MyCare Ohio FAQs
Skilled Nursing Facility

CONTENTS

Disclaimer:

The information in this document has been collected from a variety of sources including the Ohio Department of Medicaid, the managed care plans, and the long-term care associations. It is believed to be accurate as of May 2, 2014; however, it is subject to change and should only be used as a guide. Please consult the rules and contracts governing the program should you require more detailed information. You may also contact Ohio Medicaid or your association if you have further questions about MyCare Ohio. This is not a legal document and no legal advice is given.

ASSESSMENTS AND PLAN BENEFITS

1. Who will be performing level of care (LOC) assessments?

   Answer: If the person is already enrolled in the MyCare Ohio plan, any assessment is done per the policies of the managed care plan. If the person is not in MyCare Ohio, the LOC assessment is done like it currently is done today.

   a. PASRRs?

      Answer: The PASRR process will be done as it is done today via the Area Agency on Aging, the Ohio Department of Mental Health and Drug Addiction and the Ohio Department of Developmental Disabilities as appropriate.

2. Will managed care plans (MCPs or "plans") be able to use their own skilled criteria?

   Answer: The plans will be doing their own authorizations; however, Medicare and Medicaid requirements will still be relevant as that is the criteria the plans will be held against if there is an appeal. Medicare and Medicaid definitions of medical necessity must also be met.

3. Will SNF providers still use the MDS for MyCare Ohio members?

   Answer: Yes.

   a. How should a MyCare Ohio resident be coded in Section A on the MDS?

      Answer: They should be coded as if they were not enrolled in MyCare Ohio. For example, if the person has been in the facility for over 100 days and would normally be on Medicaid fee for service, they should be coded as "Medicaid." *Please note that this will most likely change as of October 1, 2014*.

4. How often will residents be assessed for care management purposes (care management assessments)?

   Answer: The frequency will ultimately depend on each plan; however there are minimum requirements built into the three-way contract. The initial minimum frequency and type of assessment will depend on the risk stratification of the resident, with higher risk (or medical need) residents being reassessed more frequently than lower risk residents. Intensive (highest) requires a reassessment every 30 days, High every 45 days, Medium every 60 days, and Low or Monitoring every 75 days. After six-months, quarterly assessments will generally become the minimum. The afore mentioned reassessment periods are minimums; residents can be assessed more frequently and will also be assessed when there is a change in status.

   a. What is the authorization period for a post-acute stay?

      Answer: This will vary between plans. For example, one plan will have a 7 day initial authorization period with ongoing assessments every 3 to 4 days for review of status change.

   b. What is the authorization period for a long-term care stay?

Answer: This will vary between plans.

5. Is the three-day hospital stay still a requirement for a skilled stay?

   Answer: This was included in the capitated rate calculation for the plans and may be relevant for provider payments depending on the contract; however, a request for NF services will be reviewed first against Medicare criteria and then against Medicaid criteria per question 2. Each plan may have a different approach, such as a review for LOC and Medicaid medical necessity if there is no 3-day stay.

6. Do plan members have to have access to services they would have access to under traditional Medicaid or Medicare?

   Answer: The criteria that will be used for appeals will be the current Medicare or Medicaid medical necessity and coverage criteria.

7. Is hospice a covered service under MyCare Ohio?

   Answer: Any Medicare hospice provider can furnish services to a MyCare member, *billing traditional Medicare*. They must be a contracted MyCare Plan provider for Medicaid covered hospice services, including room and board. Room and Board and other covered unrelated expenses are paid by the MyCare plan.

8. Who is responsible for discharge planning from a SNF and ensuring safe placement in the community?

   Answer: It is expected that the MyCare Ohio care manager will work with SNF staff on appropriate discharge planning. There is no requirement for payment outside of any authorization period (i.e. if the NF believes the person cannot be discharge to a safe environment, there is no rule requiring the plan to pay the provider). The state expects the plans to authorize medically necessary NF services, or demonstrate a plan of care or discharge to services in a lower cost alternative setting. The MyCare plan is responsible for follow-up in the community and ensuring a safe transition.

9. When benefits overlap, how is it determined what is a "Medicaid" service and what is a "Medicare" service?

   Answer: The authorization process first reviews against Medicare criteria then Medicaid criteria, so any overlap would be considered a Medicare service first. This is similar to the Medicare Advantage process.

PAYMENT AND CONTRACTING

1. What are the prompt payment regulations that a MCP has to follow?

   Answer: Federal prompt payment requirements at 42 CFR 447.46.

   a. Does this vary depending on the type of "original service" being provided (Medicaid or Medicare)?

      Answer: No; the requirement is for all claims, assessed in aggregate.

2. Does an MCP have to accept electronic claims?

   Answer: Yes, and they all have the capability to do so.

3. How often can a provider bill for services?

   Answer: The plans have all indicated they can accept electronic billing at any time. A provider should consider the impact patient liability changes could have on the claims when determining how often to bill. The general consensus is that NF providers should continue to bill monthly given that the plans will be updating their system with the latest eligibility information by the third day of the month.

4. What is the MCPs provider payment schedule?

   Answer: Actual payment schedule varies by plan, but most plans indicate they can pay a clean claim within 10 to 14 business days.

5. Who pays for services while Medicaid is pending?

   Answer: Because the individual is not enrolled in Medicaid, they are not yet eligible for MyCare Ohio. Thus, providers should follow the current Medicaid fee-for-service application process. Medicaid will cover under fee-for-service until the person is enrolled in MyCare Ohio and the plan begins coverage of services on the first of the month (or the second month) after the person selects a plan.

6. Who pays for services during an appeal?

   Answer: During MyCare Ohio enrollment, continuation of benefits applies per the current processes, when a timely request is made per Ohio Administrative Code rule 5160-58-08.4.

7. Who pays during the period when the member is enrolled and prior to MyCare Ohio coverage begins?

   Answer: Medicaid fee-for-service until MyCare Ohio coverage begins.

a. What if the member is already enrolled in MyCare Ohio and is "opting-in" for Medicare?

   Answer: The member's current Medicare coverage will continue until MyCare Ohio Medicare coverage begins.

8. Will bed-holds still be required?

   Answer: Bed hold days are a benefit in the MyCare program with authorization from the MyCare plan. Each plan will have their own policy which may mirror the current Medicaid rules.

   a. At what reimbursement rate?

   Answer: At the current Medicaid rate for non-contracted providers, including the occupancy adjustment. Otherwise, as determined in the plan-provider contract.

9. Will plans cover co-insurance for the Medicare benefit if a person is "Medicaid only?"

   Answer: This is dependent upon the plan-provider contract. Providers should bill the plan even if the plan will not pay for the co-insurance for bad-debt purposes.

   a. Is Medicare bad debt included in the MCP capitated rate calculation?

      Answer: Yes.

10. Who is responsible for collecting patient liability?

    Answer: The providers will still be responsible for collecting patient liability.

    a. How is communication of this amount and any changes handled?

       Answer: The same process as is done now at the county level with the 9401s. Plans will receive updated eligibility information monthly. Providers can have claims adjusted retroactively by providing documentation to the plans of the change in PL.

11. If a person no longer meets LOC, who pays for services during the discharge process?

    Answer: This is a collaborative effort between the provider and the plan.

12. Does a "non-network" SNF provider have to enter into a contract with a plan if a current resident selects the plan for MyCare Ohio?

    Answer: Not for long-term care Medicaid services. In most cases, a provider can enter into a "single-case" agreement with a plan. There may be a delay in services if the provider is not "loaded" into the plans system for payment. Providers are encouraged to at least provide payment information to plans even if they do not wish to contract with the plan so payment for any residents will get processed in a timely manner.

    a. What rate is the SNF provider paid and for which type of services?

Answer: The current Medicaid rate for residents who reside in the home on the effective date of enrollment in MyCare Ohio.

13. Does a provider that "sub-contracts" for ancillary services bundled in the rate have to use one that is permitted by the plan or can the provider choose any sub-contractor?

    Answer: Ancillary services may require MyCare plan contracts, and are not covered out of network unless authorized by the plan.

APPEALS AND COMPLAINTS

1. Does the appeal process depend on the "original coverage" for the type of service (Medicaid or Medicare)?

   Answer: Yes. For NF services, the member can file an appeal with the plan which will review for Medicare and Medicaid coverage, and can also request a Medicaid state hearing concurrently.

2. If a service is normally covered under both Medicare and Medicaid, can the member file simultaneous appeals under both Medicare and Medicaid protocols?

   Answer: The appeals process is not dictated by payer (see #1 above).

3. Will there be a third-party external review of appeals?

   Answer: The state hearing process will provide for external review. If a Medicare appeal is not overturned by the plan, then an independent review entity (IRE) will automatically review the appeal.

4. Will there be an appeals process for providers?

   Answer: Plans are required to offer a process for provider appeals.

5. Who is responsible for providing denial notices or termination of benefits to members?

   Answer: The plans will provide those notices. Some Medicare notices may require issuance by providers, per Medicare guidance.

6. I am a provider and have an issue with one of the MCOs, what do I do?

   Answer: Plans have provider service/relations phone numbers. If a provider is unable to resolve its issue with the MCO, then an online complaint can be submitted for review to: https://pitd.hshapps.com/external/epc.aspx.

7. I am a member and have an issue with one of the MCOs, what do I do?

   Answer: Plans have member services phone numbers and each member is assigned a care manager. Medicaid will also be able to handle member questions and complaints (800) 324-8680.

ELIGIBILITY AND ENROLLMENT

1. If an individual is on spend down each month, are they eligible for MyCare Ohio?

   Answer: Individuals on delayed spend down are not eligible for enrollment.

2. If an individual is intellectually disabled (ICF/IID eligible) but residing in a SNF, are they eligible for MyCare Ohio?

   Answer: If the individual is receiving County Board of DD Services, then they have an option to disenroll.

3. What is considered "creditable" coverage for the third party insurance exemption?

   Answer: 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. Medicare supplemental insurance ("MediGap" coverage) that covers hospital and physician co-insurance **may be** considered "creditable" coverage – depending on how the county filed the insurance in question.

4. Does a person have to be able to receive both Medicaid and Medicare services to be enrolled in MyCare Ohio?

   Answer: Yes, a person must be enrolled in both Medicaid and Medicare prior to being eligible for MyCare Ohio.

5. Once a person is enrolled in MyCare Ohio, are they eligible regardless of service setting (home, AL, SNF) or are there different eligibility criteria based on setting?

   Answer: Yes, once enrolled they are eligible regardless of service setting.

6. Can beneficiaries select different plans for their Medicare and Medicaid benefits if enrolled for both Medicare and Medicaid services in MyCare Ohio?

   Answer: No, the person must select one MyCare Ohio plan for both Medicare and Medicaid (Dual Benefits member), or for Medicaid only (Medicaid only member).

7. If a member is not enrolled for MyCare Ohio Medicare benefits, can he/she select a MA plan that is offered by a different plan than their MyCare Ohio plan?

   Answer: Yes, the person may enroll in any Medicare plan, including traditional, if they do not enroll for Medicare in MyCare Ohio.

8. When Medicare passive enrollment begins in January 1, 2015, will the member automatically be enrolled with the same plan as his/her current MyCare Ohio plan for Medicaid services?

   Answer: Yes, unless the person selects a different plan by calling the Medicaid Hotline.

9. How often can a MyCare Ohio member change plans?

Answer: Members enrolled in MyCare Ohio as dual benefits members (for both Medicare and Medicaid) can change plans each month. Members enrolled in MyCare Ohio for Medicaid only benefits can change plans for the first 3 months after initial enrollment, and during open enrollment, which will be once a year. Medicaid sends notice to members of open enrollment once a year.

10. How often can a MyCare Ohio member opt-out of the Medicare benefit?

    Answer: They can opt-out once a month effective the first of the following month.

11. Does a MyCare Ohio member have to reapply for Medicaid each year to maintain eligibility?

    Answer: Yes, eligibility for Medicaid is maintained by the county, and MyCare Ohio enrollment does not change the eligibility process.

12. How will providers know if a resident or new admit is enrolled in MyCare Ohio?

    Answer: The MITS portal will be updated daily, and will provide information about managed care enrollment as well as Medicaid Only or Dual Benefits enrollment status after the effective date of the enrollment. Also, plans have their own method for contracted providers to determine eligibility.

    a. If a member changes plans or opts-in/out of Medicare?

       Answer: The database is uploaded daily and plans are notified of the changes to update their systems. Recall that any changes to do not take place until the first day of the next month (or second month if the change is made within five business days of the end of the month).

13. What happens when a member switches to either a non-demonstration county or one where his MCP does not have a contract with the state to offer MyCare Ohio services?

    Answer: County of residence is established by the county eligibility worker. If the residence changes in CRIS-E to a county that is not a MyCare county, disenrollment will occur.

    a. How does length of stay (short-term post-acute care versus long-term care) impact what happens?

       Answer: It does not impact what happens.

ODDS AND ENDS

1. If a social worker or staff member takes the credentialing class to provide information on MyCare Ohio, can they provide information to current or potential enrollees?

   Answer: Providers are not eligible to assist residents in selection of plans.

2. Will MyCare Ohio members be included in the case-mix scores for Medicaid rate setting?

   Answer: Yes.

   a. If so, how will they be allocated between the "Medicaid only" and "all residents" scores?

      Answer: A MyCare plan member should be coded on the MDS as if they were not enrolled in the program under Section A. For example, if the member would have been on Medicaid FFS if not for MyCare, then they should be coded as "Medicaid." This allows the person to be captured in the case-mix scores. *This will most likely change October 1, 2014.*