Office of Managed Care
Medicaid Consumer Dashboard
Q1 2019

Governor Mike DeWine | Lt. Governor Jon Husted | Director Maureen Corcoran

medicaid.ohio.gov

Introduction

The Ohio Department of Medicaid (ODM), Office of Managed Care, releases a quarterly consumer dashboard summarizing managed care plans' performance in key operational areas[1]. The purpose of this quarterly consumer dashboard is to visually depict plan performance across all the plans and at an individual plan level. The key areas displayed on the dashboard represent areas for which a compliance standard exists, which allows ODM to identify trends and systemic challenges that may need to be addressed. An explanation of each of the consumer dashboard element is listed below.

Dashboard Elements

Member Complaints: Members may choose to contact the Ohio Medicaid Hotline and submit a complaint about a managed care plan (MCP). Member complaints are tracked using the Healthtrack database developed by the Hotline vendor. Healthtrack does not include complaints submitted directly to an MCP by members.

Appeals: If a member's request for a service results in a denial, reduction, suspension or limited authorization, they may request that the MCP review the adverse benefit determination. This is known as an appeal. MCPs must resolve a standard appeal within fifteen calendar days[2] (see OAC 5160-26-08.4 and 5160-58-08.4). All appeals are resolved by the managed care plans and reported to ODM monthly. If an appeal to the MCP results in an unfavorable decision to the member, they have the right to request a state hearing.

State Hearings: A member may request a state hearing once they have exhausted the plan's appeals process (see 5160-26-08.4 and 5160-58-08.4). The Office of Managed Care reviews all state hearing requests to monitor, track, and trend all decision outcomes.
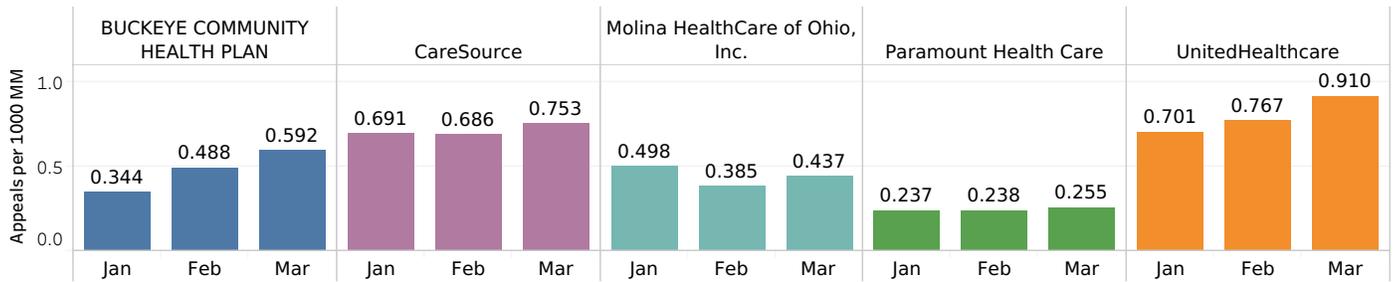
Conclusion

As stated above, the quarterly consumer dashboard does not represent the entire scope of monitoring and oversight activities conducted by ODM. Please see the Managed Care Plan Provider Agreement for specific contract requirements and associated compliance actions.

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[1] The quarterly dashboard contains information from the previous quarter due to the timing of available data elements.
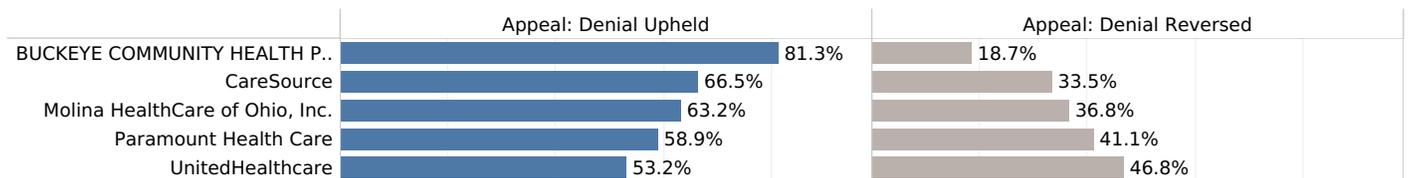[3] A member can ask for a quicker decision if their health condition requires it.

Appeals per 1000 MM

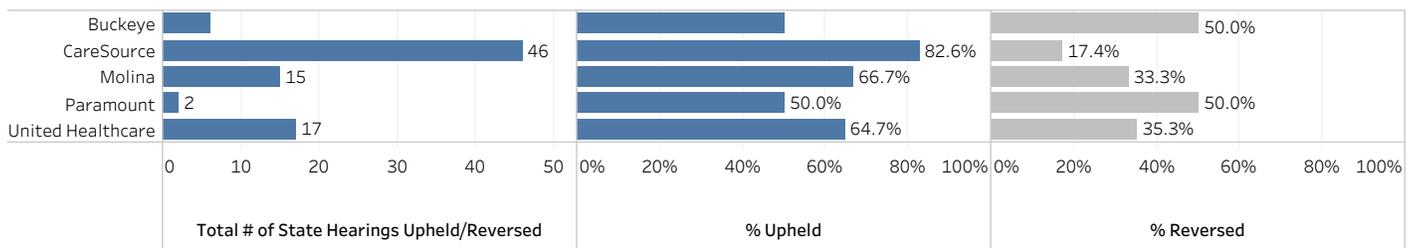|	BUCKEYE COMMUNITY HEALTH PLAN	CareSource	Molina HealthCare of Ohio, Inc.	Paramount Health Care	UnitedHealthcare
Jan	0.344	0.691	0.498	0.237	0.701
Feb	0.488	0.686	0.385	0.238	0.767
Mar	0.592	0.753	0.437	0.255	0.910

All data is Q1 2019. Data pulled and compiled 7/2019.

MM = Member Months. Calculated as # of Appeals*1000/Enrollment

Appeals to the Plan: Denial Upheld/Reversed

	Appeal: Denial Upheld	Appeal: Denial Reversed
BUCKEYE COMMUNITY HEALTH P..	81.3%	18.7%
CareSource	66.5%	33.5%
Molina HealthCare of Ohio, Inc.	63.2%	36.8%
Paramount Health Care	58.9%	41.1%
UnitedHealthcare	53.2%	46.8%

State Hearings: Plan Denial Upheld/Reversed

	Total # of State Hearings Upheld/Reversed	% Upheld	% Reversed
Buckeye			50.0%
CareSource	46	82.6%	17.4%
Molina	15	66.7%	33.3%
Paramount	2	50.0%	50.0%
United Healthcare	17	64.7%	35.3%

Member Complaints

MCP	Complaints per 1000		Billing	Dental Access	Enrollment Verification	Pharmacy	ID Card
	Total	MM					
Buckeye	24	0.027	7	2	3.0	7.0	3
CareSource	55	0.015	12	5	8.0	19.0	6
Molina	39	0.024	5	1	3.0	15.0	4
Paramount	27	0.037	5	2	0.0	13.0	7
United	27	0.032	2	1	0.0	15.0	3
Total	172		31	11	15.0	69.0	23

MM = Member Months. Calculated as # of member complaints*1000/Enrollment