



# MyCare Ohio

## Home and Community Based Care Issues

January 9, 2015



## MyCare Ohio Home and Community Based Care Issues

**Please note: The information contained in this table has been supplied to us by the various MyCare Ohio plans and is current at the time of publication. It will be updated as new information becomes available.**

### MyCare Ohio Plan Contact Information

Topic	Aetna	Buckeye/ Centene	CareSource	Molina	United
<b>Prior Authorization</b>	Phone: 855-364-0974, ask for a PA Nurse if you need immediate assistance or for urgent service requests  Fax: 855-734-9389	Care Management: 1.866.296.8731  Utilization Management: 1.866.296.8731  Fax: 1-877-861-6722	Par and non-par provider: Call and/or FAX the information to the medical management department (for skilled services) and to the care management department for non- skilled (i.e. waiver) services. If a visit needs to be made and the PA cannot be received prior to the visit, CareSource will retroactively approve the visit. This should only occur with initial evaluations. Fax: 888-752-0012 Phone 800-488-0134	Phone: (855) 322-4079  Medical PA Fax: (866) 449-6843	Prior Authorization contacts and #s 800.366.7304  Fax: 866-839-6454
<b>24/7 Care Manager/On- Call</b>	855 -364-0974 for 24/7 and After Hours calls, follow the prompts for the special services you require			Care Management: MyCare Duals (8-5 M- F) (855) 665-7862  Care Management: MyCare Medicaid Only (8-5 M-F) (855) 687-7862  Care Management (after hours) (888) 275-8750	24/7 Care Manager/On Call contacts and #s 800.542.8630 is our 24/7 Nurseline. Member services can also provide the CM name during their normal business hours: 877.542.9236 7a-8p

<b>Problems/Issues/Concerns</b>	Problems/Issues (unclear what type of problems or issues): 855-364-0974 and follow the prompts	Provider Services: 866-296-8731		Provider Services: (855) 322-4079	Problems/Issues contacts and numbers <a href="mailto:icdsprovider@uhc.com">icdsprovider@uhc.com</a> , or provider service: 1.800.600.9007
<b>Contracting</b>	Ph: 855-364-0974 (follow the prompts) Fax: 860-902-8302 Email: <a href="mailto:OH_ProviderServices@aetna.com">OH_ProviderServices@aetna.com</a>			(855) 322-4079 or complete <a href="#">Non-Par Provider Contract Non-Par Provider Contract Request Form</a> and send it to us.  By Email: <a href="mailto:Molina.Ohio@MolinaHealthcare.com">Molina.Ohio@MolinaHealthcare.com</a>	Contracting Individual/dept. and #s <a href="mailto:icdsprovider@uhc.com">icdsprovider@uhc.com</a> or <a href="http://www.uhccommunityplan.com/health-professionals/oh/unit-edhealthcare-connected.html">http://www.uhccommunityplan.com/health-professionals/oh/unit-edhealthcare-connected.html</a>
<b>Website for providers</b>		<a href="http://www.bchpohio.com/providers/mycare-ohio-resources/">www.bchpohio.com/providers/mycare-ohio-resources/</a>  MyCare Training Classes for Home & Community Based Providers Webinar Sessions ▪3:00 pm to 4:00 pm on Wednesdays ▪10:00 am to 11:00 am on Fridays ▪RSVP for the webinar is not required. ▪To listen to the webinar dial (855) 351-5537 and use Code: 4596221393 # ▪To view this training on the web go to: <a href="http://centene.adobeconnect.com/hcbs-1/">http://centene.adobeconnect.com/hcbs-1/</a>			

## Home Health Questions

Topic	Issues	Aetna	Buckeye	CareSource	Molina	United	Comments
<b>Pre-Authorization</b>	<p>What is a timely response in meeting the needs of the patient; current patient with urgent need for skilled unplanned (prn) visit.</p> <p>IMPORTANT NOTE: Per all plans, the home health agency should always provide care to the patient. Payment will be worked out with the provider afterwards.</p>	<p>Par and non-par provider: NO PA is required for an initial evaluation.</p> <p>PA is required for re-certifications.</p> <p>Based on the initial evaluation, the HH provider should collaborate with the Aetna Care manager for any services that need to be approved. The HH provider does not need to contact the PA Department.</p> <p>After the TOC period the member and the Care Manager will work on transitioning to an in-network provider for any new HH services. Existing HH provider relationships and services should not be interrupted based on network status.</p> <p>If the provider or the member have questions after hours they may contact the After Hours Nurse Advice Line or the Care Manager (This option is available 24/7)</p>	NO PA is required for an initial evaluation.	NO PA is required for an initial evaluation under Medical Management.	<p>Par and non-par providers: Allow for 3 HH vs without PA to account for processing of PA requirements</p> <p>If Urgent: Request urgent PA – turnaround time is about 48 hrs.</p> <p>Molina will look at anything retrospectively if it comes in after hours</p> <p><u>PAYMENT:</u> Provider must be in the system in order to receive payment. In order to be in the system there must be an agreement. <i>Molina will accept a verbal confirmation from the provider that provider will accept payment rate</i></p>	<p>Par and non-par provider: Call the Care Manager if cannot reach Care Manager call the PA Line (PA Line is available after hours)</p> <p>If Urgent: Call the PA line and if cannot make the call/get what is needed see the patient and then United will do a retro PA</p> <p><u>PAYMENT:</u> Provider must be in the system in order to receive payment. In order to be in the system there must be an agreement.</p>	<p><u>Transition of Care Period:</u> If a provider changes for a patient mid-stream then the Transition of Care time period does not apply.</p> <p><u>ALL NON PAR PROVIDERS:</u> if seeing a patient at time he/she elects MyCare then can continue to see patient for the Transition of Care period</p>

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	<p>2. Process for the HHA to request increased waiver services in an emergent situation.</p>	<p>Re-Certifications: The Care Manager is responsible for reaching out to the provider and in gathering the information that is needed for authorization of services.</p> <p>Urgent or Emergent Care does not require Aetna notification.</p> <p>Providers have 48 hours to notify Aetna when a service is started in order to meet the needs of the member.</p> <p>The HHA can call the Care Manager/Waiver Services Coordinator (one and the same in the Aetna Better Health Plan) or the 24/7 Nurse Advice Line to increase the services when it is medically necessary.</p>	<p>Information not available at time of publication.</p>	<p>Information not available at time of publication.</p>	<p>Call the 24/7 Care Manager/On-call number via Molina's Nurse Advice Line telephone number. If unsuccessful reaching this person call the Waiver Service Coordinator (if the patient is over 60 most likely with a AAA too)</p>	<p>Call the 24/7 Care Manager/On call number via UHC Nurse Advice Line Number If unsuccessful reaching this person call the Waiver Service Coordinator (if the patient is over 60 most likely with a AAA too)</p>	

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	3. Physicians are not in the network with the plans and their orders are not being accepted by the plan.	This is not an issue and will not hold up a PA for services the member currently receives.	This is not an issues and will not hold up a PA.	Information not available at time of publication.	This is not an issue and will not hold up a PA	This is not an issue and will not hold up a PA	All plans have Provider Directories posted on website
	4. Is the Medicare F2F document required?	None of the plans are requiring the F2F document at this time. If a provider receives a payment audit for a MyCare Ohio member, the provider should not be audited against the Medicare F2F requirement.					



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	<p>3.Plans requiring Medicare billed to receive demand denial, then bill Medicaid. There are services that HHAs never bill Medicare because they are never covered by Medicare, i.e. weekly med set ups, aide only services, waiver nursing services.</p>	<p>Should not occur in the system</p>	<p>Information not available at time of publication.</p>	<p>Information not available at time of publication.</p>	<p>8/7/14 – Has identified the issue and is making manual edits to accept without billing Medicare</p>	<p>Should not occur in the system.</p>	
<p><b>Contracts</b></p>	<p>1. Current HHA is providing services for dual eligible, how many days can they continue caring for this patient? HH/PDN/Waiver</p>	<p><b>Medicaid Home Health Services and Private Duty Nursing (PDN)</b>  Medicaid-covered home health services and private duty nursing services must continue at the level provided prior to initial MyCare Ohio enrollment for 90 days for individuals with home health needs that reside in the community and are not enrolled on a waiver, or who reside in an assisted living facility.</p> <p>For MyCare Ohio waiver enrollees, transition of the current level of service and non-contracted provider is maintained for one year, unless a significant change occurs or the member or provider elects not to continue services.</p>					

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	<p>2. Medicaid explained that a non-network home care agency has some period of time that they can continue to care for a patient coming into the dual system: What is the time frame? Will new providers be able to provide care to dual eligible?</p>	<p><b>Medicaid Home Health Services and Private Duty Nursing (PDN)</b>            Medicaid-covered home health services and private duty nursing services must continue at the level provided prior to initial MyCare Ohio enrollment for 90 days for individuals with home health needs that reside in the community and are not enrolled on a waiver, or who reside in an assisted living facility.</p> <p>For MyCare Ohio waiver enrollees, transition of the current level of service and non-contracted provider is maintained for one year, unless a significant change occurs or the member or provider elects not to continue services.</p>					

	<p>3. Plans honor contracts in place prior to MyCare? Plan requires a specific MyCare contract how will the Plan notify the provider? For out of network HHAs, will non-participating provider agreement be patient by patient basis or defined time frame?</p>	<p>For previously contracted providers: Making amendment to any previously executed contract</p> <p>Providers: When calling in and requesting the amendment be sure to specify you are asking for the MyCare Ohio amendment</p>	<p>Information not available at time of publication.</p>	<p>Information not available at time of publication.</p>	<p>For previously contracted providers: Making amendment to any previously executed contract</p> <p>Providers: When calling in and requesting the amendment be sure to specify you are asking for the MyCare Ohio amendment</p> <p>Following transition of care period, non-par providers will enter into verbal single case agreement by member (patient). This will be done during PA process.</p>	<p>For previously contracted providers: Making amendment to any previously executed contract UNLESS that contract was through Unison (previous corporation).</p> <p>If with Unison a new contract needs to be completed.</p> <p>Providers: When calling in and requesting the amendment be sure to specify you are asking for the MyCare Ohio amendment</p>	
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Topic	Issues	Aetna	Buckeye	CareSource	Molina	United	Comments
<b>Plan assignment of care manager(s), and waiver service coordinators</b>	1. Does the agency call the Plan's customer service number to get the name and contact number of the patient's care manager?	Waiver Service Coordinator and Care Manager are ALWAYS the same – they contracted this out with AAA	Information not available at time of publication.	Information not available at time of publication.	<b>Molina Care Manager</b> The Manager's info is available through the service line  <b>WAIVER Svcs. Coordinator</b> If over 60 AAA and Under 60 it is Molina	<b>United Care Manager</b> in all aspects  <b>WAIVER Svcs. Coordinator</b> If over 60: AAA If under 60: United – should be able to call customer service and get the information. After hours: call the nurse line	

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	<p>2. How are HHAs to identify the Waiver Service Coordinator and to obtain the all services plan?</p> <p>How are the plans communicating the all service plan information to consumers?</p>	<p>For Existing Services: the existing authorization is being carried through;</p> <p>Any changes should be requested by the provider through the AAA Waiver Service Coordinator/Care Manager</p>	<p>Information not available at time of publication.</p>	<p>Call the Care Manager who will make the determination and ensure the has been entered into the system</p>	<p>Call the customer service line to identify the Waiver Service Coordinator</p> <p>The request goes through the Waiver Service Coordinator and then approval goes back to the provider through the Waiver Service Coordinator.</p>	<p>Call the customer service line to identify the Waiver Service Coordinator</p> <p>The request goes through the Waiver Service Coordinator and then approval goes back to the provider through the Waiver</p>	
	<p>3. What is the process of each plan to coordinate the authorization of the all service plans and make sure the provider has the correct information?</p>	<p><i>To be addressed at future Collaborative meeting.</i></p>		<p>CareSource will be working with the AAA's to ensure that all services are correct and up to date from the historical data received. We encourage the home care providers to review their service plans on the portal and request updates as needed. This will ensure accurate claims payment.</p>			

Topic	Issues	Aetna	Buckeye	CareSource	Molina	United	Comments
	4.What is the message the HHAs should give the patient when their services stop and they are discharged from service?	<i>To be addressed at future Collaborative meeting.</i>		CareSource – would like the agency to work with the Case Manager on these issues. Service may no longer be appropriate as Medicare or State Plan – but may need to be increased as Waiver services.			
	5.When a physician refuses to continue to see a patient, and the HHA needs to then discharge the patient, what is the method of discharge notification that the HHA should use to notify the Plan?	<i>To be addressed at future Collaborative meeting.</i>		CareSource to work with the Case Manager- to coordinate an inter-disciplinary team meeting with appropriate parties to ensure that we clarify the needs of the member and address appropriately.			
	6. When consumers receiving skilled intermittent Medicare or Medicaid services meet their established POC goals and are stable, what is the method of discharge notification that the HHA should use to notify the Plan?	<i>To be addressed at future Collaborative meeting.</i>		CareSource would again like you to work with Medical Management on these services in coordination with the Case manager. There may be a need to increase Waiver services that will need to be evaluated.			

Topic	Issues	Aetna	Buckeye	CareSource	Molina	United	Comments
<b>Waiver PASSPORT Rates</b>	1.Providers are not being paid the correct regional PASSPORT rates.	Information not available at time of publication.	Information not available at time of publication.	Working with providers to update claims		United is trying to adjust without providers having to re- submit claims	All plans were working off a crosswalk that did not have the correct rates. Approximately 8/7/2014 they were given the new rates for the regions and they all are working on fixing that.
<b>Changing Plans</b>	What process should be followed by the home health agency when the member transitions to another plan	<p>Every plan looks at the CR file monthly (a file from the state). Before the 15<sup>th</sup> of the month, the managed care plan that no longer has the patient needs to send the following to the 'new' plan</p> <ol style="list-style-type: none"> <li>a. 'old' plan's most recent assessment</li> <li>b. 'old' plan's care plan</li> <li>c. 'old' plan's service plan</li> <li>d. information on whether a care conference between plans is needed</li> </ol> <p><i>The provider does not need to send anything to the new MyCare Ohio plan when this transition occurs. Provider needs to obtain a new authorization/authorization number.</i></p> <p>When the service plan goes over to the new MyCare Ohio plan, it will trigger the need for a new authorization. <i>The provider will know the member has changed by checking the system – changes should be in by the 7<sup>th</sup> day of the month.</i></p> <p><b>This process will begin in January 2015</b></p>					

<p><b>Other concerns</b></p>	<p>1. Will skilled Medicare services continue to be paid the full amount of the HHPS rate using the current methodology for one year?</p> <p>If patient is in the middle of an episode when he/she opts in to a MyCare Ohio plan, is a PA needed? If so, how is it handled?</p>	<p>Information regarding Medicare skilled services not available at time of publication.</p> <p>New episodes require PA but existing episodes do not</p>	<p>Information not available at time of publication.</p>	<p>Bill per Medicare guidelines – MyCare Ohio plan will pay according to Medicare</p> <p>New episodes require PA</p>	<p>Bill per Medicare guidelines – MyCare Ohio plan will pay according to Medicare</p> <p>New episodes require PA but existing episodes do not</p>	<p>Contracted provider – bill using the contracted rate; if not contracted United is obligated to pay under the Medicare guidelines</p> <p>New episodes require PA ; existing episodes do not <i>but a notification is still required in this instance</i></p>	<p>Providers reminded to use modifiers appropriately in order to be paid correctly</p>
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Topic	Issues	Aetna	Buckeye	CareSource	Molina	United	Comments
	2. Will the plan process home health episode RAP payments according to the Medicare method of initial episode 60/40 and subsequent episodes 50/50?	Yes, Aetna will pay RAPs the same way Medicare does	Information not available at time of publication.	Information not available at time of publication.	Information not available at time of publication.	Information not available at time of publication.	

**Hospice Questions**

Topic	Issues	Aetna	Buckeye	CareSource	Molina	United	Comments
<p><b>Pre-Authorizations</b></p>	<p>Does a <u>current NF consumer</u> need a pre-authorization when they begin receiving hospice services regardless of whether the Plan is paying the NF directly or paying the hospice directly?</p>	<p>No (because patient already has NF authorization)</p> <p>Hospice agency should notify plan that consumer admitted to Hospice.</p>	<p>Hospice agency should notify plan that consumer admitted to Hospice.</p>	<p>Room and board authorization must go through the medical management department and does require a PA</p> <p>The hospice room and board authorization is completely separate from the institutional room and board authorization Care Source will NOT deny the hospice room and board and will work with participating and non- participating providers</p>	<p>Room and board authorization must go through the medical management department and does require a PA</p> <p>The hospice room and board authorization is completely separate from the institutional room and board authorization Molina will NOT deny the hospice room and board and will work with participating and non-participating providers</p>	<p>Room and board authorization must go through the medical management department and does require a PA</p>	

Topic	Issues	Aetna	Buckeye	CareSource	Molina	United	Comments
	<p>Consumer in the community needs a NF bed, will Hospice need to obtain prior authorization for room and board before admission to the NF?</p>	<p>Yes, authorization is needed before the patient goes to the NF</p>	<p>Yes, authorization is needed before the patient goes to the NF</p> <p>Need to have PA to bring patient to facility</p>	<p>Yes, authorization is needed before the patient goes to the NF</p>	<p>Yes, authorization is needed before the patient goes to the NF</p>	<p>Yes, authorization is needed before the patient goes to the NF</p>	<p>All plans are to process the authorization as quickly as the patient's needs dictate. If the hospice cannot get the authorization it should elevate the call and contact the 24/7 number</p>

Topic	Issues	Aetna	Buckeye	CareSource	Molina	United	Comments
	<p>What is a timely response in meeting the needs of the patient? What process should a hospice use for admission to the NF when it is considered an emergency admission?</p>	<p>Authorization is needed. If necessary use the 24/7 number.</p>	<p>Authorization is needed. Will give retrospective auth.</p>	<p>Go through Medical Management leave voice mail message.</p> <p>There is a specialized team in Medical Management for hospice room and board.</p> <p>If an authorization is needed after business hours can use the 24/7 number. Will give retrospective auth.</p>	<p>Authorization is needed. If necessary use the 24/7 number.</p>	<p>Authorization is needed. If necessary use the 24/7 number.</p>	<p>The expectation is that the hospice can anticipate a NF admission if the patient is a current hospice patient</p>
	<p>Does a hospice need a PA when admitting the patient to the NF for General Inpatient (GIP) level of care?</p>	<p>No, a PA is not needed when a hospice patient is going to be in a SNF for GIP only.</p> <p>If the patient remains in the SNF under the routine home care level of care, then a room and board PA is needed.</p>	<p>No, a PA is not needed when a hospice patient is going to be in a SNF for GIP only.</p> <p>If the patient remains in the SNF under the routine home care level of care, then a room and board PA is needed.</p>	<p>No, a PA is not needed when a hospice patient is going to be in a SNF for GIP only.</p> <p>If the patient remains in the SNF under the routine home care level of care, then a room and board PA is needed.</p>	<p>No, a PA is not needed when a hospice patient is going to be in a SNF for GIP only.</p> <p>If the patient remains in the SNF under the routine home care level of care, then a room and board PA is needed.</p>	<p>No, a PA is not needed when a hospice patient is going to be in a SNF for GIP only.</p> <p>If the patient remains in the SNF under the routine home care level of care, then a room and board PA is needed.</p>	

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<b>Timely Payment</b>	Payment for Hospice, all four levels of care	Should be billed as normally would occur for that patient from a Medicare perspective.	Should be billed as normally would occur for that patient from a Medicare perspective	Should be billed as normally would occur for that patient from a Medicare perspective.	Should be billed as normally would occur for that patient from a Medicare perspective.	Should be billed as normally would occur for that patient from a Medicare perspective.	
	Current time frame for claims processing	<p>All plans must meet the same criteria of: 90% of clean claims paid in 30 days and 99% of clean claims paid in 90 days</p> <p>Cash advances are held out as the last resort – easier to resolve the claims issue then it is to get a cash advance authorized – generally try to prioritize the issues</p> <p>When not getting paid timely the provider needs to use the contact the Problems/Issues/Concerns number in the Contacts table above.</p>					
	Payment for Room and Board	Paying NF Directly	Paying Hospice for R&B	Paying Hospice for R&B	Paying Hospice for R&B	Paying NF Directly	
	Room and board authorization – how long is it good for	Number of days requested and approved; follow-up from the hospice is required	180 days	Number of days requested and approved	Information not available at time of publication	For one year	

	<p>What constitutes a clean claim for a hospice receiving the R&amp;B pass-through?</p>	<p>Hospices need to look to the plan's provider manual for instructions on billing/what is required on a claim using the 1500 form</p>	<p>Information not available at time of publication.</p>	<p>Hospices need to look to the plan's provider manual for instructions on billing/what is required on a claim using the 1500 form</p>	<p>Hospices need to look to the plan's provider manual for instructions on billing/what is required on a claim using the 1500 form</p>	<p>Hospices need to look to the plan's provider manual for instructions on billing/what is required on a claim using the 1500 form</p>	
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	Patient Liability related to hospice payment	12.19.2014 Adjustments progressing as planned	12.19.2014 Adj. should be complete by end of January or beginning of February 2015	12.19.2014 Adjustments completed	12.19.2014 Adj. progressing as planned – expected completion date December 31, 2014	12.19.2014 Adj. progressing as planned	<p>11.21.2014 All plans are now using the patient liability figure from the Form 834. All plans requested the hospice to send Form 9401 if there are discrepancies in patient liability amounts.</p> <p>All plans will adjust incorrect pymt.</p>
	Patient Liability related to hospice payment – patient elects hospice after first of the month	Information not available at time of publication	Claims should be processing as required now. For claims that were previously adjudicated incorrectly, the provider is to call the provider relations number.	Information not available at time of publication	Patient liability pulls from the first claim not the first date span. Molina will fix this so the liability is pulled based on date span.	Information not available at time of publication	The rule is that whichever provider (nursing home or hospice) the patient is enrolled with on the first day of the month is the provider's claim from which the liability is deducted.

	EFT Registration	<a href="http://www.aetnabett.com/ohio/assets/pdf/OH_EFTform.pdf">http://www.aetnabett.com/ohio/assets/pdf/OH_EFTform.pdf</a>	<a href="http://www.buckeyehealthplan.com/for-providers/electronic-transactions/payformance/">http://www.buckeyehealthplan.com/for-providers/electronic-transactions/payformance/</a>	<a href="https://www.caresource.com/providers/ohio/ohio-providers/claims-information/claims-payment/">https://www.caresource.com/providers/ohio/ohio-providers/claims-information/claims-payment/</a>	<a href="http://www.molinahealthcare.com/providers/common/duals/ediera/Pages/enrollERAFT.aspx">http://www.molinahealthcare.com/providers/common/duals/ediera/Pages/enrollERAFT.aspx</a>	<a href="http://www.uhcommunityplan.com/content/dam/communityplan/healthcareprofessionals/providerinformation/OH-GettingConnectedwithEDI-EFT-ERA.pdf">http://www.uhcommunityplan.com/content/dam/communityplan/healthcareprofessionals/providerinformation/OH-GettingConnectedwithEDI-EFT-ERA.pdf</a>	
	Do the Plans have documents explaining what constitutes a clean claim for a hospice receiving the R&B pass-through?	Hospices need to look to the plan's provider manual for instructions on billing/what is required on a claim using the 1500 form	Information not available at time of publication.	Hospices need to look to the plan's provider manual for instructions on billing/what is required on a claim using the 1500 form	Hospices need to look to the plan's provider manual for instructions on billing/what is required on a claim using the 1500 form	Hospices need to look to the plan's provider manual for instructions on billing/what is required on a claim using the 1500 form	

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<b>Contracts</b>	Do hospice's need a contract with the Plan's when the Plan is paying the R&B to the NF directly? Do hospice's need a contract with the Plan's when the Plan is paying the hospice the R&B pass-through?	A hospice contract is not required when the plan is paying the R&B to the NF.	If the Plan is paying the room and board directly to the hospice a contract /agreement needs to be in place.	No , service level agreement to accept payment is completed individually	If the Plan is paying the room and board directly to the hospice a contract/agreement needs to be in place. Contact the Contracting number in the Contacts table above.	If the Plan is paying the room and board directly to the hospice a contract/agreement needs to be in place. Contact the Contracting number in the Contacts table above.	
	Hospice provider is a non-contracted provider and has patients under MyCare Ohio	<p><i>To be addressed at future Collaborative meeting.</i></p> <p>Questions apply to all patient scenarios (1) Medicare services being provided by the plan (2) MA (3) traditional Medicare services</p> <p>What is the expected transition process after the first year?</p> <p>Will patients on service with a hospice be allowed to stay until death or discharge?</p> <p>To what extent will a Plan be able to direct hospice patients towards a hospice provider they have a relationship with?</p>					
	What about NF that are participating in MyCare Ohio and a hospice that is not contracted with that NF, will those patients continue to be served or need to berevoked from hospice because they don't have a contract with the NF.	<i>To be addressed at future Collaborative meeting.</i>		CareSource will work with the member and provider to provide continuity of care services			

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	<p>If a hospice is a participating provider but doesn't have a contract with a specific NF, will the Plans facilitate a discussion between the NF and Hospice related to contracting together?</p>	<p><i>To be addressed at future Collaborative meeting.</i></p>					
	<p>For hospice agencies that are not part of the Plan's Network will there need to be a non-par agreement in place on a patient by patient basis or a longer term basis?</p>	<p>All plans require patient-specific agreement.</p>					

<p><b>Plan assignment of care manager(s), and waiver service coordinators</b></p>	<p>Does the agency call the Plan's customer service number to get the name and contact number of the patient's care manager?</p>	<p>Waiver Service Coordinator and Care Manager are ALWAYS the same – they contracted this out with AAA</p>	<p>Care Manager and Waiver Service Coordinator are available through the service line.</p> <p>Optum does the care management for patients in nursing facilities.</p>	<p>Care Manager and Waiver Service Coordinator are available through the service line.</p>	<p><b>Molina Care Manager</b> Manager's info is available through the service line</p> <p><b>WAIVER Svcs. Coordinator</b> If over 60 AAA and Under 60 it is Molina</p>	<p><b>United Care Manager</b> in all aspects</p> <p><b>WAIVER Svcs. Coordinator</b> If over 60:AAA</p> <p>If under 60: it is United – should be able to call customer service and get the information and after hours call the nurse line</p>	<p>The Care Manager is always on the All Service Plan so ask for this document when working with facilities. The Care Manager listed on the All Service Plan can be verified by calling the service line.</p>
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Topic	Issues	Aetna	Buckeye	CareSource	Molina	United	Comments
<b>Plan assignment of care manager(s), and waiver service coordinators</b>	Does the agency call the Plan's customer service number to get the name and contact number of the patient's care manager?						
	When updates to the Level of Care occur related to need what is the procedure that the Plans want the hospice to use to notify their case managers?	<i>To be addressed at future Collaborative meeting.</i>					
	What is the procedure when a hospice has called the Plan's customer service number and there isn't a timely response?	<p>Providers of all Services should call the PA phone number and ask to speak directly to a PA Nurse.</p> <p>When you do not get a resolution to your inquiries you should call Provider Services and voice your concerns.</p>	Call the Problems/Issues/Concerns number listed in the Contacts table above	Call the Problems/Issues/Concerns number listed in the Contacts table above	Call the Problems/Issues/Concerns number listed in the Contacts table above	Call the Problems/Issues/Concerns number listed in the Contacts table above	

## Helpful Links:

Buckeye/Centene:

HCBS providers:

<http://www.buckeyehealthplan.com/for-providers/mycare-ohio-resources/mycare-ohio-home-community-based-providers/>

Molina:

<http://www.molinahealthcare.com/providers/oh/PDF/Duals/NonPar-Contract.pdf>

## ODM Webinars

Basic Medicaid State Plan – Home Health Services Webinar Handout – 2013

<http://medicaid.ohio.gov/Portals/0/Providers/ProviderTypes/Webinar-HH-2013Jan.pdf>

Basic Medicaid State Plan – PDN Services Webinar Handout – 2013

<http://medicaid.ohio.gov/Portals/0/Providers/ProviderTypes/WebinarPDN-2013Feb.pdf>

Basic Medicaid State Plan – Hospice Services Webinar Handout – 2013

<http://medicaid.ohio.gov/Portals/0/Providers/ProviderTypes/WebinarHospice-2013Feb.pdf>