



# Office of Managed Care

# MyCare Provider Dashboard

## Q2 2020

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

[medicaid.ohio.gov](https://www.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<sup>1</sup>. 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.

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<sup>1</sup> The quarterly dashboard contains information from the previous quarter due to the timing of available data elements.



# MyCare Provider Dashboard

Year  
2020

Qtr  
Q2

Plan  
All

## Prompt Pay: % Clean Claims Paid or Denied

	Behavioral Health	DME and Supplies	Home Health/PDN	Inpatient Hospital	Laboratory	Nursing Facility/Hospice Room & Board	Other Services	Outpatient Hospital	Pharmacy	Physician Services	Transporta..	Waiver Services
Aetna MyCare	20% 80%	22% 78%	2% 98%	28% 72%	14% 86%	9% 91%	21% 79%	16% 84%	21% 79%	18% 82%	44% 56%	5% 95%
Buckeye MyCare	7% 93%	20% 80%	7% 93%	24% 76%	26% 74%	7% 93%	18% 82%	17% 83%	35% 65%	18% 82%	20% 80%	4% 96%
CareSource MyCare	6% 94%	17% 83%	6% 94%	11% 89%	8% 92%	6% 94%	20% 80%	6% 94%	27% 73%	10% 90%	6% 94%	10% 90%
Molina MyCare	16% 84%	18% 82%	25% 75%	10% 90%	9% 91%	5% 95%	15% 85%	10% 90%	18% 82%	10% 90%	18% 82%	6% 94%
United Healthcare ..	11% 89%	9% 91%	6% 94%	14% 86%	25% 75%	11% 89%	19% 81%	10% 90%	0% 100%	10% 90%	43% 57%	2% 98%

**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

	Total Clean Paid or Denied Claims - 0-30 Days	Clean Pended 91+ Days	Unclean Claims - 0-30 Days
Aetna MyCare	1,882,204	657	3,174
Buckeye MyCare	878,766	6	9,281
CareSource MyCare	1,049,855	3	56,466
Molina MyCare	1,312,069	60	10,444
United Healthcare MyCare	820,844	0	10,918
<b>Grand Total</b>	<b>5,943,738</b>	<b>726</b>	<b>90,283</b>

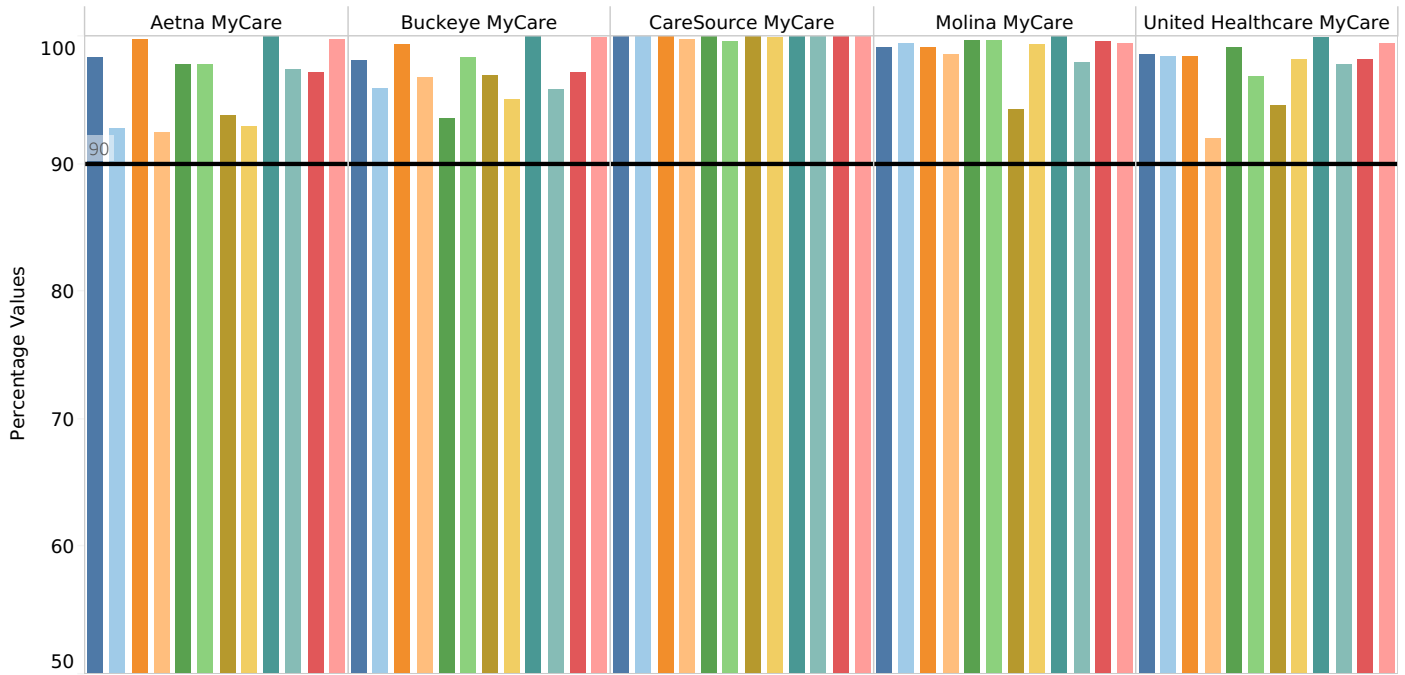
Year  
2020

Qtr  
Q2

Category of Service  
All

Plan  
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/Hospice Room and Board, Behavioral Health, Waiver Services, and All Services Excluding Nursing Facility, BH, Waiver, and Pharmacy

Category of Service

- Behavioral Health
- DME and Supplies
- Home Health/PDN
- Inpatient Hospital

- Laboratory
- Nursing Facility/Hospice Room & Board
- Other Services
- Outpatient Hospital

- Pharmacy
- Physician Services
- Transportation
- Waiver Services

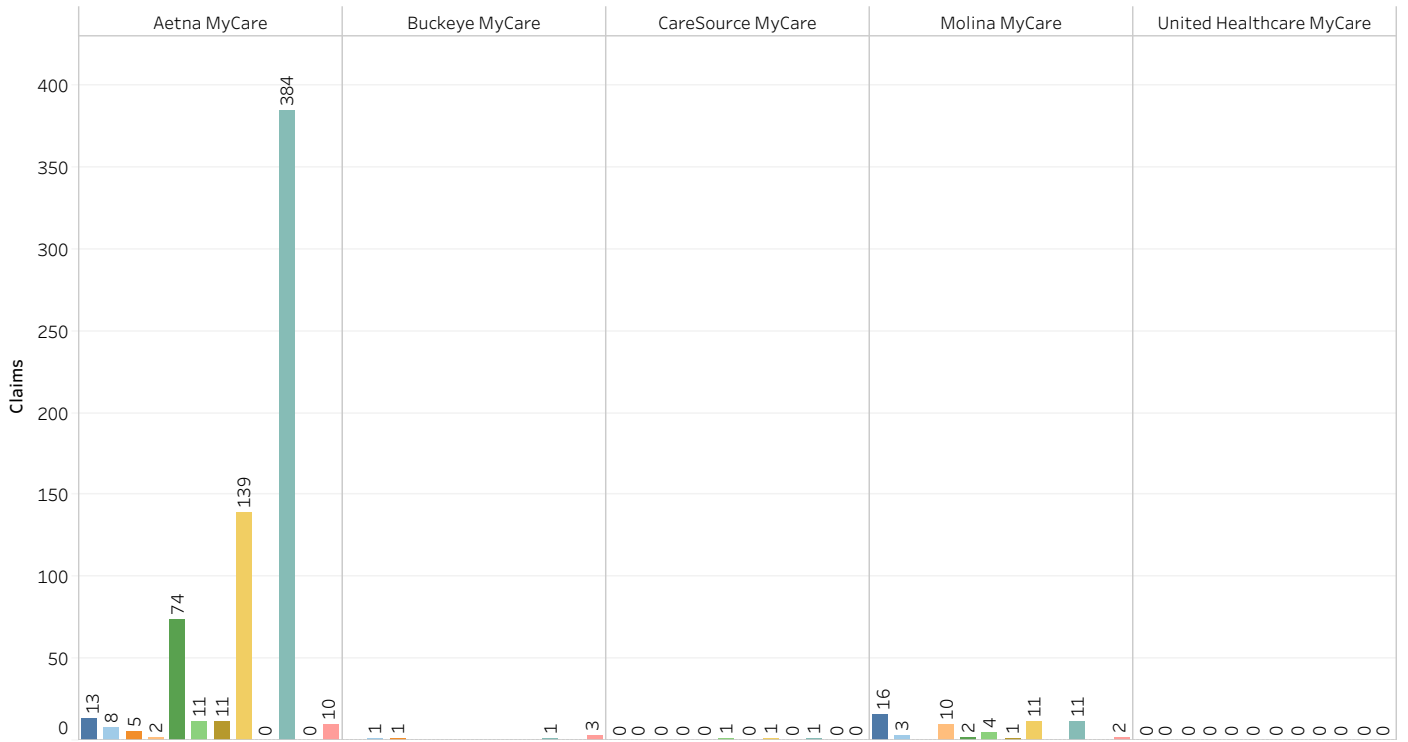
Year  
2020

Qtr  
Q2

Category of Service  
All

Plan  
All

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



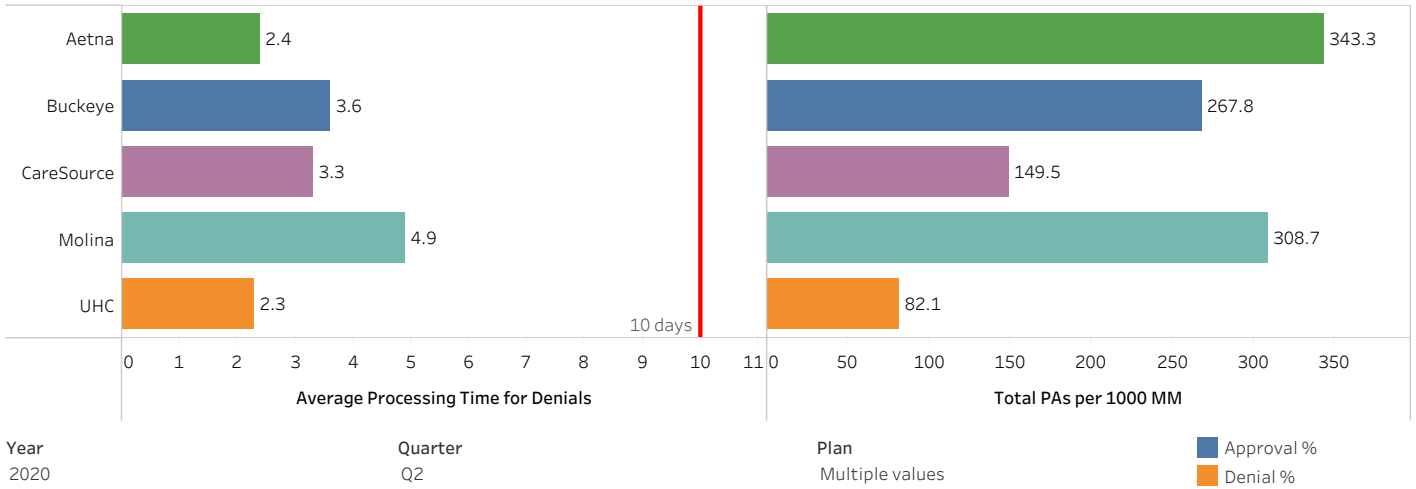
Pended claims are at a point in time and is constantly in flux

**Category of Service**

- Behavioral Health
- DME and Supplies
- Home Health/PDN
- Inpatient Hospital
- Laboratory
- Nursing Facility/Hospice Room & Board
- Other Services
- Outpatient Hospital
- Pharmacy
- Physician Services
- Transportation
- Waiver Services

# Prior Authorization

## Average Processing Time for Denials and PAs per 1000 MM



## 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	Complaints per 1000		Communication				Coverage/Service
	Total	MM	Issues	Prior Authorization	Eligibility Issue	Payment of Claims	Denials
Aetna	51	0.50	0	5	2	41	0.00
Buckeye	1	0.00	0	0	1	0	0.00
CareSource	25	0.24	3	2	3	14	0.00
Molina	2	0.01	1	0	0	1	0.00
United	13	0.12	2	0	2	2	0.00
<b>Total</b>	<b>92</b>		<b>6</b>	<b>7</b>	<b>8</b>	<b>58</b>	<b>0.00</b>

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)