OHCA
OHIO HEALTH CARE ASSOCIATION

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Managed Care and the LTSS Population

Maintaining Legislative Authority. The Administration is moving forward - without legislative approval - on a plan to move all Medicaid long-term services and supports (LTSS) recipients into managed care (MLTSS) on July 1, 2018. This plan initially would apply to the 59, largely rural counties that are not participating in MyCare Ohio. The MyCare areas eventually would be folded in.

MyCare is an experimental federal program running through December 31, 2019. Its purpose is to test managed care for dual-eligible beneficiaries (those eligible for both Medicare and Medicaid). MyCare is, in part, a MLTSS program. It covers Medicaid LTSS, so it is instructive for the new MLTSS proposal, but MyCare covers both non-LTSS consumers ("community well"), who make up 55% of the total, as well as LTSS consumers (26% on Medicaid waivers, 19% in skilled nursing centers). MyCare covers both Medicare and Medicaid services, while MLTSS would be strictly Medicaid.

The House of Representatives voted in House Bill 49 to delay implementation of MLTSS so a stakeholder committee, chaired by legislators, can study whether it is appropriate for Ohio's LTSS population. This is very much an open question, as discussed below. The final decision would be made by the legislature, ensuring *legislative authority* over this important policy change.

The House amendment is supported by all players in the LTSS arena, except for the Administration and the managed care organizations (MCOs).

As an experiment, MyCare has more than 2 1/2 years yet to run. The formal evaluations of the demonstration program required by both the federal government and state law are far from completed. While the state and the MCOs have produced some preliminary data on MyCare, the data are not applicable to LTSS.

On the other hand, a recent survey of OHCA members with more than 300 respondents shows they feel overwhelmingly that MyCare is unsuccessful in every dimension measured. Ninety-five percent of respondents recommend against expanding MLTSS. The survey results are attached, including the unedited comments of more than 100 respondents who took the time to enter their written thoughts.

In their MLTSS proposal, not only does the Administration want to take away the legislature's authority to decide if managed care is good for the LTSS population, they also want to remove the legislature's authority over skilled nursing facility (SNF) rates. Instead of being determined by statute, rates would be set by the MCOs.

The Administration claims MCOs will pay some providers higher rates, but those examples relate to hospitals that have extraordinary bargaining power. In the LTSS world, MCOs almost always pay rates below fee-for-service unless they are mandated to comply with a rate floor, as is the case now in MyCare.

"$184-Million" Issue. Members of the Administration have suggested that the House budget "opens a hole" by counting savings from delaying MLTSS. The House counted savings of $184 million state share, *but these savings are real and do not open a budget hole*.

The As-Introduced budget for State Fiscal Year (SFY) 2019 included in the requested Medicaid appropriation a significant ($493 million all funds, $184 million state share) one-time cost for implementing MLTSS.[1] Because the House eliminated the MLTSS expansion in SFY 2019, *the cost will not be incurred* in that year and should not be budgeted. Accordingly, the House removed the $184 million in state share from the Medicaid "525" line item for SFY 2019.

So long as the MLTSS expansion does not occur in SFY 2019, there is no budget hole.

In the As-Introduced version, the Administration also proposed to accelerate collection of the new MCO tax ("HIC tax") to move a portion of the revenue into SFY 2019. They applied this revenue to offset the cost of the MLTSS initiative. The House left this Administration proposal in the budget, although the revenue now offsets other Medicaid expenditures.

Savings. The MCOs and the Administration claim MyCare Ohio is saving money, but provide no supporting detail, merely an undocumented statement from the MCOs that they reduced SNF utilization by 4%. This assertion lacks foundation because SNF utilization has been declining anyway, as Director Moody pointed out in his Senate Finance testimony.[2]

The Administration provided nothing about actual MCO spending on SNFs, nothing showing that MyCare actually lowered utilization more than what otherwise would have occurred (e.g., no comparison with non-MyCare counties), and nothing on the MCOs' performance on the detailed "rebalancing" measures required in their contracts. In fact, the OHCA survey found that 44% of respondents feel MyCare does *less* to reduce SNF utilization than the previous system and 51% feel there is no difference.

In sum, there is no evidence that MyCare saves anything on LTSS.

[1] Office of Health Transformation, "Improve Care Coordination" white paper, http://www.healthtransformation.ohio.gov/LinkClick.aspx?fileticket=jzS3YBvEFIw%3d&tabid=254, Table 1, page 6.
[2] http://www.healthtransformation.ohio.gov/LinkClick.aspx?fileticket=4YYF6XJp3Rk%3d&tabid=136, sides 18-20.

Director Moody testified that MCO capitation rates declined 6.8% over two years, after starting at a point *above* fee-for-service, but provided nothing showing a connection to LTSS costs other than the questionable SNF utilization argument discussed above. As the majority of MyCare beneficiaries are not in LTSS, there could be many reasons for the capitation rate reduction.

HEDIS Measures. The Administration and the MCOs provided HEDIS and CAHPS measures on the MyCare MCOs. These measures *do not apply* to Medicaid LTSS, the target of the new proposal. They apply to the community-well population and to Medicare (e.g., physician) services. The organizations that develop HEDIS and CAHPS both have LTSS-specific products, but MyCare does not use them.

Nine of the 25 contractually-required quality measures for MyCare apply to LTSS. *None of them have been reported.* A valid way of assessing whether MLTSS is a good idea would to compare results on LTSS-specific measures between MyCare counties and non-MyCare counties. No such comparison data have been provided to date, but this would be one of the things the study committee would review after it becomes available.

The Administration and the MCOs also suggest that MyCare specifically improves the quality of LTSS, but again, they have provided no data to support that notion. The statement, relative to SNFs, that they are paid the same under fee-for-serviced regardless of quality is not true. There has been a statutory quality component to the rate for a decade, most recently revised in the last budget.[3]

Care Coordination. For decades, Ohio's existing LTSS system has featured care management and coordination. SNFs and assisted living communities manage their patients' and residents' care through assessments and care planning per regulatory requirements. The area agencies on aging and CareStar do the same for Medicaid-waiver consumers.

The MCOs only duplicate these systems in a less-effective way, they do not add value. The Department of Medicaid's (ODM's) MyCare progress report says 82% of MyCare consumers get health-risk assessments and 74% have care plans, but in LTSS under the pre-existing system, 100% of consumers already have assessments and care plans, prepared by staff who know the individuals.

ODM's report also offers a few anecdotal accounts relating to care coordination. Like the HEDIS measures, the examples of care coordination are of community-well individuals and primarily Medicare services.[4] For LTSS, 81% of OHCA survey respondents rated MCO care coordination as

[3] See Revised Code section 5165.25, entitled "Determination of per medicaid day quality rate," http://codes.ohio.gov/orc/5165.25v1.

[4] The only exception is the story about relocating patients from a SNF. The parties disagree about the actual role of the MCOs in the process, compared to those of the facility, state, and AAA personnel.

not adding value. In fact, the MCOs even can impede care by delaying or denying prior authorization or limiting available providers (see comments to OHCA survey, pages 18-29).

Prompt Payment. The Administration's subcommittee testimony included graphs showing the percentage of "clean claims" that the MyCare MCOs pay within 30 and 90 days, but payment under fee-for-service occurs in 7-10 days. The 90%-within-30-days standard means 10% of claims can be extended beyond 30 days. Moreover, the graphs do not show the considerable numbers of claims the MCOs consider "unclean" even though they were billed under standard billing protocols. MCOs also can manipulate when they deem claims "received" and "paid," which invalidates the data (e.g., one MCO considers claims paid on Saturday, but providers do not receive the money until Wednesday or Thursday).

More than four-fifths of the respondents to OHCA's survey are dissatisfied with timeliness of MyCare payments and with payment accuracy (that is, MCOs paying incorrect rates, making incorrect deductions, etc.). Seventy-seven percent report days sales outstanding have been extended by 30 days or more.

Conclusion. There is no reason for a "rush to judgment" on a question that has such a profound impact on Ohio's most vulnerable citizens, just to meet an artificial deadline of July 1, 2018. The House bill creates a rational process for evaluating the lessons of the MyCare Ohio experiment and other relevant information before the legislature makes this important decision.

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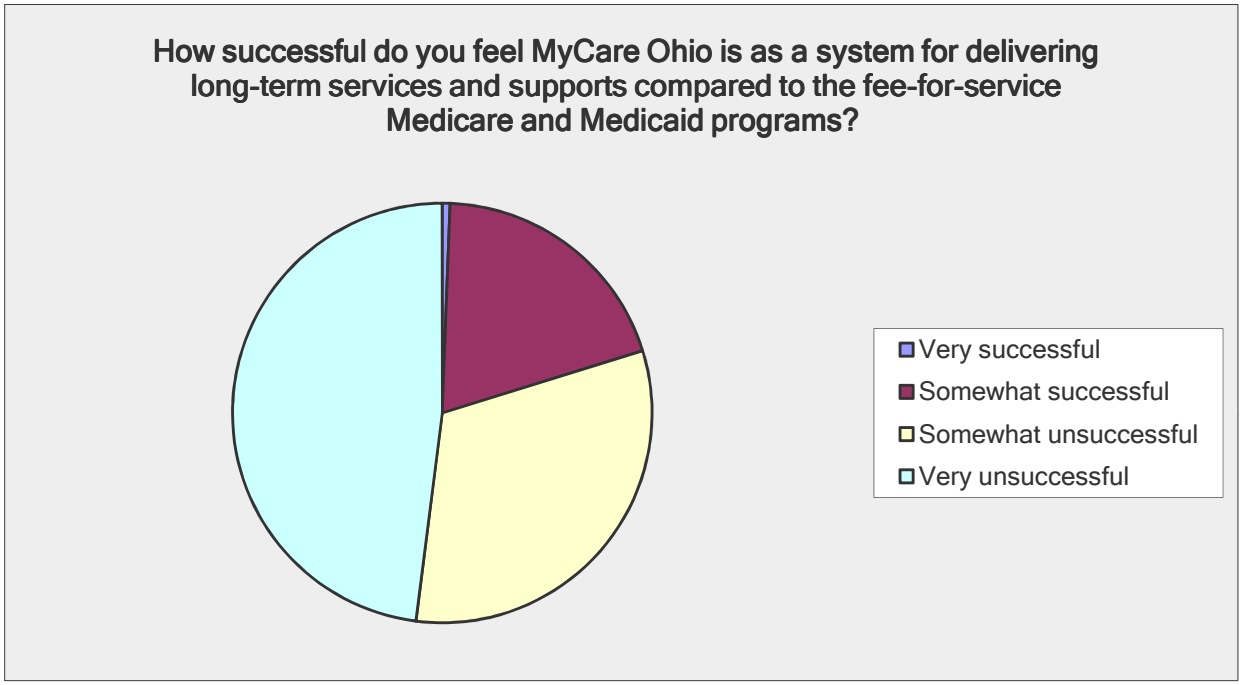
Membership Survey on MyCare Ohio

May 2017

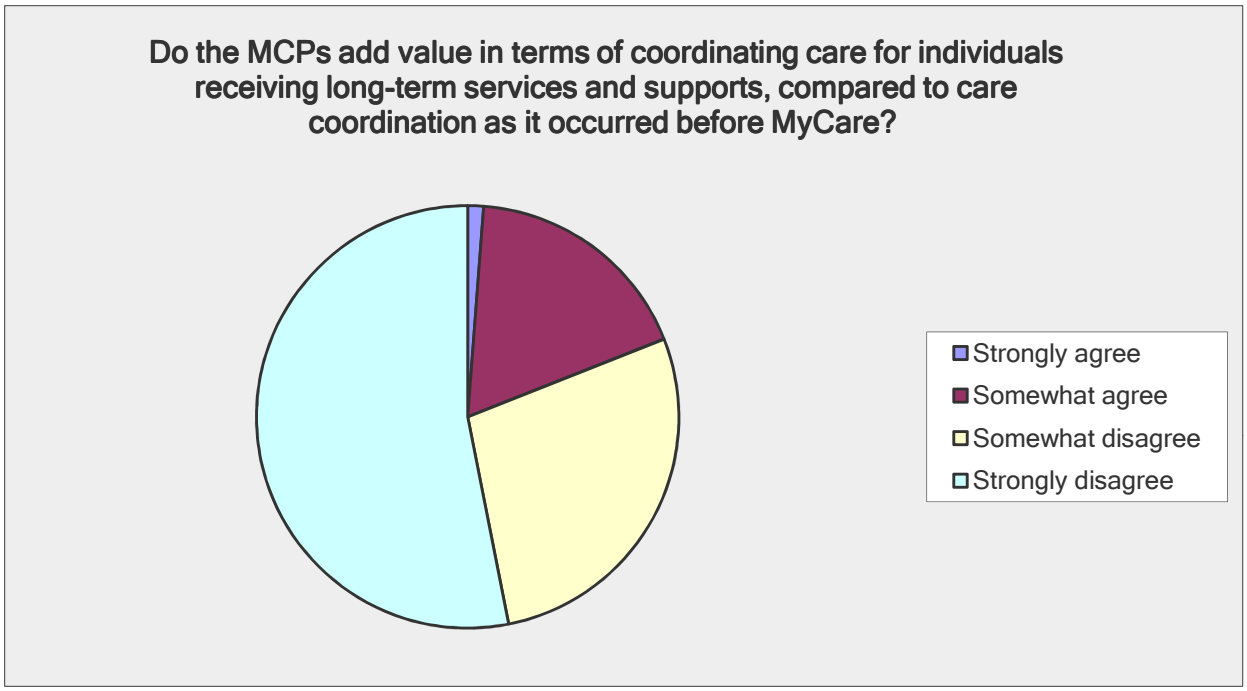
MyCare Ohio Questionnaire

How successful do you feel MyCare Ohio is as a system for delivering long-term services and supports compared to the fee-for-service Medicare and Medicaid programs?		
Answer Options	**Response Percent**	**Response Count**
Very successful	0.6%	2
Somewhat successful	19.6%	64
Somewhat unsuccessful	31.8%	104
Very unsuccessful	48.0%	157
	answered question	327
	skipped question	12



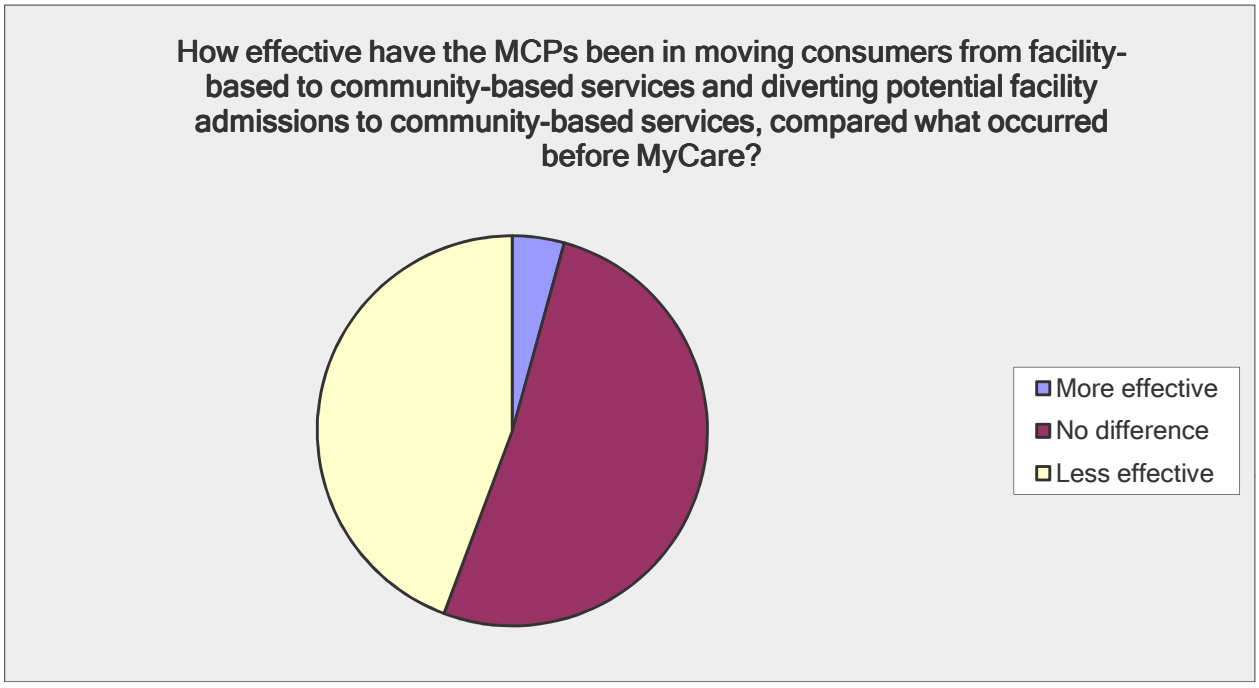
MyCare Ohio Questionnaire

Do the MCPs add value in terms of coordinating care for individuals receiving long-term services and supports, compared to care coordination as it occurred before MyCare?		
Answer Options	**Response Percent**	**Response Count**
Strongly agree	1.2%	4
Somewhat agree	17.8%	58
Somewhat disagree	27.9%	91
Strongly disagree	53.1%	173
	answered question	**326**
	skipped question	**13**



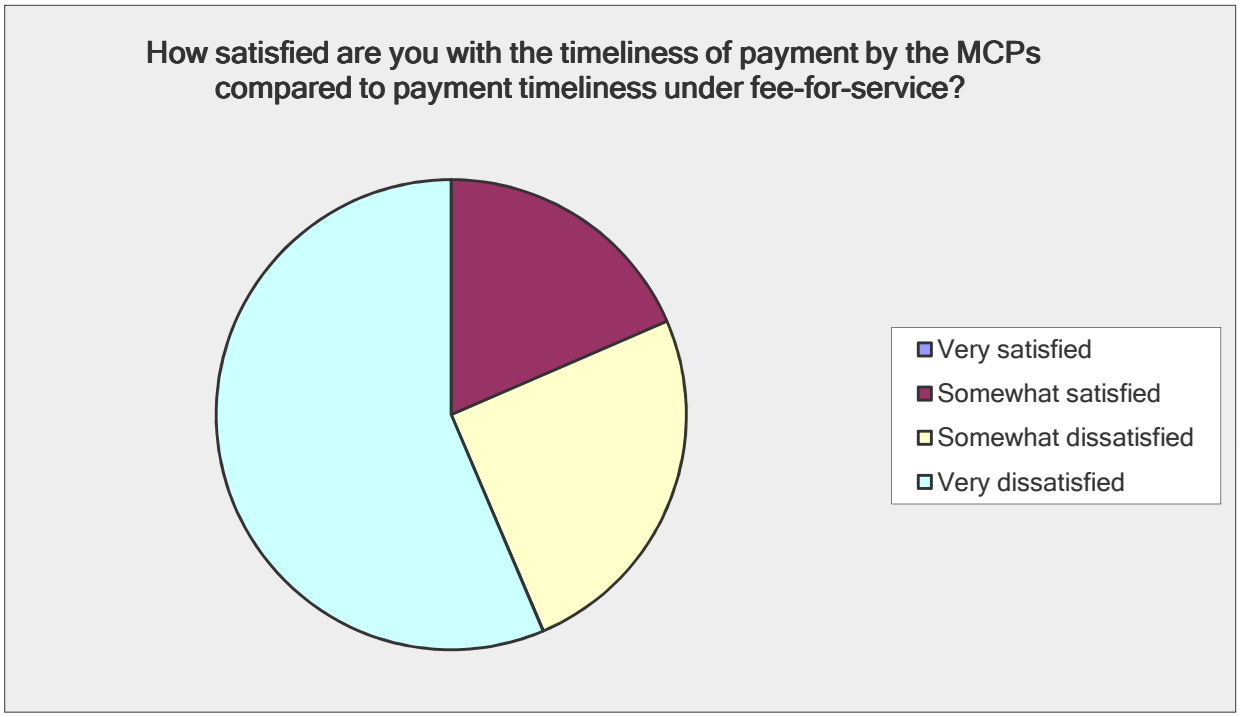
MyCare Ohio Questionnaire

How effective have the MCPs been in moving consumers from facility-based to community-based services and diverting potential facility admissions to community-		
Answer Options	**Response Percent**	**Response Count**
More effective	4.3%	14
No difference	51.4%	167
Less effective	44.3%	144
	answered question	**325**
	skipped question	**14**



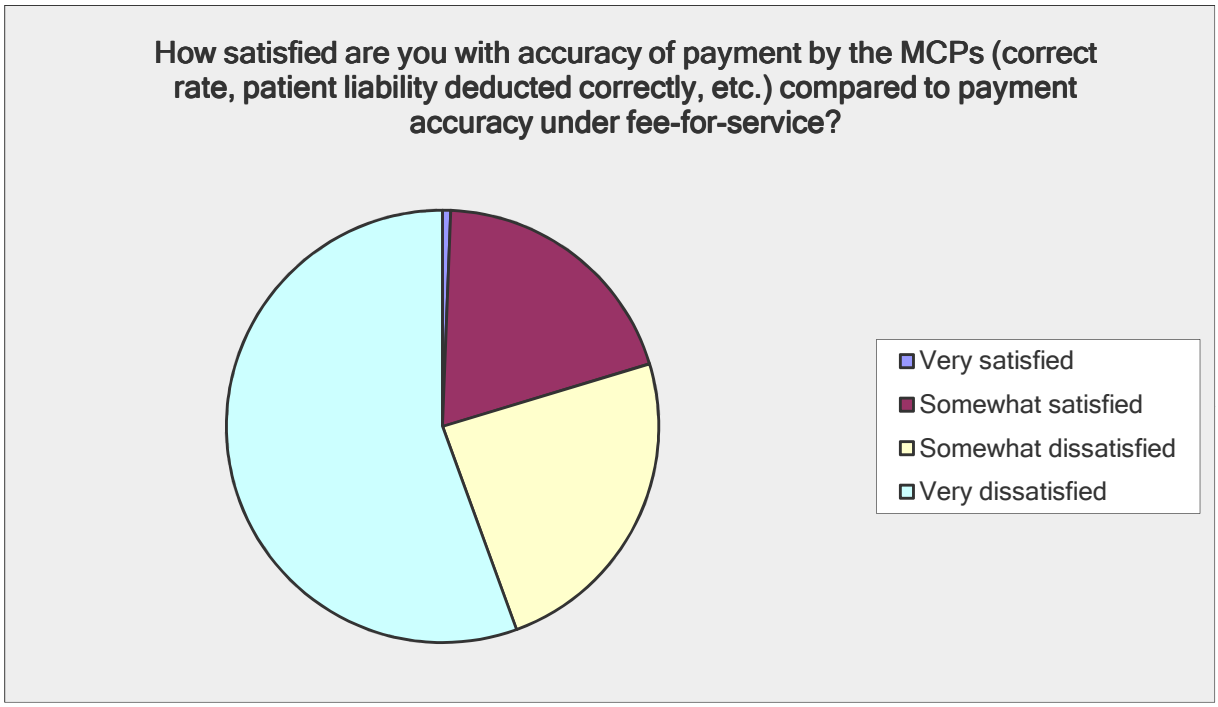
MyCare Ohio Questionnaire

How satisfied are you with the timeliness of payment by the MCPs compared to payment timeliness under fee-for-service?		
Answer Options	**Response Percent**	**Response Count**
Very satisfied	0.0%	0
Somewhat satisfied	18.5%	59
Somewhat dissatisfied	25.1%	80
Very dissatisfied	56.4%	180
	answered question	**319**
	skipped question	**20**



MyCare Ohio Questionnaire

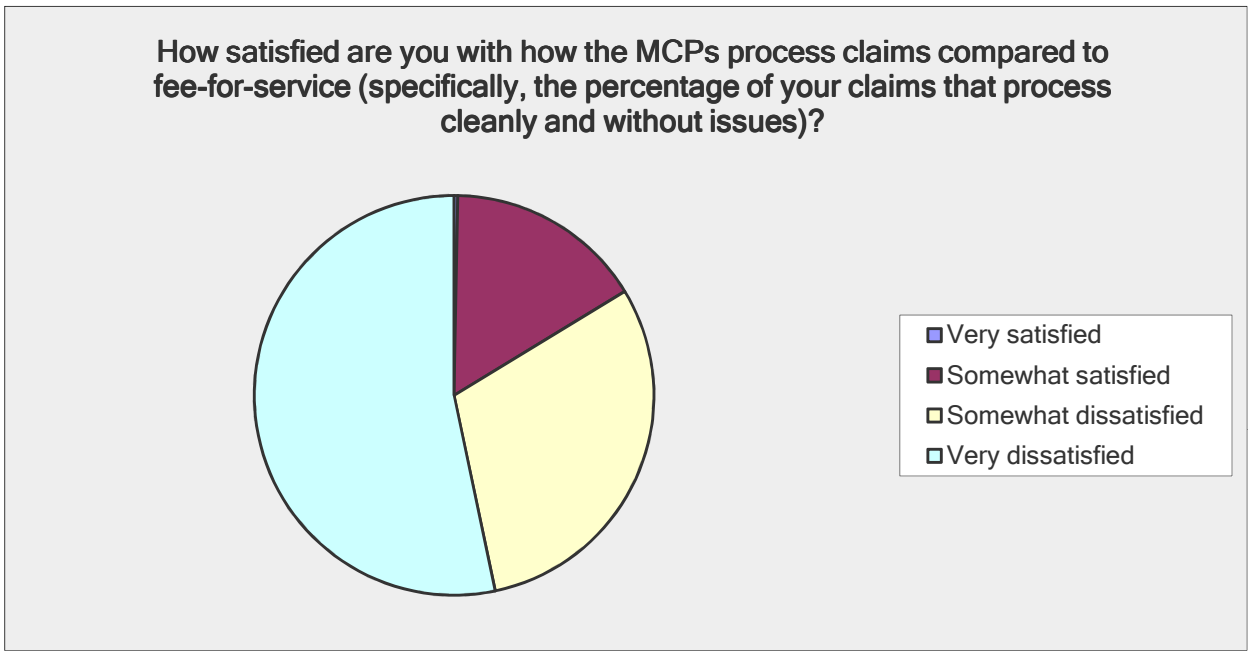
How satisfied are you with accuracy of payment by the MCPs (correct rate, patient liability deducted correctly, etc.) compared to payment accuracy under fee-for-service?		
Answer Options	**Response Percent**	**Response Count**
Very satisfied	0.6%	2
Somewhat satisfied	19.7%	63
Somewhat dissatisfied	24.1%	77
Very dissatisfied	55.5%	177
	answered question	**319**
	skipped question	**20**



MyCare Ohio Questionnaire

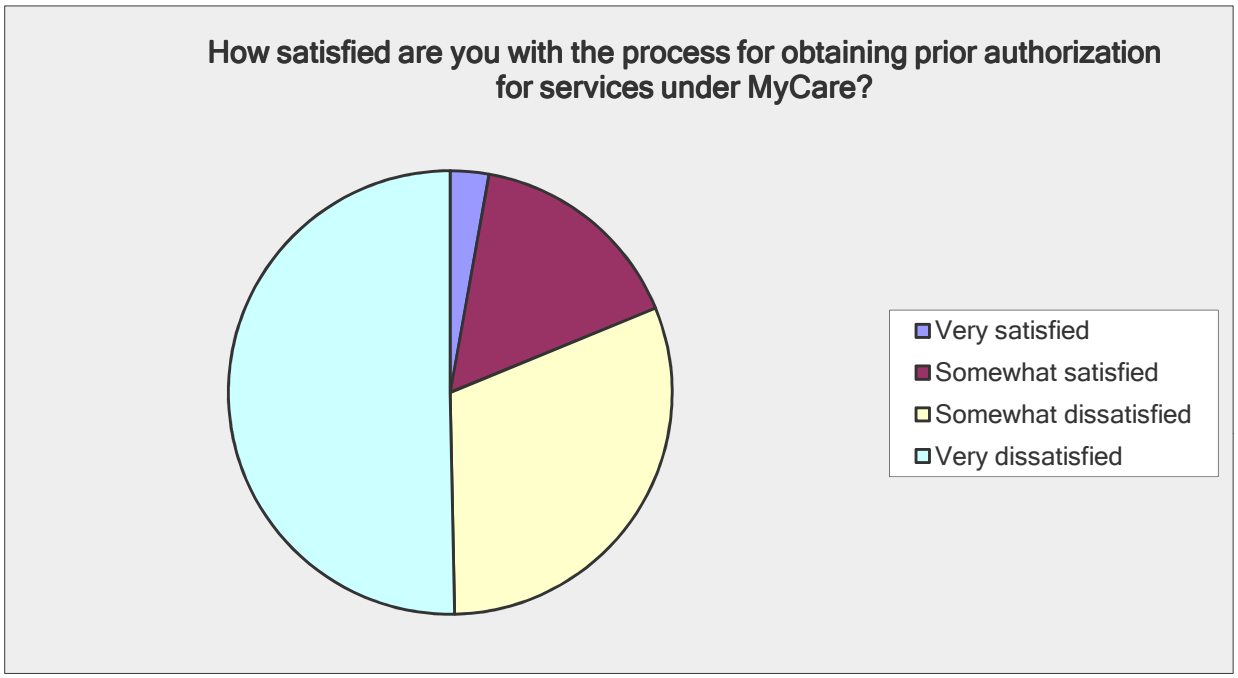
How satisfied are you with how the MCPs process claims compared to fee-for-service (specifically, the percentage of your claims that process cleanly and without issues)?

Answer Options	Response Percent	Response Count
Very satisfied	0.3%	1
Somewhat satisfied	16.0%	51
Somewhat dissatisfied	30.4%	97
Very dissatisfied	53.3%	170
answered question		319
skipped question		20



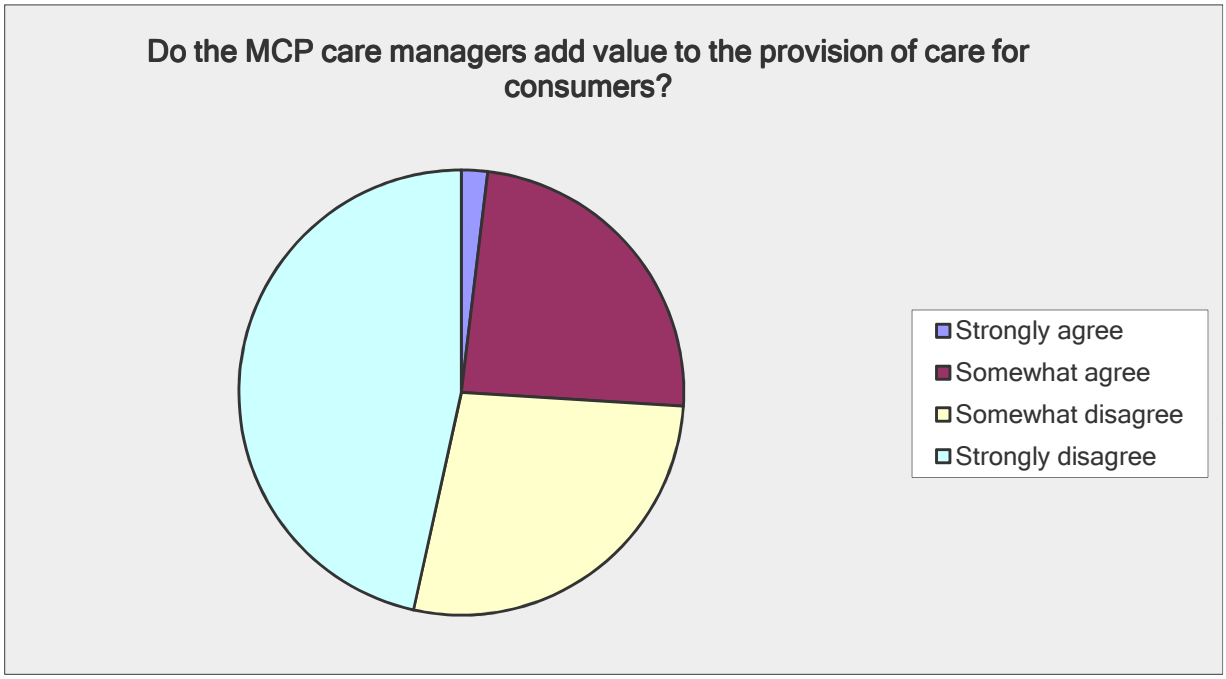
MyCare Ohio Questionnaire

How satisfied are you with the process for obtaining prior authorization for services under MyCare?		
Answer Options	**Response Percent**	**Response Count**
Very satisfied	2.8%	9
Somewhat satisfied	16.0%	52
Somewhat dissatisfied	30.9%	100
Very dissatisfied	50.3%	163
	answered question	324
	skipped question	15



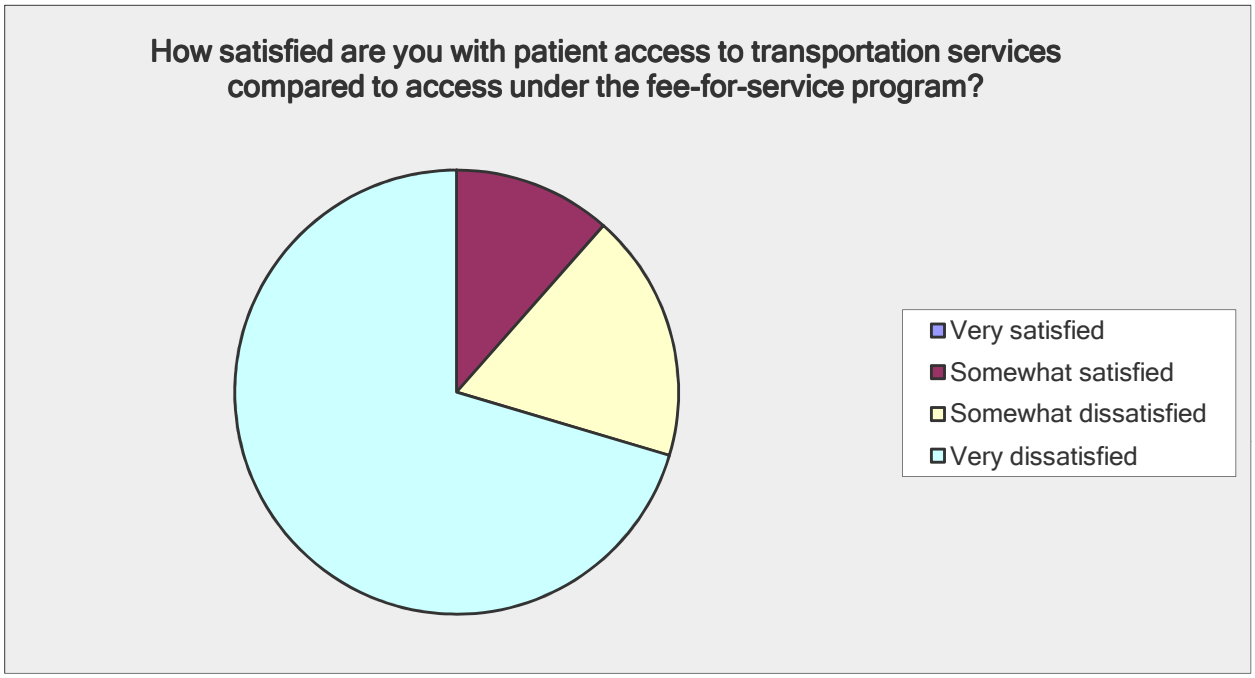
MyCare Ohio Questionnaire

Do the MCP care managers add value to the provision of care for consumers?		
Answer Options	**Response Percent**	**Response Count**
Strongly agree	1.9%	6
Somewhat agree	24.1%	78
Somewhat disagree	27.5%	89
Strongly disagree	46.6%	151
	answered question	**324**
	skipped question	**15**



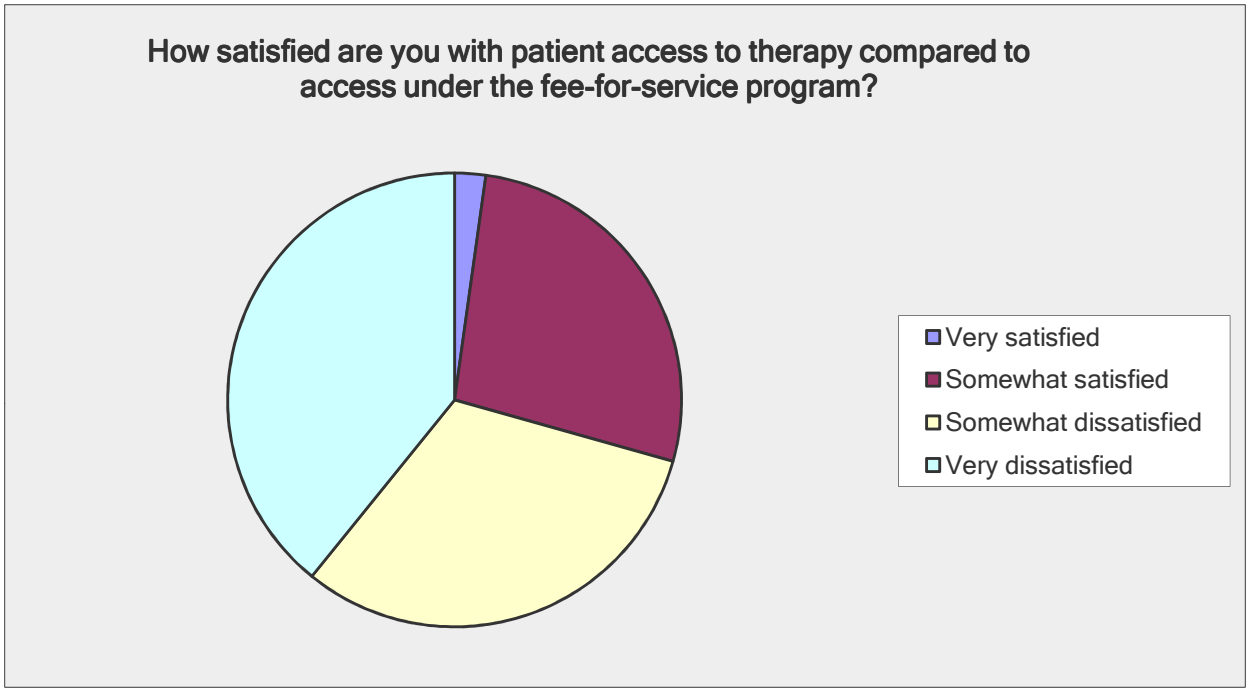
MyCare Ohio Questionnaire

How satisfied are you with patient access to transportation services compared to access under the fee-for-service program?		
Answer Options	**Response Percent**	**Response Count**
Very satisfied	0.0%	0
Somewhat satisfied	11.5%	37
Somewhat dissatisfied	18.1%	58
Very dissatisfied	70.4%	226
	answered question	321
	skipped question	18



MyCare Ohio Questionnaire

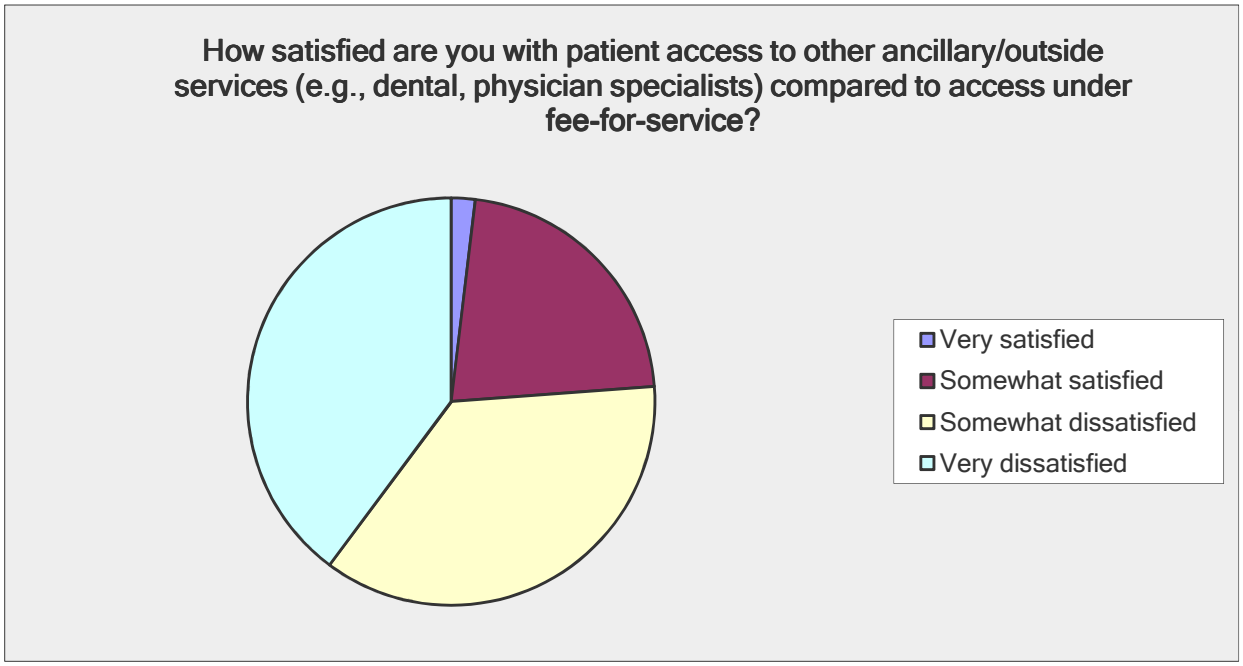
How satisfied are you with patient access to therapy compared to access under the fee-for-service program?		
Answer Options	**Response Percent**	**Response Count**
Very satisfied	2.2%	7
Somewhat satisfied	27.2%	88
Somewhat dissatisfied	31.5%	102
Very dissatisfied	39.2%	127
	answered question	324
	skipped question	15



MyCare Ohio Questionnaire

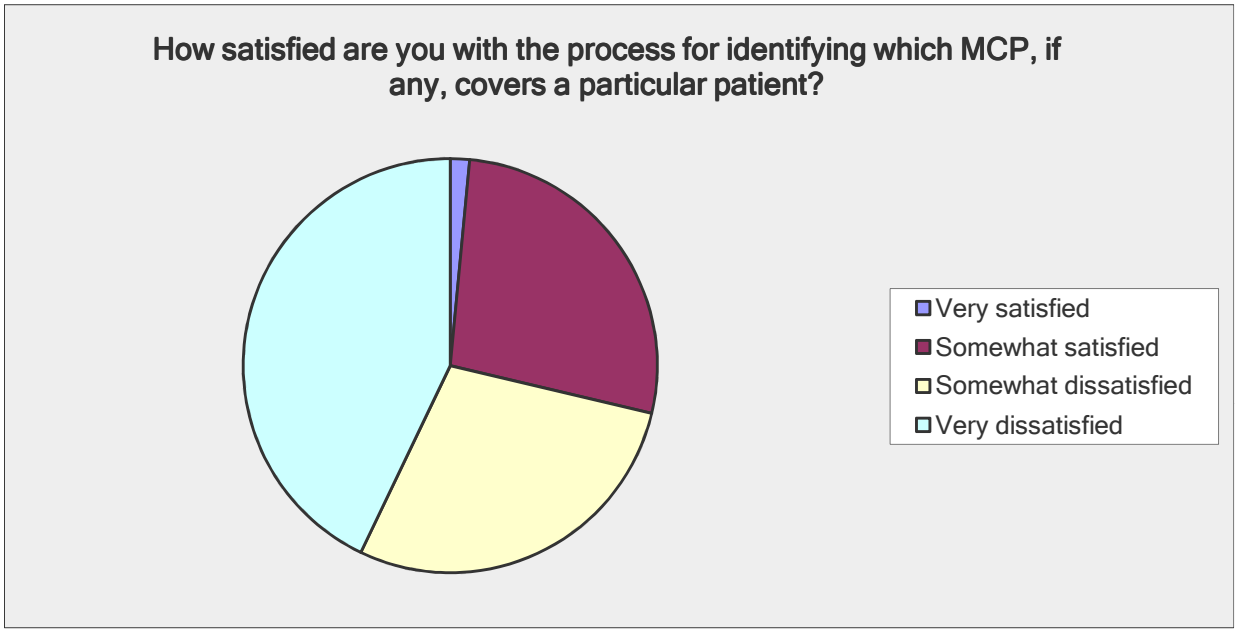
How satisfied are you with patient access to other ancillary/outside services (e.g., dental, physician specialists) compared to access under fee-for-service?

Answer Options	Response Percent	Response Count
Very satisfied	1.9%	6
Somewhat satisfied	21.9%	70
Somewhat dissatisfied	36.4%	116
Very dissatisfied	39.8%	127
	answered question	319
	skipped question	20



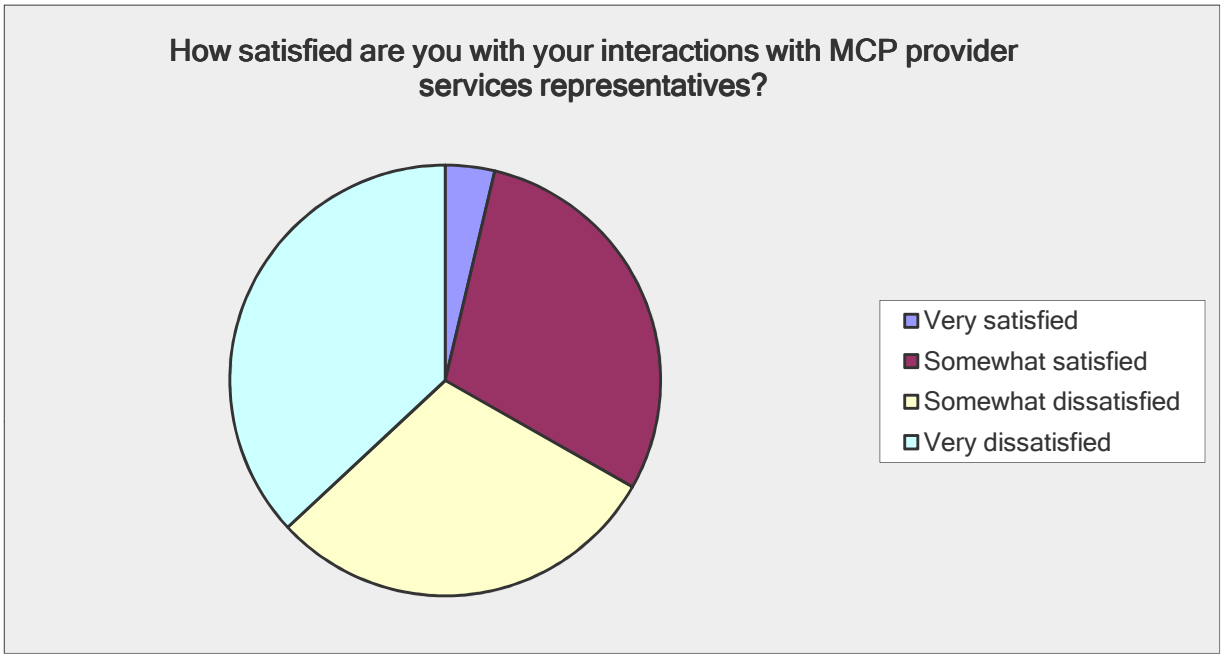
MyCare Ohio Questionnaire

How satisfied are you with the process for identifying which MCP, if any, covers a particular patient?		
Answer Options	**Response Percent**	**Response Count**
Very satisfied	1.5%	5
Somewhat satisfied	27.2%	88
Somewhat dissatisfied	28.4%	92
Very dissatisfied	42.9%	139
	answered question	**324**
	skipped question	**15**



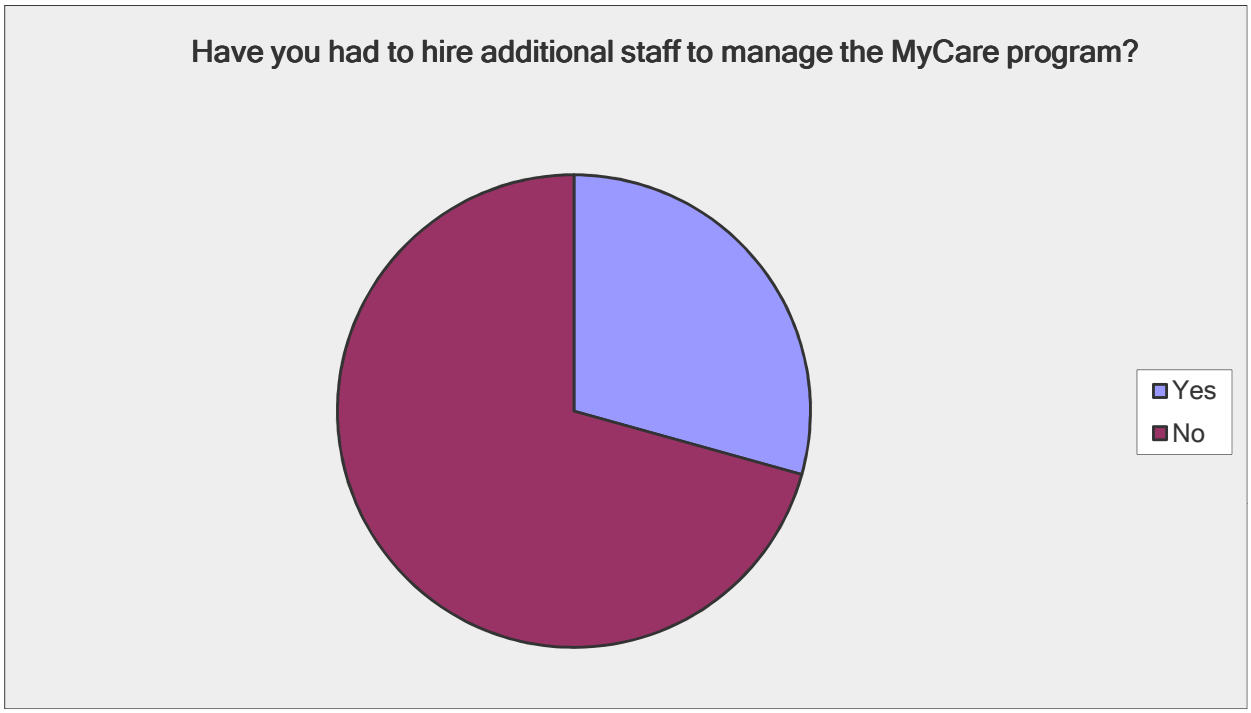
MyCare Ohio Questionnaire

How satisfied are you with your interactions with MCP provider services representatives?		
Answer Options	**Response Percent**	**Response Count**
Very satisfied	3.7%	12
Somewhat satisfied	29.5%	96
Somewhat dissatisfied	29.8%	97
Very dissatisfied	36.9%	120
	answered question	**325**
	skipped question	**14**



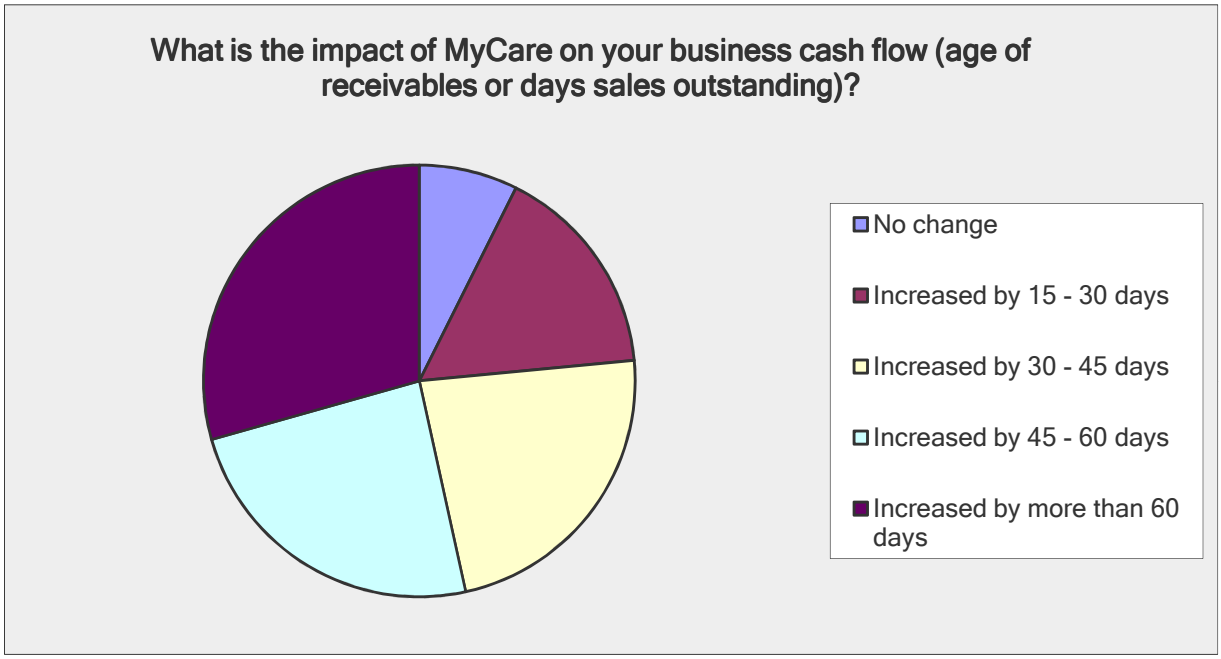
MyCare Ohio Questionnaire

Have you had to hire additional staff to manage the MyCare program?		
Answer Options	**Response Percent**	**Response Count**
Yes	29.2%	93
No	70.4%	224
	answered question	**318**
	skipped question	**21**



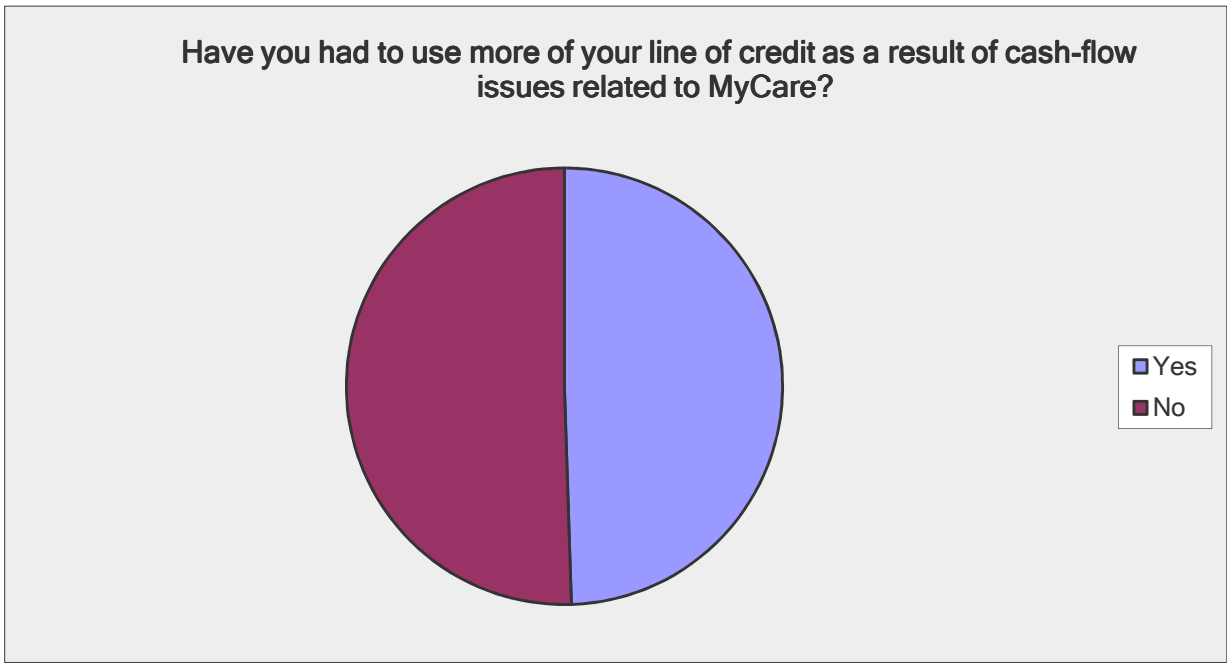
MyCare Ohio Questionnaire

What is the impact of MyCare on your business cash flow (age of receivables or days sales outstanding)?		
Answer Options	**Response Percent**	**Response Count**
No change	7.4%	22
Increased by 15 - 30 days	16.1%	48
Increased by 30 - 45 days	23.1%	69
Increased by 45 - 60 days	24.1%	72
Increased by more than 60 days	29.4%	88
	answered question	**299**
	skipped question	**40**



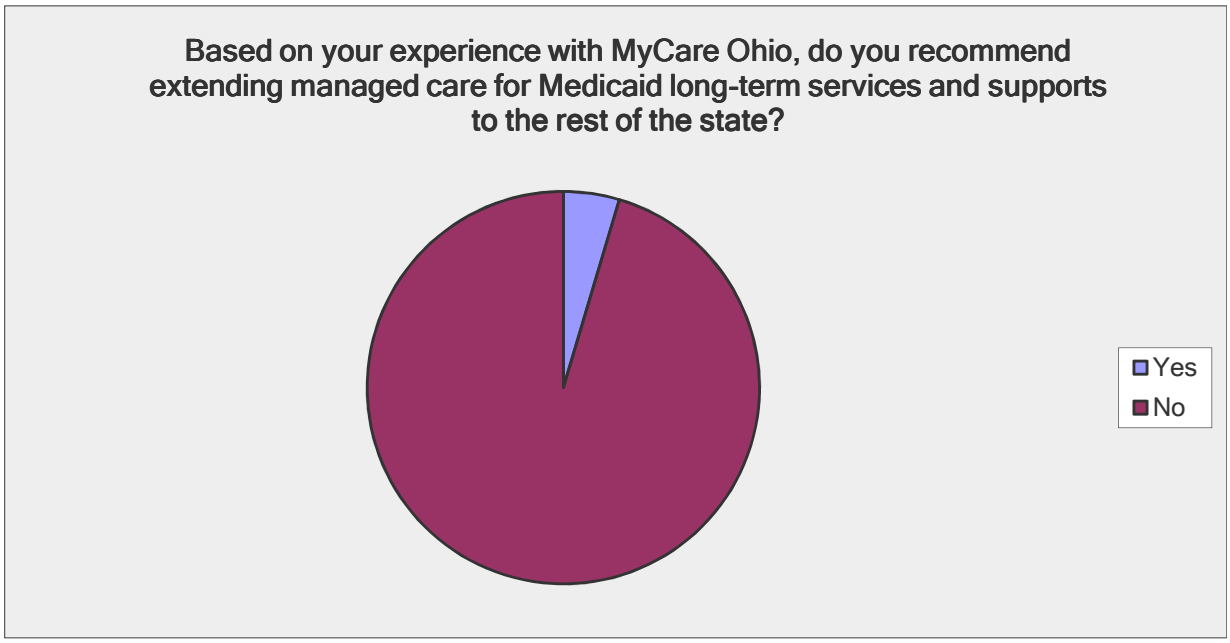
MyCare Ohio Questionnaire

Have you had to use more of your line of credit as a result of cash-flow issues related to MyCare?		
Answer Options	**Response Percent**	**Response Count**
Yes	49.5%	143
No	50.5%	146
	answered question	**289**
	skipped question	**50**



MyCare Ohio Questionnaire

Based on your experience with MyCare Ohio, do you recommend extending managed care for Medicaid long-term services and supports to the rest of the state?		
Answer Options	**Response Percent**	**Response Count**
Yes	4.6%	15
No	95.4%	308
	answered question	**323**
	skipped question	**16**



MyCare Ohio Questionnaire

Please share any comments or observations that you wish about how MyCare has affected your business and the people you serve. We appreciate your honest opinions - good or bad. OHCA may use your comments anonymously in our advocacy efforts, but

Answer Options	Response Count
	154
answered question	**154**
skipped question	**185**

Response Text
MyCare Ohio is not user friendly.
Have to fight claims that just get denied for no reason that have been paid for a while then pick up and pay again the next month. a lot of man hours wasted tracking claims for no reason.
The process to get therapy approved takes too long. You would be better off trying to look at residents in facilities that are Medicaid and could be at an ALF instead to help recover money/save.
Accuracy of paid claims is poor. Claim correction process is terrible. Required authorizations delays patient care.
We didn't add staff to address MyCare issues because we don't have the money to add billing staff. We are still paid at less than cost
Absolutely awful.
Untimely payment when new rates go into effect, January 1, and July 1 and untimely correction.
mycare has created confusion and headaches. Payment is slower and there has been no change in regards to resident care. They are receiving the exact same services and care as they were prior but there are more steps and hoops that have facilities have to go through to get there.
Patients need more options for MCO providers. Assigning MCO to regions limits access to patient choice.
Transportation has been an extreme burden on our facilities
This is the worst system for the actual patients. They do not follow Medicare/Medicaid guidelines like they are supposed to follow. They do not allow patients to get the therapy they need to be successful. This system does not allow any facility to make a profit and will end up closing thousands of facilities and leaving people who require services homeless. The mental health portion is terrible. I cannot believe this was ever passed as a demonstration.
MyCare Ohio has increased our administrative costs considerably. This has taken financial resources away from mission critical activities, such as providing direct care to our Patients.
My Care Ohio has been a constant serious issue since the inception. Customer service reps are not knowledgeable regarding skilled nursing facilities. Multiple calls and multiple answers. Questions are resulting in call backs rather than support answers. Submission is 120 days short response time vs all others at one year. Frustration with patient liability both provider and family. Turnaround time for approval/billings is excessive.
Medicaid managed care does nothing to help me, it just adds more work for me and confuses my Residents, sometimes profoundly.
MyCare has simply accomplished making every facet of healthcare even more complicated. Since healthcare providers have extreme difficulty navigating the systems, I can only imagine the difficulty that the patient encounters. Maybe this is the idea, make it so complicated that patients are unable to access needed services. Transportation has been particularly difficult resulting in an extra barrier for patients being able to access needed services.
MCD FFS was easy, convenient, no-hassle, correct rates, correct PL, timely, easy to process adjustments. DO NOT LIKE MYCARE PROGRAMS
MyCare has failed at effective Case Management of Medicaid and PASSPORT beneficiaries as it does not promote moving persons along the continuum of care and proper resource management as intended by the program design. There is a lack of coordination between consumers and their families, medical professionals, State agencies and LTCSS providers. All the stakeholders must be on the same page in order to have effective prudent case management. The tax payers and various providers as opposed to the lim
The prior authorization process has been abysmal. In some cases, it has taken beyond 30 days to get authorization for treatment of therapy. That is longer than the actual expected Length of Stay. Facilities were forced to provide treatment that had not yet been formally authorized because it was in the best interest of the resident/patient. Transportation has been millstone around the neck of MyCare from the very beginning. To date, these issues are still not reconciled. Inappropriate methods for people with high acuity and timeliness of pick up and drop off are the primary issues.
mycare is a pain for everyone. time consuming and ridiculous rules that no one can keep up with. everyone should be on the same page or limit mycare plans

My parents are both covered by MyCare in a SNF and honestly have had more problems with their care as a result of the lack of coordination from the insurance NP with the physician. Dad was rehospitalized because a NP discontinued an antibiotic prematurely causing him to become septic. He was also approached last year by a different MyCare plan and told he would get a new power wheelchair if he changed to their service. I declined that change to Buckeye and have been fighting with UHC for 11 months now trying to get that same chair replacement.
Residents are no longer receiving services they need in a timely manner due to the significant delay in response from the MyCare plans.
I have worked with MyCare since from the start. I do not feel that there has been any benefits to the residents in the nursing home nor to the staff who are trying to provide great patient care. I actually feel it hinders the care due to the time it takes away from the resident care to accommodate the needs to the staff from MyCare. There are endless phone calls for updates, trying to find transportation to appointments, a doctor to follow the resident and then there is now a new push for appointments/testing that are not necessary in this population such as scheduling annual screening test (pelvic exams).
Terrible program, expanding to other territories will be a major mistake!
You have to use meaningful data to make smart decisions. The clinical outcomes are poor and the financial performance is worse. It is not a failing program. It is a failure of key provisions and the management of key programs that make it a weak. We do not need to scrap it. We need to be smarter in what needs to be changed and how we manage it. Do NOT reinvent the wheel. Start reinventing your thought processes and use the results to drive your decisions. IT IS ALL IN THE DATA. Thank you.
the MyCare plans have made billing much more cumbersome. When payments are received they are not correct and then we have to fight to get the claim fix, both room/board and therapy. The auto enrollment with the Medicare is confusing to residents and families that do not understand the terms used and think they are staying with traditional medicare and end up in an hmo which they did not want. Facilities do not know until they run the beginning of the month check that residents have been auto enrolled in a plan or have changed plans. we had a resident auto enrolled and therapy was still not approved after a month so the medicare portion was cancelled so the resident could get the therapy they needed.
My care has been a challenge since day one. it needs to go away. It takes forever to get anything accomplished, getting authorizations or trying to move a SNF resident to ALU.
The customer service units, do not understand the benefits, and how they are to be applied, so they won't put claims thru for adjustments, and or the adjusters deny the claims, as they don't understand either. Patient Liability is not applied correctly, they don't understand what a ACT 52 is, and don't know how to adjust it. Leaving us extremely underpaid. The Insurance Portals, are not all very friendly to use. Denial reasoning doesn't match Medicaid's denials. And you can't send an adjusted claim, as they deny the claims as duplicates. Like we use to be able to do with Medicaid. This goes both ways, for additional money to be paid to us, and or refunded to them. If we do a check refund, then they turn around and reduce another payment, by what we've already sent back, double dipping. Again loss of revenue. And the timely filing limits, are all different with the MyCare's. They should match the Medicare and Medicaid filing limits at 12 months. This also can cause a big impact.
I find the process to receive an auth prior to admission takes extremely long and is unfair to the patient that is ready to be discharged from the hospital. Buckets in particular is the west that we have to deal with in terms of auths and payments. I would love to see us back on fee for services
This has been a very difficult process in identification of which MCP many of our patients have hen first admitted to our facilities. I work in clinical reimbursement for our company and can honestly say I have not seen many positive improvements in the care once the MCP were implemented.
Patient transportation is a nightmare. We have difficulty in getting transportation scheduled for our residents. Transportation has arrived an hour late causing the residents to miss their appointment. They have left 2 times while the patient has been literally walking out the front door. It has truly been unfair to the resident in the manner in which this system is currently working (consistently has poor outcomes regarding quality of customer service to our residents.)
My Care has specific physicians that residents have to attend, it takes away the right of the resident to choose who they may see. When setting up transportation, we have to use specific transport companies. The transport companies are either late in arriving, which makes the resident late for the appointment or they do not wait for the resident to get to the door. It is very hard to get payment for services, it seems like they send payment when they feel like it. It appears that my care is not resident focused, it takes away the residents right to choose how to live their life.

We call upon you to reject any effort to restructure the State Medicaid Program into any further expanded or permanent Managed Care Program. As you know, the MyCare Ohio Program was started in Ohio as an “Experiment” or “Demonstration Managed-Care Project” in May 2014 in 29 largely urban Ohio counties. This program was rolled out in a rush, hastily and with little planning or preparation. Now, nearly 3 years later, our Seniors are still continuing to experience the many problems of this “Managed Care System”. Managed Care is not at all about managing the care of our State’s Elderly. Rather it has been about the Insurance Companies managing to their bottom line. The Managed Care Insurance Companies are getting paid out of the same pot of money from the State Budget that the Providers are getting paid from. Our reimbursement is immediately decreased when you add in this “middle man”. The MyCare Ohio Demo project has proven to be inefficient and has not improved care for the elderly, in fact it has negatively impacted care for the elderly and to their providers of care by being inefficient and cumbersome. For the last 3 years we have experienced and are continuing to experience: slow pay, inaccurate payments, erroneous denials, difficulty in obtaining approval for services, and non-response/resolution of problems. The wasted time and energy spent in navigating through the mess of the MyCare Program has taken its toll on the elderly. For example the broken system for Transportation for our elderly or referrals to community based services such as Home Health or Adult Day Care has directly and physically impacted Seniors through neglect and lack of being able to access direly needed services. There is no evidence to suggest that the MyCare Ohio program has improved quality or outcomes. Nursing homes, have been coordinating care for its residents and ensure efficiencies and low re-hospitalization rates. We urge the State officials to reject any expansion of the MyCare Ohio Managed Care Program.
Some are better than others. The only one providing good patient care is UHC with Optum presence. Buckeye is very difficult and provides no help with magi clients. Buckeye's transportation issues have caused LONG delays in discharge planning due to the need to see specialists and the impossibility of obtaining reliable transportation thru Access to care. Additionally, those residents that require stretcher transportation are almost impossible to get to appointments & dialysis (without the facility paying out of pocket to a non-contracted provider) because they do not have a stretcher provider. Patient care is so negatively impacted due these issues. We have had to switch patients from Buckeye due to negligent payment practices and an inability to get the patient to critical appointments, such as dialysis.
When starting a new building, MyCare made things much more difficult with helping residents obtain preauth to transfer to the facility. Potential residents should not be penalized by participating in these programs.
If the goal was to make it as difficult as possible then they have met their goal. There is no way an elderly person could navigate this program without professional help. Major hospitals will not even except this payment type.
The major issue is that all of the MCOs currently have the autonomy to operate however they choose, so each company has a different process for precertification and LTC authorizations. And then they change so frequently and without any type of formal notice. Some programs use Optum and then it almost seems as if there's too many professionals involved in patient care.
MyCare is of zero value to anyone other than the My Care insurance companies. They are pretty aggressive in their discharge criteria which we suspect ultimately results in more frequent rehospitalizations from the community and divert scarce resources from patients and providers to their own overhead and profit requirements without contributing anything to better patient outcomes. Finally their programs have made changes in the past with inadequate planning, inadequate notice to providers/patients and poor execution. Basically the program was designed to limit patient care and skim dollars from the system As far as we can see they do nothing to enhance care coordination finally, they seek to limit patient choice as to insurers and providers
The total chaos of MyCare Ohio as I have seen it executed, including case managers who work for Buckeye and Molina visiting our Campus and essentially admitting they have no idea what they are doing was a deal breaker for my Support of our Governor as he ran for Presidents. An otherwise articulate, bright and compassionate leader who would put his stamp of approval and something so poorly managed and executed gave me great Pause. I have also seen Mycare beneficiaries denied services that they needed because a beuracrat at Buckey or Molina determined the cost was too great. Sorry, but the expansion of this sinking ship is something that I will vigorously resist. I find it out outrageous, only when the government subverts the free Market by limiting choices of tax paying Ohioans, do you get stinking messes like MyCare Ohio. How does the program save money by hiring RN Case Managers at $30 per hour who come out to the SNF and admit they have know Idea what they are doing or how to get our questions answered that we have. I would challenge anyone who has fiduciary responsibility to the taxpayers of OHIO to prove that MyCare Ohio has resulted in better outcomes or save one penny.
There has been a lack of communication between ODM and MCPs. For example, prior to 8/1/16, PL differences between MITS and the 9401 created extra work for the SNFs - some are still not resolved. SNFs were instructed to submit spreadsheets to get the payments corrected vs., this is a good idea, have MITS updated with the correct PL. The MCPs were under the impression that PASRR paperwork was not necessary for admission into a SNF - not true. The MCPs did not submit for a LOC for a SNF admission, but they did authorize the admission. Speaking of authorizations, why is it that some plans allow LT admission without an authorization while others require one. Why aren't the rules the same? Where will that leave the SNFs when adjudication audits are performed and no LOCs or authorizations are on file? Keep MyCare or not, both ODM and the MCPs need to be held accountable.

The claims process is very messy for most of the My Care Ohio plans. We have claims paying later, inaccurately (especially patient liability) and eligibility issues. In addition, the plans have a variety of timely filing guidelines and appeals deadlines. With the claims process being so inaccurate and broken, the timely filing guidelines and appeals deadlines put us as increased risk for bad debts. I suggest holding the plans more responsible for timely and accurate payment as well as timely filing guidelines that are consist with Medicaid and Medicare.
More redtape and regulations for patients to get the services they need is not the answer. This is essentially what MyCare Ohio has done.
The payment issue and correct patient liability is a big issue. There is time my group spends over 45 min on the phone waiting to get a live person that can give us answers on payment clarification. If we move to a mycare product then there needs some type of language on payment terms with these mycare products.
continued issues with precerts, residents discharging then returning usually several times, not paid correctly for skilled or ltc, transportation has been a ongoing issue.
The provider representatives have no idea what they're talking about when verifying insurance coverage, not all MyCare companies follow Medicare guidelines in relation to coinsurance, most MyCare companies do not apply the appropriate patient liability and therefore it's a lot of follow up to get these clams to pay correctly, and there are many discrepancies taking place when Medicaid/MyCare is termed/reinstated, lags and/or retro terminations for MCPs are common and are adversely impacting cash flow. Residents are cut earlier from MyCare skilled services where they would not have been cut under Medicare. Conversion for the State regarding 9401 communications is a mess regarding LOCs and who does what- Area Agency thinks MyCare company does it, so when someone changes to traditional Medicaid, there is no LOC in place and PAA does not get this corrected timely if at all in some cases. A lot of back and forth between ODM, PAA, and MCP reps- with no expedient means of resolution. Everything was much cleaner and simple with timely payments prior to the MyCare conversion.
This program should not be in nursing homes. Duplication of services. Money would be better spent on residents. Transportation is terrible. This has added much confusion to the process. Much better with just Medicare and Medicaid to bill. The plans just change without the residents or representative approval.
The insurers deny, deny until "untimely". We are currently unpaid over 150kon two claims because the process is can not keep up with the medicaid process in Cuyahoga county. OR they cannot find the originals for precerts.
The insurance companies are horrible communicating changes in their policies to their patients and the facilities that care for them . Who is monitoring these insurance companies !
We are still having trouble getting our liabilities correct with the mycare programs. We have 9401 showing one rate and they are still disputing them. We were told that the mycare did not have access to the mits portal.
My Care would be an absolute disaster.
This has been a terrible experience. I do not feel that it is doing what it was designed to do. It causes more problems that it was designed to fix
Very difficult to get transportation for our pts - 14 day advance notice needed for stretcher approval and told in State of Ohio will not allow stretcher transport at times, some pts will only get transport to and from hospital no physician appts, and another concern is that some pts are told they opted out of transport and no way to correct.
Insurance companies are so confused about their own lines of business you can't get anyone who knows the answer to many questions. Bad for the patients and for providers trying to provide great care.
Optum seems to be effective in managing their patients. Caresource and Buckeye do not visit on a routine basis. Buckeye is extremely slow and disorganized and delays care to the patients as well as many non payment issues and authorization issues to the faciility
Statewide expansion of Medicaid Managed Care will be disastrous. One can only how much more confusing and dysfunctional the Medicaid system will become, as compared to the devastating mess created by the rollout of MyCare. Our residents deserve a better system than hastily implemented managed care.
I do not like this program and wish it would all go back to traditional medicare and Medicaid programs in place of the mycare. It is extra work and hard to track monthly the changes and confuses our residents and family members. We have had issues with providers not covering due to these plans and being in or out of network for their typical doctors.
the plans do not communicate when changes in plans occur. The transportation authorizations are a nightmare, we don't get timely payment and it takes forever to get anything corrected. often the MCP's case managers don't even know who is on their caseload due to frequent changes. NIGHTMARE MUST GO AWAY!!!
I cannot get community based services for patients with Buckeye. I am told home health and equipment companies are not paid timely, therefore the stopped accepting Buckeye.

This program has shown to be busy in itself. Transportation is a nightmare as most of the time there is no availability or delayed. Reimbursement is non-existent in a timely manner which is driving bad debt expense and compromising center operations. Providers do not want to work with programs and services to assist in a patient going home is initial and that is it. No support or collaboration with centers.
My Care has placed undue hardships on our patients and long term care communities. The lack of access to services for our patients due to contracting with My Care has caused many issues/concerns. In addition, the My Care coordination has been very unorganized causing many issues with communication and care. Incorrect and untimely payments has caused cash flow issues for our communities and has caused an increase in labor hours and additions of employees. We have not seen any improvements in care or return to community efforts.
Patient access to transportation has been extremely less efficient. Scheduling through Logistacare/AccesstoCare is a nightmare. They send the least professional(cheapest) transport they can send(including taxi cabs) which negatively affects the perception of facility professionalism. I can't imagine that this managed care program has saved any money for the state, or is more efficient in any way. Many patients have had to suffer as a result of this program. Eliminate managed care for the sake of the patient.
It's a complete failure. The customer service representatives are rude and unknowledgeable about their products and whom to direct you to when you have a question. Unclear of what the Case Managers/Nurse Practitioners are suppose to do, they do not make visits to residents, only review charts and do not communicate with our staff. Transportation takes very difficult to arrange. Even after confirmation, many residents have missed important medical appointments (Including dialysis) because no transport has arrived to pick up. Find it hard to find specialist and medical equipment due to lack of providers for these products. Our resident are suffering and MyCare Ohio has prevented us to provide quality patient care.
Aetna MyCare is slower than Molina MyCare in completing therapy authorizations. Traditional Medicaid pays quicker than both MCPs. Aetna MyCare is noted to pay quicker than Molina MyCare. Both MCPs process claims incorrectly at times. Molina MyCare seems to run more efficiently, in regards to overall knowledge of their systems - in comparison to Aetna MyCare.
Very hard time getting accurate and timely payments.
We were a provider prior to MYCare and as a provider I feel things overall ran much smoother before. I have had more family complaints regarding the process as well.
rates and patient liability are inaccurate a lot. customer service does not understand SNF billing and patient liability. hard to get accurate answers. make multiple calls trying to get corrected information. turnaround time is unreasonable. appeal process is very slow. most of our complaints are with Molina. we have a little better luck with Aetna.
Transportation should be scheduled directly between the facility and transport provider. Often, logistic companies send taxi's or improper transport. Sometimes services don't show or show up not wearing uniforms.
this process has decreased care and services to the elderly
Medicaid expansion needs to exist because people need the services provided by Medicaid. With that said, the problem is involving insurance companies and other third parties in the pathway of that care delivery. The process of accepting a resident is more complicated than it needs to be. The process of delivering basic care is more complicated than it needs to be. The process of continuing that care pathway is more complicated than it needs to be. The process of billing for and setting up additional services via third parties is more complicated than it needs to be. The bottom line is just that - this is all being done to save the bottom line. The state is saving money by decreasing the amount of care that can be delivered to the Medicaid population and that does not lead to better quality of care. You cannot pretend to care about quality, when the primary objective is to save money, and anytime you add an insurance company into the equation, that's exactly want is trying to be accomplished. MyCare Ohio is not about providing "better" care. It's about providing cheaper care. Whether it's in length of stay, reducing skilled time, making it more difficult to utilize part B, get adaptive equipment, schedule transportation, etc, etc, etc... MyCare Ohio is less about delivering better quality of care and more about saving tax payer dollars, via cutting benefits. I'm not saying that the old system was successful, but it was better. Medicaid is needed for the population that inhabit our skilled nursing facilities and cutting their services is not improving their care. It might be saving money, but they are not getting better care. MyCare Ohio is a Band-Aid approach to the Medicaid spending problem. It's time to level the system and look towards something entirely different. MyCare Ohio is too "American" in it's approach. Enforcement, control, and cutting benefits; saves money, but does not improve quality.
The Transportation issue for consumers is ineffective and leaves deplorable safety issues when the timeline is not met.
Our licensed providers have their own nurse practitioners that are routinely in our building. On top of that, our nurses have to deal with RN and nurse practitioner from the MyCare programs and it still is confusing and time consuming for them to have to communicate to every provider when there is a condition change or transfer to hospital. More work for our nurses.
Medicaid fee-for-service works perfect. MyCare has cause a huge mess for Account Receivable.

The authorization errors are atrocious. Valid authorizations are "deleted" from systems so when you attempt to submit corrections to their claims processing errors, original payments are recouped in full - in error and you have to Prove to them that you had the authorization in place at the time. These payers have routinely Over paid claims in error and it is literally torture to try to get them to correct Their errors and recoup their over payments. You have to Prove you owe them and then they still don't process for recoupments based on the Proof that has been supplied to them. We are a publicly traded company and Can Not retain these credits on our books for years and years waiting for someone to accept our documentation and correct these errors. The man hours we have spent in this area has extremely affected our ability to follow claims denied / not paid - usually also in error. Some of the carriers have made strides in trying to correct these issues (nearly three years later) others have not. Even the ones that are "trying" are still rejecting over payment recoupment requests as timely. I have seen these types of programs in other States that have - after initially faltering - been able to co-ordinate their practices and become successful, but the carriers that are covering our residents in Ohio are still extremely difficult to work with and either do not respond to communication attempts - or are outright un-informed and / or rude. Expanding these programs would definitely Not be recommended.
I think that MyCare has complicated the Medicaid process. Between incorrect payments on claims, the time it takes to get prior authorizations and the issues with patients being able to access services it's been a total mess from a SNF perspective (especially Buckeye!). Claims take much longer to get paid and if they are incorrect getting them fixed and paid correctly is a ridiculously long process. Also, the patients being automatically changed to dual plans when they already have a Managed Care plan or Medicare is a bookkeeping nightmare. I've seen no positive effects resulting from MyCare for facilities or patients.
Both Buckeye and Aetna are using unreliable transportation providers for members. Neither company will allow requests for transportation providers so members are at the mercy of whomever the MCP chooses. Several times, transportation providers have left members at medical appointments for several hours after the appointment. Navigating through the system to schedule transportation is not easy.
MyCare has been one of the worst experiences, both for the staff and the residents, in my near 15 years in the business. Have other managers with 20-30 years in the SNF industry who also believe it to be one of the worse scenarios ever. There is No access to transportation. we have had multiple complaint surveys over transportation issues that have been solely the fault of the MyCare plan but consumers don't know that, all they know is that their loved one either missed an appointment or was left at a physician's office and so on. The facility always must fix the situation and it's always under an emergency type situation. Residents can no longer receive specialized wheelchairs for positioning and seating. It's a paid benefit but it does not happen, EVER. Drug formularies change so often and prior auths are needed for everything. Those prior auths, even for medications, can takes, hours, days, weeks, all the while the resident must still receive care and Always it’s the facility that must cover the cost when something is denied. Currently have added 2 plus FTE, One just does transportation, and will need to hire more if this becomes permanent or expands. The Case Managers are literally a joke. They do nothing, do not meet residents, provide NO SERVICE what so ever. Paid to do nothing. Our social worker must do all the discharge planning, setting up services in the community, applying for additional benefits or services, then hands over 'reports' of everything she has done to the Case Manager who simply wants a copy. But that same person will ask weekly how long the resident will be in facility. They do NOTHING to help and actually get in the way because they are in the building, asking staff questions, making copies of things, behind our nurses station, sometimes bring their children in the building, but provide no service and never even meet the resident. Just seems to me that MyCare is only saving money by not providing appropriate care to the resident, delaying care and services, denying services already given and added layers of wasteful employees who never speak to residents and simply move papers from one location to another. Just layers of red tape and bureaucracy on top of layers while draining the job pool of valuable nursing staff who get to do nothing but make copies, move paper, and bring their children with them to work. And, our admission manager must still get the prior auths for service and update anywhere from every 5 days to every week to every month, although the resident has a 'case manager' who comes in the building nearly daily and that person is able to meet with them or review their chart or talk with their physician. But doesn't!!! And just try to get medication, medication that is ordered by a physician. the facility doesn't order the med, their doctor, that is within their MyCare plan orders the med. But we have to get it prior authed, which takes hours of NURSING time, then it's denied then we have to give reasons why it must be that drug then denied again then facility must pay the cost.....it's an absolute nightmare!!! Everyone, everyone believes it's one of the worst situations we have ever seen, and costly, and at times downright dangerous with the medication and transportation issues!!!!
CareSource is lousy.
MCP has made everything much more complicated with discharges. I receive no help from case managers in the community with discharge plans. Transportation is awful. It takes hours to get authorizations then the transportation companies do not show up on time or not at all. We had a patient wait hours at an appointment to be picked up. The MCP's have caused nothing but extra work and more complications.
The prior authorization process is somewhat slow, billing/payment cycle is slower than prior to MyCare, there is still some confusion as to the coordination of medicare/Medicaid benefits and when they must choose a MyCare product.
MyCare has caused patient confusion, slow payment and increase in cost to manage.
It has created many barriers for the patients such as transportation to appointments and coordinating home health care. It is hard to find companies to service these patients.

I am responding from the Clinical perspective, I had a conversation with our AR director and she completed the survey from the billing side. It is difficult to answer these questions as we have had different experiences with different Insurance plan representatives at our facilities.
MyCare has some problems that need to be fixed. I understand the concept of it, but often wonder why the care communities aren't provided additional resources as they are the ones that know the residents best. The care managers come in and review the information and make suggestions and sometimes require a lot of extra time from the nursing staff. The Medical Director or resident's physician is still in charge, but there are NPs from the plans also wanting tests/orders completed. The coordination of care is just not there yet.
The whole system is bad for facilities and more importantly, horrible and confusing to the residents and family members.
It has created more bureaucracy with more hoops for the facility staff to jump through. I don't see a positive impact for the extra work created. The representative from Aetna comes to the building, but every time you ask about something, she doesn't know the answer and has the facility call someone at Aetna.
In my opinion, the My Care Demonstration has been a if not a complete; then nearly a complete disaster and disruption to the system that was in place to serve the unique needs of the skilled nursing and long term care populations we serve. With so many personnel working on each individual case, results seem to take longer, add much more confusion and disorganization to what had been a more straight forward and concise way of getting things done. Examples of this include having a MyCare Patient in the building for a short term rehab stay having a Nurse Practitioner, a care manager/social worker from the Area Agency of Aging, a nurse from the insurance agency all following the patient at one point in their admission or another, and not communicating with each other, or understanding whether or not they should be following this patient, telling our social workers and staff they are only following for 20 days then someone else will take over, or giving review dates for needed updates that don't coincide with the dates we receive from the nurse at the insurance company. In the area of discharge planning; coordinating discharge meetings between all involved, scheduling and setting up services is taking longer to get people back into the community that it had previously when applying for and setting up Passport and Waiver services. It is also duplication of services to have the insurance companies nurses, physicians and social workers doing what we are already providing in our facilities, and obtaining the resources and services that we have always been able to provide in the nursing facility environment. I also do not agree with having nursing personnel managing patient care vs. the physician. Although some improvement in understanding skilled nursing criteria and regulations has been noted, for the most part the MyCare personnel were not well trained in these systems, and the nursing home providers have had to provide education and direction overall in these programs. It is also noted that there has been significant turnover in representatives of these programs both at the facility level and at the Area of Aging level that we come in contact with. Overall, I feel that expanding these services statewide would increase cost and decrease quality to Medicaid recipients in the state. A more effective way of controlling cost and providing services to our population would be to provide facilities with adequate reimbursement and let there staff to continue to provide the needed services while in the facility and expedite transitions back to the community without having to coordinate and deal with 4 to 6 different personnel to assist one patient.
I am an AR representative. I cannot/should not answer care coordination questions. We do find that some part of the process are handled better than others depending on which MyCare plan is involved.
It is a nightmare
One particular MyCare plan has no idea how to handle claims when calling. They sit for months when needing reprocessed. Another MyCare plan still doesn't have their system set up to track correct Medicare days. It has been two years and we still have projects with them.
From a nursing point of view I don't see where this has increased our continuity of care. We usually don't know who the case managers are, then they change without notification to the client and to the nursing staff. We don't receive call backs from the c/m in a timely manner. The authorization process is very time consuming mostly because MCP reps don't know how to convert from the LTC venue to the Waiver Venue for assisted livings. They charge the wrong patient liability and do not understand assisted living room and board + patient liability is different than just LTC patient liability, which causes the assisted livings to lose money daily, without the opportunity to recoup said loses. The case managers don't update the careplans in a timely manner or do not let us know when they update the care plans. The service plans are not accessible on line as they state most of the time. From a business stand point we have suffered slow pay, wrong patient liabilities, penalties, and repeal process for denied claims. We have had to hire more staff to help with the processing of claims and authorization procedures. In our community we have had to encountered more loss of financial stability, while continuing to give services our residents require and need. This comment does not begin to encompass all the issues we face on a daily basis, dealing with the MCP's.

Mycare has been a nightmare. If this was designed to close Nursing Facilites and Assisted Living facilities, it is succeeding. There is a time frame of one year for traditional Medicaid but UHC has implemented 90 days for claims or they are untimely, and we do not receive payment. This is just one issue regarding Mycare, each one has different rules, and I am not sure any of the MyCare insurance companies have been trained properly, so the providers have to jump through more hoops now than ever to get our residents the services that they need, and to receive payment for such services. We also have some claims pending for up to 90 days. This is putting a cash flow burden for facilities. If Mycare is going to continue, I believe it should be following traditional Medicaid rules and regulations.
It has made it more difficult for our members to find dependable transportation to and from appointments. Several family members have complained. Impossible to keep up with who and who they cover.
MyCare Ohio has had a complete negative impact on our receivables. The payments are not timely, we are having issues obtaining authorizations, the patient liability amounts deducted never match what the State has provided us.
Customer service representatives do not know the difference between a long term care resident and a skilled resident. Once My Care denies a claim (incorrectly, for example deny long term care patient as benefit exhaust, it is virtually impossible to get paid and if you do it takes months. If we don't meet **** requirements, they can"kick us" out of plan. /But there is no recourse for errors made by the Mycare plans for payment denials. My cares still cannot process claims correctly in regard to patient liability and lump sums.
It is really hard to get a resident into see their doctor because they don't accept the MyCare, transportation is a mess and very time consuming. MyCare does not provide wheelchairs for resident it becomes the facility's cost, when it was just Medicaid they were able to get a new one if they have not had one in the past 10 years. Getting approval for a resident that came into a facility skilled and then needed to stay a few weeks longer under their Medicaid benefit, just did not work because the process of someone would need to come and visit that resident for a LOC and the resident would state that they intend to go home in a few weeks they would denied the stay and the facility would not get paid for that resident being in their building. I really don't see what this program has done for the resident or facility besides trouble.
The system has bogged down payments, transition of care, transportation, and quality of care.
The interaction and timeliness of the plan to resolve issues on all fronts is a problem. I would not recommend these managed Medicaid products unless vast improvements all around are made.
With traditional Medicare and Medicaid the turnaround for payment is 1-2 weeks. By using MyCare we are waiting at least 30-45 days and then the liabilities are not always correct which makes it hard to correct
Extremely difficult to get a hold of and communicate with provider reps.
Optum Health partner with Buckeye and Aetna has shown to expedite skilled services for individuals in the facility. Patient access to therapy has been a real problem especially with Aetna.
We have had better luck with Molina than we have with Buckeye. We had had so many issues with Buckeye not paying claims, or paying at the wrong amount per diem or the wrong patient liability. There are not enough hours in the day to deal with all of these issues every time we get a payment. The authorizations also take a long time with both companies! It is very frustrating to deal with tem!
As it effects SNF...I find departments inside Molina itself do not communicate well with one another. I often must reach out to several people to accomplish one task for my MyCare patients.
Hours spent on the phone for pre-auths only to be told not on this resident then to say oops no pay as there was no pre-auth. Changing providers in the middle of the year, needing up dates every 7 days or less many hours sending the same paper work to not only the first for auth but the OIG for the second only to be denied again then appeals same papers and approved 7 more day. Families furious with us when we just spend 8 hours trying to make the person get the auth they deserve.
Plans keep changing without resident approval or facility notification. We must check the MITS system monthly for updated. Transportation is awful. We are doing twice the amount of work for case management- duplication of services.). MyCare is not a good fit in nursing homes. I would much rather deal with Medicare and Medicaid. Payment is more reliable with these traditional payment sources. Keep it simple. We have complicated the system. The rates for payment are very low. Some are up to $200 a day less. Who is getting this difference? The insurance companies? How does this improve resident care.

The transportation benefit has been horrible. Frequently they don't even show up and we have been told they don't have to call and let us know so we could make other arrangements. It also seems there have been PPA discrepancies on every MyCare recipient, leaving dollars on our aging that don't belong there. As far as the care managers, I have had little to no interaction with them. They come in and out of the building without interacting with facility staff so we never even know what their purpose for being here is. The prior authorizations for the short term residents have not been a problem, but obtaining authorization for long term or respite stays has been taking over a month in some cases, which is frustrating for the family members.
Very little impact on improving quality of care. Have to deal with multiple different slow pre-auth, claims billing process. Cannot allow the plans to set rates at anything below current floor. It will put several nursing homes out of business
Extending this program would be a nightmare. I deal with all 5 MyCare companies and they all have their own rules and policies. There are different places to go to get the remits and the remits are not always easy to read. Payment times have gotten better but still not as good as traidtional Medicaid. I also think it is crazy that facilities are having hard times making arrangements for Transports. This program has been a disaster. Nothing about it has been good.
*benefits have been quoted as not needing pre cert when in actuality it does require precert...THERAPY to be exact. * With straight Medicare we are paid in 14 -15 days, it is 30-40 days for payment. * liability is listed in MITS as 1 rate and the Managed MCD either does not take it out correctly or not at all stating their information from the state was different. Adjustments of claims when it is paid incorrectly due to this is almost impossible * websites are difficult to use and you can not follow a claim clear through a process, especially if there are adjustments. Remits for non payment are not mailed to campuses which makes it very difficult to follow.
The MyCare billing has been a billing nightmare for our organization. Claims have processed and paid with 0 liability and we are still waiting after years to have them corrected. We have had very few that have processed and paid correctly and no one seems to know how we can get them corrected the right way and paid.
The Insurance companies were poorly trained...they don't understand long term care at all. When calling to speak with them regarding payment, you are told one thing but it never is the truth. This is just on BIG mess.
MCP has made our lives more difficult from a financial and resident perspective. everything takes longer to happen then when residents were on traditional Medicaid and makes it more confusing for the residents and families as well!
Not effective the State needs to manage these process not allow others to control state dollars and approval and denial for services.
The MCP consistently having pending claims. When there is no consistent payments it makes it difficult do manage a facilities payables. I don't see any benefit to the patient or facility having MCP. I have not seen any increase of denial of admission or people returned to a home setting.
This program has made almost every aspect more difficult, often causing a delay in admissions and treatment due to waiting on approvals. The accounts receivable is an absolute mess in all three of the campuses that I support with this program. We just recently had to write off over $65,000.00 in revenue due to the confusion between the MyCare representatives and our facilities resulting in the claims eventually timing out.
I feel this program is an un needed layer between resident, facility and their Medicaid benefit. Transportation is worse than horrible!!!Half the time our nurses are so upset by who they are sending, we send them away and self-transport. I have had people forgotten, so they miss appts. and people not picked up that we have retrieved. You NEVER get a call back on complaints. They are very poor communicators regarding medical requests/issues with the residents. Rare to get a call back, and timely - forget it. Why isn't the money paid to them used to improve Medicaid services for Ohio's recipients?
Customer service at insurance companies is not good. Amount of time for claim reprocessing is not acceptable. Unable to adjust claims on their websites like I can through MITS.
MyCare has not increased the transition of SNF residents to less expensive settings. In fact, we've found that it has lengthened them based on inefficient and ineffective communication between ODA, ODM and the MyCare plans. In addition, we have seen no improvement in quality through MyCare case managers and clinical personnel involved. In fact, they have become disrupters of care, such as creating news physician orders without knowing the resident and/or communicating to the physician of record. MyCare has become an additional burden rather than a facilitator of care.
I believe it has increased cost. more time in higher acuity due to poor response time to get them to nf.. If failed to get to nf during precertification process returns to community with poorer outcomes
These plans have proved a total disaster for my residents. What's worse yet is the educational offerings to those residents and families about exactly what their plan covers and requires.

Billing is overwhelmingly difficult. For example, the rates are not updated timely, yet it falls on the facility to rebill continuously in order to get it paid at the correct rate - mostly after many months and numerous re-bills. We get routine denials for missing auths, yet when we call and follow up, it is clearly in their system - just a method to delay payment. We've had instances where we were given an auth, verified benefits and had the plans come back months later to take back the funds and say they weren't really a member even though all documentation shows they were. They have not until this year paid the add on (with a signed agreement) for the Medicare/Medicaid coinsurance and trying to argue for it is simply met with "the claims were paid correctly". We usually cannot get any issues resolved until we file an official "provider complaint". We do have a couple of reps working with us and clearing up some of the old issues, but we still have discrepancies going back to the initial implementation of the program that have yet to be paid or recouped in the case of overpayments. Some of the questions regarded adding FTEs or needing to draw on credit... since the reimbursement isn't any better, adding additional staff isn't an option. We are fortunate enough to have cash reserves that has allowed us not to have to take on debt, but the cash flow concern has certainly impacted our ability to grow or take advantage of certain opportunities that have come our way... I think the survey misses that aspect. Finally, we all know that managed care programs have the ultimate goal of making a profit (that's their business - this isn't a condemnation). Once the reimbursement is out of the hands of the Medicaid program, our rates will deteriorate even further which has a direct impact on our ability to care for residents. In many cases, the goal of the managed care plans (that often appears very noble) of getting a resident home is actually bad for the resident either through lack of care or putting them in a dangerous environment. The care coordinators are pushed to get residents to move toward that goal regardless of the patient's wishes.
Inconsistent information and does not follow Medicare/Medicaid basic guidelines. Does not return pre-auth requests timely then often deny. LTC residents are not getting basic services available to them under traditional Medicare/Medicaid. May residents are choosing to opt out where available.
The coordination of services while patients are in house is still in silos. More extra facility personnel are coming into individual buildings. due to their lack of time and resources it has been rare that they function as part of the caregiving team. Numerous times during the year cash is delayed and we have to pressure them to get paid. Quite often patients are backed up in hospitals waiting to get precerted. The hospitals are now trying to pressure us in taking patients without auths and precerts to get them out of the hospital beds.
The MyCare Ohio initiative has hurt nursing homes and also residents. It would be best for all members if the initiative ended promptly.
The UHC timely filling limit which is different than the ODM filing limit has negatively impacted cash flow negatively and caused write offs which we never had with ODM. Caresource does not understand ODM forms and does not process adjustment claims.
As with the survey I completed last year, these mycare providers still fail to pay accurately. They are not taking the Patient Liability out before payment and we are still holding monies for take backs and it is quite time consuming. I'm not sure how effective this is with other facilities, but for us, this costs us more with time spent dealing with the payment issues that it should.
There is very little knowledge by the customer service representatives with the MCP's. More training is needed in understanding the processing of the different types of claims. There is also an issue with claims having take backs 2 plus years later and then not being able to dispute/adjust a claim. Appeals processing has been well over 90 days on some claims. Some of the portals do not have user friendly appeals processing where you appeal online and receive a reference number for later correspondence/proof of appeal.
Very unhappy with this program, Under traditional Medicaid we could get reimbursed/paid in a week, this program takes 30-45 days. Would desire a change in management of the Medicaid product.
The lack of knowledge on the part of the MCP's regarding our billing system and client liability has put an undue burden on the financial sense of the Medicaid Waiver program for providers who are already grossly under paid.
This has been a disaster for our organization and for our members. The time frame it takes to receive an authorizations is a disaster. The resident's have to wait on therapy due to authorizations and also cannot receive the skilled care they deserve because the plan refuses to provide the required care, requested by the physician. The plan cannot pay a claim correctly for any reason. This has been a complete disaster.
MyCare has proven to be a drain on internal resources with no benefit to the patients. We have experienced delays with our ability to provide and coordinate services due to waiting on approval from the MyCare plans. There are still not consistent case managers for MyCare members and even discharging to the community or discharging from the hospital to our facilities is more difficult and takes additional time. The resources wasted on MyCare could be much better utilized to care for and serve all of our residents.
Transportation is by far the biggest issue.
Residents are being placed on mycare retro active and we are having to go back and get retro authorizations. Payments are not coming through clean and it take a long time to get the payments resolved whether it be patient liability related or data related. We still have payments from 2014 that are unresolved.

The issues with the delay in payment is a huge problem.
My care has increased the complexity in obtaining payment for services in an already complex environment. It adds no value to the patients and only extends the reimbursement to the providers.
CARESOURCE is excellent as far as timely billing, communication through representatives, and preauth system.
It's awful for all involved.
MyCare has negatively impacted access to care and appropriate services
The care managers are a complete waste of money, they add no value and in fact take away time from our own staff. The transportation issues are innumerable, It's a complete disaster even with a new FTE devoted specifically to managing MyCare transportation. The preauthorizations for medicaid patients are taking upwards of 14 days and for Medicare patients 2-4 days, both being far greater periods of time than any other insurance.
MyCare remittance advices are very difficult to understand. There is no consistency on really any level among the plans. We have had overpayment issues ongoing that are still not corrected. We have had problems between the third parties (Optum/Advance Health and the MyCare carrier) - which adds additional steps for resolving. We aren't always notified when a resident is being enrolled in a plan creating retro-auth (and very unfair) recoveries. We have heard time and again by other MAOs that we are the ones working with the residents directly and should know what is needed and when someone needs to be cut - so why do we add the extra steps? With traditional plans, we do not have that. About THE only good thing with the MyCare plans is we have THE most wonderful reps to work with. If the plans could be streamlined with mandated consistency on how ALL matters are handled from Hospice to auths, etc. and simplified, specified dates of remit, then perhaps then I would call the plans successful.
In my experience all MyCare does is limit access to the folks who need it most and it has been proven that it saves the state not money. It's all downside no upside. My cashflow stinks because of the untimeliness of payment and denials for no reason, and I've had to increase payroll and expenses to manages these cases. This gets a huge thumbs down and the state would be fools to expand this disastrous program. We've had it for long enough to work out kinks, and they aren't getting fixed. It's time to pull the plug and admit this program is a whopping failure!
Finding services/transportation are sometimes very difficult.
My Care has hindered care in many circumstances since we have to make additional calls regarding readmission from the hospital and change of condition status. We have had conflict between the advise given by the care managers and that of the attending physician to the point that the physician has threatened to drop the resident. Neither plan in our area does anything in the same manor which is confusing to our staff who should be more focused on care then on which insurer covers the resident and their processes. Neither plan has knowledge of the waiver programs taking longer to transition residents to a lesser care environment. Neither plan reimburses timely or correctly often either overpaying or worse to us not paying or underpaying.
The mounting receivable is troubling and even when corrected are told that it is too old to refill. Facility is owed more than $100,000 dating back to the beginning of MyCare in Hamilton, Co. There is no added value for residents. Staff at facility work well with COA when residents identified for return to the community or alternate setting. Nurse practitioners have been in and out and really don't help us or the residents at all. At time therapy, transportation, hospice and other services have been difficult if not impossible to obtain for residents.
We continue to have issues with transportation in the Toledo market.
Although we have not had to add any staff since MyCare started, we are spending a great amount of our time trying to get claims to pay correctly. So, the other areas of our job are pushed back. It is very time consuming trying to get answers and get issues resolved.
Between MyCare slowing the reimbursement cycle and the state advancing the payment cycle for the bed tax we are feeling the pinch. What a novel way for the state to increase their cash flow!
While I understand and appreciate the idea behind MyCare Ohio I disagree with its effectiveness. Transportation issues have resulted in additional cost to the facility because we have to ensure residents make it to their appointments to avoid negative outcomes, billing concerns after we have authorization resulting in delayed reimbursement, increased layers of communication through insurance companies making it difficult to communicate and delay care, denial or delay of services which the patient would be entitled to under MCR and MCD. All of these concerns combined make the entire program ineffective. While there are many more concerns these would be the biggest issues I have encountered.
This Mycare has hindered patient care, and I am shocked that we have not be cited by ODH for the bumps that MyCare have caused. We need to go back to the old way.

MyCare has been an added burden on providers in all aspects of service delivery. From delayed admissions due to additional prior authorization requirements, to planning care and transportation, there is increased and duplicative paperwork with no corresponding benefit to the care and services delivered to the resident. The payment system for MyCare varies among all five providers, none of which pay consistently in a timely manner or with continued accuracy. The increase in effort by staff to re-bill, file complaints and force payments is significant. Additional managed care in Ohio would be inappropriate for nursing home and assisted living settings.
TERRIBLE