Next Generation MyCare Provider

Frequently Asked Questions

Department of Medicaid

Next Generation MyCare

The Ohio Department of Medicaid (ODM) implemented the Next Generation MyCare program across Ohio to better serve Ohioans who have both Medicaid and Medicare. This document provides answers to the most commonly asked questions about the program for providers.

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Introduction

What is the Next Generation MyCare program?

The Next Generation MyCare program provides enhanced healthcare benefits to Ohioans who have both Medicaid and Medicare. This program helps members get the care they need all in one plan and helps you better serve members through streamlined processes, better integration with the plans, and enhanced clinical coverage policies.

ODM designed the program to:

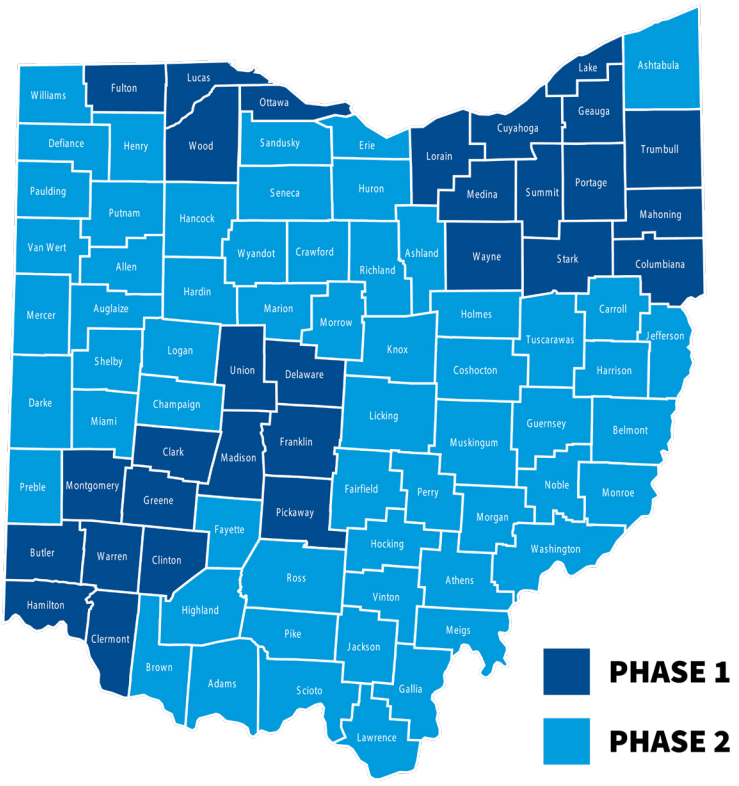
- Focus on the individual
- Help individuals and communities be healthier
- Give everyone the best care for their needs
- Help you keep making care better
- Improve care for individuals with complex needs and help them live independently in their communities
- Make the program more transparent and responsive.

How did the Next Generation MyCare program roll out?

To support a smooth transition, ODM rolled out the Next Generation MyCare program in two phases. This let us work with providers, advocates, and more to get ready for the program and give members the best experience possible.

1. Phase 1 (January 1, 2026): The program became available in the 29 counties where the original MyCare Ohio program begun.
2. Phase 2 (April 1 – August 1, 2026): The program rolled out in the rest of Ohio.

Members should locate their county in the Rollout Schedule to see when the program became available in their county.



What plans are available in the Next Generation MyCare program?

There are four Next Generation MyCare plans. Three of the plans are available for members to select statewide. These plans cover a member's Medicare and Medicaid benefits.

The plans available statewide are:

- Anthem Blue Cross and Blue Shield
- CareSource
- Molina Healthcare of Ohio

Buckeye Health Plan is not an option for new members in the program in plan year 2026.

What are the benefits of the Next Generation MyCare program?

The Next Generation MyCare program offers:

- Streamlined credentialing processes with ODM to become an Ohio Medicaid provider. You still need to contract with each of the plans separately
- Better integration with the plans, supporting shorter turnaround times for prior authorizations
- New External Medical Review (EMR) process
- Enhanced clinical coverage policies for Medicaid primary services, requiring more services to be covered by the plans. Changes to the services you provide are dependent on your contract with each plan
- Reduced burden for prior authorizations on waiver services in a member's person-centered care plan (same for private duty nursing)
- Potential for more waiver providers due to increased network requirements for the plans
- Additional transportation requirements for the plans to support members in getting to their medical visits and services

Providing Services

What are the types of Next Generation MyCare members I may see?

In the Next Generation MyCare program, members are either a dual benefit or Medicaid-only member.

- A dual benefit member is a member who gets their Medicaid and Medicare benefits from a single Next Generation MyCare plan.
- A Medicaid-only member is a member who gets only their Medicaid benefits from a Next Generation MyCare plan. They get their Medicare benefits through a separate plan.

Additionally, you may serve members on a MyCare Ohio Waiver. The MyCare Ohio Waiver helps members receive services at home or in a home-like setting. View our MyCare Ohio Waiver One-Pager to learn more.

How do I know if a patient is a Next Generation MyCare member?

Once enrolled in their plan, members should receive a new member ID card to be used at their appointments. When members come to an appointment, they should show their member ID card which details their Medicare and/or Medicaid coverage. A Next Generation MyCare logo on the back of their member ID card means they are a MyCare member.

If a member did not receive their member ID card, needs to replace it, or their information needs updated, they should contact their plan. If they do not know their plan or have questions, they should contact the Ohio Medicaid Consumer Hotline at 800-324-8680.

View the Next Generation MyCare ID Card One Pager to see the template.

How do I confirm a member's eligibility?

Helping members receive care is the ODM's priority. When you provide services to members and are confirming eligibility, the following methods can be used to support verification:

- Check the member ID card. If the ID card has a Next Generation MyCare program logo it is indicative that the member is a MyCare member.
- Check member eligibility via Provider Network Management (PNM) or the fee-for-service 270/271 process.
- Call the ODM Integrated Helpdesk at 800-686-1516 or IHD@medicaid.ohio.gov. Representatives are available Monday through Friday, 8 a.m. – 4:30 p.m. Eastern Time.

How do I confirm a member's Long Term Care Services or waiver service status?

If you have questions about a MyCare member's Long Term Care Services or waiver service status, call the member's plan or call the ODM Integrated Helpdesk at 800-686-1516.

Do I need to do something to provide services to Next Generation MyCare members?

To provide services in the Next Generation MyCare program, you must:

Enroll with ODM by visiting the Medicaid Provider Portal and completing the online application (credentialing, if required, will occur automatically during application processing).
Note: In accordance with CMS-6101-N and 42 CFR 455.470, ODM implemented a moratorium on the enrollment of Home Health and Hospice providers. Visit the Strengthening Medicaid Program Integrity webpage for more information.

Contract with the Next Generation MyCare plans. You can contact each plan you wish to contract with directly.

- Anthem Blue Cross and Blue Shield: 833-727-2170
- Buckeye Health Plan: 833-998-4892
- CareSource: 800-488-0134
- Molina HealthCare of Ohio: 855-322-4079

Refer to the Credentialing Guide and Requirements Document for more information.

*Providers who are enrolled with the Ohio Department of Aging (AGE) can continue to provide services to members and submit claims in the program. However, if you haven't already, you must still contract with the plans.

What if a Next Generation MyCare plan will not let me contract with them?

Next Generation MyCare plans are not required to contract with every provider. You may have the option to enter into a single case agreement (SCA) if you don't have a contract. The SCA is a temporary contract between the plan and provider.

I provide services to members who have changed plans or are newly enrolled in the Next Generation MyCare program. Do I have to contract with the Next Generation MyCare plans to continue to serve them?

If you have Next Generation MyCare members who have changed plans or are newly

enrolled in the program, you can continue to provide services to those members for a period of time without having a contract with the Next Generation MyCare plan to allow for continuity of care. If you want to continue to serve members in the program, you need to contract with the plans. For more information or questions, contact the plans.

- Anthem Blue Cross and Blue Shield: 833-727-2170
- Buckeye Health Plan: 833-998-4892
- CareSource: 800-488-0134
- Molina HealthCare of Ohio: 855-322-4079

Submitting Claims or Prior Authorizations

Which ID number should be used when submitting a claim for a Next Generation MyCare member where Medicaid is the primary payer?

You must use the member's Medicaid ID (MMIS number) when submitting claims through the Ohio Medicaid Enterprise System (OMES) one front door. Medicare ID numbers will not be accepted. View the Next Generation MyCare ID Card One-Pager to see the ID card and where the Medicaid ID is located.

How do I submit claims?

The process for submitting Electronic Data Interchange (EDI) claims in the program has changed. If you are not an Ohio Medicaid provider, your claims will be rejected.

- **If you are submitting claims to the plan's portal using Direct Data Entry (DDE**), submit a single claim to the plan via their existing process. The Next Generation MyCare plans do not accept paper claims.
- **If you are submitting an EDI claim for a dual benefit member (a member who gets their Medicaid and Medicare benefits from a Next Generation MyCare plan) or a Medicaid-only member (a member who gets only their Medicaid benefits from a Next Generation MyCare plan) where the Medicaid plan is the primary payer, submit the claim through the OMES one front door.** You must use the member's Medicaid ID even if they have other ID numbers. The submitted file must use the Next Generation MyCare Plan Receiver ID and the appropriate Payer ID in the 2010BB loop for claims to be directed to the correct plan for processing.

- **If you are submitting an EDI claim for a Medicare covered service for a Medicaid-only member**, submit the claim, also known as a crossover claim, to the primary payer.
  - » **If Medicare is the primary payer**, submit the claim to Medicare using your normal process. Claims for Next Generation MyCare members will be automatically crossed-over to the plan.
  - » **If the primary payer is a Medicare Advantage/Part C plan**, submit the claim to that payer using your normal process. Once the primary payer has adjudicated the claim and returned the Remittance Advice, submit the claim through the OMES one front door using the Receiver ID and Payer ID for a dual benefit claim.

Claim submissions through the OMES one front door are based on the date of submission. Any claims submitted on January 1, 2026, or after should be submitted to the OMES one front door, even if the date of service was before January 1, 2026.

Refer to the Companion Guides for more information.

I am new to billing in the Next Generation MyCare program. What process should I use?

Billing services in the Next Generation MyCare program is generally the same as the Managed Care program. If you **submit claims for Managed Care members today, consider using the same process for MyCare members.** If you use a trading partner, contact them before the program starts to check if you need to take any extra steps for your claim to be accepted by ODM.

If you **do not have an existing process** for submitting claims for MyCare members today, consider which option is best for you.

- Providers with **a smaller volume of claims typically utilize the DDE process.** Visit the Next Generation MyCare plan DDE portals to learn how to enroll and submit claims.
  - ° Anthem Blue Cross and Blue Shield
  - ° Buckeye Health Plan
  - ° CareSource
  - ° Molina HealthCare of Ohio
- Providers with **a large volume of claims typically contract with a trading partner** to support in billing and reconciliation of what has been submitted and processed. View ODM's Electronic Data Interchange (EDI) Authorized Trading Partners list to see the trading partners currently authorized to work with ODM and you. If you want to use a

trading partner, you are encouraged to contact a few to find the one that best fits your needs.

Do I need to submit claims for Electronic Visit Verification (EVV) services in the Next Generation MyCare program?

EVV helps confirm scheduled home-and community-based services have occurred and creates a visit record to validate certain Medicaid claims. As of March 1, Next Generation MyCare providers billing for services subject to EVV must submit claims for payment and have a matching EVV record in the Sandata Aggregator. Claims without a matching EVV record will be denied. To learn more, refer to ODM's Electronic Visit Verification webpage, including the Electronic Visit Verification Guide to Resolving Common Error Codes.

What happens to a member's pre-existing prior authorization for services?

If a prior authorizations for Medicaid covered services or medications was:

- Submitted and approved before the member's effective date, with a service date after the effective date, the new plan providing services to the member will honor the approved prior authorization.
- Submitted and is still being reviewed as of the member's effective date, you must submit the request to the member's new plan.
- Submitted and denied before the member's effective date, there are options available for both members and providers:
  - » Members have the right to submit an appeal to their original plan and seek a state hearing if the appeal is not in their favor, or they can submit an appeal to their new plan.
  - » You have the right to appeal and seek an external medical review if the appeal is not in the member's favor, or you can request a prior authorization from the member's new plan.

To learn more about the member appeal process, view the 'How can I help a member appeal a claim or prior authorization denial?' question.

I am an out-of-network provider. How do I provide services to Next Generation MyCare members who have changed plans or are newly enrolled in the program?

To support continuity of care, if you have Next Generation MyCare members who have changed plans or are newly enrolled, you can continue to provide services even if you are not yet

contracted with a plan. However, the steps you need to take to receive reimbursement vary by the member's specific MyCare plan.

- **Anthem:** Complete an authorization request and upload to Availity or send it to the appropriate fax number. If you agree to Anthem's rates, you do not need a Single Case Agreement (SCA). If you don't agree with the rates, Anthem will work with you to execute an SCA. Learn more by viewing the Provider Manual or contacting OhioMedicaidProvider@anthem.com.
- **Buckeye Health Plan:** Submit a prior authorization request using the Prior Authorization Pre-Auth Check tool and complete all associated steps. Buckeye will then share a SCA. Learn more by visiting Non Participating Providers - Next Generation MyCare Program or call Provider Services at 833-998-4892.
- **CareSource:** Submit a prior authorization using the Provider Portal or the Medical Prior Authorization Request Form. CareSource will then reach out with a SCA. For out of network HCBS (Home and Community-Based Services) Waiver providers servicing a Next Generation MyCare member, please contact CareSourceOHLTSSHCBSSupport@caresource.com. Learn more by visiting Next Generation MyCare Claims or contacting 800-488-0134.
- **Molina Healthcare of Ohio:** Submit a prior authorization request for medical services using the Availity Essentials portal. Molina will then contact you for rate acceptance during the utilization review process. An SCA is not required if you agree to rates. Otherwise, Molina will work with you to execute an SCA. If you serve MyCare members under a waiver benefit, you are not required to submit prior authorizations through the standard process. Instead, you should work directly with the AAA or the Molina Care Coordinator to establish the waiver service plan. Once established, the waiver service plan is converted into a prior authorization to enable claim payment. Learn more by viewing the Provider Manual or contacting 855-322-4079.

Appealing a Claim or Prior Authorization Denial

How can I help a member appeal a claim or prior authorization denial?

State and federal law outlines processes for members to appeal a plan's decision to deny, limit, terminate, or suspend a service. A member may request for you to submit an appeal on their behalf. For you to initiate a member appeal, you must complete a member appeal form. From there, follow the steps in the plan's member handbook. To get a copy of the member handbook and member appeal form, go to the plan website.

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

Completing a member appeal does not fulfill the requirement to complete a provider appeal, which is necessary for you to complete an External Medical Review (EMR).

How can I dispute a claim or appeal a prior authorization decision using the provider claim dispute resolution (PCDR) or provider appeal process?

When you receive a prior authorization denial, you have the option to request a peer-to-peer review. You also have the option to request a provider appeal. A member appeal and 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. You are required to exhaust the provider appeal process prior to requesting an external medical review (EMR- see below for definition).

When you receive a claim denial, you can utilize the provider claim dispute resolution process (PCDR). Once you have completed the PCDR process, if the decision to deny is upheld, you can request an EMR.

If the denial is due to medical necessity, then EMR may be an option for you.

You can submit EMR requests and provide documentation via the EMR entity's portal for Medicaid-primary services for Medicaid-only members and all covered services for dual benefit members. After receiving written notification of the internal appeal for a claim or prior authorization dispute, you have 30 calendar days to request EMR through the online portal along with submission of required documentation.

You can find the peer-to-peer, provider appeals, and PCDR processes within the plan's

provider manual on each plan's website, and within the EMR Provider Authorization Denial Grid or MCE Claims Denial Resource Grid respectively.

For more information, visit the plan website.

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

What is an External Medical Review (EMR)?

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. EMR can be utilized for Medicaid-primary services for Medicaid-only members and all covered services for dual benefit members.

The EMR is available at no cost to you.

Note: HCBS waiver and pharmacy services are not subject to EMR.

Pharmacy Benefits

I am a pharmacy provider. What has changed for me in the Next Generation MyCare program?

In the program, you work with the plan's Pharmacy Benefit Manager to administer pharmacy benefits for members. Refer to the **Pharmacy Billing Reference Guide** on the Pharmacy Billing Information webpage to learn more.

Medicaid-only members have a separate Medicare plan that can administer their Part D drug benefit with the Next Generation MyCare plan paying for the non-Part D drugs (i.e. cough and cold products, over-the-counter drugs, prescription vitamins, and more).

Care Coordination

Are there changes to care coordination and the care teams I work with in the Next Generation MyCare program?

In the program, members have a care coordinator who helps manage their health and support services. If a member is on a waiver or receives Medicare through a different plan, they may need to work with additional people for their care needs.

Their care team may be different depending on the options below:

- If a member is a dual benefit member (has a Next Generation MyCare plan for both their Medicaid and Medicare benefits), they have one care coordinator. Their care coordinator helps with all their care needs.
- If a member is a dual benefit member and they are on a waiver, they may have a care coordinator and a waiver service coordinator. These two work together to help them with their needs.
- If a member is a Medicaid-only member (their Next Generation MyCare plan only covers their Medicaid benefits), they may have separate teams who help them with their Medicaid and Medicare benefits. These two teams may not work together, and the member may have to be more involved in their own care.

A member's care coordinator may be from their plan and/or their local AAA. If a member doesn't know who their care coordinator is, they can call the Care Management number on the back of their member ID card for help. If they want to change their care coordinator, they should call their plan.

Member Eligibility, Impacts, and Actions

Who is eligible for the Next Generation MyCare program?

Individuals are eligible to be enrolled in the program if they meet the following criteria:

- Have full Medicaid
- Have Medicare parts A, B, and D
- Are 21 or older
- Are not already enrolled in a Program for All-Inclusive Care for the Elderly (PACE), a Developmental Disabilities waiver, an Intermediate Care Facility, or have other health insurance that covers both inpatient hospital stays and doctor visits

How does the Next Generation MyCare program improve member care?

The program coordinates a member's Medicaid and Medicare benefits through one care team focused on the member and their care needs.

For dual benefit members, this means they have communications coming from one source, one organization to contact if they need to file an appeal, and one plan that covers their entire healthcare benefit. This includes behavioral health services and long-term care services for members in the community, assisted living, and in a nursing facility. The program offers better transportation options, stronger network adequacy requirements, and shorter wait time for prior authorizations.

View the **Next Generation MyCare Plan Comparison** at ohiomh.com by clicking the "Compare Next Generation MyCare Plans" button under "Compare Plans and Find a Provider" section to learn more about the benefits each plan offers.

A member wants to pick a different Next Generation MyCare plan. When can they do that?

If a member is a Medicaid-only member and wants to pick a different Next Generation MyCare plan for their Medicaid benefits, they can pick a different plan for up to 90 days after they joined the program. They can also change plans throughout the year for just cause. Just cause is when a member is concerned with or has issues getting care due to the plan they are on.

If a member is a dual benefit member, they can change their Next Generation MyCare plan at any time through Medicare. Their new plan and benefits will begin on the first day of the month following their selection.

Members should contact the Ohio Medicaid Consumer Hotline at 800-324-8680 to discuss their options for picking a new plan.

A member wants to align their Medicare and Medicaid benefits through a Next Generation MyCare plan. When can they do that?

If a member is currently a Medicaid-only member and wants to align their Medicare and Medicaid benefits through a Next Generation MyCare plan, they have the option to enroll at any time through Medicare. Their new plan and benefits will begin on the first day of the month following their selection.

Members should contact the Ohio Medicaid Consumer Hotline at 800-324-8680 to discuss getting their Medicare and Medicaid benefits through one plan.

An individual is eligible for the Next Generation MyCare program. What does this mean for them?

- Members who selected a plan before the program was available in their county are now receiving care through their selected plan.
- Members who did not select a plan before the program became available in their county will be automatically enrolled in a plan for their Medicaid benefits. If a member has not already, they will receive a letter from ODM or their plan with additional information.
- If a member wants to get their benefits through a Next Generation MyCare plan sooner or change your plan, they should contact the Ohio Medicaid Consumer Hotline at 800-324-8680. Once they select a plan, they will start receiving care from that plan on the first day of the following month.
- Members who are eligible for the MyCare Ohio Waiver will start receiving services through the waiver once their plan starts.

Once a member is enrolled with their plan, they should receive a new member ID card and other information explaining their benefits. They should contact their plan if they do not receive or have questions about these materials.

- Anthem Blue Cross and Blue Shield: 833-727-2169
- Buckeye Health Plan: 855-445-3562
- CareSource: 855-475-3163
- Molina Healthcare of Ohio: 866-856-8295

Contact the Ohio Medicaid Consumer Hotline at 800-324-8680 if:

- They do not know their plan
- They want to pick a different plan
- They want to align their Medicaid and Medicare benefits into one plan
- They did not receive their member ID card or need help with their benefits

A member is in the Next Generation MyCare program. What if they move to another county?

If a member moves to a different county, they can stay with their current plan.

*Buckeye Health Plan will not be available in Belmont and Ashtabula counties for plan year 2026. Members who move to one of these counties should receive a letter from ODM with additional information.

A member was in the Ohio Home Care, Assisted Living, or PASSPORT waiver when they were enrolled in the Next Generation MyCare program. What does this mean for them?

If a member was in the Ohio Home Care, Assisted Living, or PASSPORT waiver when they were enrolled in the program, they are now enrolled in the MyCare Ohio Waiver. In the MyCare Ohio Waiver program, they have the same benefits, or more, available to them. If a member is not eligible for and not enrolled in the Next Generation MyCare program, they will remain on their original waiver.

If a member has questions, they should contact their care coordinator. If they don't know who their care coordinator is, they can call the Care Management number on the back of their member ID card for help.

What happens to the services a member already has approved or scheduled?

Next Generation MyCare plans provide transition of care benefits for services. After the transition period, members must use doctors and pharmacies who are part of their plan.

Members should contact their plan if they have questions about approved or scheduled services.

- Anthem Blue Cross and Blue Shield: 833-727-2169
- Buckeye Health Plan: 855-445-3562
- CareSource: 855-475-3163
- Molina Healthcare of Ohio: 866-856-8295

Did a member's doctor or hospital change due to the Next Generation MyCare program?

Most doctors and hospitals are part of the Next Generation MyCare program. If a member's doctor is not in the program, they may need to choose a new doctor.

To check if their doctor is in the program, they can:

- Contact their plan's Member Services found on the back of their member ID card
- Call their Primary Care Provider's phone number found on the front of their member ID card
- Visit their plan's website
- Use the provider search available on the Ohio Medicaid Consumer Hotline at www.ohiomh.com/home/findaprovider. They should select their Next Generation MyCare plan in the "Health Plan" dropdown and "MyCare Ohio" in the "Program" dropdown

How can members find out more information about their Next Generation MyCare plan?

To learn more about the Next Generation MyCare plans, members should contact the Ohio Medicaid Consumer Hotline at 800-324-8680 or visit www.ohiomh.com.

If they need help comparing the plans available in their area, including the Next Generation MyCare plans, they can contact the Ohio Department of Insurance Ohio Senior Health Insurance Information Program (OSHIIP) at 800-686-1578 or oshiipmail@insurance.ohio.gov.

Additional Resources

Where can I go with questions about the Next Generation MyCare program?

Contact Ohio Medicaid Integrated Helpdesk at 800-686-1516 or IHD@medicaid.ohio.gov for questions related to the following:

- OMES submitted claims, prior authorization, and other administrative tasks
- Verification of Medicaid member eligibility
- Provider application, enrollment, or waiver support
- General Medicaid payment/billing

Representatives are available Monday through Friday, 8 a.m. - 4:30 p.m. Eastern Time.

Where can a member go with questions about the Next Generation MyCare program?

To learn more about the Next Generation MyCare plans or doctors available by plan, members can contact the Ohio Medicaid Consumer Hotline at 800-324-8680 or visit www.ohiomh.com. Representatives are available Monday through Friday 7 a.m. – 8 p.m. and Saturdays 8 a.m. – 5 p.m. Eastern Time.