MyCareOhio
Connecting Medicare + Medicaid

Frequently Asked Questions
Received From Member & Provider Forums

Q.1 How quickly are the MyCare Ohio Plans (MCOP) required to pay claims?

A.1 In accordance with 42 CFR 447.46, MCOPs must pay 90% of all submitted clean claims within 30 days of the date of receipt and 99% of such claims within 90 days of the date of receipt, unless the MyCare Plan and its contracted provider(s) have established an alternative payment schedule that is mutually agreed upon and described in their contract. This is an aggregate measure of all claims. These requirements, therefore, do not apply to individual claims.

Q.2 I am a provider, will I be required to get a prior authorization for services. If so, how long will that take?

A.2 Each MCOP will determine which services require prior authorization. All non-contracted provider services require authorization. The plans' websites post information about authorization requirements. For standard authorization decisions, the MyCare Plan must provide notice to the requesting provider and member as expeditiously as the member's health condition requires but no later than fourteen calendar days following receipt of the request for service. If the standard authorization timeframe could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function, the MyCare Plan must make an expedited authorization decision and provide notice of the authorization decision as expeditiously as the member's health condition requires but no later than three working days after receipt of the request for service (ref OAC 5160-3-26-03.1). Providers and members who believe an expedited decision is appropriate are encouraged to document this as part of the request.

Q.3 What is the difference between the waiver service coordinator and the MyCare Ohio Plan care manager?

A.3 The **Care Manager** is the person ultimately accountable for the care of MyCare members. The Care Manager will lead and coordinate the member's trans-disciplinary care team and ensure overall coordination of services. The **Waiver Service Coordinator** is the MyCare waiver service expert who will ensure that all functions under the waiver occur including the monitoring of waiver service plans and health and welfare issues. They will address issues related specific to waiver services. This may or may not be someone different than the Care Manager.

Q.4 How often can members change MyCare Plans?

A.4 Dual members (those who chose to receive their Medicare services from the MyCare Plan) may change plans monthly. Medicaid-only members (those who chose to receive their Medicare services from

another Plan) may change MyCare Plans only during the first 90 days of initial enrollment into MyCare Ohio, and then again during the annual open enrollment period.

Q.5 Are their premiums and co-pays associated with MyCare Ohio?

A.5 Co-payments will apply only for MyCare members' prescription drugs as established by the plan's Part D and Medicaid combined drug formulary. Medicaid premiums will be covered by the MyCare Plan according to what is currently covered by Medicaid.

Q.6 How will Ohio know if MyCare Ohio is working?

A.6 The state and federal governments will be collecting data and feedback across many areas, such as, member satisfaction, HEDIS and other clinical performance measures including long term care, care management, and administrative process measures. Reviews of MyCare Plans performance will take place by an External Quality Review Organization, and the State. The results of this will help Ohio determine if MyCare Ohio is working.

Q.7 Are individuals who are receiving hospice services included in MyCare Ohio, and how will payment be made for hospice delivered in a Nursing Facility (NF)?

A.7 Yes individuals who receive hospice will be enrolled in MyCare Ohio. For those members who elect hospice while enrolled in MyCare Ohio, Medicare hospice is billed to FFS Medicare. When hospice is provided in a NF, the MyCare Plan is responsible for Medicaid room and board. Plans sometimes pay the NF directly and other times may pay the hospice provider, who will pay the NF. Arrangements may vary. An authorization will be required.

Q.8 What is the difference between a delayed and recurring spend down?

A.8 Individuals on a delayed spend down are not included in the MyCare Ohio demonstration. Individuals with a recurring spend down are included.
Delayed spend down: The spend down is not met until it is paid in or incurred bills are received each month. The result is a delay in eligibility each month.
Recurring spend down: The individual has a recurring health expense that automatically results it meeting the spend down requirement. The result is continuous eligibility each month.

Q. 9 What is considered "creditable" coverage for the third party insurance exemption from participation in MyCare Ohio?

A.9 A comprehensive insurance plan that covers medical and hospital care. Stand-alone dental, vision, or long-term care insurance would not make someone ineligible for MyCare Ohio.