We help seniors resolve legal & long-term care problems & fight Medicare fraud

Medicare & Medicaid Updates / Residents Rights

Miriam H. Sheline, Managing Attorney
Erin M. Campbell, Staff Attorney
Pro Seniors, Inc.

November 19, 2025

Pro Seniors, Inc. www.ProSeniors.org

Long-Term Care Ombudsman

- Advocates for the rights of people in assisted living, nursing homes and other long-term care.
- Working to resolve problems with health, safety, well-being, and residents' rights.
- Quarterly visits to LTC communities to educate residents on their rights and empower them to advocate for their rights.
- Objective help to choose a nursing home or other care provider.

Call 513-458-5518

Ohio
Long-Term Care Ombudsman
Advocates for Excellence in Your Care

Serving Butler, Clermont, Clinton, Hamilton & Warren counties in Southwest Ohio

Pro Seniors, Inc. www.ProSeniors.org

Ohio Senior Medicare Patrol (SMP)

Our volunteers stop Medicare fraud & scams by educating others to recognize the tell-tale signs. If your Medicare number has been compromised, or you suspect you have been scammed, we may be able to help!

Give us a call at **1-800-293-4767**.

www.proseniors.org/Ohio-SMP/

SMP
Senior Medicare Patrol
Preventing Medicare Fraud

4

Pro Seniors, Inc. www.ProSeniors.org

Ohio's Senior Legal Helpline:

- Staffed by experienced attorneys
- Pre-set 30-minute appointments
- By telephone
- Free legal advice and counsel
- Intake Hours:

  Monday – Friday, 9 AM to 3 PM

Call 1-800-488-6070 or 513-345-4160

Pro Seniors, Inc. www.ProSeniors.org

Mid America Pension Project

Pension attorneys to help resolve pension issues.

Call Intake at Trellis
1-866-783-5021

Pro Seniors, Inc. www.ProSeniors.org

Ohio Attorneys – Join Pro Seniors Referral Service

- Statewide
- Pre-screened clients: Referral only **after** helpline attorney has done the initial consultation
- Opportunities for attorneys to help older Ohioans.

www.proseniors.org/legal-services/hrap/

Pro Seniors, Inc. www.ProSeniors.org

Roadmap

1) MyCare Next Generation Conversion
2) Changes to Social Security: Elimination of Windfall Elimination Provision & Government Pension Offset
3) Medicaid Resource Rules on Lump Sums
4) Medicaid Update: Retirement Accounts
5) Residents Rights Review

Pro Seniors, Inc. www.ProSeniors.org

TOPIC 1

MyCare Next Generation Conversion

Pro Seniors, Inc. www.ProSeniors.org

Medicare Programs

- **Part A** Hospital Insurance **-** Hospitals, skilled nursing facility care, home health care, hospice (1966)
- **Part B** Supplementary Medical Insurance - physician services, DME, outpatient hospital procedures and treatments, and medical supplies (1966)
- **Part C -** Medicare Advantage – Replaces A & B; often includes a Part D plan (1997)
- **Part D -** Prescription Drug Benefit (2003)

10

Pro Seniors, Inc. www.ProSeniors.org

Medicare Advantage Plans

1) Medicare Advantage Plans (MAPs) are managed care health plans that are approved by Medicare and run by private, for-profit companies
2) Enrollment in a Plan is voluntary and in lieu of Original Medicare program Parts A and B, and sometimes Part D prescription drug coverage

11

Pro Seniors, Inc. www.ProSeniors.org

Medicare Advantage Plans

3) All Medicare managed care options must provide beneficiaries with same medical coverage available under Original Medicare Part A and B
4) Enrollees must get all their Medicare-covered services through their Plan which can include prescription drug coverage

12

Pro Seniors, Inc. www.ProSeniors.org

Medicare Advantage Plans

5) Some Plans require enrollees to see network doctors, be admitted only to network hospitals, get prior approval from the plan before seeing a specialist, having surgery or being hospitalized unless an emergency

6) However, out-of-network emergency care must be covered anywhere in the U.S.

13

Pro Seniors, Inc. www.ProSeniors.org

Medicaid

1) Medicaid is a joint federal and state program. It is largely federally funded. The program is subject to federal law and regulations and managed by the states

2) Provides medical insurance based on income, age, disability. Covers qualified pregnant women and children

3) States can offer home and community-based services and can chose to cover children in foster care

4) Only public medical coverage of long-term care facilities

14

Pro Seniors, Inc. www.ProSeniors.org

MyCare Overview

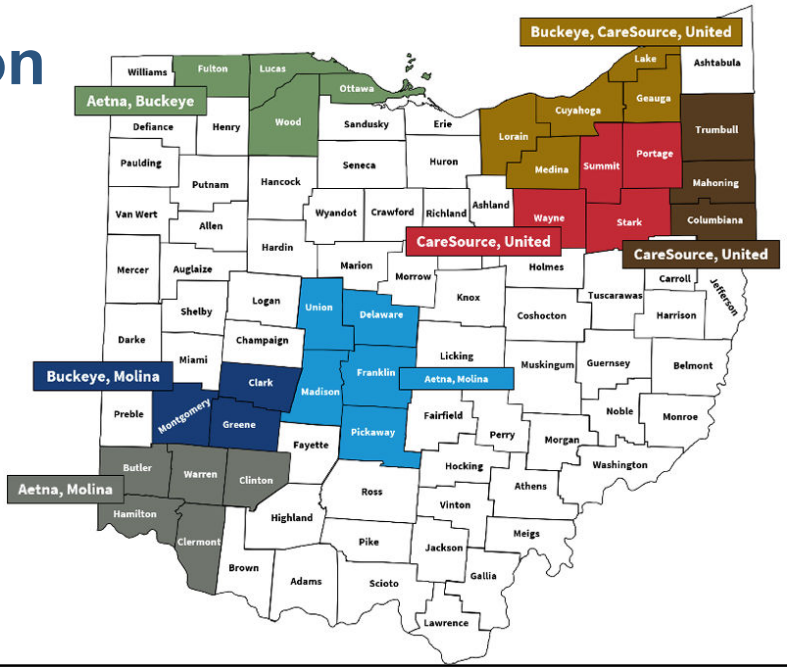
1) MyCare is a CMS Demonstration Project ending 12/31/25
2) Medicare/Medicaid dual eligible individuals in 29 demonstration counties are covered by MyCare Ohio

MyCare Ohio

15

Pro Seniors, Inc. www.ProSeniors.org

Demonstration Counties



16

Pro Seniors, Inc. www.ProSeniors.org

MyCare Overview

3) Beneficiaries can opt out of the Medicare portion of MyCare and stay on Original Medicare, Part C, and/or Part D. This is important for those with Medicare Supplements or Retiree plans

17

Pro Seniors, Inc. www.ProSeniors.org

Two Choices for Receiving MyCare Benefit

Dual benefits

- MyCare Ohio plan provides both your Medicare and Medicaid benefits.
- You are eligible to receive added benefits the plan might offer, like $0 copayments for prescription drugs covered by Medicare and extra transportation.

Medicaid-Only Benefits

- MyCare Ohio plan only covers Medicaid-covered services.
- You continue to receive prescription drugs through your Part D plan and any associated co-payments.
- Traditional Medicare or a private insurance company, commonly referred to as a "Part C" plan, provides your Medicare benefits.

https://dam.assets.ohio.gov/image/upload/medicaid.ohio.gov/Families%2C%20Individuals/Programs/MyCareOhio/MyCare_Ohio_program_member_frequently_asked_questions_RFA_award_update.pdf

18

Pro Seniors, Inc. www.ProSeniors.org

MyCare Overview

4) Instead of sending two payments per claim, MyCare plans make one payment per claim. The hope was that programs savings would allows for extra supplemental benefits
   a) *E.g.* meals, housekeeping, home modifications, fitness, transportation to health-related locations
5) Each patient has a care manager and plan of care
6) Patients had to use in network doctors

19

Pro Seniors, Inc. www.ProSeniors.org

MyCare Overview

7) No deductibles
8) Prior Authorizations required for services such as SNFs, DME, rehab services, wheelchairs
9) Community Transportation: nonemergency medical transport covered if it is more than 30 miles one way. Otherwise, unless other transport offered as a supplemental benefit, must call the county JFS

20

Pro Seniors, Inc. www.ProSeniors.org

Next Generation MyCare

The Current MyCare Program will transition to:

Fully Integrated Dual Eligible Special Needs Plan (FIDE-SNIP) model

with

fully aligned enrollment in a companion Medicaid managed care plan

subject to the Next Generation program requirements

in

January 2026

21

Pro Seniors, Inc. www.ProSeniors.org

FIDE SNP:
Fully Integrated Dual Eligible Special Needs Plan

1) Dual eligible individuals have access to Medicare & Medicaid benefits under a single entity.
   - These entities hold an MA contract with CMS and a Medicaid managed care organization contract with the applicable State;
2) Plans coordinate the needs of dual-eligible individuals
3) Fully aligned: Medicare and Medicaid provided by the same company
4) Members can opt out of Medicare MyCare, but must keep a Medicaid MyCare Plan

22

Pro Seniors, Inc. www.ProSeniors.org

Fully Integrated Dual Eligible Special Needs Plan

42 CFR Part 422

The MyCare Next Generation FIDE SNPs:

- are Medicare Advantage plans and so
- applicable regulations from 42 CFR Part 422 apply to them

Draft OAC 5160-58-01(B)(21)

42 CFR Part 422 includes:

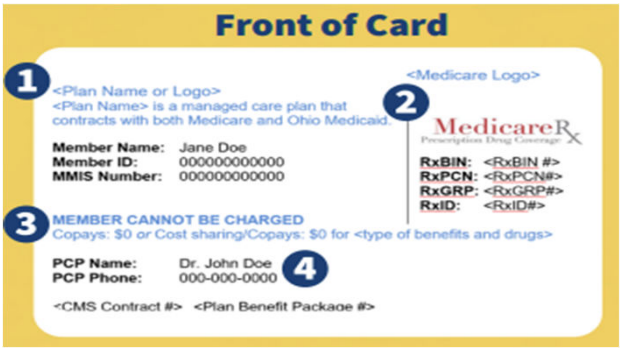
- General regulations about Medicare Advantage Plans
- Regulations on Special Needs Plans
- Regulations on Integrated Dual Eligible Special Needs Plans

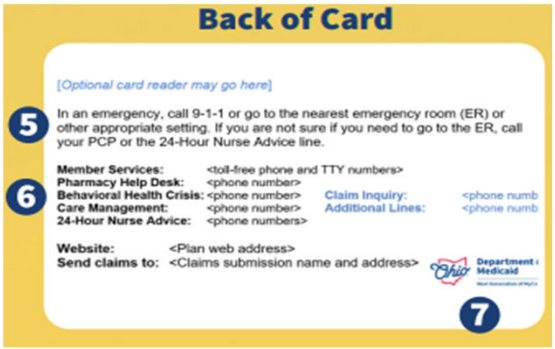
23

Pro Seniors, Inc. www.ProSeniors.org

One Member ID Card

No later than January 1, 2027, integrated Dual Eligible Special Needs plans must have an integrated member ID card that serves as the ID card for both the Medicare and Medicaid plans.





42 C.F.R. § 422.2267(e)(30)(viii);
https://dam.assets.ohio.gov/image/upload/medicaid.ohio.gov/Families%2C%20Individuals/Programs/MyCareOhio/NextGen_MyCare_Member_Cards.pdf

24

Pro Seniors, Inc. www.ProSeniors.org

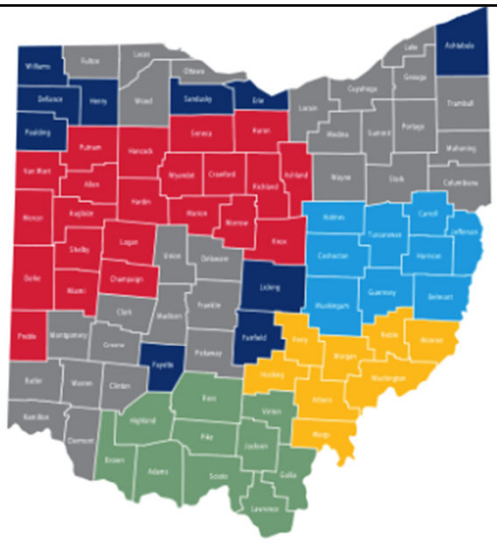
FIDE SNP Model of Care Requirements

FIDE SNPS must:

1) Conduct an **initial health risk assessment and an annual health risk assessment**. The screening must include housing stability, food security and access to transportation. Develop a plan of care through an interdisciplinary care team identifying goals and objectives with measurable outcomes
2) Must provide for **annual face to face encounters** for care coordination with a member of the enrollee's interdisciplinary team, case management and coordination staff, or contracted plan healthcare providers (with enrollee consent). Must be either in person or by telehealth.

42 C.F.R. § 422.101(f)

25



***Note:** Phase 2 begins by expanding all currently participating AAA regions to bring the counties without MyCare into the program, except for AAA2. Catholic Social Services operates as the PASSPORT Agency Administrator in the non-MyCare Counties within AAA2, so additional time is needed.

PHASE 1: Current MyCare Counties

On January 1, 2026, ODM will roll out the Next Generation MyCare program in the 29 counties where MyCare is currently available today.

Jan. 1, 2026	AA1: Butler, Warren, Clinton, Hamilton, Clermont AA2: Montgomery, Clark, Greene AA6: Franklin, Delaware, Union, Madison, Pickaway AA4: Lucas, Fulton, Ottawa, Wood AA10a: Lorain, Cuyahoga, Medina, Lake, Geauga AA10b: Summit, Portage, Stark, Wayne AA11: Columbiana, Mahoning, Trumbull

PHASE 2: Remaining Counties*

Starting on April 1, 2026, and continuing through the year, ODM will roll out the Next Generation MyCare program in the remaining counties.

Apr. 1, 2026	AA4: Sandusky, Erie, Henry, Williams, Defiance, Paulding AA6: Fayette, Fairfield, Licking AA11: Ashtabula
May 1, 2026	AA2: Preble, Darke, Miami, Shelby, Champaign, Logan AA3: Van Wert, Putnam, Hancock, Allen, Mercer, Auglaize, Hardin AA5: Seneca, Huron, Wyandot, Crawford, Richland, Ashland, Marion, Morrow, Knox
June 1, 2026	AA7: Ross, Vinton, Highland, Pike, Jackson, Gallia, Brown, Adams, Scioto, Lawrence, Guernsey, Muskingham
July 1, 2026	AA9: Holmes, Tuscarawas, Carroll, Jefferson, Coshocton, Harrison, Belmont,
Aug. 1, 2026	AA8: Hocking, Perry, Morgan, Noble, Monroe, Washington, Athens, Meigs

https://medicaid.ohio.gov/families-and-individuals/citizen-programs-and-initiatives/mycareohio/mycare-ohio

26

Pro Seniors, Inc. www.ProSeniors.org

Department of Medicaid
Next Generation MyCare

Am I eligible for the program?

Members will be enrolled if they:

- Have both Medicare and Medicaid parts A, B, and D
- Are age 21 and older
- Live in one of the 29 counties where MyCare Ohio is currently available or until the program is available in your county
- Are not already enrolled in a Program for All-Inclusive Care for the Elderly (PACE) or a Developmental Disabilities waiver, or have have health insurance that covers both inpatient hospital stays and doctor visits

What are the benefits of the program?

- New and improved services
- More in-home providers available to you
- Shorter wait time for prior authorizations
- More support for you to receive the care you need through a care team
- Better transportation options to get you to and from your appointments

https://dam.assets.ohio.gov/image/upload/medicaid.ohio.gov/NextGen_MyCare_Overview_Member_One-Pager.pdf; Proposed OAC § 5160-58-02(A), (B). Inmates are also excluded from MyCare.

27

Pro Seniors, Inc. www.ProSeniors.org

Next Generation MyCare

1) ODM awarded Next Generation MyCare contracts to four managed care organizations who will begin service in January 2026

Anthem buckeye health plan CareSource MOLINA HEALTHCARE

2) Current MyCare plans Aetna and United Healthcare will be discontinued

https://medicaid.ohio.gov/families-and-individuals/citizen-programs-and-initiatives/mycareohio/mycare-ohio

28

Pro Seniors, Inc. www.ProSeniors.org

Next Generation MyCare

3) Current dual eligibles will continue with their current plan until the end of 2025.

4) In January 2026, the selected four plans will support dual eligible Ohioans in the 29 counties where MyCare Ohio is currently available with statewide expansion following.

29

Pro Seniors, Inc. www.ProSeniors.org

Next Generation MyCare

5) Buckeye's MyCare plan is only available to those currently on it. If members move, they can keep it, unless…
   - if they move to Ashtabula or Belmont county, they cannot stay on Buckeye MyCare

6) Anyone in a MyCare county who moves to a non-MyCare county will be disenrolled from MyCare temporarily and can reenroll when MyCare comes to their new county

30

Next Generation MyCare

7) Beneficiaries with Discontinued Aetna and United Healthcare:

- Beneficiaries on these plans will need to select a Next Generation MyCare plan to begin serving them in January 2026
- **If they do not pick a new plan, they will be auto-assigned a new Medicaid MyCare plan with Original Medicare (Fee for Service)**

31

Department of Medicaid

MEDICAID.Ohio.gov

Mike DeWine, *Governor* Jim Tressel, *Lt. Governor* Maureen M. Corcoran, *Director*

If you need assistance with this letter, contact us.

Ohio Medicaid Consumer Hotline: (800) 324-8680
Monday - Friday: 7a.m. to 8p.m. and
Saturday: 8a.m. to 5p.m.
www.ohiomh.com

10/1/2025

RE:

MATT BARNES
7162 Reading Rd Ste 1150
Cincinnati, OH 45237-3849

January 1, 2026

MyCare Ohio – Connecting Medicaid and Medicare

Beginning January 1, 2026, your experiences with MyCare Ohio plans will change for the better. AETNA BETTER HEALTH INC will no longer be available effective January 1, 2026. The three Next Generation MyCare Ohio plans available to you are listed below. You will need to choose a new plan, or one will be chosen for you. Before making any decisions about your healthcare coverage, review your choices carefully, and choose the plan that best fits your needs. If you would like your MyCare Ohio plan to cover your Medicaid, Medicare, and prescription drug benefits, call Medicare directly at 1-800-MEDICARE.

Managed Care Plan	Plan Website	Plan Phone Number
Anthem Blue Cross and Blue Shield	www.anthem.com/oh/mycare	(888)925-1216
CareSource	http://www.CareSource.com/MyCare	(855)475-3163
Molina HealthCare of Ohio	http://www.molinahealthcare.com/duals	(855)665-4623

32

Pro Seniors, Inc. www.ProSeniors.org

What to consider when selecting a MyCare Ohio plan:

MyCare Ohio is designed to help your Medicare and Medicaid benefits better work together. You won't lose any of your current Medicare benefits if you choose to receive Medicare coordination with MyCare Ohio. Your MyCare Ohio plan would include:

- Your full Medicare benefits, including prescription drug coverage with no additional cost.
- Your full Medicaid benefits.
- Home-and Community-Based Services or nursing home coverage if it is medically necessary.
- Extra or value-added services, such as transportation to and from healthcare appointments and more.

You may have other questions or concerns that are important to you. You can contact the Ohio Medicaid Consumer Hotline.

33

Pro Seniors, Inc. www.ProSeniors.org

Where to get additional information:

- If you want to change your MyCare Ohio plan, or have questions about Ohio Medicaid, call the Ohio Medicaid Consumer Hotline at **800-324-8680 (TTY 711)** Monday through Friday, 7 a.m.-8 p.m. and Saturdays, 8 a.m.-5 p.m. ET, or visit www.ohiomh.com.
- If you have questions about Medicare, you can call **800-MEDICARE (800-633-4227)** 24 hours a day, seven days a week or visit http://www.medicare.gov. TTY users should call 877-486-2048.
- The Office of the State Long-term Care Ombudsman advocates for consumers receiving long-term services and support. For MyCare Ohio members, help with concerns about any aspect of care is available through the MyCare Ohio Ombudsman. Help is available to gather information about your options, resolve disputes with providers, protect rights and file complaints or appeals with any health plan. Contact an ombudsman by calling **800-282-1206** (TTY Ohio Relay Service: 800-750-0750), Monday through Friday 8 a.m.- 5 p.m. You can also contact an ombudsman by emailing MyCareOmbudsman@age.ohio.gov.
- The Ohio Senior Health Insurance Information Program (OSHIIP) provides free, objective information about Medicare plans available to you. Contact OSHIIP by calling **(800) 686-1578,** Monday through Friday 8 a.m. to 5 p.m. You can also contact OSHIIP by emailing OSHIIPmail@insurance.ohio.gov.

34

Next Generation MyCare

Beneficiaries on the Continuing Buckeye Health Plan, CareSource, or Molina HealthCare of Ohio:

- Beneficiaries on these plans will continue to receive services through that plan until January 2026
- They can keep their current plan's Next Generation plan by taking no action
- They can change their plan

35

Automated Health System
505 SOUTH HIGH STREET
SUITE 200
Columbus, OH 43215-5643

Ohio Department of Medicaid

Mailing Date: 09/16/2025
Case Number:
Case Name:

006426

Need Help?
Ohio Medicaid Consumer Hotline: (800) 324-8680
Monday – Friday: 7 a.m. to 8 p.m.
Saturday: 8 a.m. to 5 p.m.
www.ohiomh.com

MyCare Ohio Open Enrollment

Your Medicaid healthcare benefits are currently provided by your MyCare Ohio plan, MOLINA HEALTHCARE OF OHIO INC. This plan currently applies to:

MyCare Ohio open enrollment is a time of year when you can pick the health plan to get the most out of your Medicare and Medicaid benefits. The three MyCare Ohio plans are listed below. If your plan is listed, you **do not** have to take any action, but you do have the option to make a change. Before making any decisions about your coverage, review your choices carefully, and choose the plan that best fits your healthcare needs. If you want to make changes to your MyCare Ohio Medicaid plan, call the Ohio Medicaid Hotline at 800-324-8680.

36

Please keep in mind that Medicare open enrollment runs October 15-December 7. Ohio Medicaid open enrollment runs November 01-30.

MyCare Ohio Plan	Telephone	Website
MOLINA HEALTHCARE OF OHIO INC	(866) 856-8295	www.molinahealthcare.com/members/oh/en-us/hp/mycare/duals/enroll.aspx
ANTHEM BLUE CROSS AND BLUE SHIELD	(833) 727-2169	www.anthem.com/oh/mycare
CARESOURCE	(855) 475-3163	www.caresource.com/oh/plans/mycare-snp

NOTE: Buckeye Health Plan is not an option for new or current, transferring MyCare Ohio plan members at the start of the 2026 plan year. Members covered by Buckeye Health Plan today can remain with the plan, if they choose, and no action is needed.

Auto Enrollment Notice

Ohio Department of Medicaid
Medicaid Consumer Hotline
505 South High St., Ste. 200
Columbus, OH 43215

PRSRT STD
U.S. POSTAGE
PAID
COLUMBUS, OH
PERMIT NO. 1409

Time Sensitive Material Open Immediately

NOV 14 2025

Department of Medicaid
MEDICAID.Ohio.gov
Mike DeWine, Governor Jim Tressel, Lt. Governor Maureen M. Corcoran, Director

If you need assistance with this letter, contact us.

Ohio Medicaid Consumer Hotline: (800) 324-8680
Monday - Friday: 7a.m. to 8p.m. and
Saturday: 8a.m. to 5p.m.
www.ohiomh.com

ERIN CAMPBELL PRO SENIORS
7162 READING RD STE 1150
CINCINNATI, OH 45237-3849

November 10, 2025

ATTN: Authorized Representative for

MyCare Ohio – *Connecting Medicaid & Medicare*

ENROLLMENT NOTICE

Important: You're being enrolled in a new Medicaid health plan.

Medicaid enrolled you in a MyCare Ohio plan. You will not lose any of your current benefits. Your MyCare Ohio plan is:

CARESOURCE effective 1/1/2026

Important: If you don't call and choose another plan by 1/1/2026, you'll be automatically enrolled in CARESOURCE.

39

Do you have other choices? Yes. You have other choices, including:

- **Enroll in a different MyCare Ohio Medicaid plan.** The other MyCare Ohio plan(s) are like CARESOURCE but may have a different network of health care providers, pharmacies, or supplemental benefits and incentives.
- **Have CARESOURCE cover your Medicaid, Medicare, and prescription drug benefits.** You can call CARESOURCE at (855) 475-3163 or contact Medicare directly at 1-800-Medicare.

The other MyCare Ohio plans are:

ANTHEM BLUE CROSS AND BLUE SHIELD	www.anthem.com/oh/mycare	(833) 727-2169
CARESOURCE	https://www.caresource.com/oh/plans/mycare-snp	(855) 475-3163
MOLINA HEALTHCARE OF OHIO INC	https://www.molinahealthcare.com/members/oh/en-us/hp/mycare/duals/enroll.aspx	(866) 856-8295

40

CARESOURCE will send you a new Medicaid ID card to use. This new card replaces the Medicaid card you were using. For more information about your new plan, benefits, or services available to you, call (855) 475-3163 or visit https://www.caresource.com/oh/plans/mycare-snp.

Enrollment in CARESOURCE means that you can only see providers that are in the plan's network. The Medicaid Hotline can help you determine whether your current providers are in the plan's network.

- **You have the option not to enroll in a MyCare Ohio plan if you** are a member of a federally recognized Indian tribe. There are no other exceptions to enrollment for MyCare.

What should I do now?

Before making any decisions about your health care coverage, review your choices carefully.

- If you have questions about MyCare Ohio or Ohio Medicaid, call the Ohio Medicaid Consumer Hotline at **(800) 324 -8680 (TTY 711)** Monday through Friday 7 a.m. to 8 p.m. and Saturday 8 a.m. to 5 p.m. or visit **www.ohiomh.com**.
- If you have questions about Medicare, you can call **800-MEDICARE (800) 633- 4227**, 24 hours a day, 7 days a week or visit **www.medicare.gov**.
- The Office of the State Long-term Care Ombudsman advocates for consumers receiving long-term services and supports. For MyCare Ohio members, help with concerns about any aspect of care is available through the MyCare Ohio Ombudsman. Help is available to gather information about your options, resolve disputes with

41

ODM Website:

How Can I Select a Next Generation MyCare Plan?

During Medicaid or Medicare open enrollment, you can pick your Next Generation MyCare plan.

- Each year Medicaid open enrollment is from November 1 to November 30. You can call the Ohio Medicaid Consumer Hotline at 800-324-8680.
- Each year Medicare open enrollment is from October 15 to December 7. You can call Medicare at 800-633-4227.

https://medicaid.ohio.gov/families-and-individuals/citizen-programs-and-initiatives/mycareohio/mycare-ohio

42

ODM Plan Comparison Chart

https://ohfiles.blob.core.windows.net/public/OhioMHWebsite/Documents/OhioMyCareComparisonChart.pdf

Health Benefits All Plans Must Offer*

Anthem Blue Cross and Blue Shield, Buckeye Health Plan, CareSource, and Molina HealthCare of Ohio**

- Inpatient hospital services.
- Outpatient hospital services (including those provided by rural health clinics and federally qualified health centers).
- Physician services.
- Laboratory and x-ray services.
- Immunizations.
- Contraceptive services and counselling.
- Home health and private duty nursing services.
- Podiatry services.
- Chiropractic services.
- Blood glucometers and blood glucose test strips.
- Behavioral health services, including treatment for mental health and substance use disorders (see appendix for more information).
- Physical, occupational, developmental, and speech therapy services.
- Nurse-midwife, certified family nurse practitioner.
- Durable medical equipment and medical supplies.
- Nursing facility services.
- Hospice care.
- Telehealth.
- Prescription drugs and over-the-counter medications (see appendix for more information).
- One member ID card to be used at your appointments (If your Next Generation MyCare plan only covers your Medicaid benefits, you will have up to three cards for your benefits).
- One care coordination team to help you with your care for both your Medicaid and Medicare benefits.
- Dental services, including:
  - One cleaning per calendar year.
  - For pregnant members – two cleanings per calendar year.
  - Dentures, fillings, extractions, crowns, medical and surgical dental services, and root canals (based on medical necessity).
- Vision care services, including:
  - For members 21 to 59 years old - one exam and eyeglasses every 24 months.
  - For members over 60 years old – one exam and eyeglasses every 12 months.
- Transportation services, including:
  - Necessary transportation by ambulance or wheelchair van, without regard to distance.
  - Necessary transportation by standard vehicle (e.g., taxicab, sedan) when the nearest network provider is located at least 30 miles away.
  - If you exhausts the value-added transportation benefit, the health plan works with you to transition them to their county non-emergency medical transportation (NEMT), if possible.

43

ODM Plan Comparison Chart

https://ohfiles.blob.core.windows.net/public/OhioMHWebsite/Documents/OhioMyCareComparisonChart.pdf

Department of Medicaid
Next Generation MyCare

Value-Added Services for Dual Benefit Members*

	Anthem Blue Cross and Blue Shield	Buckeye Health Plan**	CareSource	Molina HealthCare of Ohio
24-Hour Nurse Hotline	• Available.	• Available.	• Available.	• Available.
Member Advisory Council	• Opportunity to participate in quarterly meetings.	• Opportunity to participate in quarterly meetings.	• Opportunity to participate in quarterly meetings.	• Opportunity to participate in quarterly meetings.
Pharmacy	• Flex card benefit of $249 per month for over-the-counter (OTC) drugs and supplies. For members with certain chronic conditions, card can be used for things like food and utilities.	• $0 copayment for prescription drugs. • Wellcare card benefit of $15 per month for OTC drugs and supplies. For members with certain chronic conditions, card can be used for things like food and utilities.	• $0 copayment for Medicare and Medicaid prescription drugs.	• Molina Complete Debit Card - $230 monthly for over-the counter drugs and supplies. Card may also be used for transportation, OTC items, groceries, and utilities if member has certain chronic conditions.
Dental	• One additional dental cleaning per calendar year. • Dental implants.	• $0 copayment for dental services. • Supplemental comprehensive dental benefit maximum of $5,000.	• $5,000 supplemental allowance subject to one oral exam, one cleaning, two fluoride treatments, plus implants.	• Additional preventative dental care. • Maximum allowance of $6,000 for select comprehensive dental services.

44

45

ODM Plan Comparison Chart

https://ohfiles.blob.core.windows.net/public/OhioMHWebsite/Documents/OhioMyCareComparisonChart.pdf

Department of Medicaid
Next Generation MyCare

Value-Added Services for Medicaid-Only Members*

	Anthem Blue Cross and Blue Shield	Buckeye Health Plan**	CareSource	Molina HealthCare of Ohio
24-Hour Nurse Hotline	• Available.	• Available.	• Available.	• Available.
Member Advisory Council	• Opportunity to participate in quarterly meetings.	• Opportunity to participate in quarterly meetings.	• Opportunity to participate in quarterly meetings.	• Opportunity to participate in quarterly meetings.
Pharmacy	• Members receive a gift card to use toward the purchase of OTC products.	• Not provided.	• Not provided.	• Not provided.
Dental	• One additional dental cleaning per year.	• Not provided.	• Not provided.	• Not provided.
Hearing	• Not provided.	• Not provided.	• Conventional hearing aids once every four years. • Digital/programmable hearing aids once every five years.	• Not provided.

46

Pro Seniors, Inc. www.ProSeniors.org

Are there other reasons to consider being a Dual Benefit Member?

1) Care Coordination Ratios based on Risk Stratification

Tier Level	Max no. members per care coordinator
Tier 1, low monitoring	up to 1:250 (nursing facility residents can be assigned this level)
Tier 2, medium	up to 1:100 (minimum level for HCBS waiver)
Tier 3, high	up to 1:75
Tier 4, intensive	up to 1:50

ODM Next Gen MyCare Ohio Provider Agreement for MyCare Ohio Plan, pg. 44 & Appendix B, pg. 114 47

Pro Seniors, Inc. www.ProSeniors.org

Are there other reasons to consider being a Dual Benefit Member?

Provider Network Requirements

1) Maintain a network sufficient in number, mix, and geographic distribution to meet member needs
2) Time and Distance Standards
3) Wait times for MyCare members cannot be longer than they are for commercial patients
4) MyCare plans must cover services with an out-of-network provider if no in network provider can provide services timely

ODM Next Gen MyCare Ohio Provider Agreement for MyCare Ohio Plan, Appendix F 48

Type of Visit	Description	Minimum Standard
Behavioral Health Non-Life-Threatening Emergency	A non-life-threatening situation in which a member is exhibiting extreme emotional disturbance or behavioral distress, has a compromised ability to function, or is otherwise agitated and unable to be calmed.	Within 6 hours
Behavioral Health Routine Care	Requests for routine mental health or substance abuse treatment from behavioral health providers.	Within 10 business days or 14 calendar days, whichever is earlier
Primary Care Appointment	Care provided to prevent illness or injury; examples include but are not limited to routine physical examinations, immunizations, mammograms, and pap smears.	Within 30 business days
Non-Urgent Sick Primary Care	Care provided for a non-urgent illness or injury with current symptoms.	Within 3 calendar days

ODM Next Gen MyCare Ohio Provider Agreement for MyCare Ohio Plan, Appendix F, pg. 235-36

49

Type of Visit	Description	Minimum Standard
Specialty Care Appointment	Care provided for a non-emergent/ non-urgent illness or injury requiring consultation, diagnosis, and/or treatment from a specialist.	Within 6 weeks
Dental Appointment	Non-emergent/non-urgent dental services, including routine and preventive care.	Within 6 weeks of request

ODM Next Gen MyCare Ohio Provider Agreement for MyCare Ohio Plan, Appendix F, pg. 235-36

50

Table F.5 LTSS Service Delivery Wait Times

Service Type	Wait Time to Receive Service
Home Delivered Meals	No more than 20 business days from the waiver service plan request or authorization.
Home Modification	No more than 60 business days from the waiver service plan request or authorization.
Personal Emergency Response Services	No more than 30 business days from the waiver service plan request or authorization.
Private Duty Nursing	No more than 20 business days from the time-of-service order or authorization.
Home Health Nursing	No more than 20 business days from the time-of-service order or authorization.
Waiver Nursing	No more than 20 business days from the waiver service plan request or authorization.
Specialized Medical Equipment and Supplies	For common items no more than 30 business days and for highly specialized items no more than 120 business days from the waiver service plan request or authorization
Non-Medical Transportation	No more than 20 business days from the waiver service plan request or authorization.
Home Health Aide	No more than 20 business days from the time-of-service order or authorization.
Personal Care	No more than 20 business days from the waiver service plan request or authorization
Homemaker	No more than 20 business days from the time-of-service order or authorization.

ODM Next Gen MyCare Ohio Provider Agreement for MyCare Ohio Plan, Appendix F, pg. 252

Next Generation MyCare

How Do Newly Eligible Beneficiaries Enroll in MyCare?

1) Newly eligible MyCare individuals are sent a Notification of Mandatory Enrollment
2) If they do not choose a plan after receiving two notices, they will be assigned a MyCare plan for Medicaid ONLY.
   - The assignment will be based on prior history with Medicaid fee-for-service, managed care organization, or MyCare membership history where available, or at the discretion of ODM

See Proposed OAC § 5160-58-02(A)(4), (B)(1)(b)

Pro Seniors, Inc. www.ProSeniors.org

Next Generation MyCare

How do Newly Eligible Beneficiaries Enroll in MyCare?

3) Those on a Medicaid Managed Care plan with an affiliated MyCare plan who become eligible for Medicare will be deemed to have elected their plan's MyCare plan for Medicaid and Medicare.

See Proposed OAC § 5160-58-02(D)(3)

53

Pro Seniors, Inc. www.ProSeniors.org

Next Generation MyCare

How else can MyCare members change plans?

1) Dual Benefit Members can contact the Medicare Call Center, the Ohio Senior Health Insurance Information program (OSHIIP), a licensed insurance broker, or go to Medicare.gov
2) Medicaid only members must call the Ohio Medicaid consumer helpline
3) The member or their authorized representative may request the change, but providers who are authorized representatives cannot change a member's plans.

Proposed OAC § 5160-58-02.1 (C)(2), (C)(3)

54

Pro Seniors, Inc. www.ProSeniors.org

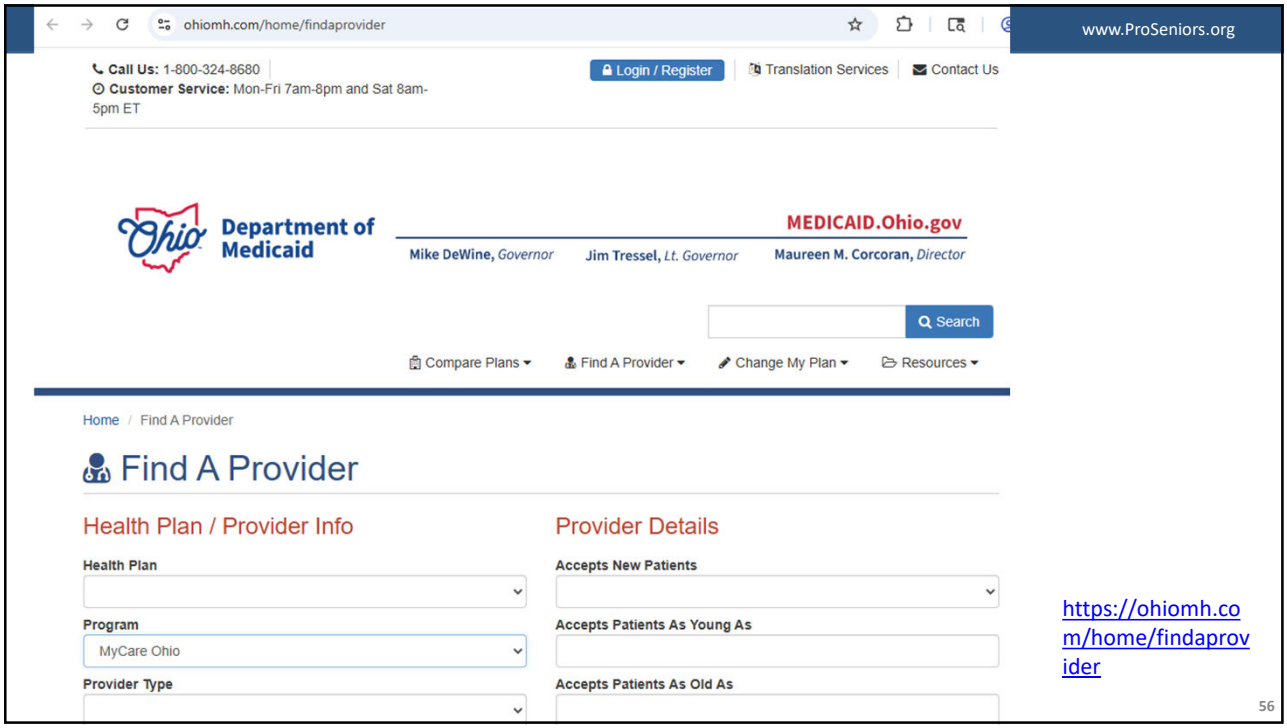
Next Generation MyCare

I am trying to decide on a plan, how to I find out if my doctor is in-network?

1) Call your doctor's office

2) Check the Ohio Department of Medicaid's website
https://ohiomh.com/home/findaprovider

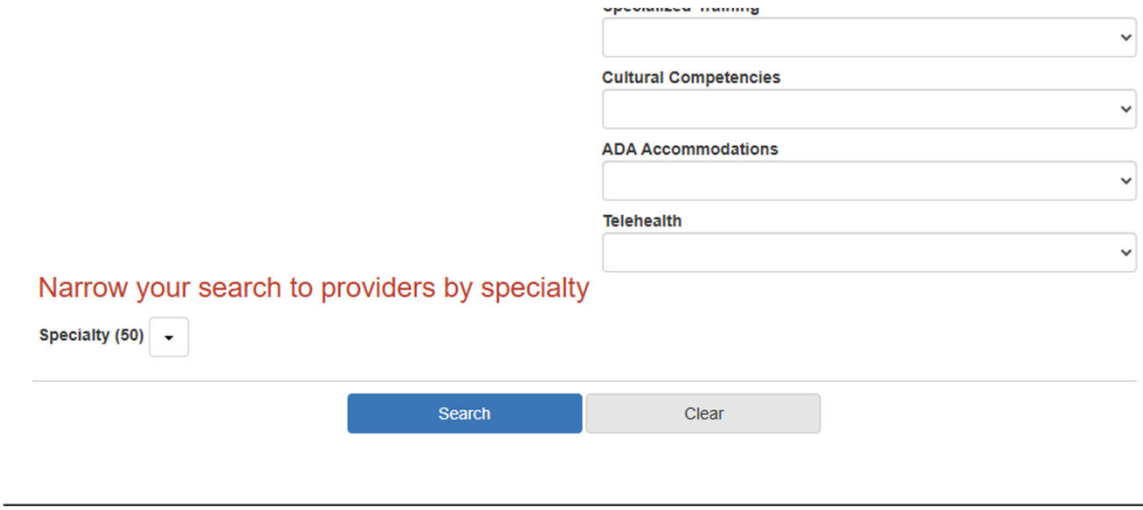
55



www.ProSeniors.org

https://ohiomh.com/home/findaprovider

56



https://ohiomh.com/home/findaprovider

57

Next Generation MyCare

What happens to my care when I am new to MyCare?

- The MyCare Plan must honor a Medicaid fee-for-service or managed care prior authorization through its expiration, even if the treating provider is out-of-network.
  - However, if your needs change enough to warrant a change in service, the new plan can conduct a medical necessity review.
  - All prior authorizations must be honored by the MyCare plan until it conducts a comprehensive assessment and medical necessity review.
- Plans must follow the chart of transition requirements:

ODM Next Gen MyCare Ohio Provider Agreement for MyCare Ohio Plan, Appendix D, pg. 196-200

58

Transition Requirements	HCBS Waiver Beneficiaries	Non-HCBS Waiver Beneficiaries with LTSS Needs (Home Health and Private Duty Nursing [PDN] use)	Nursing Facility Beneficiaries Assisted Living Beneficiaries	Beneficiaries not Identified for LTSS
Physician	180 days	180 days	180 days	180 days
Durable Medical Equipment	Must honor prior authorizations when item has not been delivered and must review ongoing prior authorizations for medical necessity.	Must honor prior authorizations when item has not been delivered and must review ongoing prior authorizations for medical necessity.	Must honor prior authorizations when item has not been delivered and must review ongoing prior authorizations for medical necessity.	Must honor prior authorizations when item has not been delivered and must review ongoing prior authorizations for medical necessity.
Scheduled Surgeries	Must honor specified provider.	Must honor specified provider.	Must honor specified provider.	Must honor specified provider.
Chemotherapy/ Radiation	Treatment initiated prior to enrollment must be authorized through the course of treatment with the specified provider.	Treatment initiated prior to enrollment must be authorized through the course of treatment with the specified provider.	Treatment initiated prior to enrollment must be authorized through the course of treatment with the specified provider.	Treatment initiated prior to enrollment must be authorized through the course of treatment with the specified provider.

59

Transition Requirements	HCBS Waiver Beneficiaries	Non-HCBS Waiver Beneficiaries with LTSS Needs (Home Health and Private Duty Nursing [PDN] use)	Nursing Facility Beneficiaries Assisted Living Beneficiaries	Beneficiaries not Identified for LTSS
Organ, Bone Marrow, Hematopoietic Stem Cell Transplant	Must honor specified provider.	Must honor specified provider.	Must honor specified provider.	Must honor specified provider.
Dialysis Treatment	180 days with same provider and level of service; and person-centered care plan documents successful transition planning for new provider.	180 days with same provider and level of service; and person-centered care plan documents successful transition planning for new provider.	180 days with same provider and level of service; and person-centered care plan documents successful transition planning for new provider.	180 days with same provider and level of service; and person-centered care plan documents successful transition planning for new provider.
Vision and Dental	Must honor prior authorization when item has not been delivered.	Must honor prior authorization when item has not been delivered.	Must honor prior authorization when item has not been delivered.	Must honor prior authorization when item has not been delivered.

60

Pro

Transition Requirements	HCBS Waiver Beneficiaries	Non-HCBS Waiver Beneficiaries with LTSS Needs (Home Health and Private Duty Nursing [PDN] use)	Nursing Facility Beneficiaries Assisted Living Beneficiaries	Beneficiaries not Identified for LTSS
Medicaid Home Health and PDN	Maintain service at current level and with current providers at current Medicaid reimbursement rates. Changes may not occur unless: A significant change occurs as defined in OAC rule 5160-45-01; or member expresses a desire to self-direct services; or after 180 days.	Sustain existing service for 90 days and then review for medical necessity after an in-person assessment that includes provider observation.	For AL: Sustain existing service for 90 days and then review for medical necessity after an in-person assessment that includes provider observation.	N/A
Assisted Living Waiver Service			Provider maintained at current Medicaid rate.	

61

Pro

eniors.org

Transition Requirements	HCBS Waiver Beneficiaries	Non-HCBS Waiver Beneficiaries with LTSS Needs (Home Health and Private Duty Nursing [PDN] use)	Nursing Facility Beneficiaries Assisted Living Beneficiaries	Beneficiaries not Identified for LTSS
Medicaid Nursing Facility Services			Provider maintained at current Medicaid rate.	
Waiver Services- Direct Care Personal Care Waiver Nursing Home Care Attendant Choice Home Care Attendant Out of Home Respite Enhanced Community Living Adult Day Health Services Social Work Counseling Independent Living Assistance	Maintain service at current level and with current providers at current Medicaid reimbursement rates. MCOP initiated changes may not occur unless: A significant change occurs as defined in OAC rule 5160-45-01; or member expresses a desire to self-direct services; or after 180 days.	N/A	N/A	N/A

62

Transition Requirements	HCBS Waiver Beneficiaries	Non-HCBS Waiver Beneficiaries with LTSS Needs (Home Health and Private Duty Nursing [PDN] use)	Nursing Facility Beneficiaries Assisted Living Beneficiaries	Beneficiaries not Identified for LTSS
Waiver Services-All other	Maintain service at current level for 180 days and existing service provider at existing rate for 90 days. MCOP initiated change in service provider can only occur after an in-home assessment and plan for the transition to a new provider.	N/A	N/A	N/A

63

Transition Requirements	HCBS Waiver Beneficiaries	Non-HCBS Waiver Beneficiaries with LTSS Needs (Home Health and Private Duty Nursing [PDN] use)	Nursing Facility Beneficiaries Assisted Living Beneficiaries	Beneficiaries not Identified for LTSS
Medicaid Community Behavioral Health Organizations (Provider types 84 & 95).	Maintain current provider, level of services documented in the behavioral health plan of care at the time of enrollment for 180 days. Medicaid rate applies during transition.	Maintain current provider, level of services documented in the behavioral health plan of care at the time of enrollment for 180 days. Medicaid rate applies during transition.	Maintain current provider, level of services documented in the behavioral health plan of care at the time of enrollment for 180 days. Medicaid rate applies during transition.	Maintain current provider, level of services documented in the behavioral health plan of care at the time of enrollment for 180 days. Medicaid rate applies during transition.
SRS	N/A	Maintain service at current level and with current providers at current Medicaid reimbursement rates for 180 days after initial enrollment.	N/A	Maintain service at current level and with current providers at current Medicaid reimbursement rates for 180 days after initial enrollment.

64

Pro Seniors, Inc. www.ProSeniors.org

Next Generation MyCare

I am changing MyCare Plans, what happens to my prior authorizations?

- Your new MyCare Plan must allow you to maintain existing services and provider in your person-centered care plan in the same scope and duration for 90 days, even if the treating provider is out-of-network.
  - All prior authorizations must be honored by the MyCare plan until it conducts a comprehensive assessment and medical necessity review.

ODM Next Gen MyCare Ohio Provider Agreement for MyCare Ohio Plan, Appendix D, pg. 204

65

Pro Seniors, Inc. www.ProSeniors.org

Next Generation MyCare

How will the transition of care requirements change once MyCare is implemented?

1) The Plans must maintain existing services and providers in the same scope and duration as authorized by the prior MyCare plan for at least 90 days from initial enrollment.
2) The prior MyCare plan's prior authorizations must be honored until the new plan can conduct a comprehensive assessment and medical necessity review.

ODM Next Gen MyCare Ohio Provider Agreement for MyCare Ohio Plan, Appendix D, pg. 204

20466

Pro Seniors, Inc. www.ProSeniors.org

Next Generation MyCare

What if changing to an in-network provider would hurt my healthcare?

1) You or your provider must notify your MyCare plan that you could suffer a detriment to your health or be at risk for hospitalization or institutionalization in the absence of continued services.

ODM Next Gen MyCare Ohio Provider Agreement for MyCare Ohio Plan, Appendix D, pg. 200-01, 204

67

Pro Seniors, Inc. www.ProSeniors.org

Next Generation MyCare

I am having trouble renewing Medicaid (or Medicare), will my care continue?

- The MyCare plan must provide six months of continued enrollment and eligibility to members experiencing a loss of Medicaid or Medicare eligibility.

ODM Next Gen MyCare Ohio Provider Agreement for MyCare Ohio Plan, Appendix A, pg. 44

68

Pro Seniors, Inc. www.ProSeniors.org

Next Generation MyCare

How will Next Generation MyCare beneficiaries switch plans?

- Currently, MyCare rules allow dual-benefits members to change plans anytime on a month-to-month basis.
- Medicaid only members can request to change plans through a just-cause request to ODM. OAC § 5160-58-02.1

69

Pro Seniors, Inc. www.ProSeniors.org

Next Generation MyCare - Transportation

When will Next Generation MyCare members get transportation from their plan?

Transportation Benefit

- To wellness visits and for dialysis, chemotherapy, and community behavioral health, even when the distance is under 30 miles.
- By ambulance or wheelchair van, without regard to distance.
- By standard vehicle (e.g., taxicab, sedan) when the nearest network provider is located at least 30 miles away
- Community members not at a nursing home and not on HCBS waiver get at least 30 one-way trips for community activities

ODM Next Gen MyCare Ohio Provider Agreement for MyCare Ohio Plan, Appendix B, pg. 114, 120

70

ODM Plan Comparison Chart

https://ohfiles.blob.core.windows.net/public/OhioMHWebsite/Documents/OhioMyCareComparisonChart.pdf

Value-Added Services for Dual Benefit Members*

	Anthem Blue Cross and Blue Shield	Buckeye Health Plan**	CareSource	Molina HealthCare of Ohio
Transportation	• Trips to wellness visits and to receive dialysis, chemotherapy, community behavioral health, and prenatal and postpartum services even when the distance is under 30 miles. • Unlimited routine, non-emergency one-way trips (within 60 miles) to locations within local service area when obtaining plan-approved health-related services. • Up to 60 one-way trips (within 30 miles) to community resources and services. • Gift card to purchase bus pass, gas card, or rideshare card.	• Trips to wellness visits and to receive dialysis, chemotherapy, community behavioral health, and prenatal and postpartum services even when the distance is under 30 miles. • 54 one-way trips (or 27 round trips) for covered health services. Community events are only applicable to members not enrolled in the MyCare Ohio HCBS waiver. Additional trips may be authorized based on enrollee's medical condition.	• Trips to wellness visits and to receive dialysis, chemotherapy, community behavioral health, and prenatal and postpartum services even when the distance is under 30 miles. • Unlimited transportation for medically necessary services, pharmacy, community/wellness services, and SDOH-related services, grocery stores, and fitness program participating gyms.	• Trips to wellness visits and to receive dialysis, chemotherapy, community behavioral health, and prenatal and postpartum services even when the distance is under 30 miles. • Non-Emergency Transportation - 104 trips to plan-approved locations. Flexible options like bus passes, Uber or Lyft, and mileage reimbursement. • Caregiver Transportation - 8 one-way trips per year to caregivers when visiting a member in a hospital, nursing facility, or intermediate care facility.

71

ODM Plan Comparison Chart

https://ohfiles.blob.core.windows.net/public/OhioMHWebsite/Documents/OhioMyCareComparisonChart.pdf

Value-Added Services for Medicaid-Only Members*

	Anthem Blue Cross and Blue Shield	Buckeye Health Plan**	CareSource	Molina HealthCare of Ohio
Transportation	• Up to 60 one-way rides to community resources and services (within 30 miles of their location) and to provider appointments.	• 30 one-way trips (or 15 round trips) for covered health services per calendar year. Community events are only applicable to members not enrolled in the MyCare Ohio HCBS waiver. Additional trips may be authorized based on enrollee's medical condition.	• Non-emergency transportation to covered health services that are 30 miles or more from member's home.	• Non-Emergency Transportation - 14 one-way trips to plan approved locations.

72

Pro Seniors, Inc. www.ProSeniors.org

Time to Appeal?

I am a Dual-Benefits Next Generation MyCare member. How do I appeal?

1) Dual-benefits members submit all grievances and appeals to their MyCare plans.

Draft OAC 5160-58-08.4(A)(1)

73

Pro Seniors, Inc. www.ProSeniors.org

Integrated Appeals for Dual Benefit Members

After receipt of an Integrated Organization Determination:

Level 1 Appeal: Integrated Reconsideration

- Must be requested in 60 days after receipt of adverse organization determination, but time runs starting 5 days after date of adverse organization determination. An extension of time can be requested for good cause.
- Expedited reconsideration available.

Level 2 Appeal

- Medicare: appeal to Independent Review Entity (IRE)
- Medicaid: State Fair Hearing Request

42 C.F.R. §§ 422.631, 422.633, 422.634

74

Pro Seniors, Inc. www.ProSeniors.org

Integrated Appeals for Dual Eligible SNPs

Note that while draft OAC 5160-58-08.4 provides for just 60 days to appeal following a denial of care,

- Ohio's Template Contract with the MyCare Plans states that "between 42 CFR 422.629-634 and OAC 5160-58-08.4, the MCOP must implement the standard(s) that is most advantageous to the dual benefit member."
- So 42 CFR § 422.633(d)(1)'s 65-day standard applies for dual benefits members.

ODM Next Gen MyCare Ohio Provider Agreement for MyCare Ohio Plan, Appendix A pg. 55.

75

Pro Seniors, Inc. www.ProSeniors.org

Integrated Appeals for Dual Benefit Members

Benefits continue pending integrated reconsideration when:

- Benefit continuation is timely requested by the later of:
  - 10 days after the plan sends notice of adverse determination OR
  - intended effected date of the adverse determination
- Appeal involves termination, suspension or reduction of previously authorized services.
- Services were ordered by an authorized provider and period covered by the original authorization has not expired

42 C.F.R. §§ 422.632, 422.633(d)

76

Pro Seniors, Inc. www.ProSeniors.org

Integrated Appeals for Dual Benefit Members

Benefits must continue unless:

- Enrollee withdraws a request for integrated reconsideration
- The integrated reconsideration is unfavorable.
- If the appeal involves Medicaid benefits, the enrollee does not request a State fair hearing within 10 calendar days after the plan sends notice of consideration
- If the enrollee withdrawals the appeal or request for State hearing
- The State Fair Hearing office issues an adverse determination

42 C.F.R. § 422.632

77

Pro Seniors, Inc. www.ProSeniors.org

Integrated Appeals for Dual Benefit members

Who pays for the care provided during an integrated appeal if the Enrollee loses?

- The plan and the State agency **cannot** pursue recovery for costs of services furnished pending integrated reconsideration, to extent services are provided under this rule
- State rules for recovery of costs apply for costs incurred for services furnished pending appeal subsequent to integrated reconsideration decision

42 C.F.R. § 422.632

78

Pro Seniors, Inc. www.ProSeniors.org

Time to Appeal?

I am a Medicaid Only Next Generation MyCare member. How do I appeal?

1) Medicare Services: submit all appeals and grievances to the organization providing Medicare services
2) Hybrid Medicare/Medicaid Services: submit appeals first to Medicare and then to the MyCare Ohio plan. Submit grievances to both Medicare and Medicaid
3) Medicaid only services: submit all appeals and grievances to the MyCare Ohio plan

Draft OAC 5160-58-08.4(A)(2)-(A)(4)

79

Pro Seniors, Inc. www.ProSeniors.org

Time to Appeal?

- If the appeal relates to services covered by Medicare and Medicaid, the appeal may be reviewed by multiple authorized entitles.
- If the outcomes differ, the MyCare Plan must adjudicate the decision most favorable to the member

ODM Next Gen MyCare Ohio Provider Agreement for MyCare Ohio Plan, Appendix A pg. 55.

80

Pro Seniors, Inc. www.ProSeniors.org

Provider Claims Dispute and Prior Authorization Denials Process

Prior Authorization Denial

When providers receive a prior authorization denial, they have the option to:

- Request a peer-to-peer review, or
- Request a provider appeal.

A member appeal and a provider appeal can be requested at the same time and the processes can run parallel to each other; however, they are two separate and distinct appeal processes. Providers are required to exhaust the provider appeal process prior to requesting an External Medical Review (EMR).

Claim Denial

When providers receive a claim denial, they can:

- Utilize the provider claim dispute resolution process (PCDR).

Once providers have completed the PCDR process, If the decision to deny is upheld, they can request an EMR.

ODM Slides, MyCare Ohio Advisory Workgroup (Nov. 7, 2025), available https://dam.assets.ohio.gov/image/upload/medicaid.ohio.gov/Stakeholders%2C%20Partners/Programs/MyCare/November_MyCare_Advisory_Workgroup_Deck.pdf 81

Pro Seniors, Inc. www.ProSeniors.org

If denial is due to medical necessity, then EMR may be an option for providers once they have exhausted the provider appeal process and/or completed the PCDR process.

External Medical Review

EMR is the review process conducted by an independent, EMR entity that is initiated by a provider who disagrees with a Next Generation MyCare plan's decision to deny, limit, reduce, suspend, or terminate a covered service for lack of medical necessity. The EMR is available at no cost to providers.

Providers will submit EMR requests and provide documentation via the EMR entity's portal. After receiving written notification of the internal appeal for a claim or prior authorization dispute, they have 30 calendar days to request EMR through the online portal along with submission of required documentation.

Providers can find the peer-to-peer, provider appeals, and PCDR processes within the Next Generation MyCare plan's provider manual and within the External Medical Review (EMR) Provider Authorization Denial Grid or MCE Claims Denial Resource Grid, respectively.

ODM Slides, MyCare Ohio Advisory Workgroup (Nov. 7, 2025), available https://dam.assets.ohio.gov/image/upload/medicaid.ohio.gov/Stakeholders%2C%20Partners/Programs/MyCare/November_MyCare_Advisory_Workgroup_Deck.pdf 82

Pro Seniors, Inc. www.ProSeniors.org

TOPIC 2

Changes to Social Security: Elimination of Windfall Elimination Provision & Government Pension Offset

Pro Seniors, Inc. www.ProSeniors.org

Government Pension Offset

1) Reduction in benefits if you received a pension for noncovered employment and were entitled for benefits on another's record
2) Government Pension Offset only applied to dependent spouses

Formula:

SSA benefit received as a dependent	-	2/3rds of noncovered pension payment paid to dependent	=	What dependent gets as a benefit

84

Pro Seniors, Inc. www.ProSeniors.org

Windfall Elimination Provision

1) Reduction in benefits if you receive both Social Security and a benefit from a noncovered pension like OPERS.
   a) Did not apply if drawing Social Security on a family member's record
   b) SSA's examples showed $300 and $400 as hypothetical deductions.
2) Windfall Application: 30+ years at SS job = no windfall
   21-29 years modified windfall
   20 years or less, full windfall
3) Repealed January 5, 2025 as of December 2023

https://www.ssa.gov/policy/docs/program-explainers/windfall-elimination-provision.html

85

Pro Seniors, Inc. www.ProSeniors.org

Repeal of Government Pension Offset and Windfall Elimination Provisions

Both Repealed January 5, 2025 as of December 2023

By July 7, 2025, the SSA made adjustments to the records of 3.1 million affected beneficiaries.

https://www.ssa.gov/benefits/retirement/social-security-fairness-act.html?tl=3%2C13

86

Pro Seniors, Inc. www.ProSeniors.org

Lingering Issues

1) Some receiving a government pension never applied for SSA on their spouse's record because of Government Pension Offset.
2) Some took SSA but then delayed their pension because of WEP.
3) Make sure lump sum payments are handled properly under Medicaid and SSI rules.

87

Pro Seniors, Inc. www.ProSeniors.org

TOPIC 3

Medicaid Resource Rules on Lump Sumps

Pro Seniors, Inc. www.ProSeniors.org

Dealing with Lump Sums

Medicaid resource limit:

- $2,000 resource limit for individuals
- $3,000 resource limit for married couples.

OAC 5160:1-3-05.1(B)(9)

Pro Seniors, Inc. www.ProSeniors.org

Medicaid Definition of Lump Sum

“Lump-sum payment” means:

- income which is accrued over two or more months or
- a money payment which is not related to any time period, such as a death benefit or inheritance.

OAC 5160:1-3-05.8(B)

Pro Seniors, Inc. www.ProSeniors.org

Anticipated Nonrecurring Lump Sum

Unearned income in month received, unless otherwise excluded

Countable resource in month following the month of receipt

Examples:

- Gifts, Prizes, or awards
- Retirement or pension funds
- Judgments and out of court settlements
- Workers compensation lump sums
- Life insurance proceeds received as a beneficiary, including social security lump sum benefits

91

Pro Seniors, Inc. www.ProSeniors.org

Unanticipated Nonrecurring Lump Sum

Not treated as unearned income in month received.

Treated as a countable resource in month following the month of receipt.

Examples:

- Proceeds received from the surrender or maturing of insurance policies.
- Proceeds received for the sale of real property.
- Replacement of income that was lost, destroyed or stolen if the original income was used to determine eligibility.

92

Pro Seniors, Inc. www.ProSeniors.org

Retroactive Payments from Social Security (RSDI & SSI)

- Are unearned income in the month received
- Are excluded as countable resources for 9 months following the month of receipt
- Unspent money must be identifiable from other resources for this exclusion to apply.

93

Pro Seniors, Inc. www.ProSeniors.org

Retroactive Payments from Social Security

- Suggest opening a new bank account for these funds
- While the funds can be comingled, they are countable if they can no longer be separately identified
- Once the money is spent, this exclusion does not apply to purchased items even if the 9-month period has not expired.

94

Pro Seniors, Inc. www.ProSeniors.org

Spending Down Lump Sums

- Increasing personal property holdings to maximums allowed
- Purchasing household goods or personal effects
- Paying personal debts
- Purchasing personal care items, like hygiene products, toiletries, and assistance with daily living activities
- Request discontinuation of Medicaid

95

Pro Seniors, Inc. www.ProSeniors.org

Spending Down Lump Sums

Repay Ohio, if:

- individual agrees, and
- repayment amount will continue to ensure the individual's resources remain within the allowable limits

Lump Sum Payment checks should be sent with a cover letter including the individual's name, social security number, case number, and reason for submitting the check to this address:

OH Dept of Medicaid/Lump Sum

L-3676

Columbus, Ohio 43260

96

Pro Seniors, Inc. www.ProSeniors.org

Reporting Requirements

Changes to income should be reported in 10 calendar days, including one-time gifts or payments

OAC 5160:1-2-08(B)(1)(d)(iii)(a)

97

Pro Seniors, Inc. www.ProSeniors.org

Medicaid Updates:

Personal Needs Allowance

Retirement Accounts

Coming Federal Changes

Pro Seniors, Inc. www.ProSeniors.org

Personal Needs Allowance

Proposed regulation will increase PNA to $75.00 to match the change in R.C. 5163.33 effective October 1, 2025.

No amended regulation is pending for Assisted Living.

2025 Ohio House Bill No. 96, Ohio One Hundred Thirty-Sixth General Assembly - 2025-2026 Session, 2025 Ohio House Bill No. 96, Ohio One Hundred Thirty-Sixth General Assembly - 2025-2026 Session

Pro Seniors, Inc. www.ProSeniors.org

D) It is the intent of the general assembly that beginning on the effective date of this amendment, the medicaid director shall increase the amounts specified in divisions (B) and (C) of this section to not less than seventy-five dollars for an individual resident and not less than one hundred fifty dollars for a married couple. Thereafter, on the thirtieth day of each September, the director shall increase those amounts effective the following January first. (Based on the CPI)

2025 Ohio Senate Bill No. 296, Ohio One Hundred Thirty-Sixth General Assembly - 2025-2026 Session, 2025 Ohio Senate Bill No. 296, Ohio One Hundred Thirty-Sixth General Assembly - 2025-2026 Session

Pro Seniors, Inc. www.ProSeniors.org

Retirement Accounts

Proposed regulation will provide exclusion of retirement accounts, such as Roth IRAs, IRAs, 401k type accounts

Pro Seniors, Inc. www.ProSeniors.org

Retirement Accounts as Income

(1) A retirement fund in which an individual has the legal ability to receive regular, periodic payments, or guaranteed lifetime payments shall be treated as a source of unearned income.

(a) When an individual has the choice between regular, periodic payments and a lump sum payment, the individual must choose regular, periodic payments for the funds to be treated as unearned income.

2025 OH REG TEXT 703170 (NS), 2025 OH REG TEXT 703170 (NS)

Pro Seniors, Inc. www.ProSeniors.org

When a retirement fund requires RMDs, the individual must take RMDs in accordance with IRS rules for the funds to be considered unearned income.

When an individual is not old enough to qualify to take RMDs, or the retirement fund does not require RMDs, the individual must take regular, periodic payments from the individual's retirement account in order for the funds to be considered unearned income.

Pro Seniors, Inc. www.ProSeniors.org

An individual who is not required to take RMDs is not mandated to take a specific payment amount, but the amount and interval of the individual's payments must be uniform.

Regular, periodic payments for an individual who is not required to take RMDs may be calculated using the IRS life expectancy tables, **but this is not required** until the individual reaches the age specified in IRS rules.

Pro Seniors, Inc. www.ProSeniors.org

Maximize payments defined

The individual is required to obtain the maximum available amount of payment from the individual's retirement fund.

(a) When a retirement fund requires RMDs, taking RMDs is considered taking the maximum available payment amount from the fund.

(b) When a retirement fund does not require RMDs, taking regular, periodic payments of a uniform amount, at a uniform interval, is considered taking the maximum available amount of payment from the fund, regardless of the amount of the payment.

Pro Seniors, Inc. www.ProSeniors.org

Spousal Consent

When a retirement fund requires benefits to be distributed in the form of a QJSA, the amount paid to the surviving spouse must be no less than fifty percent of the amount of the annuity paid during the individual's lifetime per 29 U.S.C. 1055(d)(1)(A) (as in effect October 1, 2025). The minimum spousal survivor benefit elected for a QJSA must be fifty percent, regardless of spousal consent.

When the maximum available amount of payment requires the individual's spouse to consent to a waiver of the spouse's survivor benefits, the individual must document a good faith attempt to obtain the consent, and whether consent was obtained or refused. When spousal consent is not obtained from a retirement fund that does not require the QJSA retirement distribution method, such as some 403(b) retirement plans, the individual must elect the minimum spousal survivor benefit required by the plan.

Retirement Fund as a Resource

The retirement fund shall be evaluated as a potential resource **only** after it is determined to not be income.

A retirement fund is a countable resource when the individual or the individual's spouse has an ownership interest in the retirement fund, has the legal ability to convert the fund to cash, and is not legally able to receive regular, periodic payments from the fund.

The value of a retirement fund is the amount an individual can currently withdraw from the fund. If there is a penalty for early withdrawal, the fund's value is the amount available to an individual after penalty deduction.

The amount payable shall not be further reduced by the amount of any tax incurred by the individual as a result of the conversion of the account to cash.

A retirement fund is not a resource when an individual must terminate employment in order to obtain any lump sum or payments.

Medicaid Changes- Federal

1) Work requirements for those up to age 64 start 1/1/2027 (the rule is due 6/1/26). There will be an exception for the medically frail, which includes the disabled and certain disabled veterans
2) 6-month redeterminations (or Ohio can make them even more frequently) start 1/1/2027
3) Reduced retroactive coverage (2 months for ABD Medicaid recipients) starts 1/1/2027
4) - Long-term care home equity limit for homes increased to $1m with no adjustment for inflation starts 1/1/2028.

Pro Seniors, Inc. www.ProSeniors.org

Resident Rights

Resident Rights- O.R.C. 3721.13

36 listed

Personal

Financial

Discharge Rights

Pro Seniors, Inc. www.ProSeniors.org

Resident Rights-personal

- Safe & clean living –follow federal and state regulations
- Free from abuse/ treat with respect
- Adequate and appropriate care
- Participate in decisions/Confidentiality of records
- Privacy during exams/treatment/care

Pro Seniors, Inc. www.ProSeniors.org

RESIDENT RIGHTS-Financial

- Full disclosure of basic rate and any additional charges
  - 30 day notice required for changes
- The right to receive an itemized bill
- The right to be free from financial exploitation
- Quarterly accounting statements of resident's financial transactions including:

Pro Seniors, Inc. www.ProSeniors.org

- Record of all funds, personal property or possessions deposited with nursing facility
- List of all deposits and withdrawals-supported by receipts
- Unrestricted access to resident's property @ reasonable hours

Pro Seniors, Inc. www.ProSeniors.org

Rights Regarding Discharge

- The right not to be transferred or discharged unless:
  - Cannot meet resident's needs
  - No longer need level of care
  - Health/safety of others at risk
  - Failed to pay for care- which means both
    - Medicaid application denied and
    - If appealed, denial upheld

Pro Seniors, Inc. www.ProSeniors.org

Discharge Plan Rights

- The right not to be transferred or discharged to a location that is incapable of meeting the resident's health care and safety needs.
- The right not to be transferred or discharged from the home without adequate preparation including medication, equipment, health care services, and other necessary services.
- All rights provided under 42 C.F.R. 483.15 and 483.21 and any other transfer or discharge rights provided under federal law.

R.C. 3721.13(A)(32)-(34)

Pro Seniors, Inc. www.ProSeniors.org

Discharge Notice Content

The discharge notice must be in writing and include:

(a) The reasons for the proposed discharge;

(b) The proposed date the resident is to be discharged;

(c) A proposed location to which the resident may relocate and a notice that the resident and resident's sponsor may choose another location

Pro Seniors, Inc. www.ProSeniors.org

d) Notice of the resident's and sponsor's right to an impartial hearing at the home on the proposed transfer or discharge, and of the manner in which and the time within which the resident or sponsor may request a hearing pursuant to O.R.C. 3721.161

e) A statement that the resident will not be transferred or discharged before the date specified in the notice unless the home and the resident agree to an earlier date;

f) The address of the legal services office of the department of health;

g) The name, address, and telephone number of the state long-term care ombudsman

The Discharge Process

The written discharge notice must be served on the resident's sponsor by certified mail, return receipt requested.

The administrator shall send a copy of the notice to the state department of health.

The notice shall be served at least thirty days prior to the proposed transfer or discharge

O.R.C. 3721.16; see also 42 C.F.R.483.15(c)

Hearing Rights

A resident or resident's sponsor may challenge a transfer or discharge by requesting an impartial hearing within 30 days of receipt of notice. However, practically must have hearing decision before discharge date.

Appeal Process

A resident may also appeal the state hearing decision to the Common Pleas Court. O.A.C. 3701-61-04

(1) File the appeal in Common Pleas for the county in which the home is located.
(2) Can request filing fees be waived due to indigency.
(3) Must be filed with the department and the court within thirty days after the hearing officer's decision is served. Must serve the opposing party by hand delivery or certified mail, return receipt requested.

(G) The court shall not require an appellant to pay a bond as a condition of issuing a stay pending its decision.

Pro Seniors, Inc. www.ProSeniors.org

ENFORCEMENT OF RIGHTS

- Sponsor may enforce
  - "Sponsor" means an adult relative, friend, or guardian of a resident **who has an interest** or responsibility in the resident's welfare. R.C. 3721.10(D)
- Any attempt to waive is void

Pro Seniors, Inc. www.ProSeniors.org

Litigation Remedies

- Compensatory damages if negligent
- Punitive damages- subject to O.R.C. 2315.21
- Injunctive relief
- Attorney fees (if only injunctive relief)
  O.R.C. 3721.17(G)(2)