MyCare Ohio: Frequently Asked Questions
(A Medicaid-Medicare Plan Dual Eligible Demonstration Program)

Q. What is MyCare Ohio?

A. MyCare Ohio, a three-year demonstration program, is a system of managed care plans selected to coordinate physical, behavioral, and long-term care services for individuals older than 18 who are eligible for both Medicaid and Medicare who reside in one of the 29 demonstration counties. Since May 1, 2014, the Ohio Department of Medicaid has been transitioning the fee-for-service program to one of five private sector insurance (Aetna, Buckeye, CareSource, Molina, or UnitedHealthcare).

The MyCare Ohio Program provides a central point of contact/single point of accountability; strives to improve health outcomes through prevention and better coordination; promotes independence through increased use of home and community-based care options; includes prescription drug benefits; includes strong continuity of care requirements; and increases consumer control and choice.

Individuals began enrolling in a MyCare Ohio managed care plan for Medicaid services on May 1, 2014. Enrollment was phased in through June and July until all eligible individuals were enrolled. Under the enrollment timeline, individuals have had up to eight months to decide which Medicare plan best fits their health care needs.

Beginning in January 2015, individuals who have not yet selected to be fully enrolled into a MyCare Ohio plan will be enrolled into one of the MyCare Ohio plans for their Medicare benefit to ensure full coordination of their care. A member will be passively enrolled into the same MyCare Ohio plan that currently manages the Medicaid portion of the member’s benefits. A member cannot be enrolled in two different MyCare managed care plans (i.e. a member cannot have their Medicare managed by one MyCare plan and their Medicaid by another MyCare plan). These individuals continue to have the option to opt out of the program for their Medicare services but they must make that election or they will be passively enrolled into a full MyCare plan.

Q. Who is not eligible to enroll in MyCare Ohio?

A. Individuals are not eligible to enroll in MyCare Ohio if they do not have full Medicaid benefits and Medicare Parts A and B; if they are younger than 18 years old; if they receive PACE; if they have a spend down; if they receive services from a county board of developmental disabilities; or if they have creditable medical insurance, including retiree benefits, other than a Medicare Advantage plan.
Q. What will change on January 1, 2015, with a consumer’s coverage once enrolled with a MyCare plan (therefore being assigned to a MyCare plan to receive their Medicare coverage)?

A. As of January 1, 2015, an eligible individual’s coverage with a MyCare plan will be in effect; however, they may elect to stay with traditional Medicare or a Medicare Advantage plan for their Medicare benefits (the beneficiaries who choose to “opt-out” of Medicare will still be enrolled in the Medicaid portion of MyCare Ohio). A consumer’s MyCare Ohio plan will include all benefits available through traditional Medicare and Medicaid programs, including long-term care services and supports (if applicable), and behavioral health services. A consumer may also be eligible to receive added services that their current programs cannot offer (for example: extra dental visits), depending on which MyCare Ohio plan they choose.

Q. If a patient enrolled in a MyCare plan feels they cannot access the care they need/want, can the patient disenroll from the MyCare plan and move to traditional Medicare or a Medicare Advantage Plan?

A. Patients can switch back to traditional Medicare and a Part D drug plan or Medicare Advantage plan at any time. Patients can also switch from traditional Medicare or a Medicare Advantage plan to a MyCare plan for their Medicare benefits at any time, but not into a Medicare Advantage plan. Please note a consumer will remain with the MyCare plan for their Medicaid benefits and will have the option to change their MyCare Medicaid plan during the annual enrollment period only.

Q. What is the length of time for transitions of patient care after January 1, 2015, if a physician does not participate in MyCare program?

A. For members identified as high-risk, the transition of care timeframe is 90 days from the time of Medicaid enrollment. For all other members, the timeframe is 365 days from the time of enrollment. For additional details, please see the Ohio Department of Medicaid MyCare document “Plan Payment Requirements for Existing Providers of Care.”

Q. Are there transitions of care requirements plans must follow?

A. Yes, both the Centers for Medicare and Medicaid Services and Ohio Medicaid require specific service transition periods for new members, and Ohio Medicaid specifies certain payment requirements for non-contracted providers during transition periods. For additional details, please see the Ohio Department of Medicaid MyCare document “Plan Payment Requirements for Existing Providers of Care.” The transition of care requirements vary by type of service. Physician services can be covered for up to 365 days for non-contracted physicians, unless the interdisciplinary care team the member chooses decides that a change of physician is required for execution of the member’s plan of care.
Q. If a patient's personal family physician is not contracted with the MyCare plan of the patient, will the physician be paid as though they are in-network?

A. MyCare members can continue to see their current providers through the transition of care timeframes. Please see the Ohio Department of Medicaid MyCare document “Plan Payment Requirements for Existing Providers of Care” for questions regarding payment.

Q. Can a patient's family physician refer a patient to an in-network specialist, pharmacy, diagnostic imaging, or hospital with full benefit coverage for patient?

A. Yes; however, physicians will need to request prior authorizations for specific services.

Q. Since payment levels in MyCare plans are at Medicare levels, can the rates be changed by the health plan administering MyCare?

A. If you are in-network and seeing a MyCare patient, the rate you are paid will be determined by your negotiated contract (typically tied to the Medicaid and Medicare fee schedules). Please see the Ohio Department of Medicaid MyCare document “Plan Payment Requirements for Existing Providers of Care” for additional payment questions, including questions related to out-of-network providers.

Q. Can reimbursement levels be changed by the MyCare health plan/does the MyCare plan have to pay at Medicare rates or better?

A. If you are in-network with a health plan for the MyCare program, your rate is determined by your contract. For patients that keep traditional Medicare, the rate will change when the Medicare fee schedule changes (usually in January). Please see the Ohio Department of Medicaid MyCare document “Plan Payment Requirements for Existing Providers of Care” for questions regarding payment. If you are an out-of-network physician, the MyCare plan must pay the physician at Medicare rates.

Q. Will there be a readily identifiable care manager in the MyCare plan that can facilitate coordination of special medical services?

A. All MyCare Ohio members will have a care manager. Each member should have a care plan that is shared with the physician they identify as being part of their interdisciplinary health care team. Your office may be called for assistance if there is a member the plan cannot locate. If you did not receive a copy of the member’s care plan, please contact the health plan using the numbers on the member’s ID card. It is possible that the health plan was not able to locate or contact the member.
Members are assigned a care manager at the time of enrollment. The ability of the care manager to take care of pre-certifications will vary from health plan to health plan. However, the care manager will assist in coordinating all services as they are added to the member’s care plan, including special medical services, services that need precertification, and community services. Members who are receiving “waiver services” such as Passport or adult daycare will also have those services managed by their care manager. An Area Agency on Aging waiver coordinator may also be assigned to these patients to assist with direct care coordination.

Q. Can physicians bill for a patient’s care plan review?

A. Payment would be based on the physician’s contract with the MyCare plan and/or contact the MyCare Plan to get clarification on how that particular MyCare plan handles reimbursement for these types of services. Non-contracted physicians will be paid per the Medicare payment and Medicaid fee for service fee schedules for Medicare and Medicaid covered services.

Q. How can a physician identify which of their patients are eligible to participate in the MyCare demonstration project?

A. Individuals are eligible for MyCare if they receive Medicare Parts A, B, and D and full Medicaid benefits in one of the 29 MyCare Ohio demonstration counties. If the person is a current MyCare Ohio member, the member will get an ID card from their plan, but physicians should verify eligibility through the plan portal or through the Ohio Department of Medicaid’s MITS system. It will be important to verify if the member is with the Mycare plan for their integrated benefits or if they only have the MyCare plan for the Medicaid portion of their benefits only.

Q. Can MyCare plans provide physicians a list of their patients who are eligible for MyCare and the individual care managers assigned to those patients?

A. Yes, physicians should contact the MyCare plans serving their region for a list of patients and their care managers. Many plans offer providers the option to retrieve member eligibility lists from the plan’s online provider portal. A provider must register for access to this portal and is encouraged to contact the health plan to learn more.

Q. Since the MyCare plan pays the physician 100% of the Medicare reimbursement, does the patient have to pay the 20% traditional balance of Medicare fees?

A. No, traditional Medicaid cross-over rules apply. The patient is responsible for Medicare cost share in very limited situations.

Sources:
Ohio Association of Health Plans
Ohio State Medical Association