Frequently Asked Questions: Paramount Transition out of Central/Southeast Region

Background

As of June 1, 2020, Paramount will no longer serve Medicaid members in the Central/Southeast Region of the state. To ensure a smooth transition to a new plan for the nearly 31,000 members affected, Paramount and ODM are working together to communicate and coordinate with stakeholders like you the actions needed to manage member transitions to one of the other Medicaid Managed Care Plans. As a critical stakeholder in this process, ODM has developed a list of Frequently Asked Questions. This document is designed to assist you and your staff in responding to questions from members, providers and caregivers. Please review and share with staff who are likely to receive questions from those affected by this change.

How do I know if I’m affected?

- Only Paramount Advantage Medicaid members whose official residence is in a county in the central/southeast region are affected.

What counties are in the central/southeast region?

Paramount Advantage central/southeast region counties include:

- Athens
- Belmont
- Coshocton
- Crawford
- Delaware
- Fairfield
- Fayette
- Franklin
- Gallia
- Guernsey
- Harrison
- Hocking
- Jackson
- Jefferson
- Knox
- Lawrence
- Licking
- Logan
- Madison
- Marion
- Meigs
- Monroe
- Morgan
- Morrow
- Muskingum
- Noble
- Perry
- Pickaway
- Pike
- Ross
- Scioto
- Union
- Vinton
- Washington

How do I find out if I’m in the central/southeast county?

- Medicaid members who are unsure if they reside in the central/southeast region should contact Paramount Advantage member services to determine if their current address is in the affected region.
  - Paramount can confirm that their address is up to date with the county of residence records maintained by their County Department of Job and Family Services (CDJFS).
  - Should there be a discrepancy, Medicaid members will need to work with CDJFS to correct.

My address in your system is updated and correct except for the county. I reside in a central/southeast county, but your system says I do not. What do I do?

- If your address is incorrect, please contact your county caseworker to provide your right address. Once corrected, please follow the steps outlined below to change your plan.
I am not in a central/southeast county, but your system says I am, what do I do?

We apologize for the confusion. If you don’t currently reside in the central/southeast region, there is no action for you to take.

How do I change my health plan?

- To change health plans, members can do one of the following:
  - **Call the Medicaid Hotline**
    - Monday – Friday, 7 am – 8 pm
    - Saturday, 8 am – 5 pm
    - Toll free at 800-324-8680. When prompted, choose option 3.
  - **Visit the Medicaid Hotline Member Portal**
    - www.ohiomh.com
    - 24 hours a day, seven days a week

When will be the last day I can be on the Paramount plan?

- Members can enroll in a new plan immediately. However, they have until April 30, 2020 to make their choice. Once enrollment is complete, your new plan will begin on the first day of the following month.
- Members who do not select a new plan by April 30, 2020, will be assigned to one with an effective date of June 1, 2020.
- The following chart illustrates the various timelines possible between selection and start of a new plan.

<table>
<thead>
<tr>
<th>Date member selected a new plan</th>
<th>Date until member is enrolled in Paramount</th>
<th>Date member is enrolled in new plan</th>
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<tbody>
<tr>
<td>January 1 – January 31</td>
<td>January 31</td>
<td>February 1</td>
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<tr>
<td>February 1 – February 29</td>
<td>February 29</td>
<td>March 1</td>
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<td>March 1 – March 31</td>
<td>March 31</td>
<td>April 1</td>
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<tr>
<td>April 1 – April 30</td>
<td>April 30</td>
<td>May 1</td>
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<tr>
<td><strong>After April 30, ODM assigns you to a new plan</strong></td>
<td>May 31</td>
<td><strong>June 1</strong></td>
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Can I change my new health plan?

- You can change your managed care plan within the first three months after enrollment, during annual open enrollment, or at any time for Just Cause. Any changes in enrollment are effective the first day of the month following your request.

Since my health plan is changing now, will I be able to change health plans during the Open Enrollment period?

- You will still be able to select a new plan during the November 1 – November 30, 2020, annual open enrollment period.
If I don’t select a new health plan, when will I be notified about my new health plan?

- You will be assigned a new plan sometime in early May. Your new plan will be effective on June 1. Once your new plan is assigned, you will receive a letter in the mail containing the relevant transfer information.
- Your new plan will send a new ID card shortly after you are assigned to the new health plan.

Do you know why Paramount is leaving?

- Paramount made a business decision to reduce the size of its Medicaid network. It chose the central/southeast region due to a lower population of Medicaid members, thereby lessening the number of affected individuals.

Will Paramount still accept providers located in central/southeast region?

- Paramount is not terminating provider contracts. If you live in a different region, but see providers in the central/southeast region, you may continue to see those providers. Paramount Medicaid providers will remain contracted and will continue to be eligible to see Paramount members. Members in the west and northeast regions will remain Paramount Advantage Medicaid managed care members and will continue receiving health insurance benefits.

I live in Cleveland, why did I get this letter?

- To ensure full transparency, Paramount notified all its members of its transition from the central/southeast region. However, if you do not live in the central/southeast region this change does not affect you.

I do not live in the central/southeast region, and I am a Paramount member. Can I change my health plan today?

- No, only affected members have the option to change plan right now. Members who are considering a change can make that decision during the Ohio Medicaid Open Enrollment period in the month of November.

Does this mean that I am losing my Medicaid benefits?

- Paramount Advantage Members ARE NOT LOSING MEDICAID BENEFITS.

What health plan do you recommend?

- Ohio Medicaid’s managed care plans are required to provide identical, medically necessary health care services to all members. However, each has its own network of providers.
- We recommend you start the selection process by verifying in-network access to your healthcare providers with the managed care plan you are considering.
Ohio Medicaid publishes a quality report card each year that compares performance of Ohio Medicaid’s managed care plans across key performance areas.

- The Ohio Medicaid 2019 Managed Care Plan Report Card is available at: https://medicaid.ohio.gov/Portals/0/Resources/Reports/mcp-reportcard.pdf
- You can also compare plans by visiting www.ohiomh.com.
- The Medicaid Hotline also is available to assist you in reviewing plans, working with you to ensure your providers are in network with the new plan.

I am a foster/kinship parent, what do I do?

- The Ohio Departments of Medicaid (ODM) and Job and Family Services (ODJFS) will work with Public Children Services Agencies and IV-E Courts to ensure continuity of care for children in custody, or under the supervision of state agencies who reside in the central/southeast region.
  - Ohio Department of Jobs and Family Services and Ohio Department of Medicaid are also available to help with this process.
  - Please note: Foster parents and kinship parents who do not have custody of a child do not have legal authority to change their foster child’s managed care plan and should not contact the Medicaid Hotline to enroll their foster child. Only custody holders / legal guardians can change plans on behalf of the children in their care.
- For children receiving adoption assistance who are enrolled in Paramount Advantage Medicaid plan in the affected region, legal guardians must select a new managed care plan for their adopted child(ren).
- Children in custody and those receiving adoption assistance must adhere to the same timeline provided above:
  - Members without a plan selected by April 30, 2020, will be automatically assigned to a new plan with an effective date of June 1, 2020 (notice of new plan will be sent May 1, 2020).
  - Members automatically enrolled in a new plan on June 1, 2020 have 90 days to switch plans.

What happens to my Primary Care Provider (PCP)?

- When selecting your new health plan, make sure your current PCP will be a part of your new health plan. If you have any questions about which health plans your PCP is affiliated with, please call the Medicaid Hotline. Representatives will be able to help.
  - Call the Medicaid Hotline
    - Monday – Friday, 7 am – 8 pm
    - Saturday, 8 am – 5 pm
    - Toll free at 800-324-8680. When prompted, choose option 3.

What happens to my prescriptions?

- Your new health plan is required to honor current prescriptions for at least the first 90 days of enrollment. The only exception would be if your provider submits a prior authorization and your new plan completes a medical necessity review. Your new plan will inform you as to how to ensure you can receive your prescriptions after the first 90 days.
What happens to my prior authorizations?

- Your new plan will honor any existing prior authorization approved before your transition to a new plan and through the expiration of the authorization, regardless of whether the authorized or treating provider is in or out-of-network with the new plan.

Paramount already approved my prior authorization for medical procedures and my surgery was scheduled in advance. What happens when the next plan starts?

- If your medical procedure will be performed before you transition plans, there will be no change.
- If your medical procedure is scheduled for after the transition to your new plan, both Paramount and your new health plan will follow the usual transition of care requirements. Your new plan is required to honor any prior authorizations approved by Paramount until the date the authorization expires, regardless of whether the authorized or treating provider is in or out-of-network. Surgical procedures also include follow-up care as prescribed by your provider.

What happens with my behavioral health services?

- If you were receiving behavioral health services prior to July 1, 2018, you will continue to receive services if the provider is enrolled as a Medicaid provider with the Ohio Department of Medicaid. Your new plan will:
  - Work with the service provider to add the provider to its network;
  - Implement a single case agreement with the provider; or
  - Assist you in finding a provider currently in network.

What happens to my home health and private duty nursing services?

- Your new plan will provide private duty nursing, home care services, and durable medical equipment (DME) at the same level as Paramount, until your new plan conducts a medical necessity review.