ADMINISTRATIVE POLICY STATEMENT
Ohio MyCare

Policy Name & Number	Date Effective
Benefits Coordination-OH MYCARE-AD-0785	12/01/2022
Policy Type	
ADMINISTRATIVE	

Administrative Policy Statement prepared by CareSource and its affiliates are derived from literature based on and supported by clinical guidelines, nationally recognized utilization and technology assessment guidelines, other medical management industry standards, and published MCO clinical policy guidelines. Medically necessary services include, but are not limited to, those health care services or supplies that are proper and necessary for the diagnosis or treatment of disease, illness, or injury and without which the patient can be expected to suffer prolonged, increased or new morbidity, impairment of function, dysfunction of a body organ or part, or significant pain and discomfort. These services meet the standards of good medical practice in the local area, are the lowest cost alternative, and are not provided mainly for the convenience of the member or provider. Medically necessary services also include those services defined in any Evidence of Coverage documents, Medical Policy Statements, Provider Manuals, Member Handbooks, and/or other policies and procedures.

Administrative Policy Statements prepared by CareSource and its affiliates do not ensure an authorization or payment of services. Please refer to the plan contract (often referred to as the Evidence of Coverage) for the service(s) referenced in the Administrative Policy Statement. If there is a conflict between the Administrative Policy Statement and the plan contract (i.e., Evidence of Coverage), then the plan contract (i.e., Evidence of Coverage) will be the controlling document used to make the determination.

According to the rules of Mental Health Parity Addiction Equity Act (MHPAEA), coverage for the diagnosis and treatment of a behavioral health disorder will not be subject to any limitations that are less favorable than the limitations that apply to medical conditions as covered under this policy.

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A. Subject

Benefits Coordination

B. Background

Ohio MyCare is a program designed for members in Ohio who receive both Medicaid and Medicare benefits. During enrollment, eligible members have two choices for how to receive their MyCare benefits: Members can choose either dual-benefits or Medicaid-only benefits. The primary advantage of dual-benefits from one health plan is to have coordinated services with a single point of contact.

C. Definitions

- **Dual-benefits (Opt in)** - A member who has the same health plan administer both their Medicaid and Medicare benefits.
- **Medicaid-only benefits (Opt out)** - A member who has one health plan administer their Medicaid benefits in conjunction with their traditional Medicare plan or private insurance company.
- **Eligible members** -
  - Are age 18 years or older;
  - Live in one of the 29 demonstration counties; and
  - Currently have full Medicaid and Medicare parts A, B, and D.

D. Policy

I. CareSource will follow the hierarchy specified in Appendix A below for dual-benefit members.

II. Medicaid-only members will follow CareSource Ohio Medicaid policies.

E. Conditions of Coverage

N/A

F. Related Policies/Rules

Medical Necessity Determination

G. Review/Revision History

DATES		ACTION
Date Issued	02/05/2020	
Date Revised	10/14/2020	Title change from Coordination of Benefits; updated hierarchy to match caresource.com
	07/20/2022	Annual review. OH MYCARE hierarchy updated
Date Effective	12/01/2022	
Date Archived		

H. References

1. Ohio Department of Medicaid. MyCare-Ohio. (May 20 2021). Retrieved July 1, 2022 from www.medicaid.ohio.gov
2. Ohio Department of Medicaid. (2022). MyCare Ohio FAQ. Retrieved July 1, 2022 from www.ohiomh.com
3. Ohio Laws and Administrative Rules. (January 1, 2021). Rule 5160-20-01 | Coordinated services program. Retrieved July 1, 2022 from www.codes.ohio.gov

I. Appendix A