Testimony to the Ohio Senate Finance Health & Medicaid Subcommittee

Regarding: Managed Long Term Services & Supports

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Good morning. Thank you for the opportunity to speak with you today in support of the House budget provision to create a Managed Care Study Commission.

My name is Michael Coury. I am the CEO of Generations Healthcare Management. We are a second- generation, family owned organization located in the Cleveland area. We operate both skilled nursing and assisted living communities.

Because of the locations of our communities, we are in the unique position of dealing with all five MyCare managed care plans. We also manage a skilled nursing center that is located in a traditional Medicaid fee for service county.

We have been engrossed in MyCare since its inception in May 2014. While there has been some improvement since its beginning, problems continue in both the provision of resident services and the billing aspects of the plans. From delayed access to admission due to prior authorization requirements, to delayed and inaccurate payment concerns, the frustrations with MyCare continue. I would like

to outline some of the differences we experience daily between the MyCare centers we operate and the traditional Medicaid fee for service center.

Admission and Care Planning

In the traditional fee for service facility, we communicate directly with the hospitals for referrals, make a timely admission decision and often admit a patient in the same day the initial referral was received. We admit 7-days per week and reduce unnecessary hospital days because we can respond quickly without additional barriers. In the MyCare regions, when a referral is received, we must solicit a prior authorization which, depending on the carrier, the day of the week, and the time of day can often delay an admission for 24-48 hours leaving them in the more costly hospital setting. This adds additional stress to the patient, family and hospital discharge planners who are accountable for the acute length of stay.

In the fee for service setting, once we accept an admission, we coordinate care and services through development of a care plan including goals for discharge and manage all necessary services needed to achieve that discharge goal. All of this is required per state and federal regulations, and all of this is necessary to provide quality care and services. In the MyCare regions, we perform this same care coordination, and are burdened with reporting care plans and interventions to the

carrier often with little to no additional input. We must meet calendar deadlines to provide the carrier with "plan of care updates" which are often faxed to a general intake number. We have experienced MyCare managers calling to say they did not receive the required information, only to have us prove the original was sent with fax confirmations and then resubmit what was already sent. This takes valuable staff time away from our primary duties of managing and coordinating care and services. Some plans will send Care Managers to visit their patients on a sporadic basis. These visits again take staff time, when all that is happening is a review of the care plans and processes already in place. Other carriers do not send anyone out, and rely only on the information requested via facsimile. We see no difference in the care coordination provided in the fee for service facility vs. what is offered in the MyCare centers. The main difference is the increased bureaucracy and staff time to meet the demands of the carrier.

Ancillary Services & Supports

In the fee for service center, we directly coordinate appropriate transportation to outside doctor appointments, we directly coordinate dental visits as necessary, and we directly order medical equipment as needed. In the MyCare centers we must manage these same tasks with the added burden of prior authorization and plan

specifications as to how these tasks are to be completed. The MyCare process is much more burdensome, and the results are not always timely and with the same quality as when we coordinate directly with preferred vendors.

Billing & Payment for Services

In the fee for service center, we bill Medicaid our daily rate in the traditional manner. We are routinely paid correctly within 7-10 days of billing. Patient Liability is computed correctly. We can count on the revenue stream and predictable cash flow which is vital to maintain an efficient operation. Since the inception of MyCare we have battled with all five carriers for *accurate and timely payment*. To this day, the carriers either do not understand our reimbursement system, or are unwilling to adapt their systems to ensure rates are updated and paid properly, and patient liability is calculated appropriately. When, inevitably the payment is incorrect, there are five different appeals processes to work through between the carriers. We have unfortunately found, that our most effective appeal process is to file a complaint with the Ohio Department of Medicaid MyCare hotline, after we have tried on our own to work with the carriers. We never receive a more timely response from the "correct person" than when we file a formal complaint with the department.

Assisted Living

Finally, I would like to address our experience with MyCare in the Assisted Living environment. Before MyCare, we coordinated directly with the Area Agency on Aging to evaluate the appropriateness of an individual for the Assisted Living waiver, and to determine the Tier Level service based upon the resident's needs. Once the resident was enrolled and the payment level determined, we billed the Agency for corresponding services and were paid accurately on a routine basis.

Because the MyCare plans contract the care management to the Area Agency, we have seen no change in the methodology for determining the eligibility and level of care to be provided. At times, there have been delays in obtaining transportation or some ancillary services.

What we have experienced with MyCare is a repetition of the billing concerns already addressed. Payments are often inaccurate, and timeliness is a concern. Each of the three carriers we work with have their own billing processes and procedures with no continuity among them. This has caused additional staff time to manage the bureaucracy established by each carrier. We see no change in resident care and services with MyCare in the Assisted Living setting, yet are burdened with additional processes and unpredictable cash flow.

In summary, with MyCare we see no added value to the resident care coordination and management already implemented in our settings. Instead we are burdened with additional bureaucracy and payment delays which have the opposite outcome than would be desired. I strongly urge your serious consideration of all these concerns, and ask that you endorse the ***Managed Care Study Committee*** concept as proposed in the House version of the budget.

Thank you again for the opportunity to speak with you today. I would be happy to answer any questions you may have.