Disability Rights OHIO

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MEDICAID: Managed Care Plans

What is a managed care plan?

A managed care plan is a health insurance company the Ohio Department of Medicaid pays to provide health care services to some people. In Ohio, most people who have Medicaid must join a managed care plan to receive their health care. Ohio's five managed care plans are: Buckeye Health Plan, CareSource, Molina Healthcare, Paramount Advantage and United Healthcare. If you have a managed care plan, you should receive a managed care card in the mail.

Some people in Ohio are in a special managed care program called MyCare Ohio, which is supposed to coordinate both Medicare and Medicaid benefits. The MyCare Ohio plans include: Aetna, Buckeye, CareSource, Molina and United Healthcare. **This factsheet does not discuss MyCare Ohio plans.**

What services do managed care plans provide?

Managed care plans must provide the same services as traditional (fee-for-service) Medicaid. However, a managed care plan may have different rules for deciding whether you can get a service. They might also make you get approval ahead of time (also called prior authorization) before you can get a service. Some managed care plans offer optional benefits that are not included in traditional Medicaid. When you enroll in a managed care plan, you should receive a member booklet with information about the benefits. Your doctor or other medical provider should also be able to help you find out these limits and how to request authorization for your medical services.

It is important to remember that all managed care plans must provide Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services for children under age 21. EPSDT (called HealthChek in Ohio) includes services that are not provided for adults or that are limited for adults. However, you may still have to request prior authorization for an EPSDT service. See DRO's FAQ on EPSDT for more information: **https://www.disabilityrightsohio.org/medicaid-epsdt**.

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How do I enroll in and choose a managed care plan?

If you are approved for Medicaid and are required to enroll in a managed care plan, you will get a letter asking you to pick a plan. If you do not choose a managed care plan, you will be automatically enrolled in one and notified about it.

Once you have been assigned to a managed care plan, you will have three months to choose a new plan, if you like. After that, you generally may change your plan every year during the open enrollment period or if you can show "just cause" for the change. Examples of "just cause" include:

- You move out of the plan's service area and need a non-emergency service before your plan ends;
- You need services that the plan does not cover for moral or religious reasons;
- You need multiple services at the same time, but all of the services are not available through the plan and receiving services separately would put you at unnecessary risk;
- You receive poor quality of care and cannot get appropriate care within the plan;
- You do not have access to medically necessary services;
- You do not have access to providers who are experienced in dealing with your health care needs;
- The only primary care provider (PCP) who speaks your primary language leaves the plan, and there is another plan with a PCP who speaks your primary language; and
- The Ohio Department of Medicaid determines that your enrollment in the plan would be harmful to your interests.

Can I keep my same doctors if I enroll in managed care?

Not necessarily. Each managed care plan has its own panel of medical providers that are covered by the plan. Before you choose a managed care plan, you should find out if your doctors are covered by that plan. You can call the managed care plan's member services or find a list of providers on the managed care plan's website. If your medical provider is not within network, you can talk to your provider and managed care plan to see if the provider can be added to the network.

In limited situations, you may be able to receive services from a provider that is not covered by the plan. This is sometimes referred to as the managed care plan's ability to make a "single case agreement" with the provider. You must talk to your managed care plan to determine whether you can receive the services outside of the plan. These situations can include:

- If the plan does not have a provider for your medically necessary services; and
- If you have already scheduled services with a provider before you enroll in the plan.

Can I be on a waiver and also have a managed care plan?

Yes, but it depends on which waiver you have. Some people on waivers are required to enroll in a managed care plan, some have a choice of whether to enroll in a managed care plan, while others are not allowed to enroll in a managed care plan. With the exception of certain people who have the MyCare Ohio waiver, your waiver services continue to be coordinated by your waiver case management agency, even if you also have a managed care plan. Your managed care plan and your waiver case management agency should work together to make sure you are getting the services you need.

The Ohio Department of Developmental Disabilities has an FAQ on optional managed care enrollment for individuals enrolled on the Level One, SELF and IO waivers on its website: **https://dodd.ohio.gov/wps/wcm/connect/gov/f177e99f-e78b-4565-a42c-d2e110fe7e95/FAQ+DD_Managed+Care+FINAL+Nov_2016.pdf?MOD=AJPERES&CONVERT_TO=url&CACHEID=ROOTWORKSPACE.Z18_M1HGGIK0N0JO00QO9DDDDM3000-f177e99f-e78b-4565-a42c-d2e110fe7e95-mOXjKQA**.

What are my rights if I disagree with a decision by a managed care plan?

If you disagree with an "adverse benefit determination" made by a managed care plan, you have the right to "appeal" the decision. See DRO FAQ Medicaid Appeal Overview for more information.

If you have a complaint about something other than an "adverse benefit determination," you have the right to file a "grievance." Grievances can include issues with the quality of care or services provided to you, poor behavior by a provider or employee, or failure to respect your rights.

Your member handbook should provide information on how to file appeals and grievances.