Office of Managed Care

Medicaid Provider Dashboard

Q2 2020

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 provider dashboard summarizing managed care plans' performance in key operational areas[1]. The purpose of this quarterly provider 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 provider dashboard elements is listed below.

Dashboard Elements

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

Prior Authorizations: MCPs may require prior authorization for specific services. Either a member or a provider may request coverage for a service through the prior authorization (PA) process. MCPs are required to report information on all PA decisions rendered for their members. This includes PA requests for **all services**, including requests for services when the MCP is not the primary payer. For standard authorization decisions, plans must either approve or deny the request within **ten calendar days** and this is a standard that the Office of Managed Care would take compliance on if not met (see OAC 5160-26-03.1). Plans must approve or deny pharmacy authorizations within 24 hours for Medicaid managed care or 72 hours for MyCare Ohio. If a PA is denied, the member has the option to appeal to the MCP. Possible reasons why an MCP may deny a request could be due to lack of medical necessity or no medical documentation.

Prompt Pay: ODM monitors the MCPs claim processing activities to ensure ongoing compliance with prompt pay requirements. For Medicaid Managed Care Behavioral Health, plans must pay 90% of all submitted clean claims within 15 days of date of receipt and 99% of such claims within 60 days of the date of receipt. For the other categories of service listed below, plans must pay 90% of all submitted clean claims within 30 days of date of receipt and 99% of such claims within 90 days of the date of receipt.

Medicaid Managed Care

1. Nursing Facility
2. Pharmacy – Retail
3. All Services Excluding Nursing Facility and Pharmacy

MyCare Managed Care

1. Nursing Facility/Hospice Room and Board
2. Behavioral Health
3. Waiver Services
4. All Services Excluding Nursing Facility/Hospice, Behavioral Health, Waiver, Pharmacy

Conclusion

As stated above, the quarterly provider 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.

[1] The quarterly dashboard contains information from the previous quarter due to the timing of available data elements.

Ohio | Department of Medicaid

Medicaid Managed Care Provider Dashboard

Qtr	Year	Category of Service	Plan
Q2	2020	All	All

Prompt Pay: % Clean Claims Paid or Denied

	Behavioral Health	Dental	Emergency Services	Inpatient Hospital	Nursing Facility	Other Medical Services	Outpatient Facility Services	Pharmacy — Retail	Physician/ Professional Services	Rad/Path/Lab Services
Buckeye	4% / 96%	8% / 92%	2% / 98%	8% / 92%	7% / 93%	6% / 94%	3% / 97%	37% / 63%	5% / 95%	8% / 92%
CareSource	6% / 94%	21% / 79%	1% / 99%	12% / 88%	17% / 83%	13% / 87%	2% / 98%	32% / 68%	6% / 94%	10% / 90%
Molina	9% / 91%	12% / 88%	5% / 95%	14% / 86%	11% / 89%	8% / 92%	6% / 94%	19% / 81%	7% / 93%	8% / 92%
Paramount	8% / 92%	0% / 100%	7% / 93%	11% / 89%	30% / 70%	12% / 88%	11% / 89%	26% / 74%	16% / 84%	5% / 95%
United Healthcare	6% / 94%	0% / 100%	3% / 97%	9% / 91%	18% / 82%	14% / 86%	4% / 96%	0% / 100%	7% / 93%	13% / 87%

Time Period: Q2 2020. Calculation for % Paid: (# of Claims Paid 0-30 Days)/(Total Paid or Denied 0-30 Days)*100. Calculation for % Denied: (# of Claims Denied 0-30 Days/Total Paid or Denied 0-30 Days)*100

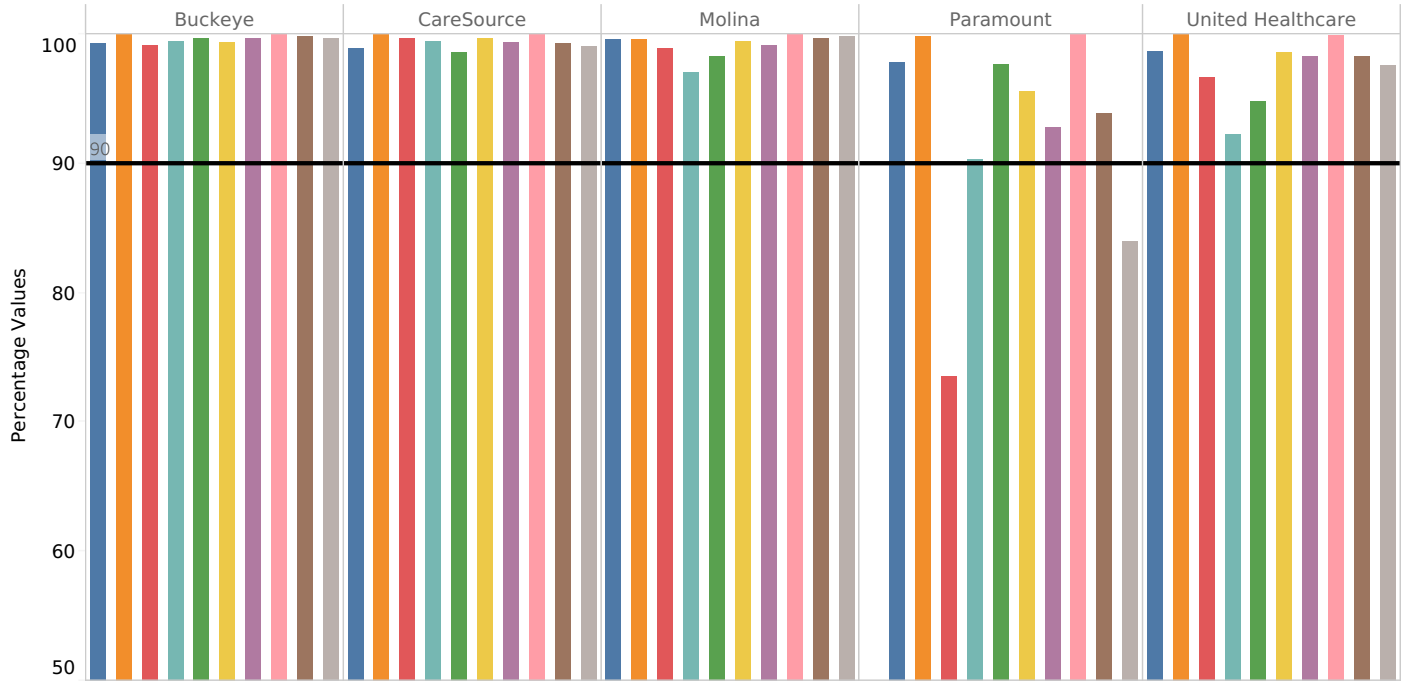
% Clean Claims Denied
% Clean Claims Paid

Prompt Pay: # of Claims by Status

Plan	Total Clean Paid or Denied Claims - 0-30 Days	Clean Pended Pended 91+ Days	Unclean Claims - 0-30 Days
Buckeye	3,709,413	58	36,203
CareSource	13,027,858	5,745	468,765
Molina	3,073,726	31	64,892
Paramount	1,965,438	1,537	39,649
United Healthcare	3,123,058	0	21,828
Grand Total	**24,899,493**	**7,371**	**631,337**

Qtr	Year	Category of Service	Plan
Q2	2020	All	All

Prompt Pay:
% Clean Claims Paid or Denied Within 30 Days



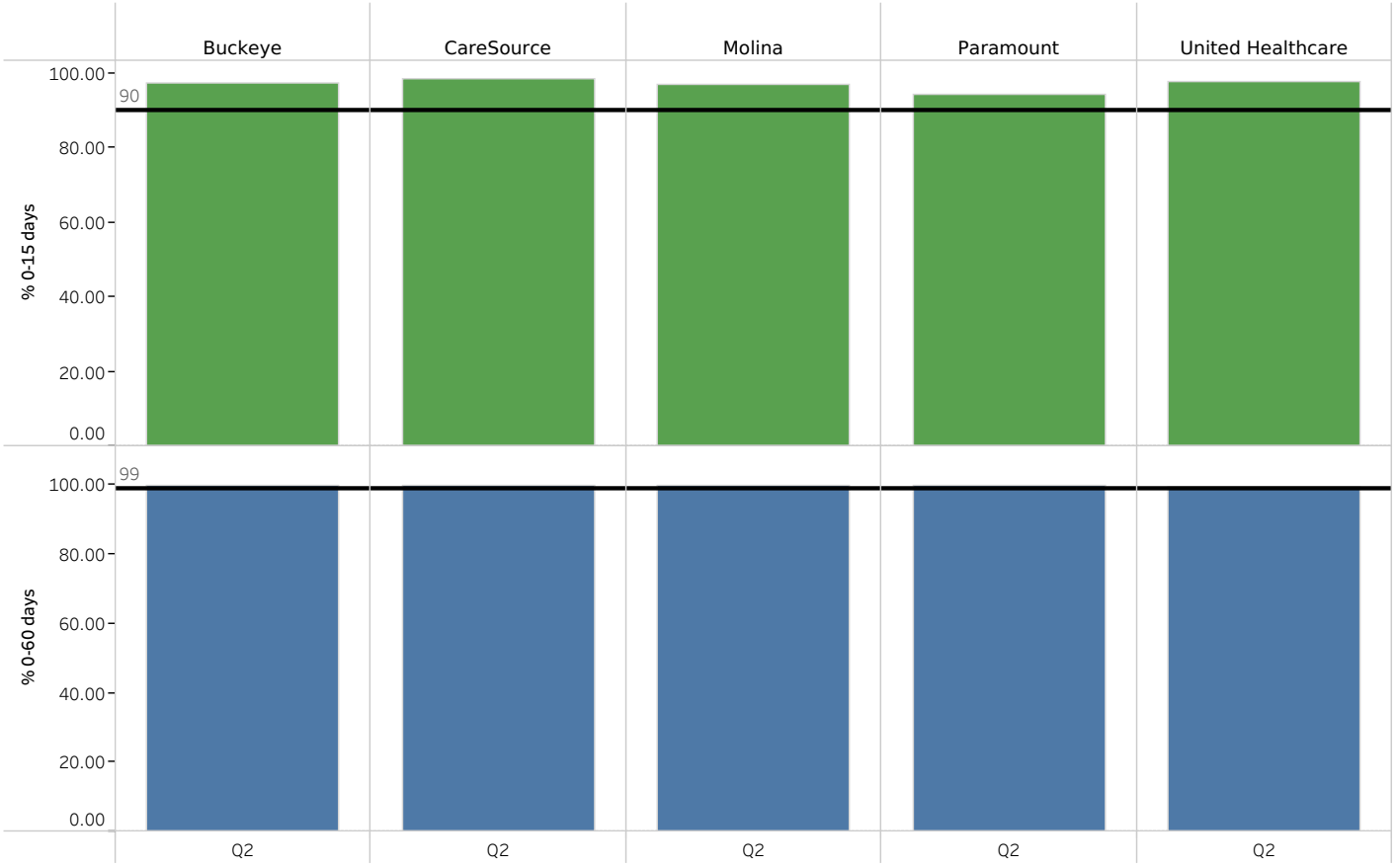
For the categories of service listed, plans must pay 90% of all submitted clean claims within 30 days of date of receipt: Nursing Facility, Pharmacy—Retail, Behavioral Health, and All Services Excluding Nursing Facility and Pharmacy

Category of Service

- Null
- Behavioral Health
- Dental
- Emergency Services
- Inpatient Hospital
- Nursing Facility
- Other Medical Services
- Outpatient Facility Services
- Pharmacy — Retail
- Physician/Professional Services
- Rad/Path/Lab Services

Qtr	Year	Category of Service	Plan
Q2	2020	Behavioral Health	All

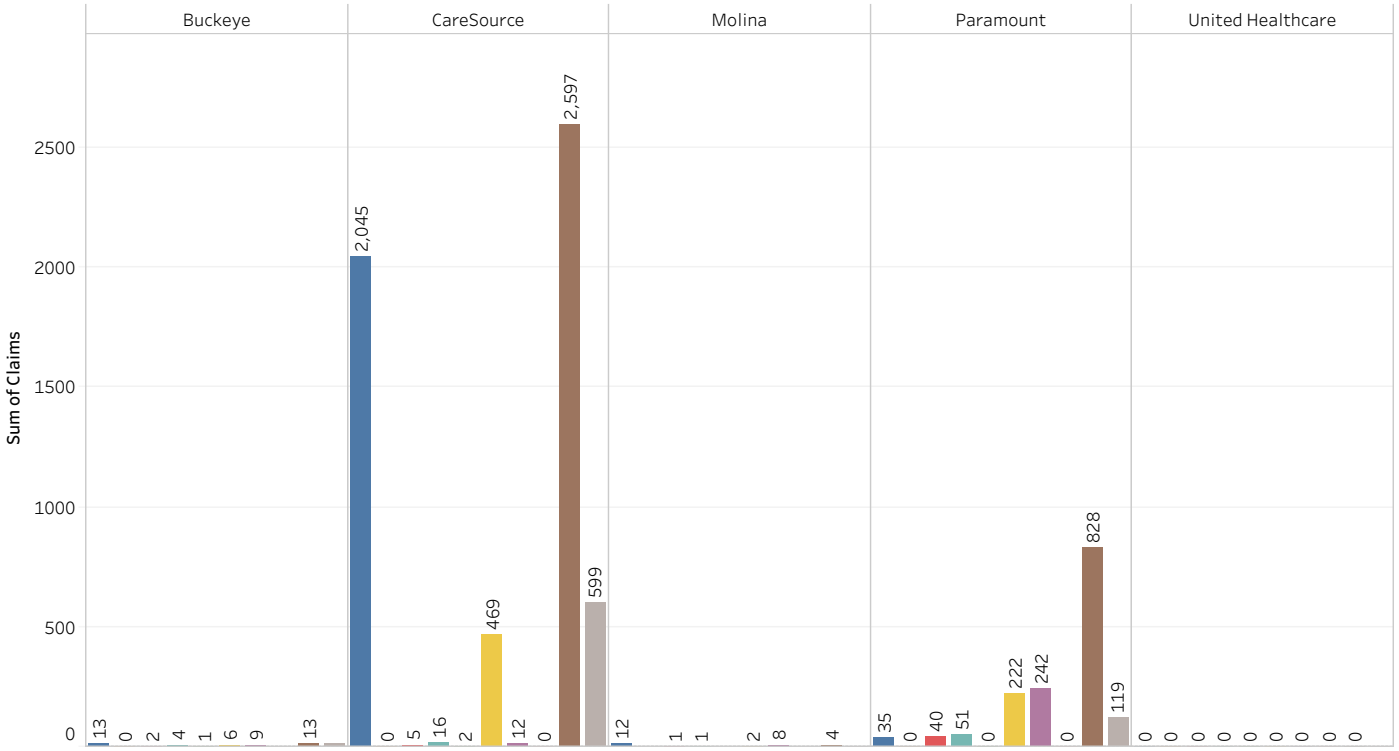
Behavioral Health:
% Clean Claims Paid or Denied Within 15 & 60 days



Begining July 1st 2019, Plans are required to pay or deny 90% of Behavioral health clean claims within 15 days and 99% within 60 days.

Qtr	Year	Category of Service	Plan
Q2	2020	All	All

Prompt Pay: Clean Pended Claims 91+ Days by Category of Service



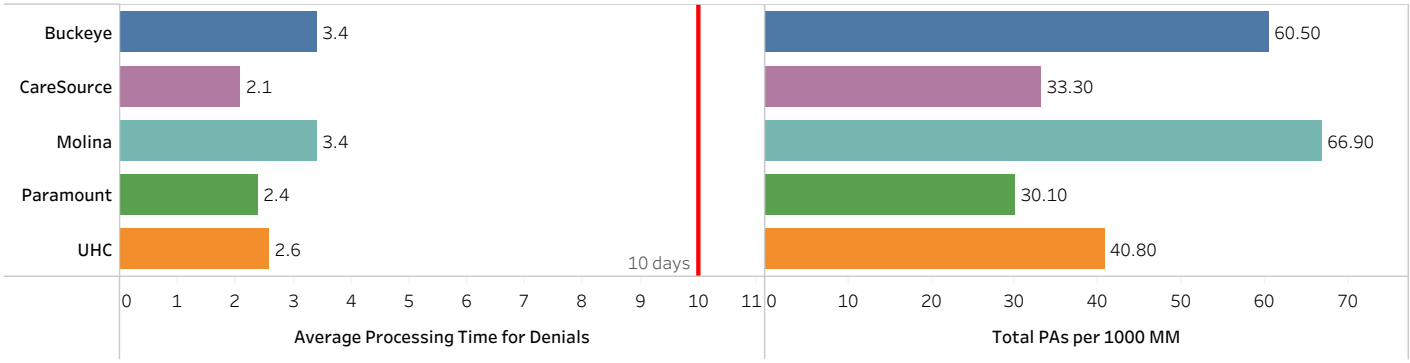
Pended claims are at a point in time and is constantly in flux

Category of Service

- Behavioral Health
- Dental
- Emergency Services
- Inpatient Hospital
- Nursing Facility
- Other Medical Services
- Outpatient Facility Services
- Pharmacy — Retail
- Physician/Professional Services
- Rad/Path/Lab Services

Prior Authorization

Average Processing Time for Denials and PAs per 1000 MM



Quarter
Q2

Year
2020

Plan
Multiple values

Approval %
Denial %

Prior Authorizations - % Approved/Denied

All data is Q2 2020. Data pulled and compiled 11/2020.
MM = Member Months. Calculated as # of prior auths denied*1000/Enrollment

Provider Complaints

MCP	Total	Complaints per 1000 MM	Communication Issues	Coverage/Service Denials	Eligibility Issue	Payment of Claims	Prior Authorization
Buckeye	245	2	5	19	3	203	9
CareSource	436	4	3	39	9	342	33
Molina	215	2	2	22	3	177	8
Paramount	166	2	5	12	4	129	8
United	207	2	3	27	6	165	5
Total	1,269		18	119	25	1,016	63

MCPs listed alphabetically and top 5 categories shown. Provider Complaints per 1000 providers are based on plans' reported network as of November 2020

Complaints per 1000 Providers: This calculation is the (# of complaints*1000)/(number of providers contracted for Q2 2020)