0	0	0	0	0	0	8	0	2	5	3	0.07
SUPERMED HMO	1	0	0	1	0	2	1	2	0	7	2	0.03
TOTAL HEALTH CARE	1	0	0	0	0	0	0	6	1	7	5	0.04

Statewide Totals

17 0 0 1 4 8 17 44 20 83 26 0.04

* Total may not equal the sum of the categories as a complaint may be defined in more than one category.

**Remedial Action is any action which an MCP takes or should take to resolve a problem for which the MCP or its providers is culpable.

*** Complaint calculation is based on ODHS member months data; Complaints= Complaints x 1000 divided by the Member Months.

Please refer to the text for further information.

Source: ODHS, Bureau of Managed Health Care
12/21/1998 MHS

Statewide

Date of Service: January - December 1997

PHYSICIAN & CLINIC ENCOUNTER DATA CLAIMS VOLUME

The encounter data volume shown is for physician and outpatient clinic claims submitted for date of service in SFY 1997 and SFY 98. ODHS also collects encounter data for inpatient and outpatient hospital, among other services. Performance measures have been developed to assess MCP performance using this encounter level data. The report reflects encounter data submissions received by June 3, 1998.

MCP	Member Months Jan - Dec 1997 (x 1,000)	3rd Quarter SFY 97 Encounters/1,000 MM DOS 1/1/97 - 3/31/97	4th Quarter SFY 97 Encounters/1,000 MM DOS 4/1/97 - 6/30/97	1st Quarter SFY 98 Encounters/1,000 MM* DOS 7/1/97 - 9/30/97	2nd Quarter SFY 98 Encounters/1,000 MM* DOS 10/1/97 - 12/31/97
DAYMED HMP INC	242	335	334	323	304
DAYTON AREA HEALTH PLAN	748	443	426	426	421
EMERALD HMO INC	62	409	370	369	321
FAMILY HEALTH PLAN**	146	377	298	321	171
GENESIS HEALTH PLAN**	25	165	165	186	165
HEALTH POWER HMO INC	398	495	483	428	403
HMO HEALTH OHIO	313	324	369	364	301
PARAMOUNT	203	530	470	469	424
PERSONAL PHYSICIAN CARE**	663	206	111	58	59
QUALCHOICE	247	358	429	463	314
SUMMACARE	108	465	402	265	303
SUPERMED	529	248	296	262	210
TOTAL HEALTH CARE**	371	113	188	179	126
Statewide Average	312	339	325	305	267

* 1st quarter and 2nd quarter SFY 1998 totals have lower volume due to the six-month time lag of receiving data from MCPs.

** MCPs currently under a corrective action plan due to low encounter data volume.

Note: Claims/1000 MM = Claims x 1,000 divided by member months for the period.

Please refer to the text for further information.

Statewide

Periods Ending 12/31/97 and 03/31/98

MCP NET WORTH PER MEMBER

MCPs are required to submit copies of all Ohio Department of Insurance (ODI) financial reports to ODHS quarterly and annually. Net worth per member (NWPM) represents the MCPs' total assets less total liabilities, as reported on the ODI statutory filings, in accordance with standards established by the National Association of Insurance Commissioners, divided by the total enrollment for the period under review. The ODHS minimum standard for NWPM is \$50.

MCP Name	Member Months Jan - Dec 1997 (x 1,000)	Net Worth @ 12/31/97	Enrollment @ 12/31/97	NWPM @ 12/31/97	Member Months Jan - Mar 1998 (x 1,000)	Net Worth @ 03/31/98	Enrollment @ 03/31/98	NWPM @ 03/31/98
DAYMED HMP INC	242	(\$1,922,840)	26,660	(\$72)	56	(\$2,890,357)	25,766	(\$112)
DAYTON AREA HEALTH PLAN	748	\$6,890,338	65,200	\$106	186	\$8,047,740	65,200	\$123
EMERALD HMO INC	62	(\$1,653)	31,074	(\$0)	23	\$1,767,738	36,788	\$48
FAMILY HEALTH PLAN	146	\$1,575,596	36,626	\$43	34	\$1,619,089	48,102	\$34
GENESIS HEALTH PLAN	25	\$1,748,045	3,904	\$448	8	\$2,120,008	5,260	\$403
HEALTH POWER HMO INC	398	\$577,347	31,663	\$18	89	\$149,208	31,361	\$5
HMO HEALTH OHIO	313	\$127,527,240	1,398,177	\$91	67	\$124,400,581	1,372,549	\$91
PARAMOUNT HEALTH CARE	203	\$5,867,818	101,937	\$58	48	\$4,504,246	106,746	\$42
PERSONAL PHYSICIAN CARE	663	(\$15,882,559)	65,000	(\$244)	153	*	*	*
QUALCHOICE	247	\$8,347,933	44,253	\$189	65	\$7,227,954	44,225	\$163
SUMMACARE	108	\$2,419,754	51,958	\$47	29	\$1,908,843	55,435	\$34
SUPERMED HMO	529	\$127,527,240	1,398,177	\$91	124	\$124,400,581	1,372,549	\$91
TOTAL HEALTH CARE	371	\$13,878,238	28,904	\$480	84	\$12,841,584	28,084	\$457
Statewide Average	312	\$21,427,115	252,579	\$85	74	\$23,841,435	266,005	\$90

*Complete financial details for Personal Physician Care were not available for the period pending the results of an examination by the Ohio Department of Insurance.

Note: 12/31/97 data is from the ODI Calendar Year 1997 Cost Report and the 3/31/98 data is from the ODI Quarterly Cost Report period end March 31, 1998.

Member months data represents only Medicaid enrollment while enrollment data represents total organization enrollment.

Please refer to the text for further information.

Source: ODHS, Bureau of Managed Health Care

09/17/98 GLL

Statewide January - June 1998 POINT COMPLIANCE SYSTEM

The purpose of the compliance assessment (point) system is to improve the MCP's performance through a progressive series of actions to correct program deficiencies or violations. The BMHC works on an ongoing basis with each MCP to improve their performance. When certain specified requirements are not met or when required program improvements do not occur, this results in the assessment of specified point values to the MCP. The remedies attached to each point assessment are progressive based on the severity of the violation, or a repeated pattern of violations.

Statewide County MCPs	Points	Category	Remedy	Fine
EMERALD HMO INC	5	Failure to Submit Required Documentation	CAP	
HEALTH POWER HMO INC	10	Failure to Maintain Minimum Provider Requirement	CAP	\$2,500.00
SUMMACARE	5	Untimely Submission of Required Documentation	CAP	
SUMMACARE	5	Use of unapproved materials	CAP	\$2,500.00
TOTAL HEALTH CARE	2	Failure to Submit Required Documentation	CAP	

CAP = Corrective Action Plan

Only those managed care plans assessed points during the reporting period are listed above.

Please refer to the text for further information.

Statewide

January - June 1998

STATE HEARINGS

ODHS collects state hearing information from the notices that are sent out by MCPs when an MCP proposes to reduce, terminate or deny a service or denies payment of a service. Information regarding the number of state hearings requested and the outcomes of all hearings are tracked for each MCP.

MCP Name	Member Months Jan - June 1998 (x 1,000)	Reason for MCP Decision				Hearings Requested	Outcome			
		No Referral	ER Non-emergency	No Medical Necessity	Other		Abandoned	Withdrawn	Sustained	Overruled
DAYMED HMP INC	108	0	0	0	1	0	0	0	0	0
DAYTON AREA HEALTH PLAN	358	0	9	0	1	0	0	0	0	0
EMERALD HMO INC	61	0	0	1	1	1	0	1	0	0
FAMILY HEALTH PLAN	67	6	49	0	0	1	0	0	0	1
GENESIS HEALTH PLAN	11	2	7	0	2	1	0	1	0	0
HEALTH POWER HMO INC	171	0	0	7	0	0	0	0	0	0
HMO HEALTH OHIO	129	17	19	1	1	2	0	2	0	0
PARAMOUNT HEALTH CARE	94	0	2	0	0	1	0	1	0	0
PERSONAL PHYSICIAN CARE	274	0	0	0	2	3	1	2	0	0
QUALCHOICE	130	0	3	4	2	0	0	0	0	0
SUMMACARE	73	1	3	0	6	0	0	0	0	0
SUPERMED HMO	243	49	59	0	2	4	0	4	0	0
TOTAL HEALTH CARE	168	0	0	0	0	0	0	0	0	0
Statewide Totals	1,888	75	151	13	18	13	1	11	0	1

Please refer to the text for further information.

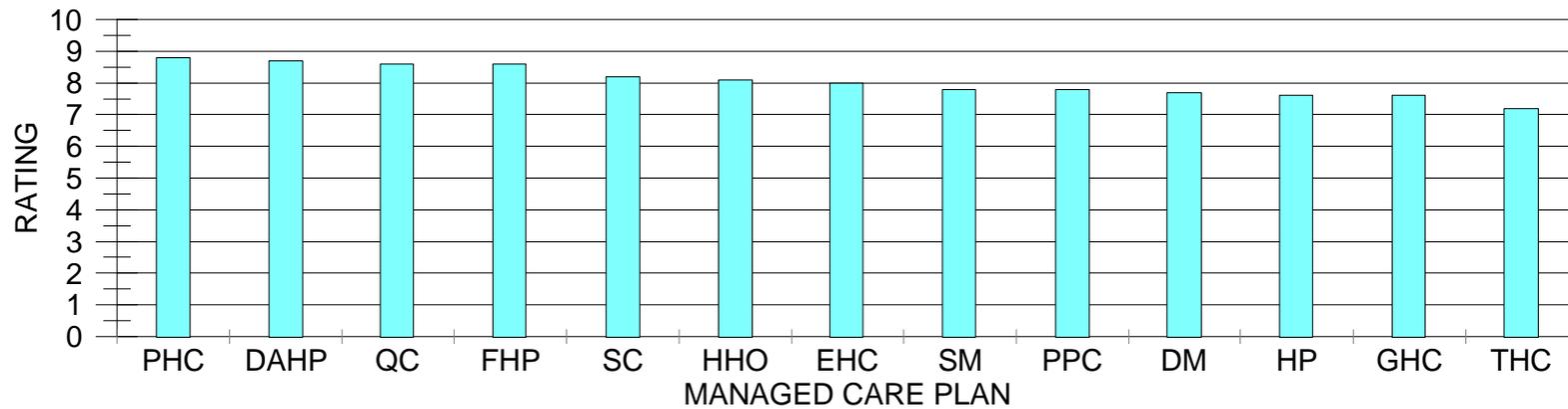
STATEWIDE

OCTOBER, 1997

OVERALL CONSUMER SATISFACTION WITH MCP

1997 OHIO MEDICAID MCP CONSUMER SURVEY

The graph represents each Managed Care Plan's enrollee population's rating of overall satisfaction in 1997. Enrollees were asked to rate their managed care plan on a scale of "0" to "10" with "0" being the worst possible health insurance plan and "10" being the best possible health insurance plan.



Note: Members were enrolled at least six months before October, 1997.
Please refer to the text for further information.

Source: Bureau of Managed Health Care
9/18/98 ANC

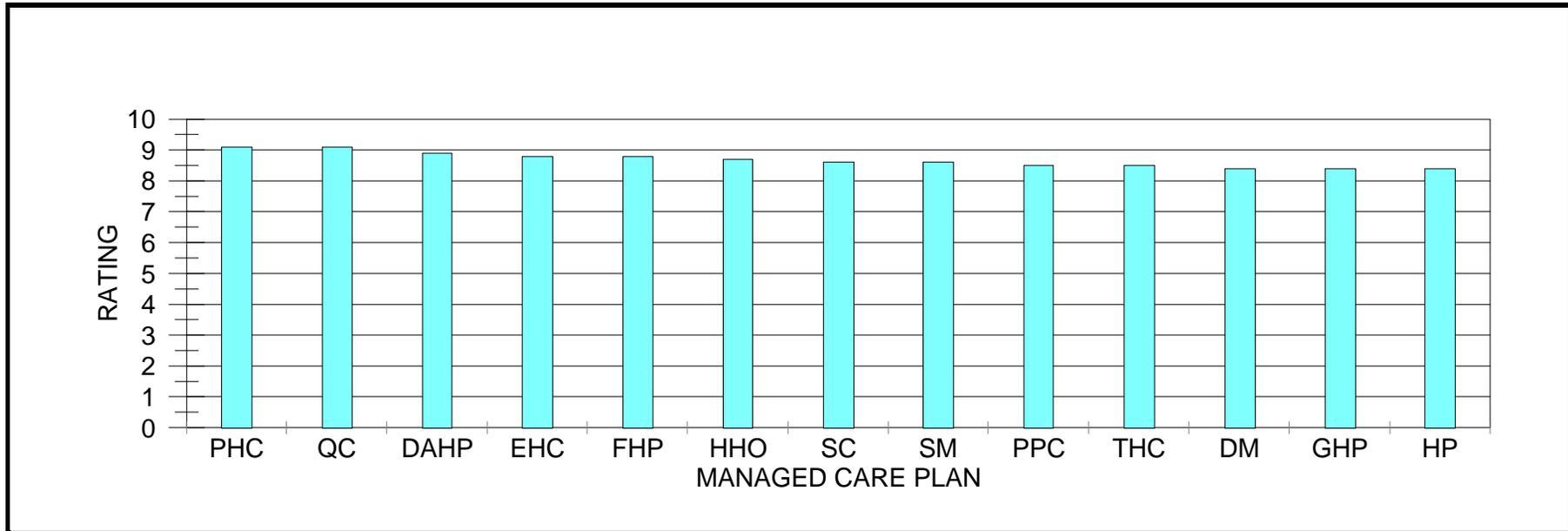
STATEWIDE

October, 1997

SATISFACTION WITH ALL HEALTH CARE

1997 OHIO MEDICAID MCP CONSUMER SURVEY

The graph represents each Managed Care Plan's sample enrollee population rating of satisfaction with all health care in 1997. Enrollees were asked to rate all health care in the last six months from all doctors and other health professionals on a scale of "0" to "10" where "0" represents the worst possible health care and "10" represents the best health care possible.



Members were enrolled at least six months before October 1997.
Please refer to the text for further information.

Source: Bureau of Managed Care
9/18/98 ANC

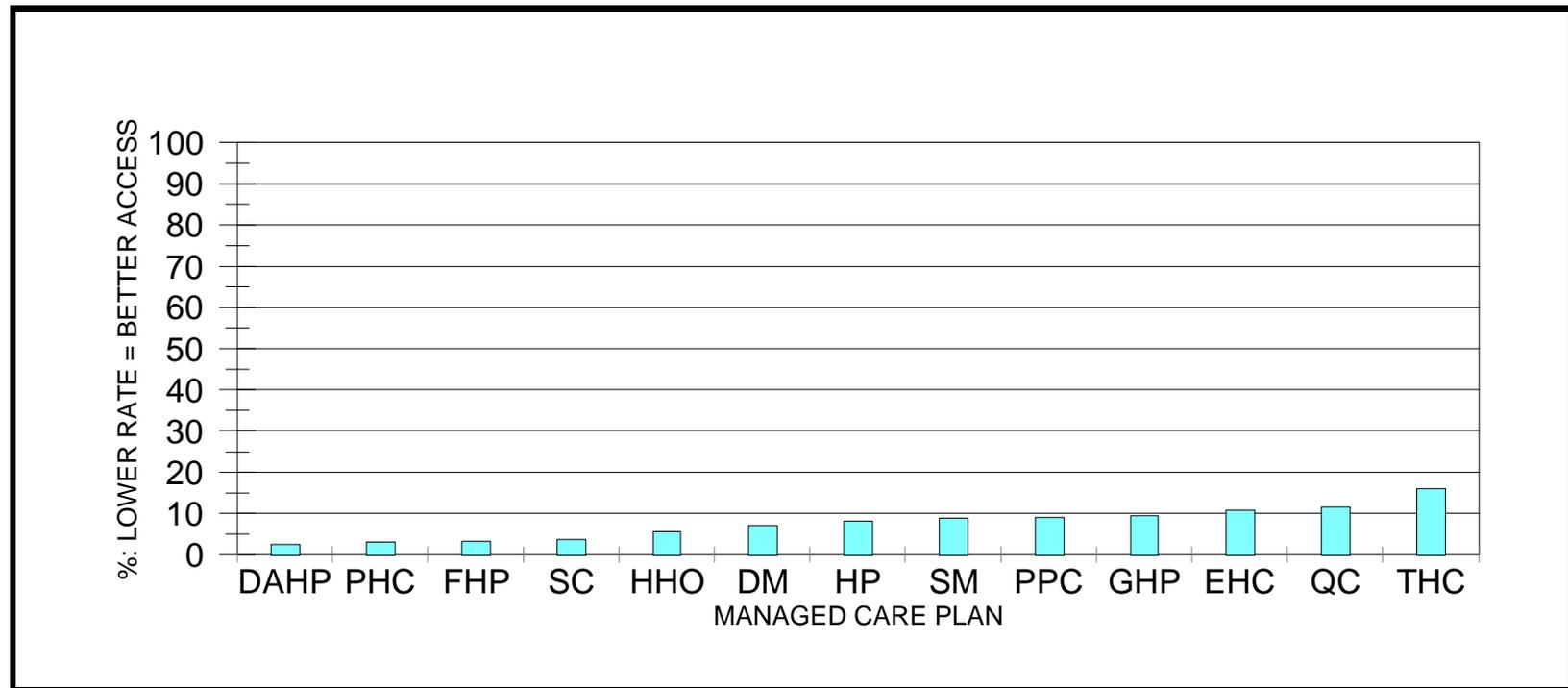
STATEWIDE

October, 1997

SATISFACTION WITH ACCESS TO CARE

1997 OHIO MEDICAID CONSUMER SATISFACTION SURVEY

The graph represents each managed care plan's sample enrollee population's responses when asked how long they had to wait for an appointment for regular or routine care. A lack of satisfaction is indicated by a wait time over one month for a routine appointment. Lower rates represent better access to routine care.



Members were enrolled at least six months before October, 1997.
Please refer to the text for further information.

Source: Bureau of Managed Health Care
9/18/98 ANC

Statewide

January- June 1998

ASSET TRANSFERS

This chart summarizes MCP asset transfers that were approved during the reporting period.

TRANSFEROR'S NAME	TRANSFeree'S NAME	COUNTY(S)	ENROLLMENT FREEZE	APPROVED TRANSFER
DayMed	THCP	Franklin & Summit	09/17/97	01/01/98
THCP	DayMed	Butler & Hamilton	09/17/97	01/01/98
DAHP	Emerald	Cuyahoga & Summit	10/17/97	03/01/98
PPC	FHP	Lucas	10/21/97	03/01/98
PPC	THCP	Franklin	12/10/97	05/01/98
Health Power HMO	HMO Health Ohio	Butler	12/23/97	06/01/98
HMO Health Ohio	Health Power HMO	Montgomery	12/23/97	06/01/98
PPC	SummaCare	Stark & Summit	12/29/97	05/01/98
Genesis HP	Emerald	Cuyahoga and Summit	12/30/97	05/01/98
Health Power HMO	Emerald	Cuyahoga	12/23/97	06/01/98
Health Power HMO	THCP	Mahoning	12/23/97	05/01/98
DayMed	Emerald	Cuyahoga	02/26/98	06/01/98

Please refer to the text for further information.