

Managed Care Plan Progress Report

Statewide

July - December 1998

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

STATEWIDE PROGRESS REPORT

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Ohio Medicaid Managed Care Program

The Ohio Department of Human Service (ODHS) is the single state agency responsible for the implementation and administration of the Medicaid program. As a value purchaser of health care, Ohio Medicaid has incorporated the use of managed care to enhance system accountability for access and quality as well as to achieve greater cost predictability and perhaps savings. Managed care offers an opportunity to assure access to a primary care provider, emphasize preventive care, and encourage the appropriate utilization of services in the most cost-effective settings.

Purpose of the Progress Reports

An essential component of a value purchasing strategy is an emphasis on performance and information. The progress reports were developed to consolidate and summarize the information available about Ohio's Medicaid managed care program and the performance of its contracting managed care plans (MCPs).

Plan performance in the key areas of access, quality, and consumer satisfaction is crucial to the overall value of the program. Administrative capacity, the ability to provide accurate and complete information and operate required program elements such as member services and grievance

systems, is also essential to program value. The "Quality Agenda," which is attached as Appendix A, identifies the information used to assess plan performance in each of the value components (Access, Quality, Consumer Satisfaction, Administrative Capacity). The Progress Report describes the status of the program during the six-month reporting period, summarizes performance for that time period in each of the value components, and includes data reports in specific areas. (Data reports are available for individual counties as well as statewide.)

It is important to note that MCP performance should not be assessed based on any one indicator in isolation but by reviewing a combination of indicators.

Statewide Summary: July 1998 -December 1998

During this reporting period, the Medicaid managed care program continued to be affected by the volatile environment in the overall health care industry. Mergers and acquisitions occurred throughout the industry and across the country, resulting in a decrease in the number of managed care plans. In the Ohio program, the number of contracting plans decreased by one from July 1998 to December 1998; other MCPs transferred members and left some counties of operation. As of December 1998, thirteen plans were under contract to serve Medicaid enrollees in sixteen counties. In early 1999, two more plans left the market.

The most controversial event during this period was the insolvency of Personal Physician Care (PPC), a long-time participant in the Medicaid managed care program. After several months of supervision by the Ohio Department of Insurance (ODI) and more than eight months of purchase negotiations, ODI placed the plan in liquidation in August 1998. The ODHS moved immediately to terminate the provider agreement with PPC and return enrollees to Medicaid fee-for-service (FFS) coverage pending their selection of another MCP. At no time was any Medicaid member left without coverage. Two more contracting plans went into liquidation in early 1999: DayMed and Health Power. Again, ODHS acted to terminate provider agreements and assure health insurance coverage through the traditional Medicaid FFS delivery system. This decline in plans servicing the Medicaid managed care consumers reflects a national trend of more closely aligning the appropriate number of financially and programmatically solid plans with the number of consumers.

Another factor influencing the managed care program during this time was the continuing and dramatic decline in the welfare caseload. By August 1998, managed care enrollment had fallen to 289,912 from a June 1997 enrollment of 352,833. Such an unexpected loss of volume affected the financial outlook for MCPs which had assumed a certain level of enrollment and compensation when entering provider agreements with the Department.

Several key program enhancements and initiatives in the Medicaid managed care program were implemented during this reporting period:

- (1) The procurement process which began with the issuance of a Request for Proposals on April 1, 1998 concluded with the signing of new provider agreements effective December 1, 1998. All current plans, along with a new contractor, Primetime Health Plan (or "MediPlan"), received contracts.
- (2) As of December 1998, three additional counties became mandatory enrollment counties; they are Lorain, Stark, and Wood. The total number of mandatory counties reached ten, with six counties remaining voluntary.
- (3) Performance Improvement Agreements (PIA) between the Bureau of Managed Health Care (BMHC) and each MCP were implemented in conjunction with the new provider agreements. The purpose of the PIA is to identify key program components where MCP improvement is expected both to assure the MCP's ongoing ability to meet program requirements and to advance performance. The PIA process was designed to promote cooperation between the BMHC and MCPs in

developing a personalized improvement plan for each MCP.

- (4) ODHS continued to work toward improving the reliability of MCP encounter data. Activities initiated by ODHS included the comparison of encounter data with other reported data, data validation using medical records, and expanded data reporting requirements
- (5) BMHC added two provisions to the current MCP provider agreement. First, MCPs must now meet prompt claims payment and electronic claims adjudication requirements. Second, performance measurement language was enhanced to define more specifically encounter data reporting requirements and related penalties for noncompliance. BMHC continues to review MCP program requirements for appropriateness and effectiveness.
- (6) Automated Health Systems, Inc. (AHSI), assumed responsibility for the provision of enrollment services in all managed care counties with the exception of Cuyahoga, Franklin, and Hamilton through June 30, 1999, at which time AHSI incorporated those counties as well. Enrollment

services in those counties continued to be processed by separate Enrollment Information Centers.

- (7) Access to enrollment services by phone was made available in all managed care counties to assure easier information gathering and enrollment processing for eligible consumers in all counties.
- (8) Responsibility for data entry for all enrollment transactions in the Client Registry Information System-Enhanced (CRIS-E) passed from county departments of human services (CDHS) to Automated Health Systems, Inc.
- (9) The Notification of Mandatory Enrollment (NME) was automated through CRIS-E, which assured that eligible individuals received notices immediately following their authorization for Ohio Works First, Healthy Start Medicaid (including CHIP). Previously, forms were completed on hard copy by caseworkers at the time of application or redetermination for assistance.

Value Components

Access

Plans must meet and document specified minimums in terms of number and types of providers prior to receiving a contract and must maintain satisfaction of the requirement throughout the contract period. Primary care provider capacity and location (to assure reasonable travel time) must also meet minimum specifications. A provider database and Geographic Information System are in place to assess and monitor these requirements over time; in addition, grievances and complaints are reviewed to indicate potential problem areas. Enrollees are to select a primary care provider upon enrollment and plans are required to distribute member handbooks and provider directories to each member.

Plans are meeting these requirements as indicated by documentation, panel mapping, performance on the consumer satisfaction survey, and the few complaints or grievances reported related to provider access. Primary care provider capacity in each county remains well above the number of eligibles who could enroll, despite plan withdrawals.

Access is also measured through the submission of encounter data. Encounter data reflects each visit by an

enrollee to a provider and the services provided. Since July 1996, managed care plans have been required to submit this data. As anticipated, the volume of data has been low and therefore the completeness and reliability of the data are questionable at this point. This is not inconsistent with other states' experience in collecting encounter data.

A progressive series of disciplines are implemented for plans that fall below requirements related to the submission of encounter data. Encounter data provides information on access, service utilization, and quality of care and is therefore essential to program oversight.

Plans vary in performance and demonstrable improvement. Performance standards assessed using encounter data have so far been unreliable due to incomplete data. National experience with encounter data collection suggests that three years is the norm to ensure data sufficiency and four to assure reliability; this would indicate that within six to nine months of the end of SFY 2000 (i.e., March 2001), Ohio's managed care encounter data and resulting reports will be valid and dependable.

Consumer Satisfaction

Tools used to assess consumer satisfaction include the annual independent consumer satisfaction survey, required managed care plan surveys, complaints and grievances, voluntary disenrollment rates and reasons, and the number of and

reasons for just cause disenrollments (“just cause” are reasons which allow an individual to make an enrollment change outside of the semi-annual open enrollment month).

As reported previously, all plans met the required minimum score of 70% on the annual independent consumer satisfaction survey with satisfaction scores for individual plans ranging from 72% to 88%.

Voluntary disenrollment rates have been consistently low in the program at a level of less than 1%; disenrollment due to loss of eligibility is far higher, typically over 10% of total enrollment each month. For this reporting period, voluntary disenrollments again averaged less than 1%, with a range of .06% to .61%.

Grievances are also low, at an average of fewer than three per 1000 member months. The majority of grievances in the first half of SFY 1999 reflected claims payment issues for five plans.

From all indications, there is a significant level of consumer satisfaction with managed care enrollment. Contributing to enrollee satisfaction are program requirements that plans provide a number of member services, including member services telephone lines, internal grievance processes, and 24-hour lines that offer

medical advice and direction. These systems are tested on a routine basis by Medicaid staff in the Bureau of Managed Health Care.

Quality of Care

Mechanisms to assess clinical quality of care include the annual external quality review, which includes a survey of medical records to determine compliance with established clinical care protocols. The latest survey results (for services delivered in SFY 1997) found overall scores ranging from 79% to a high of 96%. Any areas of deficiency subject plans to specific quality improvement strategies monitored by Bureau of Managed Health Care staff. Comparable record reviews and accountability are not currently available in the FFS system.

Aggregate utilization reports, which are self-reported semi-annually by the managed care plans, are also assessed as a quality indicator, especially in the key areas of physician visits, emergency room use, and inpatient utilization. For the second half of SFY 1998 (the most recent data available), primary care physician visits were 166.55 per 1000 member months; specialist visits were 158.8 per 1000 member months; inpatient days stood at 39 per 1000 member months; and emergency room visits were 45 per 1000 member months. Among a comparable FFS population during the most recently available reporting period (SFY 1997),

inpatient days were 61 per 1000 member months and emergency room visits were 88 per 1000 member months. ODHS compares utilization information with other indicators (such as encounter data, grievances, and reasons for disenrollment) to identify patterns which may indicate problem areas.

Efforts continue to accurately assess the actual utilization and quality of care. Current information does indicate consistently that managed care has resulted in reduced inpatient and emergency utilization compared to FFS; also, complaints, grievances and consumer satisfaction indicate at least comparable quality to that in the FFS system.

Administrative / Information

Managed care plans perform at varying levels of sophistication in the area of administrative capacity. The ability to report information accurately and completely is essential to the determination of value; otherwise, there will continue to be uncertainty with the assessment of access, quality, and other performance indicators.

Most plans have had difficulty achieving the encounter data reporting requirements, although only two plans were operating under a corrective action plan for volume of submissions as of September 1998. The Bureau of

Managed Health Care reviews monthly reports to monitor the MCP's encounter data submissions. If a plan's encounter data volume is low, ODHS will require a corrective action plan (CAP) to increase the volume by identifying and correcting data problems (e.g., incorrect coding, delayed submissions or incomplete submissions). Failure to comply with a CAP can result in the imposition of a refundable fine. Once the problems identified by the CAP are resolved to the satisfaction of ODHS, the money is refunded to the plan. Reporting timeliness and accuracy in others areas (e.g., grievances, utilization reports, costs) also vary by plan, with failures to meet minimum specifications resulting in progressive penalties.

Another indicator of administrative capacity is the annual review of net worth per member. While oversight of the financial solvency of all MCPs in the state is the statutory responsibility of the Ohio Department of Insurance and only plans licensed by ODI are considered for Medicaid contracts, ODHS does monitor MCP financial reports for signs of difficulties which could create access or quality concerns. As a partial indicator of financial stability, ODHS established a measure of \$50 net worth per member (NWPM) for Medicaid contracting plans which is assessed annually. Any plan found to be below this standard is further reviewed and monitored for any indication of compromised quality or access. Corrective action plans are required from MCPs that fall below this annual minimum standard.

Deficiencies in many administrative areas result in the assessment of points under the managed care program's "Point Compliance System." After a specified number of occurrences, points are accrued and/or fines, enrollment freezes, and other penalties may be assessed along with required corrective action. As of December 1998, three plans had points assessed, and two had reached the fine level. This tool, while important to identify and correct deficiencies in plan operations, is less effective as a performance improvement mechanism since it does not offer a prospective incentive for improvement.

During this report period, an area of increasing concern for the Medicaid managed care program was the apparent inability of some plans to consistently and timely reimburse providers. The reasons for claims payment problems may be financial, or simply a change in the claims processing system, but the negative repercussions in terms of provider satisfaction and participation are potentially great. In an attempt to improve prompt provider payment by contracting plans, program requirements expanded from simply requiring plans to accept electronic billing to requiring the capacity to electronically adjudicate claims to final status and to report a claim's status to a provider with thirty days of submission.

The ability of plans to perform administrative and reporting program requirements is a major contributor to value. While grievances and consumer satisfaction indicators suggest there is no reason to suspect quality or access problems, the current uneven performance among plans and difficulties in verifying the operation of certain components remains a major oversight challenge.

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

Quality Agenda

For Oversight and Assessment of Medicaid MCPs

QUALITY OF CARE	ACCESS	CONSUMER SATISFACTION	ADMINISTRATIVE CAPACITY
<ul style="list-style-type: none"> ▶ MCP Internal Quality Program ▶ Annual External Quality Review (EQRO) <ul style="list-style-type: none"> • Clinical Studies ▶ Care Coordination <ul style="list-style-type: none"> • Emergency Department Diversion • Case Management • Triage Procedures ▶ Performance Standards ▶ Utilization Reports 	<ul style="list-style-type: none"> ▶ Provider Panel Requirements ▶ Provider Panel Submissions ▶ Provider Panel Database ▶ Geographic Information System (GIS) ▶ MCP Grievance Monitoring ▶ ODHS Complaint Monitoring ▶ 24 Hour Call-In System ▶ Appropriate, timely access <ul style="list-style-type: none"> • Emergency Department Diversion • Triage Procedures • Case Management ▶ Utilization Reports ▶ Encounter Data 	<ul style="list-style-type: none"> ▶ ODHS Annual Survey ▶ Annual MCP Member Satisfaction Surveys ▶ MCP Grievance Monitoring ▶ ODHS Complaint Monitoring ▶ Prior approval of marketing and member services materials ▶ Minimum Enrollment Requirements ▶ Disenrollment <ul style="list-style-type: none"> • Voluntary • Just Cause 	<ul style="list-style-type: none"> ▶ Encounter Data Submissions ▶ Reporting <ul style="list-style-type: none"> • Grievances • Utilization • Cost • Provider Additions and Deletions ▶ MCP Internal Quality Program ▶ Member Services ▶ Information Technology

MCP=Managed Care Plan

Source: ODHS Bureau of Managed Health Care
February 3, 1999
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Appendix B

Data Reports

The following data reports provide a summary of several Quality Agenda indicators monitored by the BMHC. A more detailed narrative of the data reports is available from the BMHC.

Statewide

December 1998

PCP CAPACITY

An MCP must subcontract with a minimum number of full time (FTE) PCPs; the required number is based on the number of MCP eligibles in a county. At least one FTE PCP is required for every 2000 Medicaid enrollees. The report represents the PCP capacity created by all MCPs operating within a particular country.

County	Total Capacity *	% Capacity at Full Enrollment	% of Excess Capacity
Butler	62,543	14.85%	85.15%
Clark	15,439	58.57%	41.43%
Cuyahoga	931,881	12.80%	87.20%
Franklin	251,881	22.11%	77.89%
Greene	13,146	33.86%	66.14%
Hamilton	203,538	22.26%	77.74%
Lorain	38,000	40.33%	59.67%
Lucas	178,086	20.43%	79.57%
Mahoning	124,698	16.16%	83.84%
Montgomery	68,585	40.92%	59.08%
Pickaway	2,556	96.56%	3.44%
Stark	65,520	28.75%	71.25%
Summit	352,118	9.46%	90.54%
Trumbull	65,300	20.87%	79.13%
Wood	13,271	19.16%	80.84%
Statewide Average	159,104	30.47%	69.53%

Note: The county PCP capacity totals contain duplication because the same doctors may have contracted with one or more MCPs.

* Capacity at full enrollment would be the total enrollment within a county if all eligibles were enrolled.

Please refer to the text for further information.

Source: ODHS, Bureau of Managed Health Care

5/10/1999 MHS

Statewide

Date of Service: July 1997- June 1998

PHYSICIAN & CLINIC ENCOUNTER DATA CLAIMS VOLUME

The encounter data shown is for the physician and outpatient claims for the date of service in SFY98. ODHS collects encounter data for the inpatient and outpatient hospital, among other services. Performance measures have been developed to assess MCP performance using this encounter data. The report reflects encounter data submissions received by March 1, 1999.

MCP	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	3rd Quarter SFY 98 Encounters/1,000 MM* DOS 1/1/98-3/31/98	4th Quarter SFY 98 Encounters/1,000 MM* DOS 4/1/98- 6/30/98
DAYMED HMP INC	335	341	335	333
DAYTON AREA HEALTH PLAN	425	425	447	391
EMERALD HMO INC	425	383	263	144
FAMILY HEALTH PLAN	356	324	343	300
GENESIS HEALTH PLAN	192	182	186	179
HEALTH POWER HMO INC	495	428	391	331
HMO HEALTH OHIO	352	352	305	270
PARAMOUNT	480	446	367	439
QUALCHOICE	478	354	284	324
SUMMACARE	270	314	434	270
SUPERMED	263	217	273	262
TOTAL HEALTH CARE	267	258	326	316
Statewide Average	362	335	330	297

* 3rd quarter and 4th quarter SFY 1998 totals have lower volume due to the six-month time lag of receiving data from MCPs.

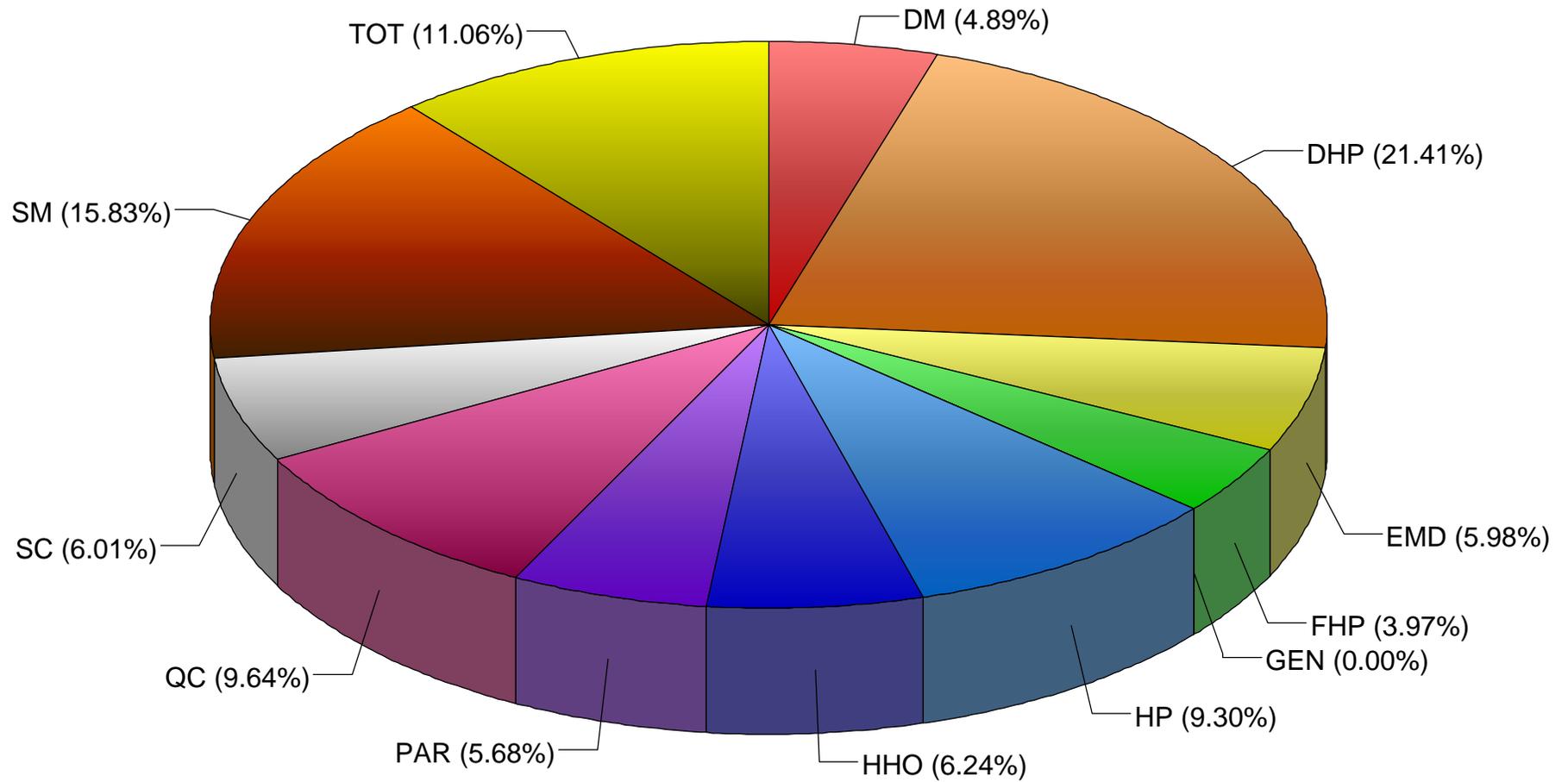
Note: Claims/1000 MM = Claims x 1,000 divided by member months for the period.

Please refer to the text for further information.

Source: ODHS, Bureau of Managed Health Care
5/4/1999 MHS

Statewide December 1998 Enrollment Status

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



Please refer to the text for further information.

Source: ODHS, Bureau of Managed Health Care
2/23/99 MHS

Statewide
July- December 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 Dec 1998	Avg. Monthly Enrollment	Avg. Monthly Voluntary Disenrollments	Avg. Monthly Voluntary Disenrollment Rate
DAYMED HMP INC	12,297	13,670	37.17	0.27 %
DAYTON AREA HEALTH PLAN	53,870	54,232	31.17	0.06 %
EMERALD HMO INC	15,050	14,889	58.17	0.39 %
FAMILY HEALTH PLAN	9,982	10,153	24.17	0.24 %
GENESIS HEALTH PLAN	0	98	0.33	0.34 %
HEALTH POWER HMO INC	23,399	24,303	109.83	0.45 %
HMO HEALTH OHIO	15,694	16,911	56.67	0.34 %
PARAMOUNT HEALTH CARE	14,303	14,294	15.67	0.11 %
QUALCHOICE	24,249	22,634	26.50	0.12 %
SUMMACARE	15,117	15,543	21.17	0.14 %
SUPERMED HMO	39,823	38,238	84.67	0.22 %
TOTAL HEALTH CARE	27,822	28,167	172.00	0.61 %

STATEWIDE TOTALS **251,606** **253,132** **637.50** **0.25 %**

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 total disenrollments for July- December 1998: 150,281
Statewide voluntary disenrollments for July- December 1998: 3,853

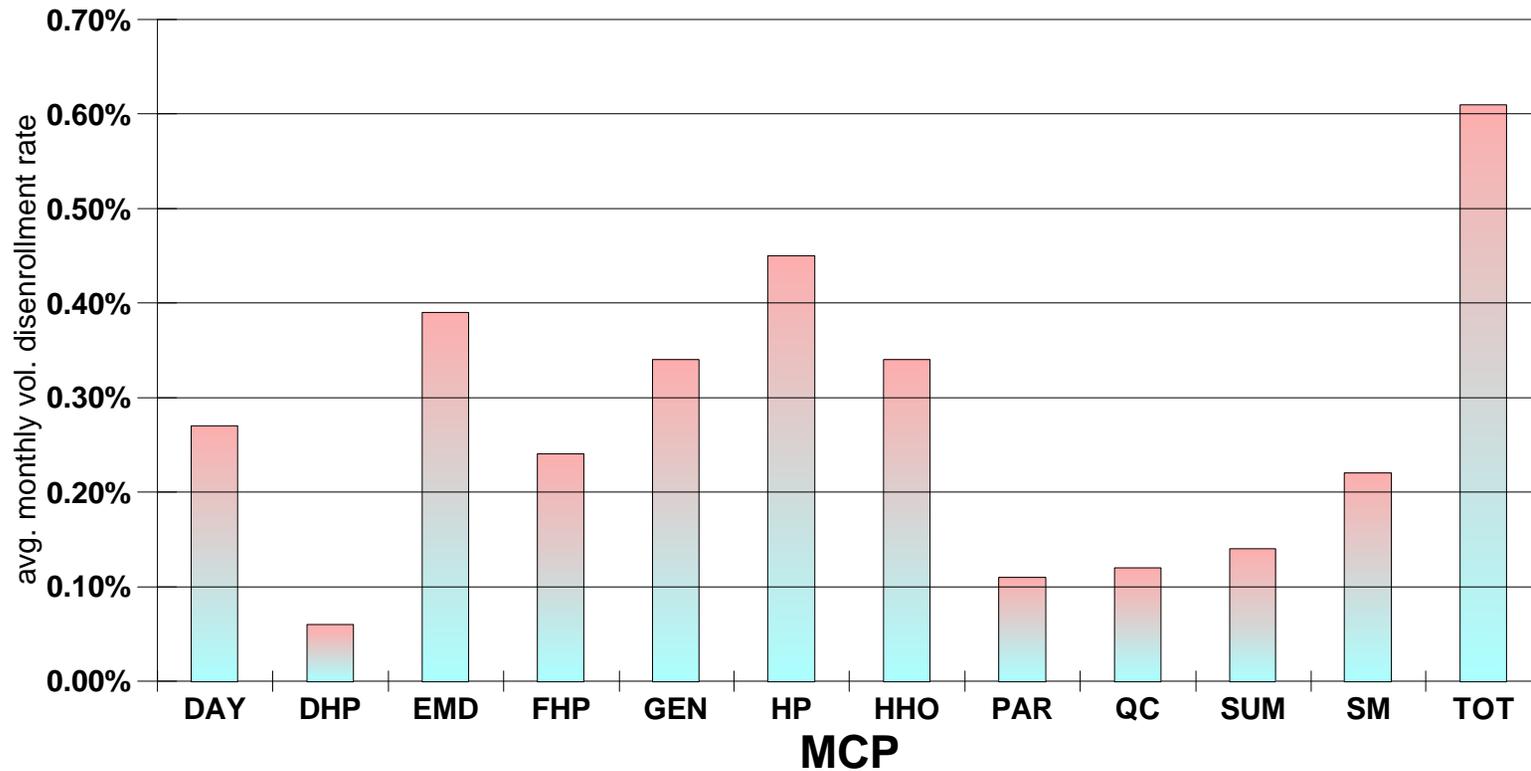
Please refer to the text for further information.

Statewide

July- December 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 monthly enrollment.



Please refer to the text for further information.

Source: ODHS, Bureau of Managed Health Care
3/5/99 MHS

Statewide July- December 1998

VOLUNTARY DISENROLLMENT REASONS

ODHS collects voluntary disenrollment information from the enrollment change forms completed by MCP members. Also, ODHS reports primary reasons for disenrollment as a percentage of each MCP's total voluntary disenrollments, as well as county and statewide percentages.

MCP	Avg. Monthly Voluntary Disenrollment Rate	Primary reasons for voluntary disenrollment									
		Provider not in plan	Physician left MCP	Assigned to plan	Extra Services of New MCP	Did not like provider	Denied services	Claim denied	Can't reach provider	Other	No reason
DAYMED HMP INC	0.06%	37.6%	0.0%	0.0%	2.3%	3.7%	0.4%	0.0%	7.4%	0.0%	28.2%
DAYTON AREA HEALTH PLAN	0.01%	15.9%	0.0%	8.7%	15.9%	7.2%	4.3%	0.0%	14.5%	0.0%	33.3%
EMERALD HMO INC	0.38%	42.9%	0.3%	1.7%	9.5%	8.5%	17.9%	7.4%	7.1%	0.6%	4.1%
FAMILY HEALTH PLAN	0.09%	37.2%	0.0%	0.0%	18.6%	9.3%	4.7%	0.0%	4.7%	0.0%	25.6%
GENESIS HEALTH PLAN	0.85%	0.0%	0.0%	0.0%	40.0%	0.0%	0.0%	0.0%	60.0%	0.0%	0.0%
HEALTH POWER HMO INC	0.06%	59.7%	0.0%	0.2%	12.3%	8.3%	2.4%	1.7%	13.0%	0.0%	2.4%
HMO HEALTH OHIO	0.05%	52.5%	2.5%	3.5%	10.4%	9.4%	3.0%	0.0%	5.9%	3.0%	9.9%
PARAMOUNT HEALTH CARE	0.11%	25.0%	0.0%	8.3%	8.3%	29.2%	0.0%	8.3%	4.2%	0.0%	16.7%
QUALCHOICE	0.14%	58.8%	0.0%	2.0%	6.5%	11.1%	15.7%	0.0%	2.6%	0.0%	3.3%
SUMMACARE	0.33%	31.0%	0.0%	0.0%	32.4%	1.4%	19.7%	7.0%	3.8%	0.0%	5.6%
SUPERMED HMO	0.05%	35.4%	0.0%	0.0%	7.3%	6.5%	9.8%	4.5%	3.0%	2.3%	31.2%
TOTAL HEALTH CARE	0.16%	38.7%	0.7%	5.7%	3.5%	16.5%	9.6%	5.7%	5.4%	2.2%	12.2%
Statewide Totals	0.25%	43.23%	0.43%	2.44%	10.10%	10.10%	8.35%	3.60%	6.73%	1.24%	13.81%

Average Voluntary Disenrollment Rate= Average monthly disenrollments divided by the average monthly enrollment.

MCP % = MCP specific number disenrolled/ MCP total rounded to the nearest tenth of 1%.

Please refer to the text for further information.

Statewide

July 1, 1998 - December 31, 1998

COMPLAINTS

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

MCP	Access	Quality	MCP Admn. Svcs.	Sat/Prov Svcs.	Billing Issues	Other	Total*	Remedial Action**	Complaints per 1,000 MM***
DayMed	2	0	1	0	0	0	3	1	0.037
Dayton Area Health Plan	5	0	4	0	4	0	11	7	0.034
Emerald HMO	5	0	1	0	0	0	6	2	0.067
Family Health Plan	0	0	1	0	1	0	2	1	0.033
HMO Health Ohio	5	1	1	0	0	0	6	2	0.059
Health Power HMO	2	0	0	0	1	0	3	1	0.021
Paramount Health Care	2	0	0	0	0	1	3	1	0.035
QualChoice Health Plan	1	0	0	0	0	0	1	0	0.007
SummaCare	2	0	1	0	0	0	2	2	0.021
SuperMed HMO	4	0	1	0	5	0	10	7	0.044
Total Health Care Plan	3	0	1	0	7	0	10	8	0.059
Statewide Totals	31	1	11	0	18	1	57	32	0.036

* 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 based on ODHS member month data; Complaints = Complaints x 1000 divided by Member Months.

Please refer to the text for further information.

Statewide

July 1, 1998 - December 31, 1998

GRIEVANCES

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

MCP	Access	Quality	MCP Admn. Svcs.	Sat/Prov Svcs.	Billing Issues	Other	Total*	Remedial Action**	Grievances per 1,000 MM***
DayMed	40	0	25	0	8	0	62	31	0.756
Dayton Area Health Plan	4	2	10	1	7	0	22	5	0.068
Emerald HMO	33	4	54	13	107	0	208	157	2.328
Family Health Plan	19	13	54	1	326	2	389	138	6.386
Genesis Health Plan of Ohio	0	0	0	0	1	0	1	1	1.706
HMO Health Ohio	37	6	23	0	357	4	425	286	4.189
Health Power HMO	11	6	9	1	30	1	51	13	0.350
Paramount Health Care	92	4	4	6	146	1	249	116	2.903
QualChoice Health Plan	36	0	2	0	176	2	216	103	1.591
SummaCare	128	29	326	20	493	82	1,037	652	11.120
SuperMed HMO	88	4	36	8	946	12	1,086	727	4.734
Total Health Care Plan	0	1	2	2	493	0	498	73	2.947
Statewide Totals	488	69	546	52	3,092	104	4,247	2,302	2.673

* Total may not equal the sum of the categories as a grievance 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.

*** Grievance calculation based on ODHS member month data; Grievances = Grievances x 1000 divided by Member Months.

Please refer to the text for further information.

Statewide

January- June 1998

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	108,719	149.56	119.23	47.71	41.63
DAYTON AREA HEALTH PLAN	358,761	228.54	299.28	53.55	49.30
EMERALD HMO INC	62,386	73.53	52.34	44.87	36.11
FAMILY HEALTH PLAN	68,169	106.66	74.10	18.16	27.01
GENESIS HEALTH PLAN	11,056	146.89	235.98	39.89	84.39
HEALTH POWER HMO INC	202,125	124.02	114.23	28.12	27.46
HMO HEALTH OHIO	114,162	165.70	56.37	28.71	70.18
PARAMOUNT HEALTH CARE	94,148	232.73	151.21	50.48	57.30
QUALCHOICE	130,438	91.13	141.21	37.32	55.86
SUMMACARE	77,838	137.71	375.02	34.40	22.95
SUPERMED HMO	238,609	150.54	53.71	36.53	57.09
TOTAL HEALTH CARE	167,890	275.36	143.17	29.83	32.87

Statewide Totals

1.634.301

166.55

158.80

39.02

45.53

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

Please refer to the text for further information.

Source: ODHS, Bureau of Managed Health Care

6/22/1999 MHS

Statewide

Periods Ending 12/31/1997 and 12/31/1998

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- Dec 1998 (x 1,000)	Net Worth @12/31/98	Enrollment @12/31/98	NWPM @12/31/98
DAYMED HMP INC	242	(\$1,922,840)	26,660	(\$72)	190	**	**	**
DAYTON AREA HEALTH PLAN	743	\$6,890,388	65,200	\$106	684	\$8,345,697	54,005	\$155
EMERALD HMO INC	62	(\$1,653)	31,074	(\$0)	151	\$2,043,411	39,055	\$52
FAMILY HEALTH PLAN	146	\$1,575,596	36,626	\$43	128	\$3,010,880	52,423	\$57
GENESIS HEALTH PLAN	25	\$1,748,045	3,904	\$448	12	\$1,805,264	3,761	\$480
HEALTH POWER HMO INC	398	\$577,350	31,663	\$18	317	(\$235,342)	25,685	(\$9)
HMO HEALTH OHIO	313	\$127,527,240	1,398,177	\$91	230	*\$11,876,784	173,870	*\$68
PARAMOUNT HEALTH CARE	203	\$5,867,818	101,937	\$58	180	\$4,390,722	116,515	\$38
QUALCHOICE	247	\$8,347,933	44,253	\$189	265	\$16,215,450	53,934	\$301
SUMMACARE	108	\$2,419,754	51,958	\$47	167	\$1,580,003	68,662	\$23
SUPERMED HMO	529	*	*	*	473	*	*	*
TOTAL HEALTH CARE	371	\$13,878,238	28,904	\$480	337	\$8,208,323	28,017	\$293
Statewide Average	282	\$13,908,989	151,696	\$92	261	\$3,780,367	251,606	\$161

*Due to a reorganization, SuperMed and HMO Health Ohio are now reported as one entity in all financial calculations.

**Complete financial details for DayMed Health Plan were not available for the period.

Note 1: As a result of financial difficulties, DayMed was subsequently placed into liquidation by ODI. ODHS terminated their provider agreement effective March 31, 1999.

Note 2: ODI subsequently revoked Health Power's license to operate as a managed care plan. ODHS terminated their provider agreement effective April 30, 1999.

Note 3: 12/31/97 and 12/31/98 data is from the ODI Financial Statement Calendar Year 1997 and 1998 respectively.

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
9/24/1999 MHS

Statewide July - December 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
QUALCHOICE	5	Failure to Attend Mandatory Meeting	CAP	
QUALCHOICE	5	Failure to Provide Language Assistance Services	CAP	
QUALCHOICE	5	Inaccurate Information Provided by 24 hr System	CAP	\$2,500.00
SUMMACARE	5	Failure to Submit Required Documentation	CAP	\$2,500.00
TOTAL HEALTH CARE	5	Untimely Submission of 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

July- December 1998

MCP ASSET TRANSFER

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

COUNTY	TRANSFEROR'S NAME	TRANSFeree'S NAME	DATE OF ENROLLMENT FREEZE	APPROVED TRANSFER DATE
Montgomery	Health Power HMO	DayMed	06/24/98	10/01/98
Hamilton	DayMed	Health Power HMO	06/24/98	10/01/98

Please refer to the text for further information