

**Ohio Medicaid  
Managed Care Plan  
1999 Statewide Progress Report**

**Ohio Department of Job and Family Services  
Bureau of Managed Health Care**

**STATEWIDE PROGRESS REPORT**

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## Ohio Medicaid Managed Care Program

The Ohio Department of Job and Family Services (ODJFS) (formerly Ohio Department of Human Services, 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. 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 for Covered Families and Children<sup>1</sup> 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

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<sup>1</sup> Program eligibles include Ohio Works First, Healthy Start and CHIP

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 twelve 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 all individual counties as well as statewide.)

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

### 1999 Statewide Summary

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 two from January 1999 to December 1999 and other MCPs left some counties of operation. As of December 1999, eleven plans were under contract to serve Medicaid enrollees in sixteen counties. This decline in the number

of plans serving 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.

By the end of the year, three mandatory enrollment counties (Butler, Hamilton, and Montgomery) became voluntary enrollment counties. This change in designation was made due to the withdrawal or termination of one or more MCPs from these counties. The total number of mandatory counties as of January 2000 was seven, with nine counties designated as voluntary.

Early in the year, the Ohio Department of Insurance (ODI) placed DayMed in liquidation. Health Power made the decision to self-liquidate its organization and, in both cases, ODJFS moved immediately to terminate the provider agreement with both MCPs 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.

In December, ODJFS sent notice to Total Health Care Plan (THCP) of its decision not to renew its provider agreement for Stark and Summit Counties. This proposed action was the result of noncompliance with a number of ODJFS program requirements. In February 2000 this action was extended for all THCP contracting counties. THCP appealed this decision and an administrative hearing has taken place. THCP continues to be responsible for serving their current enrollees and meeting contract requirements pending a final decision.

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

- (1) The prompt payment of claims requirement was added to the provider agreement effective March 1, 1999. As federally required, all MCPs must ensure that 90% of clean claims are paid within 30 days and that 99% of all clean claims are paid within 90 days of receipt, unless other contracted provisions have been agreed to. The BMHC closely monitors this requirement and has penalties for noncompliance.
- (2) The BMHC revised twelve Ohio Administrative Code rules for MCPs. Areas addressed included member services, enrollee rights, and MCP financial responsibility.
- (3) The BMHC, through an independent external quality review organization, conducted MCP administrative and clinical studies during the year using SFY 1998 data. Prior authorization, emergency department diversion, diabetes, and asthma care studies were performed.
- (4) ODJFS increased capitation rates paid to MCPs. This increase was based upon changes in case mix, a decline in the number of Medicaid Ohio Works First eligibles, and the impact of welfare reform.
- (5) In October, ODJFS released a Request for Proposals (RFP) to obtain proposals from MCPs interested in

operating in Butler, Cuyahoga, Franklin, Hamilton, and Montgomery Counties.

## **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 comply with the requirements throughout the contract period. Primary care provider (PCP) capacity and location must also meet minimum specifications. A provider database and Geographic Information System (GIS) 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.

*PCP Capacity was four times higher than the number of Medicaid eligibles.* Each PCP commits to a number of Medicaid eligibles when signing an MCP provider agreement. Summing this number across provider agreements gives the total capacity. The comparison of total capacity with the number of Medicaid eligibles is a strong indication of the access to PCPs. PCP capacity in each county remains well above the number of eligibles who could enroll, despite plan withdrawals.

*Over 90% of eligibles are within 10 miles of a PCP with capacity in most Medicaid managed care counties.* The geographical analysis of MCPs' PCP panels compares the location and capacity of PCPs to the location of all eligibles at a county level. The closer PCPs and their capacity are to the Medicaid eligibles, the better the access to primary care services. In addition, most MCP PCP provider panels have experienced reasonable turnover rates and few access related complaints and grievances have been filed by enrollees.

Three MCPs did experience relatively high PCP turnover rates. Emerald's turnover rate was due to the loss of two provider groups and a change in contracting arrangements. The realignment of SuperMed's provider panel resulted in a large number of provider deletions. For Total Health Care Plan, non-payment and late payment of claims resulted in providers terminating their subcontracts with the MCP. The BMHC monitors all MCPs' provider panels to ensure adequate numbers of providers and that panel composition requirements are being met.

*Plans are meeting and, in some instances, exceeding access related program requirements.* In addition to meeting program requirements, plans also provide access related services beyond those required by Medicaid fee-for-service. These include transportation for members to providers, extended visit times for providers, member educational materials, and issuance of a managed care plan identification card.

### **Consumer Satisfaction**

Tools used to assess consumer satisfaction include an independent consumer satisfaction survey, required managed care plan surveys, review of 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).

*Overall satisfaction of consumers improved with several MCPs receiving very high satisfaction scores according to preliminary survey results.* A draft version of the consumer satisfaction survey conducted on individuals enrolled in Medicaid MCPs during 1999 has been completed and the final report should be available in the fall of 2000.

*Voluntary disenrollments averaged less than 0.5% during 1999.* 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. MCP rates varied from .06% to 1.5%.

Two MCPs did experience disenrollment rates higher than those for other MCPs. Mediplan’s higher rate may have been due to enrollees disenrolling due to their limited provider panel. Total Health Care Plan’s (THCP) higher rate was most likely related to

poor performance in member satisfaction and the loss of several providers. This also explains THCP’s large number of PCP related requests for Just Cause. As CY 2000 began, the BMHC was monitoring THCP to ensure that enrollees have access to medical services while ODJFS pursues termination of THCP’s provider agreement.

*Grievances and complaints are also low, averaging fewer than three per 1000 member months.* The majority of grievances in 1999 reflected claims payment issues for five plans. This will be addressed in each MCPs’ performance improvement agreement (PIA).

The aforementioned findings indicate that consumer satisfaction with managed care enrollment continues to be high. Also contributing to enrollee satisfaction are enhanced member services provided by MCPs including member services telephone lines, internal grievance processes, member educational materials, and 24-hour lines that offer medical advice and direction.

### **Quality of Care**

Mechanisms to assess clinical quality of care include the annual external quality review, consumer satisfaction survey results, and utilization reviews. Complaints and grievances are also reviewed to assess the quality of care received through MCPs.

*The external quality review survey indicates MCP providers comply with appropriate antibiotic prescribing patterns 93% of the time.* In addition, the latest survey results (for services delivered in SFY 1998) found the average overall external quality review score for all MCPs to be 81% with individual scores ranging from 68% to a high of 88%. A clinical review of MCP case management activities revealed deficiencies which MCPs were required to address in their quality improvement plans (QIP). Case management will again be reviewed as part of the clinical study in 2000. Any areas of deficiency subject plans to specific quality improvement strategies monitored by Bureau of Managed Health Care staff.

*Utilization review indicates more appropriate use of medical services.* Aggregate utilization reports, which are self-reported semi-annually by MCPs, are also assessed as a quality indicator, especially in the key areas of physician visits, emergency room use, and inpatient utilization. For SFY 1999, primary care physician visits were 135 per 1000 member months; specialist visits were 123 per 1000 member months; inpatient days stood at 36 per 1000 member months; and emergency room visits were 58 per 1000 member months. Among a comparable FFS population during the most recently available reporting period (SFY 1998), inpatient days were 67 per 1000 member months and emergency room visits were 86 per 1000 member months. ODJFS compares utilization information with other indicators (such as encounter data and grievances) to identify patterns which may indicate problem areas.

PCP visits for two MCPs, Emerald and THCP, were low compared to other MCPs. Data integrity for Emerald may be an issue due to an internal system conversion and a loss of claims data from a specific provider. THCP also underwent a systems conversion and provider numbers decreased due to their termination with the MCP. As previously stated, the BMHC monitors these situations and assists enrollees, on an individual basis if necessary, to ensure that MCPs are providing access to care.

*Very low number of quality related complaints and grievances.* Quality related complaints and grievances reported by MCP enrollees were less than 0.95 per 1000 member months. Each quality related complaint or grievance received by the BMHC is reviewed by a nurse who follows up with the MCP.

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 while providing enrollees with quality related enhancements. MCPs provide over the counter medications, expanded vision benefits, reminder cards for preventive care (e.g., immunizations, well child visits), prenatal care incentive programs, health educational activities and materials, and health assessments for new members.

### **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.

Some plans have had difficulty achieving the encounter data reporting requirements, although only one was operating under a corrective action plan for volume of submissions as of December 1999. This indicates that MCP submission of encounter data is improving although questions remain regarding the reliability of the data first submitted by MCPs. Consistent with national and other states' experience, the BMHC expected that three years of data collection would be necessary to ensure data sufficiency and four to assure reliability.

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, ODJFS 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 ODJFS, 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 currently considered for Medicaid contracts, ODJFS does monitor MCP financial reports for signs of difficulties which could create access or quality concerns. As a partial indicator of financial stability, ODJFS established a measure of net worth per member (NWPM) for Medicaid contracting plans which is assessed annually. Any plan found to be below the standard is further reviewed and monitored for any indication of compromised quality or access. In addition, the BMHC will require, in late 2000, MCPs to meet two additional financial requirements. At a minimum, corrective action plans will be required from MCPs that fall below these annual financial standards.

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 1999, seven plans had points assessed, and three 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.

Performance Improvement Agreements (PIA) have been created for each MCP. These documents, mutually developed by both the

MCP and BMHC, serve as both an early warning system and an outline of activities the MCP can carry out to increase performance beyond minimum program requirements.

The ability of plans to perform administrative and reporting program requirements is a major contributor to value. While grievances and consumer satisfaction indicate no reason to suspect quality or access problems, the current uneven administrative performance among plans remains a major oversight challenge.

# Ohio Department of Job & Family Services

Office of Ohio Health Plans  
Bureau of Managed Health Care

# Quality Agenda

For Oversight and Assessment of  
Medicaid MCPs

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

## **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.

MCP abbreviations used in the following data reports:

DHP	Dayton Area Health Plan
EMD	Emerald HMO
FHP	Family Health Plan
GEN	Genesis Health Plan
HHO	HMO Health Ohio
MP	Mediplan
PAR	Paramount Health Care
QC	QualChoice
SC	SummaCare
SM	SuperMed HMO
THC	Total Health Care

# Statewide December 1999 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	Ratio of Capacity to Enrollment*	Ratio of Capacity to Eligibles*
Butler	784.33%	247.43%
Clark	784.27%	75.76%
Cuyahoga	1097.56%	977.73%
Franklin	296.97%	227.32%
Greene	3177.25%	103.47%
Hamilton	648.92%	125.29%
Lorain	652.91%	481.93%
Lucas	324.34%	291.93%
Mahoning	3513.68%	198.59%
Montgomery	367.19%	140.45%
Pickaway	1298.45%	96.76%
Stark	430.08%	344.73%
Summit	394.58%	339.24%
Trumbull	24941.86%	78.55%
Wood	443.80%	346.92%

**Statewide Average**

**678.01%**

**432.22%**

\* December 1999 figures

**Please refer to the text for further information.**

Source: ODHS, Bureau of Managed Health Care

2/6/2000 MHS

# Statewide

January - December 1999

## PCP TURNOVER RATE

Provider turnover rate is the ratio of the number of PCPs in the provider network on January 1, 1999 to the number no longer in the network on December 31, 1999.

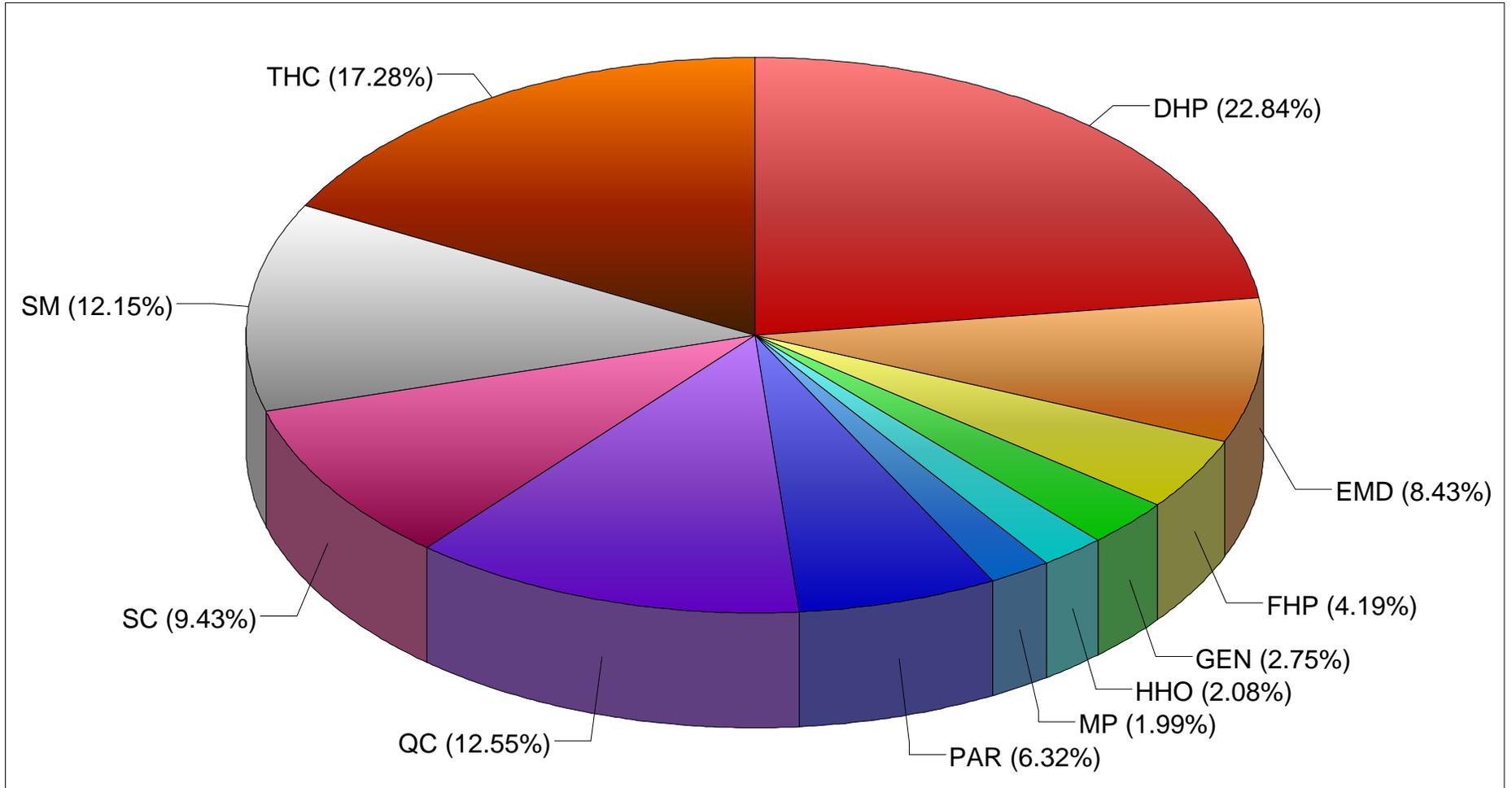
<b>MCP</b>	<b>PCP TURNOVER RATE</b>
DAYTON AREA HEALTH PLAN	8%
EMERALD HMO INC	24%
FAMILY HEALTH PLAN	7%
GENESIS HEALTH PLAN	17%
HMO HEALTH OHIO	16%
MEDIPLAN	13%
PARAMOUNT HEALTH CARE	8%
QUALCHOICE	13%
SUMMACARE	6%
SUPERMED HMO	24%
TOTAL HEALTH CARE	20%

**Statewide Average**

**15%**

# Statewide December 1999 Enrollment Status

The graph represents the eligible enrollment percentage for each MCP statewide as of December 1999.



Please refer to the text for further information.

Source: ODHS, Bureau of Managed Health Care  
12/17/99 MHS

# Statewide

January-December 1999

## 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 1999	Avg. Monthly Enrollment	Avg. Monthly Voluntary Disenrollments	Avg. Monthly Voluntary Disenrollment Rate
DAYTON AREA HEALTH PLAN	59,332	59,331	36.08	0.06%
EMERALD HMO INC	21,189	21,062	169.42	0.80%
FAMILY HEALTH PLAN	10,877	11,798	41.67	0.35%
GENESIS HEALTH PLAN OF OHIO	7,155	4,675	7.75	0.17%
HMO HEALTH OHIO	5,399	5,832	46.67	0.80%
MEDIPLAN	5,158	4,254	62.25	1.46%
PARAMOUNT HEALTH CARE	16,429	16,499	16.50	0.10%
QUALCHOICE	32,591	32,280	70.58	0.22%
SUMMACARE	24,502	22,825	79.75	0.35%
SUPER MED HMO	31,560	36,218	151.67	0.42%
TOTAL HEALTH CARE PLAN INC	44,879	42,072	507.33	1.21%
<b>STATEWIDE TOTAL</b>	<b>259,071</b>	<b>256,844</b>	<b>1,189.67</b>	<b>0.46%</b>

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

Average monthly disenrollment = Sum of the monthly 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 January-December 1999: 274,749

Statewide voluntary disenrollments for January-December 1999: 14,276

**Please refer to the text for further information.**

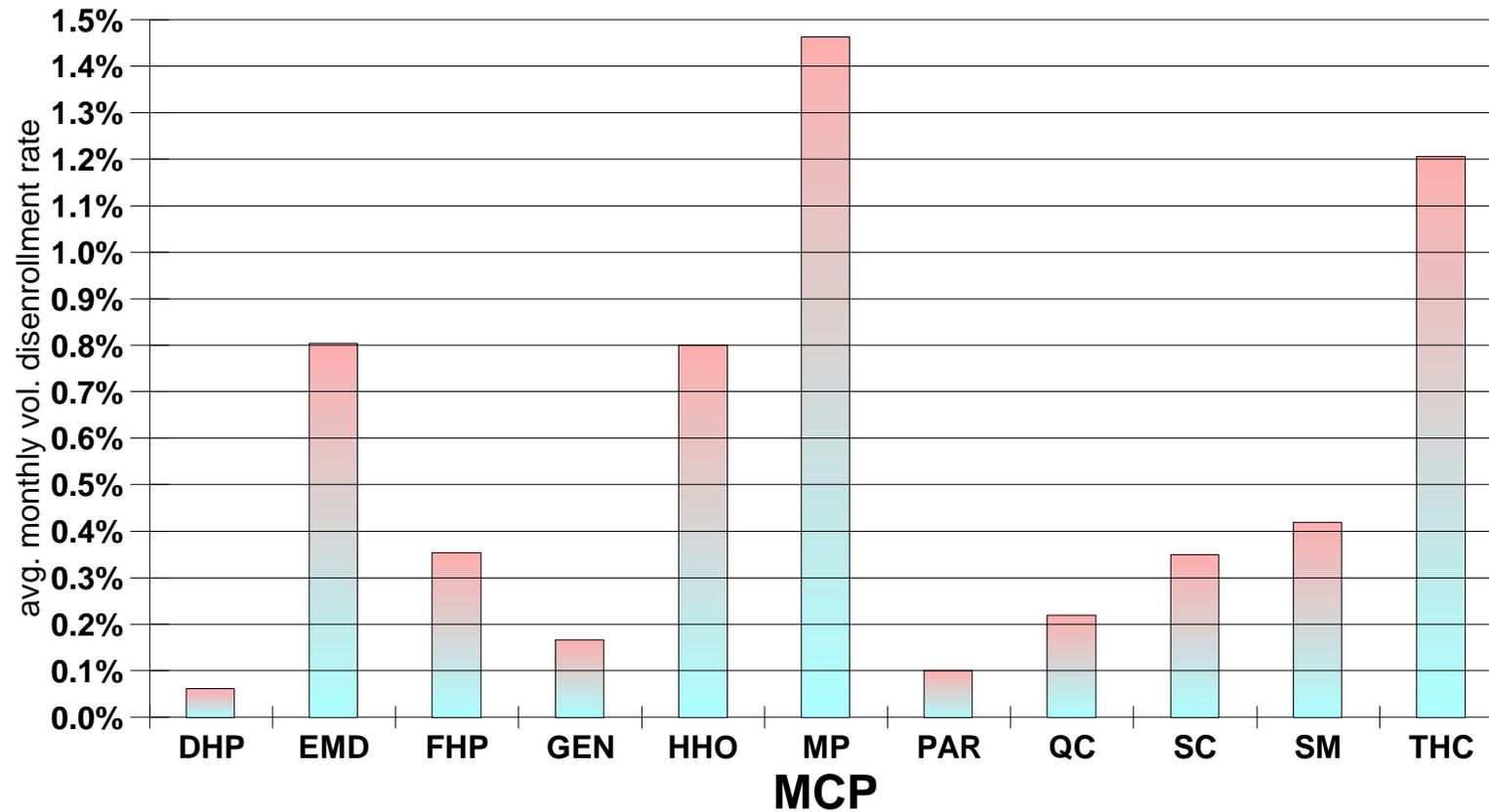
Source: ODHS, Bureau of Managed Health Care  
1/14/2000 MHS

# Statewide

January- December 1999

## 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.

# Statewide

## January-December 1999

# JUST CAUSE

Enrollees of Medicaid-serving MCPs who want to change their MCP outside of the initial month of enrollment must apply to ODHS for a Just Cause Disenrollment. The following is a summary of the Just Cause activity in 1999.

MCP	PCP left Panel	Primary Language	Special Medical Condition	Asst. Group Moved	Other	MCP Total per 1000 MMs	Approved	Denied	Denied/ Enrollment Changed
Dayton Area Health Plan	0	0	0	0	51	0.07	5	9	11
Emerald	30	0	3	1	226	1.03	102	53	26
Family HP	2	0	0	4	55	0.43	16	16	11
Genesis	0	0	0	0	59	1.05	14	14	9
HMO Health Ohio	2	0	1	0	105	1.54	23	28	19
MediPlan	0	0	1	0	111	2.19	28	18	20
Paramount	0	0	0	0	51	0.26	13	13	11
QualChoice	0	0	1	0	64	0.17	20	19	6
SummaCare	1	0	1	0	199	0.73	61	34	30
SuperMed	3	0	6	0	151	0.37	30	42	18
Total HP	380	0	9	0	665	2.09	499	191	103

<b>Statewide Totals</b>	<b>418</b>	<b>0</b>	<b>22</b>	<b>5</b>	<b>1737</b>	<b>0.90</b>	<b>811</b>	<b>437</b>	<b>264</b>
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\* Reasons represent those Just Cause applications received during the reporting period. Decisions represent Just Cause applications processed during the reporting period. As a result, decisions may not necessarily equal requests received.

**Please refer to the text for further information.**

Source: ODHS, Bureau of Managed Health Care  
01/26/2000 MHS

**Statewide**  
**January 1, 1999 - December 31, 1999**

## COMPLAINTS AND GRIEVANCES

ODHS reviews complaints and grievances in order to address concerns from enrollees and insure quality of service from MCPs.									
MCP	Access	Quality	MCP Admn Svcs.	Sat/Prov Svcs.	Billing Issues	Other	Total*	Remedial Action**	Complaints/Grievances Per 1,000 MM***
Dayton Area Health Plan	14	15	9	17	57	1	108	15	0.171
Emerald HMO	41	0	212	4	63	0	290	273	1.372
Family Health Plan	38	6	19	20	286	35	390	42	3.273
Genesis Health Plan of Ohio	6	1	10	1	1	3	16	10	0.409
HMO Health Ohio	14	1	5	0	290	2	311	74	4.646
MediPlan	55	0	1	6	55	8	95	43	2.603
Paramount Health Care	170	8	491	28	928	13	1,633	1,014	9.411
QualChoice Health Plan, Inc.	6	0	9	0	261	1	274	239	0.833
SummaCare	167	15	48	28	627	3	870	658	3.890
SuperMed HMO	67	17	22	4	1405	13	1,527	259	3.942
Total Health Care Plan	11	0	125	2	851	2	986	178	2.387
<b>Statewide Totals</b>	<b>589</b>	<b>63</b>	<b>951</b>	<b>110</b>	<b>4,824</b>	<b>81</b>	<b>6,500</b>	<b>2,805</b>	<b>2.380</b>

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

\*\*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/Grievance calculation based on ODHS member month data; Complaints/Grievances=Complaints/Grievancesx1000 divided by Member Months.

**Please refer to the text for further information.**

# Statewide

January-December 1999

## STATE HEARINGS

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

MCP	Reason for MCP Decision					Hearings Requested	Outcome			
	Member Months Jan -Dec 1999 (x 1,000)	No Referral	Non-ER Emergency	No Medical Necessity	Other		Abandoned	Withdrawn	Sustained	Overruled
DAYTON AREA HEALTH PLAN	712	0	0	0	0	0	0	0	0	0
EMERALD HMO INC	253	0	0	1	0	1	0	1	0	0
FAMILY HEALTH PLAN	142	3	5	1	1	0	0	0	0	0
GENESIS HEALTH PLAN	56	0	0	0	0	0	0	0	0	0
HMO HEALTH OHIO	70	74	2	16	11	0	0	0	0	0
MEDIPLAN	51	1	24	0	12	3	0	3	0	0
PARAMOUNT HEALTH CARE	198	0	0	1	3	0	0	0	0	0
QUALCHOICE	387	4	0	13	22	0	0	0	0	0
SUMMACARE	274	9	14	34	96	12	3	1	1	1
SUPERMED HMO	435	175	30	7	14	17	7	1	0	0
TOTAL HEALTH CARE PLAN	505	0	0	0	3	0	0	0	0	0
<b>Statewide Totals</b>	<b>3,082</b>	<b>266</b>	<b>75</b>	<b>73</b>	<b>162</b>	<b>33</b>	<b>10</b>	<b>6</b>	<b>1</b>	<b>1</b>

The totals for hearing requests and outcomes may not be equal, as outcomes can occur in a different reporting period than the request.

**Please refer to the text for further information.**



# Statewide

Periods Ending 12/31/98 and 12/31/99

## 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 1998 (x1,000)	Net Worth @12/31/98	Enrollment @12/31/98	NWPM @12/31/98	Member Months Jan-Dec 1999 (x1,000)	Net Worth @12/31/99	Enrollment @12/31/99	NWPM @12/31/99
DAHP	685	\$8,345,697	54,005	\$155	690	\$9,094,649	59,332	\$153
EMERALD	152	\$2,043,411	39,055	\$52	234	\$1,857,129	43,586	\$43
FHP	130	\$3,010,880	52,423	\$57	132	\$1,874,830	62,082	\$30
GENESIS	12	\$1,805,264	3,761	\$480	50	\$1,509,066	15,219	\$99
MEDIPLAN	x	x	x	x	288	\$3,955,121	24,146	\$164
MICO	641	\$11,876,784	173,870	\$68	493	\$15,013,356	165,139	\$91
PARAMOUNT	180	\$4,390,722	116,515	\$38	191	\$10,523,707	162,309	\$65
QUALCHOICE	270	\$16,214,450	53,934	\$301	363	\$19,415,397	63,826	\$304
SUMMA	173	\$1,580,003	68,662	\$23	252	\$4,638,684	71,974	\$64
THC	339	\$7,563,633	28,017	\$270	465	\$1,883,402	44,879	\$42
<b>Statewide</b>	<b>2,582</b>	<b>\$56,830,844</b>	<b>\$590,242</b>	<b>\$96</b>	<b>3,158</b>	<b>\$69,765,341</b>	<b>712,492</b>	<b>\$98</b>

\*Due to parent company organization, SuperMed and HMO Health Ohio are now reported as one entity in all financial calculations. 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  
08/21/00 RD

# Statewide January-December 1999 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.

MCP	Points	Category	Fine
DAYTON AREA HEALTH PLAN	5	Failure to comply with mandatory meeting requirements	
EMERALD HMO	5	Failure to provide enrollees with ID cards/new member packets in a in a timely manner.	
HMO HEALTH OHIO	5	Failure to provide enrollees with ID cards/new member packets in a in a timely manner.	
QUALCHOICE	5	Failure to submit provider panel deletions in a timely manner	
QUALCHOICE	5	Failure to submit required reports within ODHS required time frames (grievance report)	\$2,500
QUALCHOICE	5	Failure to submit required report within ODHS required time frames (newborn procedures)	\$2,500
QUALCHOICE	5	Failure to provide enrollees with ID cards or to provide alternative assistance for members with incorrectly logged addresses	\$5,000
QUALCHOICE	5	Failure to submit reports within ODHS required timeframes (encounter data report)	\$5,000
QUALCHOICE	5	Failure to issue member identification (ID) cards with Medicaid Management Information System(MMIS) billing number	\$10,000
QUALCHOICE	5	Failure to provide enrollees with ID cards/new member packets in a in a timely manner.	\$10,000
SUMMACARE	10	Failure to electronically accept & adjudicate non-pharmacy claims to final status by the May 1, 1999 deadline	\$2,500
SUMMACARE	0	Failure to meet requirements to electronically adjudicate non-pharmacy claims to final status	\$143,708*
SUPERMED HMO	5	Failure to provide enrollees with ID cards/new member packets in a timely manner.	
TOTAL HEALTH CARE PLAN INC	5	Failure to submit required reports/documentation within ODHS time frames	
TOTAL HEALTH CARE PLAN INC	5	Failure to provide interpreter services for LEP enrollees	\$2,500
TOTAL HEALTH CARE PLAN INC	5	Failure to submit CAP in a timely manner	\$2,500
TOTAL HEALTH CARE PLAN INC	0	Failure to meet Prudent Layperson Standard	
TOTAL HEALTH CARE PLAN INC	8	Failure to develop and implement written policies to ensure enrollees have and are informed of their rights to a state hearing	\$5,000
TOTAL HEALTH CARE PLAN INC	8	Failure to provide enrollees with ID cards/new member packets in a in a timely manner.	\$10,000
TOTAL HEALTH CARE PLAN INC	5	Failure to have an operational and accessible member service telephone lines within the county of operation during normal	\$10,000
TOTAL HEALTH CARE PLAN INC	5	Failure to submit reports within ODHS required timeframes (encounter data report)	\$15,000
TOTAL HEALTH CARE PLAN INC	5	Failure to attend a mandatory Joint Advisory Committee (JAC) in Franklin County	\$15,000
TOTAL HEALTH CARE PLAN INC	5	Failure to have an accessible member service line within the county of operation during normal business hours	\$15,000
TOTAL HEALTH CARE PLAN INC	8	Failure to have the toll-free 24 hr call in system operational and accessible	\$15,000
TOTAL HEALTH CARE PLAN INC	10	Failure to meet prompt payment requirements	\$15,000
TOTAL HEALTH CARE PLAN INC	5	Failure to submit required reports within ODHS required time frames (monthly progress reports)	\$15,000
TOTAL HEALTH CARE PLAN INC	5	Failure to provide member's in writing at least 30 days prior to the effective date of provider termination	
TOTAL HEALTH CARE PLAN INC	5	Failure to submit required reports within ODHS required time frames	
TOTAL HEALTH CARE PLAN INC	5	Failure to submit required reports within ODHS required time frames	
TOTAL HEALTH CARE PLAN INC	5	Failure to submit required reports within ODHS required time frames	

\* refundable fine

Note: All occurrences, points, and fines are assessed in conjunction with a request for a corrective action plan (CAP).