



# Member Handbook

Ohio Medicaid

June 2018



## CONTACT US

### Member Services Department

**Phone:** **1-800-488-0134**  
(TTY: 1-800-750-0750 or 711)

**Street Address:** 230 N. Main Street, Dayton, Ohio, 45402

**Hours:** Monday through Friday, 7 a.m. to 7 p.m.

For 2018, CareSource is closed on:

New Year's Day, January 1

Memorial Day, May 28

Independence Day, July 4

Labor Day, September 3

Thanksgiving Day, November 22

Day after Thanksgiving, November 23

Christmas Eve, December 24

Christmas Day, December 25

Please note that a holiday that falls on a Saturday is observed on the Friday before; one that falls on a Sunday is observed on the Monday after.

**Online:** **CareSource.com**

**CareSource24® Nurse Advice Line**

**Phone:** **1-866-206-0554**  
(TTY: 1-800-750-0750 or 711)

### CareSource Transportation Services

**Phone:** **1-800-488-0134**  
(TTY: 1-800-750-0750 or 711)

## MOBILE APP

You can download the CareSource mobile app if you haven't already. For no extra cost, you will have easy access to your health plan information when you need it "on the go."

The mobile app lets you:

- View your member ID card
- Access your secure My CareSource account
- Find a doctor, hospital, clinic, urgent care or pharmacy near you (get directions or make a call)
- Review your plan benefits
- Call our nurse advice line and speak with a nurse 24/7
- Call and speak with Member Services
- And more!

Creating a My CareSource account helps you get the most out of the app. Set up your My CareSource account through the app or at **MyCareSource.com**.

Download it through the App Store for iPhone or Google Play for Android today!

## IMPORTANT FIRST STEPS

### Step 1 - Become familiar with your member ID card.

Your ID card was sent with your welcome letter. Each person in your family who is a CareSource member will have their own card. See page 3 for more information.

### Step 2 - Make an appointment with your doctor (see page 16)

If you need to change your primary care provider (PCP), visit us online at **CareSource.com** and click on Find a Doctor/Provider on the right side of the page or call Member Services.

### Step 3 - Learn About Your Benefits

Read this handbook to learn about member benefits and how to use them. Keep it in a safe place so you can refer to it. Visit us online at **CareSource.com**

### Step 4 - Keep Your Current Treatment Plans and Care

If you are being treated for a health issue, call Member Services so we can help you continue your care and prescription drugs. Turn to page 2 to learn more.

### Step 5 - Create your custom MyHealth Well plan:

CareSource wants you to stay healthy. You can get valuable customized tips and ideas to help you when you fill out the CareSource MyHealth risk assessment.

You can do it online by going to:

**CareSource.com/members/hra-health-risk-assessment/**

### Step 6 - Set Up a My CareSource® Account

Set up a secure online member account at **MyCareSource.com**. You can:

- Change your doctor
- Request a new ID card
- View claims and plan details
- And more

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# WELCOME

**Welcome to CareSource! Thank you for choosing CareSource. We are glad to have you as a member!**

You are now a member of a health care plan, also known as a managed care plan (MCP). CareSource provides health care services to Ohio residents who are eligible, including individuals with low income, pregnant women, infants, and children, older adults, and individuals with disabilities.

CareSource may not discriminate on the basis of race, color, religion, gender, sexual orientation, age, disability, national origin, veteran's status, ancestry, health status, or need for health services in the receipt of health services.

At CareSource, our mission is to make a lasting change in our members' lives by improving their health and well-being. We know life is busy and we are here to make things a little easier as you start your health journey with us. We believe you deserve more than high quality health care. You deserve to be covered with kindness.

We would like to hear what you think of CareSource. We welcome your suggestions for better service. If you want to tell us about things you think we should change, please call Member Services. Let us know if you ever have a question or concern about your health care or our services. We want you to be a healthy and happy CareSource member.

If you have a problem reading or understanding this information or any other CareSource information, please contact our Member Services at **1-800-488-0134** (TTY: 1-800-750-0750 or 711) for help at no cost to you. We can explain this information in English or in your primary language. We may have this information printed in some other languages. If you are visually or hearing-impaired, special help can be provided.

If you are new to CareSource or were on Medicaid fee-for-service the month before you became a CareSource member and have health care services already approved and/or scheduled, it is important that you call the Member Services department immediately (today or as soon as possible).



## CONTINUING CURRENT TREATMENT PLANS AND CARE

In certain situations and for a specified time period after you enroll, we may allow you to receive care from a provider that is not a CareSource network provider. Additionally, we may allow you to continue to receive services that were authorized by Medicaid fee-for-service. **However, you must call CareSource before you receive the care.** If you do not call us, you may not be able to receive the care and/or the claim may not be paid. For example, you need to call the Member Services department if you have the following services already approved and/or scheduled:

- Transplants: organ, bone marrow or hematopoietic stem cell
- Third trimester prenatal care, including baby delivery
- Any inpatient/outpatient surgery or hospital admission
- Appointment with a primary care or specialty provider
- Chemotherapy or radiation treatments
- Treatment following discharge from the hospital in the last 30 days
- Non-routine dental or vision services (for example braces or surgery)
- Medical equipment
- Services you receive at home, including home health, therapies and nursing services

## CURRENT PRESCRIPTION COVERAGE

After you enroll, CareSource will tell you if any of your current medications require prior authorization that did not require authorization when they were paid by Medicaid fee-for-service. It is very important that you look at the information CareSource provides and contact our Member Services department if you have any questions. You can also look on our website at **CareSource.com** to find out if your medication(s) require prior authorization. You may need to follow up with the prescriber's office to submit a prior authorization request to CareSource if it is needed. If your medication(s) need prior authorization you cannot get the medication(s) until your provider submits a request to CareSource and it is approved.




## YOUR MEMBERSHIP ID CARD

You should have received a CareSource member ID card. Each member of your family who has joined CareSource will receive their own card. These cards replace your monthly Medicaid card. Each card is good for as long as the person is a member of CareSource. You will not receive a new card each month as you did with the Medicaid card.

### Never let anyone else use your CareSource ID card.

You will receive a new card if you request a replacement or if you change your Primary Care Provider (PCP).

If you are pregnant, you need to let CareSource know. You must also call when your baby is born so we can send you a new ID card for your baby.

 <span style="float: right; font-size: small; color: white;">Health Care with Heart</span>	<p align="center"><b>THIS CARD IS FOR IDENTIFICATION ONLY AND DOES NOT VERIFY ELIGIBILITY.</b></p> <p><b>MEMBER:</b> Show your ID card to medical providers BEFORE you receive care. Never let anyone else use your ID card. In case of emergency, call 911 or go to the nearest emergency room (ER) or other appropriate setting. If you are not sure if you need to go to the ER, call your primary care provider or call our 24-hour toll-free nurse advice line (see front of card for phone number).</p> <p><b>HEALTH CARE PROVIDERS:</b> You must verify member eligibility for the date of service. Visit <a href="http://www.CareSource.com">www.CareSource.com</a> or call <b>1-800-488-0134</b> to access this information. Authorization required for inpatient admission.</p> <p><b>MAIL MEDICAL CLAIMS TO:</b> CareSource, P.O. Box 8730, Dayton, OH 45401-8730</p> <p><b>PHARMACY:</b> Providers call 1-800-488-0134</p> <p><b>BENEFITS MANAGER:</b> CVS Caremark  RxBIN 004336    RxPCN MCAIDOH    RxGRP RX0797</p> <p align="right" style="font-size: x-small;">www.CareSource.com</p>
<p><b>Member Name</b> Mary Doe</p> <p><b>CareSource Member ID #:</b> 12345678900</p> <p><b>MMIS #:</b> 987654321000      <b>Case #:</b> 7654321000</p> <p><b>Primary Care Provider/Clinic Name:</b> Good, Iam A.</p> <p><b>Provider/Clinic Phone:</b> (937) 123-4567</p> <p><b>Member Services:</b> 1-800-488-0134 (TTY: 1-800-750-0750 or 711)</p> <p><b>CareSource24® Line:</b> 1-866-206-0554 (TTY: 1-800-750-0750 or 711)</p>	

### ALWAYS KEEP YOUR ID CARD(S) WITH YOU

You will need your CareSource ID card each time you get medical services. This means that you need your CareSource ID card when you:

- See your primary care provider (PCP)
- See a behavioral health counselor or physician
- See a specialist or other provider
- Go to an emergency room
- Go to an urgent care facility
- Go to a hospital for any reason
- Get medical supplies
- Get a prescription
- Have medical tests
- Use transportation services

To serve you faster, please have your member ID number from your card available whenever you call our Member Services department.

Call CareSource Member Services department as soon as possible at **1-800-488-0134** (TTY: 1-800-750-0750 or 711) if:

- You have not received your card(s) yet
- Any of the information on the card(s) is wrong
- You lose your card(s)
- You have a baby



## MEMBER SERVICES AND CARESOURCE.COM

Our Member Services department is open Monday through Friday from 7 a.m. to 7 p.m., except on the holidays noted on the inside of this cover.

Our phone number is **1-800-488-0134** (TTY: 1-800-750-0750 or 711).

We are located at **230 N. Main Street in Dayton, Ohio, 45402** and online at **CareSource.com**.

For your convenience, there's a "Contact Us" page at the beginning of this handbook.

You can call or visit us online to:

- Ask questions about CareSource benefits, claims, eligibility, utilization management or prior authorization requests
- Find out what services are covered and how to access them
- Request a new member ID card
- Change your primary care provider (PCP)
- File a complaint about CareSource or a provider, or if you think you have been discriminated against
- Get help choosing a participating provider
- Let us know of changes to personal information, such as your address or phone number; you will also need to contact your county caseworker
- Let us know if you are pregnant
- Request interpreter services or if you or a family member are visually or hearing impaired and need help

We want to make sure your concerns are taken care of and your questions are answered. Have your member ID number handy when you call. This will help us serve you faster.

After business hours, our Member Services phone is answered by our self-service agent, KATIE. Katie can help with routine requests, such as requesting a new ID card. For more complex, non-urgent requests, please leave a call back number with Katie and we will return your call the next business day.

## INTERPRETER SERVICES

If there is a CareSource member in your family whose primary language is not English, is visually or hearing impaired, or has limited reading skills, please call us to arrange interpreter services. We offer sign and language interpreters for members who need language assistance communicating with CareSource or their health care provider. By calling Member Services, you can arrange to get interpreter services over the phone or in person. We can also provide some printed materials in other languages or formats, such as large print, or we can explain materials orally, if needed. This is a service to you free of charge.

## MY CARESOURCE®

My CareSource is your confidential and personalized member account where you can get information about your benefits and make changes (like changing your doctor). You can sign up online at [CareSource.com/members/ohio](https://www.caresource.com/members/ohio).

## CARESOURCE24® NURSE ADVICE LINE

**Our nurses can help you:**

- With pain or symptom relief
- Decide if your injury or illness is an emergency
- Treat an illness or injury at home
- Decide when to go to your doctor, an urgent care or emergency room
- Know what to ask your doctor
- Learn about your medications
- Get information about medical tests or surgery
- Learn about nutrition and wellness

**To reach CareSource24, call 1-866-206-0554 (TTY: 1-800-750-0750 or 711).**

# SERVICES COVERED BY CARESOURCE

## Important Information:

- You must receive services covered by CareSource from facilities and/or providers on the CareSource network. For exceptions, see page 22.
- When you see a health care provider who is not participating with CareSource, prior authorization is required except in emergency situations.
- You do not need a prior authorization for any office visit or procedure done at participating provider offices (PCP or specialty provider).
- Please check the Prior Authorization list on our website prior to your request as changes may occur throughout the year.
- Please note the difference between a referral and a prior authorization.

As a CareSource member, you will continue to receive all medically necessary Medicaid-covered services at no cost to you. Medically necessary means you need the services to prevent, diagnose, or treat a medical condition. You should not be billed for these services. If you receive a bill, please call us. Services covered by CareSource are included in the chart on pages 9-12.

**Prior Authorization (PA):** This means that CareSource must approve the service before you receive it. Your health care provider will request the approval from CareSource.

**Referral:** This means that your PCP or health care provider will recommend or request these services for you before you can get them. Your PCP will either call and arrange these services for you, give you a written approval to take with you for the referred services, or tell you on what to do.

## About your benefits

Many services are available to you from your PCP and CareSource does not need to approve these services before you get them. All you need to do is make an appointment with a doctor in our CareSource network. Look at your provider directory or the Find a Doctor/Provider link on our website. Then make an appointment yourself. Please call us if you need help finding a provider for any service or making an appointment.

Some services need a **prior authorization** from CareSource before you can receive them. You will find information about PAs noted in the chart on the following pages. Your PCP or health care provider will ask for a prior authorization from us. Your PCP or health care provider will usually schedule these services for you. CareSource cannot be responsible for services that need prior authorization if they were received without the approval.

For a detailed list of services that require a prior authorization from your doctor please visit [caresource.com/documents/oh-med-prior-auth-list-mycaresource/](https://caresource.com/documents/oh-med-prior-auth-list-mycaresource/) or please call Member Services at **1-800-488-0134** (TTY: 1-800-750-0750 or 711).

**Some services may require a referral. These services are indicated by an asterisk “\*” in the Benefits Guide on pages 9-12.**

To see services that are not covered by CareSource go to page 14. The services listed are examples; it is not possible to provide a complete list of the services that are not covered. If you have a question about if something is covered, please call Member Services at **1-800-488-0134** (TTY: 1-800-750-0750 or 711).



# YOUR BENEFITS

## BENEFITS GUIDE

SERVICE	NOTES	PRIOR AUTHORIZATION (PA) REQUIRED
Addiction Services		For inpatient services
Acupuncture	Acupuncture coverage is limited to the pain management of migraine headaches and lower back pain.	After 30 visits
Ambulance and Ambulette (Wheelchair Van) Transportation*		Only for trips by Ambulance home from hospital
Certified Nurse Midwife Services (CNM)	Check your provider directory or call Member Services for names of available CNMs.	
Certified Nurse Practitioner Services (CNP)	Check your provider directory or call Member Services for names of available CNPs.	
Chiropractic (back) Services		After 30 visits if under 21 year old After 15 visits if 21 or older
Dental Services*	Certain services such as orthodontia require a referral.	Some services require a PA, including dentures; talk with your dentist or call Member Services with questions.
Developmental Therapy Services*	For children birth to 6 years old	
Diagnostic Services* (lab, x-ray)		Some services require a PA; talk with your health care provider or call Member Services with questions.
Emergency Services	See “Emergency Services” section of this handbook on page 20 for appropriate use.	
Family Planning Services/Supplies	You may receive services from your PCP or any obstetrician, gynecologist or qualified family planning provider (QFPP) listed in your provider directory such as Planned Parenthood. You may self-refer for these services.	

\* indicates a service requires a referral.

SERVICE	NOTES	PRIOR AUTHORIZATION (PA) REQUIRED
Federally Qualified Health Center or Rural Health Clinic services		
Free-standing birth center services	Call Member Services for available qualified centers	
Healthchek (well-child) exams	Children 21 and younger	
Hearing exams & hearing aids		
Home Health Services*		Yes Skilled Nurse visits > 2 hours/day All Home Health Aides All Private Duty Nursing
Hospice Care* (terminally ill patients such as cancer patients)		Yes for inpatient only
Immunizations (Shots)		
Inpatient Hospital Services*		Yes
Medical Supplies	Prescription required	Some services require a PA; talk with your health care provider or call Member Services if you have questions.
Substance Use Disorder Treatment Services (also referred to as Behavioral Health)	Can self-refer to an Ohio Department of Mental Health and Addiction Services (MHAS) certified community mental health center or treatment center. See your provider directory.	Many mental health and substance use services require NO REFERRAL or PA. If needed, your provider will request.
Nursing Facility Services*	CareSource covers the stay unless the Ohio Dept. of Medicaid determines the member will return to fee-for-services Medicaid. Call Member Services for information about available providers.	Yes
Obesity Screening and Counseling	Can be obtained from or through your PCP if medically necessary	
Obstetric/Maternity Care	Prenatal and postpartum, including at-risk pregnancy services and gynecological services. You may self-refer to any women's health specialist in our network or you may see your PCP.	
Out of Network Services*		Yes

\* indicates a service requires a referral.



SERVICE	NOTES	PRIOR AUTHORIZATION (PA) REQUIRED
Orthotics/Prosthetics*		Some services require a PA; talk with your health care provider or call Member Services if you have questions.
Outpatient Hospital Services*		Some Outpatient services require a PA; talk with your health care provider or call Member Services if you have questions.
Over-the-Counter (OTC) Medications	Covered with a prescription from a doctor.	
Pap Smear exam for cervical cancer		
Physical and Occupational Therapy*		After 30 visits if 21 or older No PA is needed if under 21
Physicals for employment/job training	Covered if exam is not provided free of charge by another source	
Podiatry (foot) Services		
Preventive mammogram		
Prostate screening		
Primary Care Provider Services		
Prescription Medications	Also see over-the-counter (OTC). Pharmacies are in our provider directory.	Varies by drug – refer to page 34 on how to find out
Psychiatry		
Renal dialysis (kidney disease)*		
Residential treatment		Yes
Respite Services*	For caregivers of qualifying (SSI) members under the age of 21	Yes
Services for Children with Medical Handicaps (Title V)*	Can be obtained from your PCP or from a specialist with a PCP referral.	
Pain management procedures*		Yes
Durable Medical Equipment* (examples include hearing aids, customized wheelchairs, contact lenses)	Some exclusions apply	Some services require a PA; talk with your health care provider or call Member Services if you have questions.

\* indicates a service requires a referral.

SERVICE	NOTES	PRIOR AUTHORIZATION (PA) REQUIRED
Specialist Services*	Includes visits to participating specialists such as a dermatologist. Participating specialists are listed in the provider directory.	
Speech and Hearing Services (see Durable Medical Equipment, page 11)		After 30 visits if 21 or older No PA is needed if under 21
Vision (eye care) Services	Includes eyeglasses, routine checkups and services from optometrists, varies by age. See page 13. <i>Deluxe frames, transitions and progressive lenses are not covered.</i>	
Well-child (see Healthcheck, page 10 & 32)		
Yearly well-adult exams		

\* indicates service requires a referral.

Please call the CareSource Member Services department if you have any questions about covered services.

## BEHAVIORAL HEALTH SERVICES

Behavioral health, or mental health & addiction services, is an important part of your overall wellness. Our goal is to take care of all your health needs. Whether it's depression, anxiety, alcohol or drug dependence, we provide treatment and counseling options to help you through difficult times in your life. We believe in recovery. We believe that treatment works. And we can help you find treatment with an experienced provider.

These are just a few of the services we provide to help you take care of you. (See also the Benefits Chart, pages 9-12 and additional information on page 25).

- Assessments or screenings to help diagnose a problem
- Counseling for individuals and/or families
- Opioid treatment, including detoxification and ongoing therapy

It's okay to ask for help. CareSource behavioral health services can help you cope with all sorts of issues. If you need mental health and/or substance use services, we can help you figure out what type of care you need. We can help connect you to mental health or addiction services and we can help you find an experienced provider. You can get a PCP referral or you may also self-refer directly to an Ohio Department of Mental Health and Addiction Services (MHAS) certified community mental health center or treatment center. Please see your provider directory, visit **CareSource.com** and use our Find A Doctor tool or call Member Services for the names and telephone numbers of the facilities near you.

## DENTAL SERVICES

Good dental care is an important part of your health. We encourage you to get a checkup every six months. Routine dental care can help identify and correct any problems before they get worse. CareSource will pay for two dental exams every year. CareSource also covers the following:

- X-rays
- Fillings
- Extractions
- General anesthesia
- Healthchek screenings

CareSource may also pay for one set of full or partial dentures every eight years with prior authorization. Some services may require a referral from your dentist and/or prior authorization from CareSource. Your dentist will take care of this for you. See additional benefits for more information, page 25.

## VISION SERVICES

Routine checkups and services from optometrists, as well as eyeglasses, do not require a referral. (Deluxe frames, transitions and progressive lenses are not covered.) You can get an eye exam each year. You can get eyeglasses once every year or once every two years depending on your age:

- Members 20 years old or younger: 1 pair of eyeglasses each year; one replacement pair if needed.
- Members 21-59: 1 pair of eyeglasses every 2 years.
- Members 60 and older: 1 pair of eyeglasses each year.

If you must travel 30 miles or more from your home to receive covered health care services, CareSource will provide transportation to and from the provider's office. Please contact **1-800-488-0134** for assistance at least 48 hours (two business days) before you need a ride.

In addition to the transportation assistance that CareSource provides, members can still receive assistance with transportation for certain services through the local County Department of Job and Family Services Non-Emergency Transportation (NET) program. Call your County Department of Job and Family Services or your case worker for assistance with NET services.

## EXCLUSIONS: NON-COVERED SERVICES

CareSource will not pay for services or supplies received without following the directions in this handbook. CareSource will not pay for the following services that are not covered by Medicaid:

- Abortions except in the case of a reported rape, incest or when medically necessary to save the life of the mother
- Biofeedback services
- All services or supplies that are not medically necessary
- Assisted suicide services, defined as services for the purpose of causing, or assisting to cause the death of an individual
- Experimental services and procedures, including drugs and equipment, not covered by Medicaid and not in accordance with customary standards of practice
- Infertility services for males or females, including reversal of voluntary sterilizations
- Paternity testing
- Plastic or cosmetic surgery that is not medically necessary
- Services for the treatment of obesity unless determined medically necessary
- Services to find cause of death (autopsy) or services related to forensic studies
- Services determined by Medicare or another third-party payer as not medically necessary
- Sexual or marriage counseling
- Voluntary sterilization if under 21 or legally incapable of consenting to the procedure
- Medications that are being used for erectile dysfunction, weight loss, infertility or cosmetic purposes

This is not a complete list of the services that are not covered by Medicaid or CareSource. If you have a question about whether a service is covered, please call Member Services.

# YOUR PRIMARY CARE PROVIDER (PCP)

## CHOOSING A PRIMARY CARE PROVIDER (PCP)

Each member of CareSource must choose a primary care provider (PCP) from the CareSource provider directory. Your PCP is an individual physician, physician group practice, advanced practice nurse or advanced practice nurse group practice trained in family medicine (general practice), internal medicine or pediatrics.

Your PCP will work with you to direct your health care. Your PCP will do your checkups, shots and treat you for most of your routine health care needs. If needed, your PCP will send you to other doctors (specialists) or admit you to the hospital.

Sometimes there may be a reason that a specialist may need to be your PCP. If you and/or your specialist believe that they should be your PCP, you should call the Member Services department to discuss.

You can reach your PCP by calling the PCP's office. Your PCP's name and telephone number are printed on your CareSource ID card. If you are a new patient to your PCP, please call the PCP office to schedule an appointment. This will help your PCP get to know you and understand your health care needs right away. You should also have all of your past medical records transferred to your new doctor.

The provider directory is a list of doctors and other health care providers who accept CareSource members. **If you haven't chosen a PCP yet**, please choose one from the directory. You can request a printed provider directory by calling Member Services or by returning the postcard you received with your new member letter and member identification (ID) card. The provider directory lists all of our network providers as well as other non-network providers you can use to receive services. You can also visit our website at **CareSource.com** to view up-to-date provider network information or call Member Services at **1-800-488-0134** (TTY: 1-800-750-0750 or 711), Monday – Friday, 7 a.m. to 7 p.m. for assistance. We can help you find a PCP or send you a printed directory.

## CHANGING YOUR PCP

We hope you are happy with the PCP you have chosen, but we know that you may decide to choose a different PCP in the future. If for any reason you want to change your PCP, you must first call the Member Services department to ask for the change. You can change your PCP as often as once a month, if needed. We will process your change on the day you call. CareSource will send you a new member ID card to let you know that your PCP has been changed and the date you can start seeing the new PCP. The Member Services department can also help you schedule your first appointment, if needed.

For the names of the PCP in the CareSource network, you may look in your provider directory if you requested a printed copy, on our website at **CareSource.com**, or you can call our Member Services at **1-800-488-0134** (TTY: 1-800-750-0750 or 711) for help.

If your PCP tells us that he/she is moving away, retiring or leaving CareSource for any reason, we will assign another PCP for you and let you know by mail within 45 days whenever possible. You can call us if you need help choosing another PCP. We also inform you if any of our participating hospitals within your region stop participating.

## PROVIDER DIRECTORY

Our directory is subject to change. Some providers may have been added or removed since it was printed.

If you have a question or want to know which providers participate with CareSource, we can help. Just visit our website at **CareSource.com**. If you don't have access to our website, you can call our Member Services department and ask for a copy of our directory.

We can give you the most current information with more details about providers when you call. We want to make sure you are aware of all of your options.

## DOCTOR APPOINTMENTS

Please schedule appointments with your doctor as far in advance as possible.

It is important to keep your scheduled appointments. If you need to cancel or change appointments, please call the doctor's office at least 24 hours in advance. If you miss too many appointments, your doctor may ask that you choose another doctor.

The Ohio Department of Medicaid (ODM) requires that CareSource provide transportation if you must travel 30 miles or more from your home to receive covered health care services. Please refer to your provider directory or the CareSource website to determine which providers are affected by this requirement.

# PREVENTIVE CARE

## Preventive Care is Important

Your PCP will play an important part in your preventive care. This means making regular visits to your doctor even if you do not feel sick. Routine checkups, tests and screenings can help your doctor find and treat problems early before they become serious. Preventive care includes:

- Immunizations for children
- Healthcheck exams for children under the age of 21
- Yearly well-adult exams
- Pap smears
- Breast exams
- Regular dental and medical checkups

We have preventive health guidelines for:

- Men
- Women
- Pregnant women
- Babies and children

To access these and our clinical practice guidelines, please call the Member Services department or visit our website at **CareSource.com**.

## WHERE TO GET CARE

We want to make sure you get the right care from the right health care provider when you need it. The following information will help you decide where you should go for medical care:

Nurse Advice Line	Primary Care Provider	Convenience or Retail Clinic	Urgent Care	ER
Available 24/7	Available weekdays, office hours and some may have limited after hours	Available weekdays, some evening and weekend hours	Available weekdays, some evening and weekend hours	Available 24/7
Any question about injury or illness	Routine and chronic care, minor illness and injuries	Common and minor illness and injuries	Illness and injuries needing immediate attention	Serious or life-threatening condition
A nurse can help with how to care for an illness or injury at home. Can tell you when to go to a doctor or the ER.	They know your health history. This helps when making choices about your treatment and necessary tests.	Examples: common cold, sore throat, rash, cough, ear-ache, pink eye	Examples: Broken bone, sprain, strains, colds, fever, rash, ear infection, minor cuts	Examples: Severe chest pain, severe difficulty breathing, uncontrolled bleeding, facial or limb weakness, spinal or head trauma, seizures

Not every situation falls neatly into one of the above options. Our nurse advice line provides access to talk with a registered nurse about your illness or injury. A registered nurse can help you decide where to get care. We're here for you 24 hours a day, 7 days a week.

Just call **1-866-206-0554** to talk to a CareSource24 nurse.



## PRIMARY CARE PROVIDER (PCP)

You should see your PCP for all routine visits. Some examples of conditions that can be treated by your PCP are:

- Dizziness
- High/low blood pressure
- Swelling of the legs and feet
- High/low blood sugar
- Persistent cough
- Earache
- Backache
- Constipation
- Rash
- Sore throat
- Loss of appetite
- Restlessness
- Joint pains
- Colds/flu
- Headache
- Removal of stitches
- Vaginal discharge
- Pregnancy tests
- Pain management

## CONVENIENCE CARE CLINICS

If you are not able to see your PCP, we want to make it easy for you and your family to get medical help when you need it most. CareSource members (18 years and older) can go to health care clinics at select locations to see board-certified family nurse practitioners or physician assistants for basic care. At the clinic, you can:

- Get vaccines
- Get health screenings and physicals
- Get care for aches and pains, illnesses and minor injuries

At most convenience care clinics, walk-ins are welcome. They are typically open 7 days a week and later than most doctor offices.

## URGENT CARE CENTERS

You can visit an urgent care center for non-emergency situations to keep an injury or illness from getting worse when your PCP's office is closed or if your PCP is not able to see you right away. If you think you need to go to an urgent care center, you can:

1. Call your PCP for advice. You can reach your PCP, or a back-up doctor, 24 hours a day, 7 days a week.

OR

2. Call CareSource24, our nurse advice line, at **1-866-206-0554** (TTY: 1-800-750-0750 or 711).

OR

3. Go to a participating urgent care center listed in your provider directory or on our website at **CareSource.com**. After you go, always call your PCP to schedule follow-up care.

Sometimes you get sick or injured while you are traveling. If you think you need to go to an urgent care center while you are away from home and are out of the counties that CareSource covers, call your PCP or CareSource24, our nurse advice line. The number is **1-866-206-0554** (TTY: 1-800-750-0750 or 711). They can help you decide what to do. If you go to an urgent care center, call your PCP as soon as you can to let him or her know of your visit.

## EMERGENCY SERVICES

Emergency services are services for a medical problem that you think is so serious that it must be treated right away by a doctor. We cover care for emergencies, both in and out of the county where you live. These services may be done in or out of the hospital and/or may include medical transportation. You can use any hospital or other appropriate setting or emergency services. Some examples of "emergency medical conditions" when emergency services are needed include:

- Miscarriage/pregnancy with vaginal bleeding
- Severe chest pain
- Shortness of breath
- Loss of consciousness
- Seizures/convulsions
- Uncontrolled bleeding
- Severe vomiting

- Rape
- Major burns
- Behavioral Health emergency

You do not have to contact CareSource for an okay before you get emergency services. If you have an emergency, call 911 or go to the NEAREST emergency room (ER) or other appropriate setting. If you are not sure whether you need to go to the emergency room, call your primary care provider or CareSource24 nurse advice line at **1-866-206-0554** (TTY: 1-800-750-0750 or 711).

Your PCP or CareSource24 nurse advice line can talk to you about your medical problem and give you advice on what you should do.

Remember, if you need emergency services:

- Go to the nearest hospital emergency room or other appropriate setting. Be sure to tell them that you are a member of CareSource and show them your ID card.
- If the provider that is treating you for an emergency takes care of your emergency but thinks that you need other medical care to treat the problem that caused your emergency, the provider must call CareSource.
- If you are able, call your PCP as soon as you can to let him or her know that you have a medical emergency, or have someone call for you. Then call your PCP as soon as you can after the emergency to schedule any follow-up services.
- If the hospital has you stay, please make sure that CareSource is called within 24 hours.

## **FOLLOW UP CARE** (also called **post-stabilization care**)

You may need more care after your emergency. This is called follow up care. It's important to let CareSource know that you have had an emergency. If you have a Care Manager it's a good idea to tell him/her. They can help you transition back home and schedule follow up visits. CareSource will talk to the doctors that give you care during your emergency. The doctors will tell us when your medical emergency is over. They need to tell us if you need more care to treat any problems that may have caused the emergency. Your doctor can tell us by calling **1-800-488-0134** and asking for approval of these services. If needed, CareSource will cover care for you after your emergency situation 24 hours a day, seven days a week. We want to be sure you continue to improve and your condition is stable and resolved if possible. If your emergency care was from out-of-network providers, CareSource will work to get network providers to take over your care as soon as possible.

## WHEN YOU CAN SEE A NON-PARTICIPATING PROVIDER

Your primary care provider (PCP) is your personal health provider. For any routine medical needs, contact your PCP first.

It is important to remember that you must receive services covered by CareSource from facilities and/or providers in the CareSource network. See pages 7-13 for information on services covered by CareSource. The only time you can use providers that are not in the CareSource network is for:

- Emergency services
- Federally Qualified Health Centers/Rural Health Clinics
- Qualified family planning providers

OR

- An out-of-network provider that CareSource has approved you to see

In addition, your PCP may decide that you need medical care that you can only get from a doctor or other health care provider who is not participating with CareSource. If your PCP gets prior approval from CareSource for these services, they will be covered.

## WHEN YOU TRAVEL OUTSIDE OF OUR SERVICE AREA

Sometimes you get sick or injured when you are traveling. Here are suggestions for what to do if this happens:

If it's an **emergency**:

- Call 911 or go to the nearest emergency room

If it's **not an emergency**:

- Call your PCP for help on what to do

If you're **not sure if it's an emergency**:

- Call your PCP

OR

- Call CareSource24, our nurse advice line. The phone number is **1-866-206-0554** (TTY: 1-800-750-0750 or 711). We can help you decide what to do.

# CARE COORDINATION SERVICES

CareSource's mission is "To make a lasting difference in our members' lives by improving their health and well-being." To meet this mission, CareSource offers 3 levels of care coordination services to meet EVERY member's needs at any time.

## LEVEL 1 CARE COORDINATION: SELF-MANAGEMENT

CareSource offers self-management tools called "MyHealth" and "myStrength" to help members manage their physical and behavioral health. These tools offer health assessments to help members understand their health and any health risks better. The tools will then help guide members to take small steps to a healthier life.

CareSource encourages members to fill out a Health Risk Assessment so we can identify if you may need Level II or Level III services.

CareSource offers HealthChek, Ohio's early and periodic screening, diagnostic, and treatment benefit. HealthChek includes free preventive medical and dental screenings, lab test, and education for members 21 years and younger. See the the HealthChek section on page 32 for more details.

## LEVEL II CARE COORDINATION: RISING RISK

CareSource has registered nurses, social workers, and other outreach workers that help members experiencing a physical, behavioral, social, or economic need that may have an impact on their health. These needs may include finding appropriate community resources. They may contact you if:

- Your doctor requests it
- If you request help
- If our staff feels their services would be helpful to you or your family

CareSource offers a program designed to assist you and/or your family members upon discharge from the hospital.

The goals of the program:

- Answer any questions related to any discharge questions
- Ensure that you and/or your family members understand the medications and be available to answer any questions related to your medications
- To help coordinate your primary care and/or specialist appointments
- To help obtain any needed equipment or supplies needed at home

If you or your family member needs assistance with discharge from the hospital you can reach a member of the Care Transition team at **1-866-867-0421**.

## LEVEL III CARE COORDINATION: 1:1 CARE MANAGEMENT

CareSource offers 1:1 care management services available to children and adults with special health care needs. These members may have multiple medical and behavioral conditions, and/or social issues that are having a large impact on their health. Members may be notified for Level III Care Coordination based on member request, provider referral, or based on medical, behavioral, and/or social conditions.

A member of the CareSource Care Management team may ask you questions to learn more about your health, and then a dedicated team will work with you one-on-one by telephone and in person to assist you.

Our staff will provide you with information to help you understand how to care for yourself and access services, including local resources. Our staff will talk to your PCP and other service providers to make sure you receive coordinated care. Our staff can also work with you if you need help figuring out when to get medical care from your doctor, urgent care, or the emergency department.

CareSource offers 1:1 care management for medical conditions such as:

- Asthma
- Chronic obstructive pulmonary disease
- Heart failure/Coronary artery disease
- Diabetes
- Depression
- High blood pressure
- Bipolar disease
- Pain management
- High-risk pregnancy

CareSource offers care management for social issues such as:

- Lack of needed resources like food or clothing
- Lack of safe transportation to receive medical care
- Unstable housing
- Difficulty getting a job

Please call us if you have any questions about care management or feel that you would benefit from care management services. We are happy to assist you. You can reach Care Management Support Services at **1-800-993-6902**.

## ADDITIONAL CARESOURCE BENEFITS

CareSource also offers extra services and/or benefits to members. These added CareSource benefits are available at no cost to you. They include:

### **MENTAL HEALTH AND SUBSTANCE USE DISORDER TREATMENT SERVICES**

**Effective 7/1/18, mental health and substance use disorder treatment services are available through your CareSource plan.**

These services include:

- Medical Services such as visits to the psychiatrist
- Medication-Assisted Treatment for Addiction
- Office Administered Medications
- Psychological Testing including assessments and screenings
- Day Treatment for Mental Health
- Substance Use Disorder Services, including Peer Recovery Support, Partial Hospitalization, and Residential Treatment
- Therapeutic Behavioral Service such as counseling
- Psychosocial Rehabilitation to help you return to living in the community
- Community Psychiatric Support Services including case management

In addition to these services, two new services are also available: Assertive Community Treatment (ACT) and Intensive Home Based Treatment (IHBT). Both these services offer help to those with serious mental illness or emotional disturbances. For information on finding a provider see page 12.

### **DENTAL CARE**

Good dental care is an important part of your health. We encourage you to get a checkup every six months. Ohio Medicaid covers one dental exam every year for members ages 21 and older. For members who are younger than 21, Ohio Medicaid covers two dental exams every year. As a CareSource member, you can receive two dental exams every year regardless of your age.

## myStrength

Take charge of your Mental Health and try our wellness tool called myStrength. This is a safe and secure tool designed just for you. It offers personalized support to help improve your mood, mind, body and spirit. You can access it online or on your mobile device at no cost to you. myStrength offers online learning, empowering self-help tools, wellness resources and inspirational quotes and articles.

You can visit <https://www.mystrength.com/r/caresource> for more information and to sign up. Complete the myStrength sign-up process and personal profile. You can also download the myStrength app for Apple and Android devices at [www.mystrength.com/mobile](http://www.mystrength.com/mobile) and SIGN IN using your login email and password.

## MYHEALTH

CareSource offers MyHealth for members over the age of 18. Use MyHealth to take health assessments, set goals and track activities. Take online health training based on your needs. Start by signing on to your **My.CareSource.com** account. If you have any questions, call Member Services or go to **CareSource.com**.

## EXPRESS BANKING

We have partnered with Fifth Third Bank to offer our members Express Banking®. This is a bank account from Fifth Third that offers:

No monthly service charge

No balance requirement

No overdraft fees

A debit card for purchases

Your financial health is key to your well-being. This account is a simple way to manage your money and reach your financial goals. For more details, go to [www.53.com/CareSource](http://www.53.com/CareSource).

If you're visiting a Banking Center, reference CareSource member code: 56706

## HEALTH INFORMATION

Preventive medical and dental care is an important part of keeping you and your family healthy. Regular care helps your primary care provider find problems early so they can be treated before they get worse.

Knowing how to lead a healthy lifestyle also helps you to stay well. CareSource offers information about well-child care, immunizations, family planning and health and safety through our many brochures and member newsletters. You may receive health information:

- Through the mail
- From our website at **CareSource.com**
- By calling us at **1-800-488-0134** to request it



## CARESOURCE24® NURSE ADVICE LINE

With CareSource24, you have unlimited access to talk with a caring and experienced staff of registered nurses through a toll-free number. You can call 24 hours a day, 7 days a week. CareSource24 services are available at no cost to you. The nurses will talk through your symptoms. They will help you figure out your next steps for care. Please see page 18 of this handbook for more details.

## DISEASE MANAGEMENT

CareSource offers disease management programs. These programs can help you learn about your health and how you can better manage your specific health conditions. Our goal is to make sure you have the right tools to stay as healthy as possible. These programs are available to you at no cost. If we receive information from your doctor, pharmacy or other health care source, letting us know that you would benefit from one of these programs, you will receive information about the program. You may also contact us at any time if you believe you could benefit from our disease management programs. If at any time you choose to not participate in the program, you may opt out by contacting us at the number below.

We have programs for Asthma and Diabetes.

Goals of our programs include:

- Helping you understand how to take good care of yourself
- Helping you adopt a healthy lifestyle (if you need help to stop smoking, a Care Manager can assist you)
- Working with your doctor to reach your health goals

If you would like additional information on these conditions, please call **1-888-882-3614**. We are committed to improving the health and wellness of our members.

## COMPREHENSIVE PRIMARY CARE (CPC)

Comprehensive Primary Care is Ohio's patient-centered medical home program. CareSource is working with health providers across the state to better coordinate the health and safety needs of our members. The goal of CPC is to provide comprehensive care that addresses all of your needs. Your PCP will lead and coordinate your care. The same CareSource services and resources are available to you through the CPC program. In fact, you will benefit from our stronger partnership with providers as they take the lead to help you achieve your health needs and goals.

What this means for you is that your care management will be part of a care team located at your PCP office. The care team will coordinate behavioral, physical and social needs from the central CPC practice with your PCP. This team will be able to help you make medical appointments, get transportation or access community resources. Our goal is to work with CPC providers to deliver the best care possible to our members.

## TRANSPORTATION

If you must travel 30 miles or more from your home to receive covered health care services, CareSource will provide transportation to and from the provider's office. Please call **1-800-488-0134** to arrange a ride at least 48 hours (two business days) before your appointment. CareSource also offers additional transportation services, if needed.

We also cover up to 30 one-way trips per member per calendar year to any health care, WIC or redetermination appointments. Remember, if you have an emergency, please call 911 or go directly to the nearest emergency room.

In addition to the transportation assistance that CareSource provides, members can still receive assistance with transportation for certain services through the local County Department of Job and Family Services Non-Emergency Transportation (NET) program. Call your County Department of Job and Family Services or your case worker for assistance with NET services.

### CARESOURCE TRANSPORTATION POLICY

Please review the following information carefully to understand your responsibilities. These rules have been made to help ensure your safety and to avoid transportation delays.

#### Member Transportation Responsibilities

1. Members are expected to:
  - Call to arrange non-emergent transportation 48 hours (two business days) in advance. Saturday, Sunday, and holidays do not count.
  - Have the complete address of the health care provider's office that you are going to.
  - Be at your pick-up address no later than the time given to you as your earliest pick-up time. This will ensure that the driver has adequate travel time so you are not late for your appointment.
  - Be ready when the driver gets there for curbside pick-up and drop-off services. The driver can wait for only five minutes. After five minutes, he/she will leave and this will count against you as a "no-show."
  - If you can't make it, please call to cancel transportation at least two hours before your scheduled pick-up time. Ask the provider's office to call the transportation company for your return trip home.
  - If you need to have a prescription filled at the provider's facility before leaving, please do so before requesting the return-trip call.

2. Members who are not ready and waiting cause no-show transportation charges for attempting to pick you up for your appointment. The transportation company reserves the right to take away your transportation benefit for six months after three no-shows within three months. A no-show is defined as:
  - Not being at the pick-up address at the time given to you as your earliest pick-up time.
  - The driver waits five minutes and leaves.
  - Not calling to cancel at least two hours before the scheduled pick-up time.
3. Members are expected to be courteous and show respect to the transportation company and CareSource staff. Improper, discourteous behavior may result in a 6-month suspension of transportation benefit for the family. Improper behavior includes:
  - Use of profanity (swearing), name-calling, or verbal abuse.
  - Threats of physical abuse to the transportation company, drivers or CareSource staff.

***CareSource and the transportation company reserve the right to immediately discontinue transportation services to members who violate these guidelines or misuse or abuse the transportation benefit.***

Please keep this policy in mind. We want your transportation experiences to be positive. Please call the Member Services department if you have any questions or concerns.

# PREGNANCY & FAMILY PLANNING

## DIRECT ACCESS TO FAMILY PLANNING SERVICES

Whether you are thinking about having a baby in the future or you are expecting a baby soon, CareSource wants you to have a healthy pregnancy. Here is how you can take advantage of the services and benefits we have to offer.

### FAMILY PLANNING

CareSource offers direct access to family planning services without a referral. If the provider you wish to see is not in the CareSource network, you may need a prior authorization before your visit. Call Member Services at **1-800-488-0134** (TTY: 1-800-750-0750 or 711) to let them know who you will be seeing for your family planning.

### SEXUALLY TRANSMITTED INFECTIONS

Screening, diagnosis and treatment of sexually transmitted infections are a direct access service. This means you can receive services for sexually transmitted infections without a referral for the service. If the provider you wish to see is not in the CareSource network, you will need to call Member Services at **1-800-488-0134** (TTY: 1-800-750-0750 or 711).

### BEFORE YOU ARE PREGNANT

It is never too early to prepare for a healthy pregnancy. If you are thinking of having a baby, you can do some things now to be as healthy as possible before getting pregnant. These actions can reduce potential problems during pregnancy:

- Make an appointment to see your doctor for a physical exam
- Talk with your doctor about what makes a healthy diet
- Take folic acid every day
- Don't drink alcohol or use illegal drugs
- Stop smoking now

### QUIT FOR TWO

CareSource can help you to quit smoking during pregnancy or following the delivery of your baby with our Quit for Two program. A trained counselor will work with you throughout your pregnancy and until your baby turns one. Call **1-855-852-7001** to enroll in this program.

## DURING PREGNANCY

If you are pregnant, make an appointment with an obstetrician (OB). You can find an OB in your provider directory. If you need help, call Member Services at **1-800-488-0134** (TTY: 1-800-750-0750 or 711). Be sure to make an appointment as soon as you know you are pregnant.

## AFTER YOU HAVE YOUR BABY

Call CareSource to tell us that you had your baby. You can reach Member Services at **1-800-488-0134** (TTY: 1-800-750-0750 or 711). You should also contact your case worker at your county Department of Job and Family Services.

It is also important to have a postpartum checkup with your OB. He or she will make sure your body is healing and recovering properly after giving birth. Call your OB to schedule an appointment for 4 to 6 weeks after your baby is born. If you had a C-section or had any problems during delivery, make your appointment within the first or second week after your baby is born.

## BABIES FIRST

CareSource offers a program you can sign up for if you are pregnant:

- **Babies First** – when you keep your OB appointments and take your newborn for well-child doctor visits, you can receive rewards (up to \$150) that you can use to get care items for you and your baby. For more information, call Member Services at **1-800-488-0134** (TTY: 1-800-750-0750 or 711), or visit **CareSource.com/ohbabiesfirst**.

## TEXT4BABY

If you are pregnant, you can sign up to have helpful text messages delivered right to your cell phone.

This app can provide:

- Information about a healthy diet while you are pregnant
- Appointment reminders about prenatal and well child appointments
- Weekly updates about how your baby is growing
- Additional information and videos on topics such as baby's development

Sign up at <https://secureforms.caresource.com/Text4Baby> and fill out the form. You will start receiving texts within a few days.

## HEALTHCHEK

Healthchek is Ohio's early and periodic screening, diagnostic, and treatment (EPSDT) benefit. Healthchek covers medical exams, immunizations (shots), health education, and laboratory tests for everyone eligible for Medicaid under the age of 21 years.

The Healthchek exams are important to make sure that children are healthy and are developing physically and mentally. Mothers should have prenatal exams and children should have exams at:

- Birth
- 3-5 days of age
- 1 month
- 2 months
- 4 months
- 6 months
- 9 months
- 12 months
- 15 months
- 18 months
- 24 months
- 30 months

After that, children should have at least one exam per year.

Healthchek also covers medical, vision, dental, hearing, nutritional, developmental, and behavioral health exams, in addition to other care to treat physical, behavioral, or other problems or conditions found by an exam. Some of the tests and treatment services may require prior authorization.

Healthchek services are available at no cost to members and include:

- Preventive checkups for newborns, infants, children, teens and young adults under the age of 21
- Healthchek screenings:
  - Medical exams (physical and development screenings)
  - Vision exams
  - Dental exams
  - Hearing exams
  - Nutrition checks
  - Developmental exams
  - Lead testing
- Laboratory tests (age and gender appropriate exams)

- Immunizations
- Medically necessary follow-up care to treat health problems or issues found during a screening. This could include, but is not limited to, services such as:
  - Visits with a primary care provider, specialist, dentist, optometrist and other CareSource providers to diagnose and treat problems or issues
  - Inpatient or outpatient hospital care
  - Clinic visits
  - Prescription drugs
  - Laboratory tests
- Health education

It is very important to get preventive checkups and screenings so your providers can find any health problems early and treat them, or make a referral to a specialist for treatment, before the problem gets more serious. Remember, some services may require a referral from your PCP or prior authorization by CareSource. Also, for some EPSDT items or services, your provider may request prior authorization for CareSource to cover things that have limits or are not covered for members over age 20. Please see pages 9-12 to see what services require a referral and/or prior authorization.

As a part of Healthchek, care management services are available to all members under the age of 21 years who have special health care needs. Please see page 23 to learn more about the care management (also referred to as care coordination) services offered by CareSource.

Call your PCP or dentist to schedule an appointment for a Healthchek exam. Make sure to ask for a Healthchek exam when you call your PCP. CareSource asks that you schedule exams for all eligible family members regularly. You should try to schedule the first exam within 90 days of becoming a member. If you would like more information on the Healthchek program, please contact our Member Services department. We can help you:

- Access care
- Find a provider
- Make an appointment
- Find out what services are covered and which ones may need prior authorization
- Arrange transportation, if needed
- Get referrals for Women, Infant and Children (WIC), Help Me Grow, Bureau for Children with Medical Handicaps (BCMh), Headstart and other community resources

## PRESCRIPTION DRUGS

While CareSource covers all medically necessary Medicaid-covered medications, we use a preferred drug list (PDL). These are the drugs we prefer your provider prescribes. We may also require that your provider submit information to us (a prior authorization request) to explain why a specific medication and/or a certain amount of a medication is needed. We must approve the request before you can get the medication. Reasons why we may “prior authorize” a drug include:

- There is a generic or pharmacy alternative drug available.
- The drug can be misused/abused.
- There are other drugs that must be tried first

Some drugs may also have quantity (amount) limits on how much can be given to a member at one time and some drugs are never covered, such as drugs for weight loss.

If we do not approve a prior authorization request for a medication, we will send you information on how you can appeal our decision (see information below).

To learn more about how to use our pharmaceutical management procedures, look in the summary section of the PDL that can be found on our website. If you do not have access to the internet, please call Member Services and they will be able to assist you.

Typically, our preferred drug list (formulary) includes more than one drug for treating a particular condition. These different possibilities are called “alternative” drugs. Many alternative drugs are just as effective as other drugs and do not cause more side effects or other health problems.

Members may need to try one drug before taking another. This is called Step Therapy. A member must try a medicine on the Formulary before a drug that is not on the Formulary would be approved by CareSource. Certain drugs will be covered only if Step Therapy is used.

A pharmacy will provide a generic drug if available in place of a brand-name drug. This is called Generic Substitution. Members and PCPs can expect the generic to produce the same effect and have the same safety profile as the brand-name drug. If a brand name product is requested when a generic equivalent is available, a prior authorization request will need to be submitted from your provider.

Sometimes a member might have a drug allergy or intolerance, or a certain drug might not be effective and a non-formulary agent is requested. The provider will then need to submit a prior authorization request. This is called Therapeutic Interchange.



CareSource has an exception process that allows the member or the member's representative to make a request for an exception. Reasons for exceptions may include intolerance or allergies to drugs, or inadequate or inappropriate response to drugs listed on PDL. The member or member's representative must initiate the request by calling Member Services. CareSource then reaches out to the provider to obtain the appropriate documentation.

There are certain medications that are more complex for diseases that require special attention and need to be handled differently than medications you pick up at your local pharmacy. These medications are called "specialty" medications, and most of these drugs require a prior authorization from your doctor.

Many of these medications need to be given to you by a doctor or nurse, and your doctor's office will help you get that done. If the prior authorization is approved, we will work with your doctor's office and the specialty pharmacy to get the medications you need.

You can call the Member Services department at **1-800-488-0134** (TTY: 1-800-750-0750 or 711) to request information on our PDL and medications that require prior authorization. You can also look on our website at **CareSource.com**. Please note that our PDL and list of medications that require prior authorization can change so it is important for you and/or your provider to check this information when you need to fill/refill a medication.

## **MEDICATION THERAPY MANAGEMENT (MTM)**

At CareSource, we understand the impact that proper medication use can have on your health. That's why we have an MTM program for our members. This program is geared towards helping you learn about your medications, prevent or address medication-related problems, decrease costs, and stick to your treatment plan.

This program is available from many local pharmacists. In most cases, a pharmacist will reach out to you and ask if you are interested in learning more about your medications. They are asking because they want to help you. The pharmacist may ask to schedule time with you to go over all of your medications, which includes any pills, creams, eye drops, herbals or over the counter items. Through the program, your local pharmacist will get alerts and information about your medications and decide if you may need extra attention. They offer ways to help you with your medications and how to take them the right way. They will also work with your doctor and others to address your needs and improve how you use your medications.

This service, and the pharmacist's help and information, are part of being a CareSource member and are available at no cost to you.

MTM benefits to providers and members:

- Improves safe use of medications
- Improves coordination with all your doctors and other caregivers
- Increases knowledge of your medications and how to use them correctly
- Improves overall health

## **COORDINATED SERVICES PROGRAM (CSP)**

Consumers eligible for Ohio Medicaid may be selected for enrollment in the Coordinated Services Program (CSP). The program coordinates treatment for members who have high patterns of utilization of both medications and services.

Except in pharmacy emergencies, CSP enrollees:

- Must choose one pharmacy to fill their prescriptions
- May be assigned to one PCP who will coordinate care with other providers

Enrollees can change their pharmacy or PCP under limited circumstances. Members selected for the CSP will be notified in writing, provided additional information, and notified of their state hearing rights.



# MEDICAID ELIGIBILITY AND OTHER HEALTH INSURANCE

## ACCIDENTAL INJURY OR ILLNESS (SUBROGATION)

If a CareSource member has to see a doctor for an injury or illness that was caused by another person or business, you must call the Member Services department to let us know. For example, if you are hurt in a car wreck, by a dog bite, or if you fall and are hurt in a store then another insurance company might have to pay the doctor's and/or hospital's bill. When you call we will need the name of the person at fault, their insurance company and the name(s) of any attorneys involved.

## OTHER HEALTH INSURANCE (COORDINATION OF BENEFITS – COB)

If you or anyone in your family has health insurance with another company, it is very important that you call the Member Services department and your county caseworker about the insurance. For example, if you work and have health insurance or if your children have health insurance through their other parent then you need to call the Member Services department to give us the information. It is also important to call the Member Services department and your county caseworker if you have lost health insurance that you had previously reported. Not giving us this information can cause problems with getting care and with bills.

You will need to show your CareSource ID card and any other health insurance ID cards at all of your appointments. **Please bring all your health insurance ID cards with you to every appointment.**

**Members with other insurance:** CareSource follows Ohio insurance guidelines for members who have other insurance. Your other insurance coverage is considered your primary coverage. CareSource is secondary. You should follow the guidelines of your primary insurance when you get medical care. Be sure to show your providers and pharmacists both insurance ID cards at every visit.

Providers will bill your primary insurance first. After your primary insurance pays its allowable amount, your provider will bill CareSource. CareSource will pay the remaining amount after the primary insurance payment (up to the amount CareSource would have paid as the primary insurance).

You should let CareSource and your county caseworker know right away if your “other” insurance changes.

## **LOSS OF INSURANCE NOTICE (CERTIFICATE OF CREDITABLE COVERAGE)**

Anytime you lose health insurance, you should receive a notice, known as a certificate of creditable coverage, from your old insurance company that says you no longer have insurance. It is important that you keep a copy of this notice for your records because you might be asked to provide a copy.

## **LOSS OF MEDICAID ELIGIBILITY**

It is important that you keep your appointments with the County Department of Job and Family Services. If you miss a visit or don't give them the information they ask for, you can lose your Medicaid eligibility. If this happened, CareSource would be told to stop your membership as a Medicaid member and you would no longer be covered by CareSource. If you have questions about your eligibility, please contact your county caseworker.

Transportation can be provided for your redetermination appointment, if needed. Please see pages 28-29 in this handbook or call our Member Services department for more details.

## **AUTOMATIC RENEWAL OF MCP MEMBERSHIP**

If you lose your Medicaid eligibility but it is started again within 60 days, you will automatically become a CareSource member again.



## YOUR MEMBERSHIP RIGHTS

As a member of CareSource you have the following rights:

- To receive information about CareSource, our services, our practitioners, our providers, and member rights and responsibilities.
- To receive all services that CareSource must provide.
- To be treated with respect and with regard for your dignity and privacy.
- To be sure that your medical record information will be kept private.
- To be given information about your health. This information may also be available to someone who you have legally authorized to have your information, or who you have said should be reached in an emergency when it is not in the best interest of your health to give it to you.
- To discuss information on any appropriate or medically necessary treatment options for your condition, regardless of cost or benefit coverage.
- To be able to take part in decisions about your health care unless it is not in your best interest.
- To get information on any medical care treatment, given in a way that you can follow.
- To be sure others cannot hear or see you when you are getting medical care.
- To be free from any form of restraint or seclusion used as a means of force, discipline, ease, or revenge as specified in federal regulations.
- To ask for, and get, a copy of your medical records, and to be able to ask that the record be changed/corrected if needed.
- To be able to say yes or no to having any information about you given out unless CareSource has to by law.
- To be able to say no to treatment or therapy. If you say no, the doctor or CareSource must talk to you about what could happen and a note must be placed in your medical record about the treatment refusal.
- To be able to file an appeal, a grievance (complaint) or state hearing. See pages 49-53 of this handbook for information.
- A right to voice complaints or appeals about the organization or the care it provides.

- To be able to get all CareSource written member information from CareSource:
  - At no cost to you.
  - In the prevalent non-English languages of members in the CareSource service area.
  - In other ways, to help with the special needs of members who may have trouble reading the information for any reason.
- To be able to get help free of charge from CareSource and its providers if you do not speak English or need help in understanding information.
- To be able to get help with sign language if you are hearing impaired.
- To be told if the health care provider is a student and to be able to refuse his/ her care.
- To be told of any experimental care and to be able to refuse to be part of the care.
- To make advance directives (a living will). See pages 62-67 which explain about advance directives. You can also contact the Member Services department for more information.
- To file any complaint about not following your advance directive with the Ohio Department of Health.
- To change your primary care provider (PCP) to another PCP on the CareSource network at least monthly. CareSource must send you a notice in writing that says who the new PCP is and the date the change began.
- To be free to carry out your rights and know that CareSource, CareSource's providers or the Ohio Department of Medicaid (ODM) and the Centers for Medicare and Medicaid (CMS) will not hold this against you.
- To know that CareSource must follow all federal and state laws, and other laws about privacy that apply.
- To choose the provider that gives you care whenever possible and appropriate.
- If you are a female, you must be able to go to a woman's health provider in CareSource's network for covered woman's health services.
- To be able to get a second opinion from a qualified provider in CareSource's network. If a qualified provider is not able to see you, CareSource must set up a visit with a provider not in its network.

- If CareSource is unable to provide a necessary and covered service in our network, CareSource will cover these services out of network for as long as we are unable to provide the service in network. If you are approved to go out of network, this is your right as a member and the services will be provided at no cost to you.
- To get information about CareSource from us.
- To make recommendations regarding CareSource's member rights and responsibility policy.
- To contact the United States Department of Health and Human Services Office of Civil Rights and/or the Ohio Department of Job and Family Services' Bureau of Civil Rights at the addresses below with any complaint of discrimination based on race, color, religion, gender identity, sex, sexual orientation, age, disability, national origin, veteran's status, ancestry, health status or need for health services.

Office for Civil Rights

United States Department of Health and Human Services

233 N. Michigan Ave. – Suite 240

Chicago, Illinois 60601

Ph: (312) 886-2359

TTY: (312) 353-5693

Bureau of Civil Rights

Ohio Department of Job and Family Services

30 E. Broad St., 30th Floor

Columbus, Ohio 43215

Ph: (614) 644-2703 1-866-227-6353 TTY: 1-866-221-6700

Fax: (614) 752-6381

## YOUR MEMBERSHIP RESPONSIBILITIES

As a member of CareSource you have the responsibility to:

- Use only approved providers.
- Keep scheduled doctor appointments, be on time, and to call 24 hours in advance of a cancellation.
- Follow the advice and instructions for care you have agreed upon with your doctors and other health care providers.
- Always carry your ID card and present it when receiving services.
- Never let anyone else use your ID card.
- Notify your county caseworker and CareSource of a change in your phone number or address.
- Contact your PCP after going to an urgent care center or after getting medical care outside of CareSource's covered counties or service area.
- Let CareSource and your county caseworker know if you have other health insurance coverage.
- Provide the information that CareSource and your health care providers need, to the extent possible, in order to provide care for you.
- Understand as much as possible about your health issues, follow plans and instructions, and take part in reaching goals that you and your health care provider agree upon.
- Report any suspected fraud, waste or abuse to CareSource using the information provided on pages 59-61.

Consult our website, **CareSource.com** or newsletters annually for any updates to Member Rights and Responsibilities.



# CARESOURCE NOTICE OF PRIVACY PRACTICES

*This notice describes how health information about you may be used and given out. It also tells how you can get this information. Please review it carefully. The terms of this notice apply to CareSource. We will refer to ourselves simply as “CareSource” in this notice.*

## YOUR RIGHTS

When it comes to your health information, you have certain rights:

Get a copy of your health and claims records

- You can ask to review or obtain a copy of your health and claims records. You can also request other health information we have about you. Ask us how to do this.
- We will give you a copy or a summary of your health and claims records. We often do this within 30 days of your request. We may charge a fair, cost-based fee.

Ask us to fix health and claims records

- You can ask us to amend your health and claims records if you feel they are wrong or not complete. Ask us how to do this.
- We may say “no” to your request. If we do, we will tell you why in writing within 60 days.

Ask for private communications

- You can ask us to contact you in a specified way, such as home or office phone. You can ask us to send mail to a different address.
- We consider all fair requests. We must say “yes” if you tell us you would be in danger if we do not.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for care, payment, or our operations.

However, we may not honor your request. We may be unable to fulfill your request due to the affect it may have on your care or for other reasons not listed.

Get a list of those with whom we’ve shared information

- You can ask for a list showing the times we’ve shared your health information. This list is limited to a six year history from before the date you ask. You may ask who we shared your information with, and why.

- We will include all the disclosures except for those about:
  - care
  - amount paid
  - health care operations
  - certain other disclosures (such as any you asked us to make)
- We will provide you with one list each year for free. If you ask for another within 12 months, we will charge a fair, cost-based fee.

#### Get a copy of this privacy notice

- You can ask for a paper copy of this notice at any time. You can ask even if you have agreed to get the notice electronically. We will provide you a paper copy promptly.

#### Give CareSource consent to speak to someone on your behalf

- You can give CareSource consent to talk about your health information with someone else on your behalf.
- If you have a legal guardian, that person can use your rights and make choices about your health information. CareSource will provide health information to your legal guardian. We will make sure a legal guardian has this right and can act for you before we take any action.

#### File a complaint if you feel your rights are violated

- You may file a complaint if you feel we have violated your rights, by contacting us and using the information at the end of this notice.
- You may file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting [www.hhs.gov/ocr/privacy/hipaa/complaints/](http://www.hhs.gov/ocr/privacy/hipaa/complaints/).
- We will not take action against you for filing a complaint. We may not require you to give up your right to file a complaint as a condition of:
  - care,
  - payment,
  - enrollment in a health plan, or
  - eligibility for benefits.

## YOUR CHOICES

For certain health information, you can tell us your choices about what we share. If you have a clear decision for how we share your information in the situations described below, contact us. Tell us what you want us to do. We will follow your instructions.

In these cases, you have both the right and choice to tell us how to:

- Share information with your family, close friends, or others involved in payment for your care
- Share information in a disaster relief situation

If you are not able to tell us your choice, such as if you are unconscious, we may share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and close threat to health or safety.

In these cases we often cannot share your information unless you give us written consent:

- Marketing purposes
- Sale of your information
- Disclosure of psychotherapy notes

## OTHER USES AND DISCLOSURES

How do we typically use or share your health information? We typically use or share your health information in these ways:

Help you get health care treatment

- We can use your health information and share it with experts who are treating you. Example: A doctor sends us information about your diagnosis and care plan so we can arrange more care.

Run our company

- We can use and give out your information to run our company and contact you when needed.
- We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage.

Pay for your health care

- We can use and give out your health information as we pay for your health care. Example: We share information about you with your dental plan to arrange payment for your dental work.

### Run our business

- We may use or share your health information to run our business. Example: We may use your information to review and improve the quality of health care you and others receive. We may give your health information to outside groups so they can assist us with our business. Such outside groups include lawyers, accountants, consultants and others. We require them to keep your health information private, too.

## HOW ELSE CAN WE USE OR SHARE YOUR HEALTH INFORMATION?

We are allowed or required to share your information in other ways. These ways are often used to help the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these reasons. For more information see: [www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html](http://www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html)

### To help with public health and safety issues

- We can share health information about you for certain reasons such as:
  - Preventing disease
  - Helping with product recalls
  - Reporting harmful reactions to drugs
  - Reporting suspected abuse, neglect, or domestic violence
  - Preventing or reducing a serious threat to anyone's health or safety

### To do research

- We can use or share your information for health research. We can do this as long as certain privacy rules are met.

### To obey the law

- We will share information about you if state or federal laws require it. This includes the Department of Health and Human Services if it wants to see that we are obeying federal privacy laws.

### To respond to organ and tissue donation requests and work with a medical examiner or funeral director

- We can share health information about you with organ procurement organizations.
- We can share health information with a coroner, medical examiner, or funeral director when a person dies.

To address workers' compensation, law enforcement, and other government requests

- We can use or share health information about you:
  - For workers' compensation claims
  - For law enforcement purposes or with a law enforcement officer
  - With health oversight agencies for activities allowed by law
  - For special government functions such as military, national security, and presidential protective services

To respond to lawsuits and legal actions

- We can share health information about you in response to a court or administrative order, or in response to a court order.

We may also make a collection of “de-identified” information that cannot be traced back to you.

Special Rules for CareSource Members in Ohio: Ohio law requires that we get your approval in many cases before:

- Giving out the performance or results of an HIV test or diagnosis of AIDS or an AIDS-related condition;
- Giving out information about drug and alcohol treatment you may have received in a drug and alcohol treatment program;
- Giving out information about mental health care you may have received; and
- Giving out certain information to Ohio's long-term care investigators.
- For full information on when such approval may be needed, you can contact the CareSource Privacy Officer.

## OUR RESPONSIBILITIES

- We protect our members' health information in many ways. This includes information that is written, spoken or available online using a computer.
  - CareSource employees are trained on how to protect member information.
  - Member information is spoken in a way so that it is not inappropriately overheard.
  - CareSource makes sure that computers used by employees are safe by using firewalls and passwords.
  - CareSource limits who can access member health information. We make sure that only those employees with a business reason to access information use and share that information.

- We are required by law to keep the privacy and security of your protected health information and to give you a copy of this notice.
- We will let you know quickly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice. We must give you a copy of it.
- We will not use or share your information other than as listed here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: [www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html](http://www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html).

## **EFFECTIVE DATE AND CHANGES TO THE TERMS OF THIS NOTICE**

The original notice was effective April 14, 2003 and this version was effective September 1, 2014. We must follow the terms of this notice as long as it is in effect. If needed, we can change the notice and the new one would apply to all health information we keep. If this happens, the new notice will be available upon request and will be posted on our web site. You can also ask for a paper copy of our notice at any time by mailing a request to the CareSource Privacy Officer.

The CareSource Privacy Officer can be reached by:

Mail: CareSource  
Attn: Privacy Officer  
P.O. Box 8738  
Dayton, OH 45401-8738

Email: [HIPAAPrivacyOfficer@caresource.com](mailto:HIPAAPrivacyOfficer@caresource.com)

Phone: 1-800-488-0134, ext. 12023

## GRIEVANCES & APPEALS

### HOW TO LET CARESOURCE KNOW IF YOU ARE UNHAPPY OR DO NOT AGREE WITH A DECISION WE MADE

We hope you will be happy with CareSource and the service we provide. If you are unhappy with anything about CareSource or its providers you should contact us as soon as possible. This includes if you do not agree with a decision we have made. You, or someone you want to speak for you, can contact us. If you want someone to speak for you, you will need to let us know this. CareSource wants you to contact us so that we can help you. To contact us, you can:

- Call the Member Services department at **1-800-488-0134** (TTY: 1-800-750-0750 or 711),  
OR
- Fill out the form in your member handbook,  
OR
- Call the Member Services department to request they mail you a form,  
OR
- Visit our website at **CareSource.com**,  
OR
- Write a letter telling us what you are unhappy about. Be sure to put your first and last name, the number from the front of your CareSource member ID card, and your address and telephone number in the letter so that we can contact you, if needed. You should also send any information that helps explain your problem.

Mail the form or your letter to:

CareSource  
Attn: Grievance Department  
P.O. Box 1947  
Dayton, OH 45401-1947

CareSource will send you something in writing if we make a decision to:

- Deny a request to cover a service for you,
- Reduce, suspend or stop services before you receive all of the services that were approved, OR
- Deny payment for a service you received that is not covered by CareSource.

We will also send you something in writing if, by the date we should have, we did not:

- Make a decision on whether to okay a request to cover a service for you, OR
- Give you an answer to something you told us you were unhappy about.

If you do not agree with the decision/action listed in the letter, and you contact us **within 60 calendar days** to ask that we change our decision/action, this is called an **appeal**. The 60 calendar day period begins on the day after the mailing date on the letter. If we have made a decision to reduce, suspend or stop services before you receive all of the services that were approved, your letter will tell you how you can keep receiving the services if you choose and when you may have to pay for the services.

Unless we tell you a different date, we will give you an answer to your appeal in writing within 15 calendar days from the date you contacted us. If we do not change our decision or action as a result of your appeal, we will notify you of your right to request a state hearing. You may only request a state hearing after you have gone through the CareSource appeal process.

If you contact us because you are unhappy with something about CareSource or one of our providers, this is called a **grievance**. CareSource will give you an answer to your grievance by phone (or by mail if we can't reach you by phone) within the following time frames:

- Two working days for grievances about not being able to get medical care
- 30 calendar days for all other grievances except grievances that are about getting a bill for care you have received
- 60 calendar days for grievances about getting a bill for care you have received

If your grievance is about getting a bill for care you or a family member received, please call the telephone number on the bill to make sure they have your CareSource ID number, or give them the primary insurance for the family member who received the care. If they tell you they have this information, please ask them why you are receiving a bill.



After you have done this, please contact our Member Services department and provide us with the following information contained on your bill:

- The date you or your family member received services
- The amount of the bill
- The provider's name
- The telephone number
- The account number
- Tell us why the provider's office told you they were billing you

If you are not happy with our answer to your grievance, please contact our Member Services department and we will be happy to discuss it with you.

You also have the right at any time to file a complaint by contacting the:

Ohio Department of Medicaid  
Bureau of Managed Care  
Compliance and Oversight  
P.O. Box 182709  
Columbus, Ohio 43218-2709  
1-800-605-3040 or 1-800-324-8680  
(TTY: 1-800-292-3572)

Ohio Department of Insurance  
50 W. Town Street  
3rd Floor – Suite 300  
Columbus, Ohio 43215  
1-800-686-1526

## STATE HEARINGS

**You must first exhaust the appeal process with CareSource before a State Hearing can be requested.**

A State Hearing is a meeting with you or your authorized representative, someone from the County Department of Job and Family Services, someone from CareSource, and a hearing officer from the Bureau of State Hearings within the Ohio Department of Job and Family Services (ODJFS). In this meeting, you will explain why you think CareSource did not make the right decision and CareSource will explain the reasons for making our decision. The hearing officer will listen and then decide who is right based on the rules and the information given.

CareSource will notify you of your right to request a state hearing if:

- We do not change our decision or action as a result of your appeal
- A decision is made to propose enrollment or continue enrollment in the Coordinated Services Program
- A decision is made to deny your request to change your Coordinated Services Program provider

If you want a state hearing, you or your authorized representative must request a hearing **within 120 calendar days**.

The 120 calendar day period begins on the day after the mailing date on the hearing form. If your appeal was about a decision to reduce, suspend or stop services before all of the approved services are received, your letter will tell you how you can keep receiving the services if you choose to and when you may have to pay for the services. If we propose to enroll you in the Coordinated Services Program and you request the hearing within 15 calendar days from the mailing date on the form, we will not enroll you in the program until the hearing decision.

To request a hearing you can sign and return the state hearing form to the address or fax number listed on the form, call the Bureau of State Hearings at 1-866-635-3748, or submit your request via email at [bsh@jfs.ohio.gov](mailto:bsh@jfs.ohio.gov). If you want information on free legal services but don't know the number of your local legal aid office, you can call the Ohio State Legal Services Association at 1-800-589-5888 for the local number.

State hearing decisions are usually issued no later than 70 calendar days after the request is received. However, if CareSource or the Bureau of State Hearings decides that the health condition meets the criteria for an expedited decision, the decision will be issued as quickly as needed but no later than three (3) working days after the request is received. Expedited decisions are for situations when making the decision within the standard time frame could seriously jeopardize your life or health or ability to attain, maintain, or regain maximum function.

# MEMBER GRIEVANCE/APPEAL FORM

# OHIO

Member Name \_\_\_\_\_ Member ID# \_\_\_\_\_

Member Address \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Member Telephone \_\_\_\_\_

If the grievance or appeal concerns a provider(s), please supply the following information, if known.

Name of Provider(s) \_\_\_\_\_

Address \_\_\_\_\_

Telephone \_\_\_\_\_

Please write a description of the grievance/appeal with as much detail as possible. Attach extra pages, if needed.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_  
(Member Signature)

\_\_\_\_\_  
(Date Filed)

## OFFICE USE ONLY

Date Received:

Received By:

Grievance Level 1 2

Hearing Date:

Action taken to resolve grievance/appeal:

\_\_\_\_\_  
(Signature Plan Rep)

\_\_\_\_\_  
(Resolution Date)

LEFT BLANK INTENTIONALLY

# MEMBERSHIP TERMINATIONS

We hope you will be happy with CareSource and discuss with us any problems or concerns you may have so we can try to resolve them.

## ENDING YOUR MCP MEMBERSHIP

As a member of a managed care plan, you have the right to choose to end your membership at certain times during the year. You can choose to end your membership during the first three months of your membership or during the annual open enrollment month for your area. The Ohio Department of Medicaid will send you something in the mail to let you know when your annual open enrollment month will be. If you live in a mandatory enrollment area, you will have to choose another managed care plan to receive your health care.

If you want to end your membership during the first three months of your membership or open enrollment month for your area, you can call the Medicaid Hotline at 1-800-324-8680 (TTY: 1-800-292-3572). You can also submit a request online to the Medicaid Hotline website at [www.ohiomh.com](http://www.ohiomh.com). Most of the time, if you call before the last 10 days of the month, your membership will end the first day of the next month. If you call after this time, your membership will not end until the first day of the following month. If you chose another managed care plan, your new plan will send you information in the mail before your membership start date.

### Choosing A New Plan

If you are thinking about ending your membership to change to another managed care plan, you should learn about your choices, especially if you want to keep your current doctor(s). Remember, each managed care plan has its own list of doctors and hospitals that they will allow you to use. In addition, each managed care plan has written information which explains the benefits it offers and the rules that it has. If you would like written information about a managed care plan you are thinking of joining or if you simply would like to ask questions about the managed care plan, you may either call the plan or call the Medicaid Hotline at 1-800-324-8680 (TTY: 1-800-292-3572). You can also find information about the managed care plans in your area by visiting the Medicaid Hotline website at [www.ohiomh.com](http://www.ohiomh.com).

## JUST CAUSE MEMBERSHIP TERMINATIONS

Sometimes there may be a special reason that you need to end your membership with a plan. This is called a “Just Cause” membership termination. Before you can ask for a just cause membership termination you must first call CareSource and give us a chance to resolve the issue. If we cannot resolve the issue, you can ask us for a just cause termination at any time if you have one of the following reasons:

1. You move and your current MCP is not available where you now live and you must receive non-emergency medical care in your new area before your MCP membership ends.
2. The MCP does not, for moral or religious objections, cover a medical service that you need.
3. Your doctor has said that some of the medical services you need must be received at the same time and all of the services aren’t available in your MCP’s network.
4. You have concerns that you are not receiving quality care and the services you need are not available from another provider on your MCP’s network.
5. Lack of access to medically necessary Medicaid-covered services or lack of access to providers that are experienced in dealing with your special health care needs.
6. The PCP that you chose is no longer on your MCP’s network and he/she was the only PCP on your MCP’s network that spoke your language and was located within a reasonable distance from you; or another health plan has a PCP on their network that speaks your language that is located within a reasonable distance from you and will accept you as a patient.
7. If you think staying as a member in your current managed care plan is harmful to you and not in your best interest.

You may ask to end your membership for Just Cause by calling the Medicaid Hotline at 1-800-324-8680 (TTY: 1-800-292-3572). The Ohio Department of Medicaid (ODM) will review your request to end your membership for Just Cause and decide if you meet a Just Cause reason. You will receive a letter in the mail to tell you if the Ohio Department of Medicaid will end your current membership and the date it ends. If you live in a mandatory enrollment area, you will have to choose another managed care plan to receive your health care unless the Ohio Department of Medicaid tells you differently. If your Just Cause request is denied, the Ohio Department of Medicaid will send you information that explains your state hearing right for appealing the decision.

## THINGS TO KEEP IN MIND IF YOU END YOUR MEMBERSHIP

If you have followed any of the above steps to end your membership, remember:

- Continue to use CareSource doctors and other providers until the day you are a member of your new health plan or back on regular Medicaid.
- If you chose a new MCP and have not received a member ID card before the first day of the month when you are a member of the new plan call the plan's Member Services Department. If they are unable to help you, call the Medicaid Hotline at 1-800-324-8680 (TTY: 1-800-292-3572).
- If you were allowed to return to the regular Medicaid card and you have not received a new Medicaid card, call your county caseworker.
- If you have chosen a new MCP and have any medical visits scheduled, please call your new plan to be sure that these providers are on the new plan's list of providers and any needed paperwork is done. Some examples of when you should call your new plan include: when you have an appointment to see a new doctor, a surgery, blood test or X-ray scheduled and especially if you are pregnant.
- If you were allowed to return to regular Medicaid and have any medical visits scheduled, please call the providers to be sure that they will take the regular Medicaid card.

## OPTIONAL MEMBERSHIP TERMINATIONS

You have the option not to be a member of a managed care plan if:

- You are a member of a federally recognized Indian tribe, regardless of your age.
- You are an individual who receives home and community based waiver services through the Ohio Department of Developmental Disabilities.

If you believe that you or your child meet any of the above criteria and do not want to be a member of a managed care plan, you can call the Medicaid Hotline at 1-800-324-8680 (TTY: 1-800-292-3572). If someone meets the above criteria and does not want to be an MCP member, their membership will be ended.

## EXCLUDED FROM MCP MEMBERSHIP

The following individuals are not permitted to join a managed care plan.

- Dually eligible under both the Medicaid and Medicare programs.
- Institutionalized (in a nursing home and are not eligible under the Adult Extension category, long-term care facility, ICF-MR, or some other kind of institution)

- Receiving Medicaid Waiver services and are not eligible under the Adult Extension category.
- If you are eligible for Medicaid under the Adult Extension category, you will receive your nursing home services through the Managed Care Plan. Additionally, Adult Extension members approved for waiver services will remain in the Managed Care Plan.

If you believe that you meet any of the above criteria and should not be a member of a managed care plan, you must call the Medicaid Hotline at 1-800-324-8680 (TTY: 1-800-292-3572). If you meet the above criteria, your MCP membership will be ended.

## CAN CARESOURCE END MY MEMBERSHIP?

CareSource may ask the Ohio Department of Medicaid to end your membership for certain reasons. The Ohio Department of Medicaid must okay the request before your membership can be ended. The reasons that CareSource can ask to end your membership are:

- For fraud or for misuse of your CareSource ID card
- For disruptive or uncooperative behavior to the extent that it affects CareSource's ability to provide services to you or other members

CareSource provides services to our members because of a contract that CareSource has with the Ohio Department of Medicaid. If you want to contact the Ohio Department of Medicaid you can call or write to:

Ohio Department of Medicaid  
Office of Managed Care Compliance and Oversight  
P.O. Box 182709  
Columbus, Ohio 43218-2709  
1-800-324-8680  
TTY: 1-800-292-3572

You can also visit the Ohio Department of Medicaid on the web at [www.medicaid.ohio.gov](http://www.medicaid.ohio.gov).

You can contact CareSource to get any other information you want including the structure and operation of CareSource and how we pay our providers.

If you want to tell us about things you think we should change, please call the Member Services department at **1-800-488-0134** (TTY 1-800-750-0750 or 711).



## FRAUD, WASTE AND ABUSE

We have a comprehensive fraud, waste and abuse program in our Special Investigations Department. It is designed to handle cases of managed care fraud. Help us by reporting questionable situations.

Fraud can be committed by providers, pharmacies or members. We monitor and take action on any provider, pharmacy or member fraud, waste and abuse.

Examples of provider fraud, waste and abuse include doctors or other health care providers who:

- Prescribe drugs, equipment or services that are not medically necessary
- Fail to provide patients with medically necessary services due to lower reimbursement rates
- Bill for tests or services not provided
- Use wrong medical coding on purpose to get more money
- Schedule more frequent return visits than are medically necessary
- Bill for more expensive services than provided
- Prevent members from getting covered services resulting in underutilization of services offered

Examples of pharmacy fraud, waste and abuse include:

- Not dispensing medicines as written
- Submitting claims for a more expensive brand name drug that costs more when you actually receive a generic drug that costs less
- Dispensing less than the prescribed quantity and then not letting the member know to get the rest of the drug

Examples of member fraud, waste and abuse include:

- Inappropriately using services such as selling prescribed narcotics or trying to get controlled substances from more than one provider or pharmacy
- Changing or forging prescriptions
- Using pain medications you do not need
- Sharing your ID card with another person

- Not disclosing that you have other health insurance coverage
- Getting unnecessary equipment and supplies
- Receiving services or picking up medicines under another person's ID (identity theft)
- Giving wrong symptoms and other information to providers to get treatment, drugs, etc.
- Too many ER visits for problems that are not emergencies
- Misrepresenting eligibility for Medicaid

Members who are proven to have abused or misused their covered benefit may:

- Be required to pay back any money that we paid for services which were determined to be a misuse of benefit
- Be prosecuted for a crime and go to jail
- Lose your Medicaid benefit
- Be locked in to one PCP, one controlled substance provider, one pharmacy and/or one hospital for non-emergency services.

## IF YOU SUSPECT FRAUD, WASTE OR ABUSE

If you think a doctor, pharmacy or member is committing fraud, waste or abuse, you must inform us. Report it to us in one of these ways:

- Call **1-800-488-0134** (TTY: 1-800-750-0750 or 711). Select the menu option for reporting fraud
- Complete the Fraud, Waste and Abuse Reporting Form. You can write a letter and mail it to us. Or you can go to our website and fill out the form. Our website is **CareSource.com**.

Send your letter to:

CareSource  
Attn: Special Investigations Unit  
P.O. Box 1940  
Dayton, OH 45401-1940

You do not have to give us your name when you write or call. There are other ways you may contact us that are not anonymous. If you are not concerned about giving your name, you may also use one of the following ways to contact us:

- Send an email\* to [fraud@caresource.com](mailto:fraud@caresource.com)
- Fax us at 1-800-418-0248

When you report fraud, waste or abuse, please give us as many details as you can. Include names and phone numbers.

You may remain anonymous. If you do, we will not be able to call you back for more information. Your report will be kept confidential to the extent permitted by law.

*\*Most email systems are not protected from third parties. This means people may access your email without you knowing or saying it's okay. Please do not use email to tell us information that you think is confidential, like your member ID number, social security number or health information. Instead, please use the form or phone number noted above. This can help protect your privacy.*

**Thank you for helping us keep fraud, waste and abuse out of health care.**

# ADVANCE DIRECTIVES

## USING ADVANCE DIRECTIVES TO STATE YOUR WISHES ABOUT YOUR MEDICAL CARE

Many people today worry about the medical care they would get if they became too sick to make their wishes known.

Some people may not want to spend months or years on life support. Others may want every step taken to lengthen life.

### YOU HAVE A CHOICE

A growing number of people are acting to make their wishes known. You can state your medical care wishes in writing while you are healthy and able to choose.

Your health care facility must explain your right to state your wishes about medical care. It also must ask you if you have put your wishes in writing.

This information explains your rights under Ohio law to accept or refuse medical care. It will help you choose your own medical care.

This information also explains how you can state your wishes about the care you would want if you could not choose for yourself.

This information does not contain legal advice, but will help you understand your rights under the law.

For legal advice, you may want to talk to a lawyer. For information about free legal services, call 1-800-589-5888, Monday through Friday, 8:30 a.m. to 5 p.m.

### WHAT ARE MY RIGHTS TO CHOOSE MY MEDICAL CARE?

You have the right to choose your own medical care. If you don't want a certain type of care, you have the right to tell your doctor you don't want it.

### WHAT IF I'M TOO SICK TO DECIDE? WHAT IF I CAN'T MAKE MY WISHES KNOWN?

Most people can make their wishes about their medical care known to their doctors. But some people become too sick to tell their doctors about the type of care they want. Under Ohio law, you have the right to fill out a form while you're able to act for yourself. The form tells your doctors what you want done if you can't make your wishes known.

## WHAT KINDS OF FORMS ARE THERE?

Under Ohio law, there are four different forms, or advance directives, you can use. You can use either a Living Will, a Declaration for Mental Health Treatment, a Health Care Power of Attorney or a Do Not Resuscitate (DNR) Order.

You fill out an advance directive while you're able to act for yourself. The advance directive lets your doctor and others know your wishes about medical care.

## DO I HAVE TO FILL OUT AN ADVANCE DIRECTIVE BEFORE I GET MEDICAL CARE?

No. No one can make you fill out an advance directive. You decide if you want to fill one out.

## WHO CAN FILL OUT AN ADVANCE DIRECTIVE?

Anyone 18 years old or older who is of sound mind and can make his or her own decisions can fill one out.

## DO I NEED A LAWYER?

No, you don't need a lawyer to fill out an advance directive. Still, you may decide you want to talk with a lawyer.

## DO THE PEOPLE GIVING ME MEDICAL CARE HAVE TO FOLLOW MY WISHES?

Yes, if your wishes follow state law. However, Ohio law includes a conscience clause. A person giving you medical care may not be able to follow your wishes because they go against his or her conscience. If so, they will help you find someone else who will follow your wishes.

## LIVING WILL

This form allows you to put your wishes about your medical care in writing. You can choose what you would want if you were too sick to make your wishes known. You can state when you would or would not want food and water supplied artificially.

## HOW DOES A LIVING WILL WORK?

A Living Will states how much you want to use life-support methods to lengthen your life. It takes effect only when you are permanently unconscious or terminally ill and unable to communicate.

The people giving you medical care must do what you say in your Living Will. A Living Will gives them the right to follow your wishes.

Only you can change or cancel your Living Will. You can do so at any time.

## DO NOT RESUSCITATE ORDER

State regulations offer a Do Not Resuscitate (DNR) Comfort Care and Comfort Care Arrest Protocol as developed by the Ohio Department of Health. A DNR Order means a directive issued by a physician or, under certain circumstances, a certified nurse practitioner or clinical nurse specialist, which identified a person and specified that CPR should not be administered to the person so identified.

CPR means cardiopulmonary resuscitation or a component of cardiopulmonary resuscitation, but it does not include clearing a person's airway for a purpose other than as a component of CPR.

The DNR Comfort Care and Comfort Care Arrest Protocol lists the specific actions that paramedics, emergency medical technicians, physicians or nurses will take when attending to a patient with a DNR Comfort Care or Comfort Care Arrest order. The protocol also lists what specific actions will not be taken.

You should talk to your doctor about the DNR Comfort Care and Comfort Care Arrest order and protocol options.

## HEALTH CARE POWER OF ATTORNEY

A Health Care Power of Attorney is different from other types of powers of attorney. This information is only about a Health Care Power of Attorney, not about other types of powers of attorney.

A Health Care Power of Attorney allows you to choose someone to carry out your wishes for your medical care. The person acts for you if you can't act for yourself. This could be for a short or a long while. However, Ohio law does place limitations on the authority of the Health Care Power of Attorney in certain situations.

## WHO SHOULD I CHOOSE?

You can choose any adult relative or friend whom you trust to act for you when you can't act for yourself. Be sure to talk with the person about what you want. Then write down what you do or don't want on your form. You should also talk to your doctor about what you want. The person you choose must follow your wishes.

## WHEN DOES MY HEALTH CARE POWER OF ATTORNEY TAKE EFFECT?

The form becomes effective whenever you lose the ability to make your own health care decisions, even if only temporarily. During these times, health care decisions will be made by the person you choose.

## **DECLARATION FOR MENTAL HEALTH TREATMENT**

A Declaration for Mental Health Treatment gives more specific attention to mental health care. A Declaration for Mental Health Treatment lets you to state your choices about your mental health treatment. You can also choose a person to make mental health care choices for you when you are not able to. For example, you may want to be treated at a certain place or be given certain medications. A Declaration for Mental Health Treatment will allow you to make these choices known.

The Declaration for Mental Health Treatment supersedes a Health Care Power of Attorney regarding decisions mental health care, but does not supersede a Living Will.

## **WHAT IS THE DIFFERENCE BETWEEN A HEALTH CARE POWER OF ATTORNEY AND A LIVING WILL?**

Your Living Will explains, in writing, the type of medical care you would want if you were not able to make your wishes known.

Your Health Care Power of Attorney lets you choose someone to carry out your wishes for medical care when you can't act for yourself.

## **IF I HAVE A HEALTH CARE POWER OF ATTORNEY, DO I NEED A LIVING WILL, TOO?**

You may want both. Each addresses different parts of your medical care.

A Living Will makes your wishes known directly to your doctors, but states only your wishes about the use of life-support methods.

A Health Care Power of Attorney allows a person you choose to make health care decisions when you can't act for yourself. A Health Care Power of Attorney does not supersede a Living Will.

## **CAN I CHANGE MY ADVANCE DIRECTIVE?**

Yes, you can change your advance directive whenever you want. If you already have an advance directive, make sure it follows Ohio's law. You may want to contact a lawyer for help. It is a good idea to look over your advance directives from time to time. Make sure they still say what you want and that they cover all areas.

## **IF I DON'T HAVE AN ADVANCE DIRECTIVE, WHO CHOOSES MY MEDICAL CARE WHEN I CAN'T?**

If you are in terminal condition or a permanently unconscious state, then Ohio law recognizes an order of decision makers if you are unable to make health care decisions for yourself and you do not have an advance directive. Ohio law recognizes this order of your decision makers: legal guardian, spouse, majority of adult children, parents, and other nearest relative.

## OTHER MATTERS TO THINK ABOUT

### WHAT ABOUT STOPPING OR NOT USING ARTIFICIALLY SUPPLIED FOOD AND WATER?

Artificially supplied food and water means nutrition supplied by way of tubes placed inside you. Whether you can decide to stop or not use these depends on your state of health.

- If you are expected to die and can't make your wishes known, and your Living Will simply states you don't want life-support methods used to lengthen your life, then artificially supplied food and water can be stopped or not used.
- If you are expected to die and can't make your wishes known, and you don't have a Living Will, then Ohio law follows the order of decision makers and allows certain individuals, in order of priority, to stop or not use artificially supplied food and water.
- If you are in a coma that is not expected to end, and your Living Will states you don't want artificially supplied food and water, then artificially supplied food and water may be stopped or not used.
- If you are in a coma that is not expected to end, and you don't have a Living Will, then Ohio law follows the order of decision makers and allows certain individuals, in order of priority, to stop or not use artificially supplied food and water.

### BY FILLING OUT AN ADVANCE DIRECTIVE, AM I TAKING PART IN EUTHANASIA OR ASSISTED SUICIDE?

No, Ohio law doesn't allow euthanasia or assisted suicide.

### WHERE DO I GET ADVANCE DIRECTIVE FORMS?

Many of the people and places that give you medical care have advance directive forms. A lawyer could also help you.

### WHAT DO I DO WITH MY FORMS AFTER FILLING THEM OUT?

You should give copies to your doctor and health care facility to put into your medical record. Give one to a trusted family member or friend. If you have chosen someone in a Health Care Power of Attorney, give that person a copy.

Put a copy with your personal papers. You may want to give one to your lawyer or clergy person.

Be sure to tell your family or friends about what you have done. Don't just put these forms away and forget about them.



## ORGAN AND TISSUE DONATION

Ohioans can choose whether they would like their organs and tissues to be donated to others in the event of their death. By making their preference known, they can ensure that their wishes will be carried out immediately and that their families and loved ones will not have the burden of making this decision at an already difficult time. Some examples of organs that can be donated are the heart, lungs, liver, kidneys and pancreas. Some examples of tissues that can be donated are skin, bone, ligaments, veins and eyes.

There are two ways to register to become an organ and tissue donor:

1. You can state your wishes for organ and/or tissue donation when you obtain or renew your Ohio Driver License or State ID Card, or
2. You can complete the Donor Registry Enrollment Form that is attached to the Ohio Living Will Form, and return it to the Ohio Bureau of Motor Vehicles.

## WHAT IS A GUARDIAN?

A guardian is someone chosen by a court to be legally in charge for another person.

## WHEN WILL A GUARDIAN BE CHOSEN?

A court will choose a guardian for someone who can no longer make safe choices by themselves. This is usually due to legal or mental incapacity. In certain situations a minor may also have a guardian chosen for them.

## HOW DO I GET A GUARDIANSHIP?

Only a court can choose a guardian. The court that chooses a guardian is your local court. This could differ based on where you live. Call your local court, a local lawyer, or local legal aid service for more information.

## QUALITY HEALTH CARE

We want to make sure that you receive quality health care. We do this by:

- Reviewing the care you receive from your doctors and other health care providers
- Finding and correcting any problems related to proper medical care
- Making sure care is available to you when you need it
- Providing health education information to you and your providers

### REVIEW OF HEALTH CARE SERVICES

CareSource keeps track of the services you get from health care providers. We discuss some services with your providers before you get them to make sure they are appropriate and necessary. For example, we review surgeries or stays at a hospital (unless they are emergencies). This is called utilization management. It makes sure you get the right amount of care you need when you need it.

All utilization management determinations are made by qualified Physician Reviewers. CareSource monitors the work of our reviewers on an ongoing basis. Part of the monitoring includes testing reviewers by presenting each of them with the same cases to ensure they make consistent and objective determinations.

CareSource determines if a service can be covered or not within 14 calendar days. This can be done quicker if the member's medical condition warrants it. We notify your doctor in writing of the determination and the reason for it. If we are not able to cover the service, we notify you in writing, too. The letter includes our phone number in case you want to call us for more information. If you are not happy with the determination, you can appeal it by calling or writing to CareSource. Your case will be re-reviewed by a different doctor from an appropriate specialty area, and you will be notified of the determination in writing.

You can contact us at any time about utilization management or prior authorization requests. Just call the Member Services department at **1-800-488-0134** (TTY: 1-800-750-0750 or 711). You can also send us an email at any time through our website. Just visit **CareSource.com**. Staff are identified by name, title and organization name when initiating or returning calls regarding utilization management issues.

Any decisions we make with your providers about the medical necessity of your health care are based only on how appropriate the care setting or services are. CareSource does not reward providers or our own staff for denying coverage or services. We do not offer financial incentives to our staff that encourage them to make decisions that result in underutilization.

CareSource may decide that a new development not currently covered by Medicaid will be a covered benefit. This includes newly developed:

- Health care services
- Medical devices
- Therapies
- Treatment options

We will review requests for new developments and make a decision about coverage based on:

- Updated Medicaid and Medicare rules
- External technology assessment guidelines
- Food and Drug Administration (FDA) approval
- Medical literature recommendations

You can contact CareSource to get any other information you want including the structure and operation of CareSource and how we pay our providers. You can also find out about:

- How we work with other health plans if you have other coverage
- Results of member surveys
- How many members dis-enroll from CareSource
- Benefits, eligibility, claims or participating providers

# CARESOURCE QUALITY IMPROVEMENT PROGRAM

## PROGRAM PURPOSE

Your care means a lot to us. The purpose of the CareSource Quality Improvement Program is to ensure that CareSource has the necessary infrastructure to:

- Coordinate care
- Promote quality
- Ensure performance and efficiency on an ongoing basis
- Improve the quality and safety of clinical care and services provided to CareSource members.

## THERE ARE TWO GUIDING TENANTS FOR THE PROGRAM:

Our mission, which is our heartbeat, is to make a lasting difference in our members' lives by improving their health and well-being. Our vision is to transform lives through innovative health and life services.

The Institutes for Healthcare Improvement's Triple Aim: Simultaneously improving the health of the population, enhancing the experience and outcomes of the patient, and the per capita cost of care for the benefit of communities.

The CareSource Quality Improvement Program includes both clinical and non-clinical services and is revised as needed to remain responsive to member needs, provider feedback, standards of care, and business needs.

## PROGRAM GOALS AND OBJECTIVES

CareSource strives to be a top performing health plan nationally. Performance goals are determined and aligned with national benchmarks where available. The goals and objectives of the program are:

### NCQA Excellent Accreditation

- Compliance with NCQA Accreditation standards
- High level of HEDIS performance
- High level of CAHPS performance
- Comprehensive Population Health Management Program
- Comprehensive Provider Engagement Program

### NCQA Health Plan Rating of 5

- High level of HEDIS performance
- High level of CAHPS performance
- Comprehensive Population Health Management Program
- Comprehensive Provider Engagement Program

## PROGRAM SCOPE

The Quality Improvement Program governs quality assessment and improvement activities. The scope includes:

- Meeting the quality requirements of the Centers for Medicare and Medicaid Services (CMS) as outlined in the CMS's Medicare Managed Care Manual, Chapter 5, Quality Assessment; and 42 CFR§422.152;
- Establishing safe clinical practices throughout the network of providers;
- Providing quality oversight of all clinical services;
- Compliance with NCQA accreditation standards;
- HEDIS compliance audit and performance measurement;
- Monitoring and evaluating member and provider satisfaction;
- Managing all quality of care and quality service complaints;
- Developing organizational competency in the Institute of Healthcare Improvements' Model;
- Ensuring that CareSource is effectively serving members with culturally and linguistically diverse members;
- Ensuring that CareSource is effectively serving members with complex health needs;
- Assessing the characteristics and needs of the member population;
- Assessing the geographic availability and accessibility of primary and specialty care providers.

## QUALITY METRICS

CareSource continually assesses and analyzes the quality of care and services offered to our members. This is accomplished by using objective and systematic monitoring and evaluation to implement programs to improve outcomes.

CareSource uses the Healthcare Effectiveness Data and Information Set (HEDIS®) to measure the quality of care delivered to members. HEDIS is one of the most widely used means of health care measurement in the United States. HEDIS is developed and maintained by The National Committee for Quality Assurance (NCQA). The HEDIS tool is used by America's health plans to measure important dimensions of care and service and allows for comparisons across health plans in meeting state and federal performance measures and national HEDIS benchmarks. HEDIS measures are based on evidence-based care and address the most pressing areas of care. Potential quality measures are:

### Wellness and Prevention

- Preventive Screenings (breast cancer, cervical cancer, chlamydia)
- Well-Child Care

### Chronic Disease Management

- Comprehensive Diabetes Care
- Controlling High Blood Pressure

### Behavioral Health

- Follow-up After Hospitalization for Mental Illness
- Antidepressant Medication Management
- Follow-up for Children Prescribed ADHD Medication

### Safety

- Use of Imaging Studies for Low Back Pain

CareSource also uses the annual member survey, Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Surveys, to capture member perspectives on health care quality. CAHPS is a program overseen by the United States Department of Health and Human Services – Agency for Healthcare Research and Quality (AHRQ). Potential CAHPS measures include:

- Customer Service
- Getting Care Quickly

- Getting Needed Care
- How Well Doctors Communicate
- Ratings of All Health Care, Health Plan, Personal Doctor, Specialist

## PREVENTIVE GUIDELINES AND CLINICAL PRACTICE GUIDELINES

CareSource recommends nationally accepted standards and guidelines to help inform and guide the clinical care provided to CareSource members. Guidelines are reviewed and approved by the CareSource Clinical Advisory Committee at least every two years or more often as appropriate, and updated as necessary. The guidelines are then presented to the CareSource Quality Enterprise Committee. The use of these guidelines allows CareSource to measure the impact of the guidelines on outcomes of care. Topics for guidelines are identified through analysis of CareSource members. Guidelines may include, but are not be limited to:

- Preventive Health
- Behavioral Health (i.e. depression)
- Chronic Condition Management (i.e. hypertension, diabetes, cardiovascular disease, cerebrovascular disease, and chronic obstructive pulmonary disease)
- Population Health (i.e. obesity, tobacco cessation)

Information about clinical practice guidelines and health information are made available to CareSource members via member newsletters, the CareSource member website, or upon request. Preventive Guidelines and Health Links are available to members and providers via the website or hard copy.

Your health is important. Here are some ways that you can maintain or improve your health:

- Establish a relationship with a health care provider.
- Make sure you and your family have regular checkups with your health care provider.
- If you have a chronic condition (such as asthma or diabetes), see your doctor regularly. Follow the treatment that your doctor has given you. Make sure that you take the medications that your doctor has asked you to take.
- Remember CareSource24 is available to help you. You can call the number on your member ID card 24/7/365.

If you would like more information on CareSource Quality Improvement, please call Member Services department at **1-800-488-0134** (TTY: 1-800-750-0750 or 711).

## WORD MEANINGS

**Advance Directives or Living Will** — Documents you sign in case you become seriously ill to let your doctor and others know your wishes concerning medical treatment. You sign them while you are still healthy and able to make such decisions.

**Benefit** — Health care services that are covered by CareSource.

**Durable Medical Equipment (DME)** — Certain items your doctor orders for use in your own home. Examples of these items are wheelchairs, crutches, IV infusion pumps, oxygen equipment, medical supplies, nebulizers and walkers.

**Grievance** — A complaint about CareSource or its health care providers.

**Guardian** — A person appointed by a court to be legally responsible for another person.

**Member** — An eligible Medicaid recipient who has joined CareSource and receives health care services from participating providers.

**Non-Participating Provider** — A doctor, hospital, pharmacy or other licensed health care professional who has not signed a contract agreeing to provide services to CareSource members. Please see “When You Can See a Non-Participating Provider” on page 22 of this handbook.

**Participating Provider** — A doctor, hospital, pharmacy or other licensed health care professional who has signed a contract agreeing to provide services to CareSource members. They are listed in our provider directory.

**Primary Care Provider (PCP)** — A participating provider you have chosen to be your personal doctor. Your PCP works with you to coordinate your health care, such as giving you checkups and shots, treating you for most of your health care needs, sending you to specialists if needed, or admitting you to the hospital.

**Prior Authorization** — Sometimes participating providers contact CareSource about the care they want you to get. This is done before you get the care to make sure that it will be covered. It is needed for some services that are not routine, such as home health care or some scheduled surgeries.

**Provider Directory** — A list of the doctors, other health care providers and pharmacies you can go to as a CareSource member.



**Provider Network** — A complete listing of all health care providers actively participating with CareSource from which the provider directory is created. Sometimes referred to as a “panel.”

**Referral** — A request from a PCP for his or her patient to see a specialist, such as a surgeon, for care. This means you need to get an OK from your provider before you can get the service.

**Service Area** — The geographical locations in Ohio where CareSource is an option as a managed care provider for Medicaid members.

**Specialist** — A doctor who focuses on a particular kind of health care such as a surgeon or a cardiologist (heart doctor).





# Notice of Non-Discrimination

CareSource complies with applicable state and federal civil rights laws and does not discriminate on the basis of age, gender, gender identity, color, race, disability, national origin, marital status, sexual preference, religious affiliation, health status, or public assistance status. CareSource does not exclude people or treat them differently because of age, gender, gender identity, color, race, disability, national origin, marital status, sexual preference, religious affiliation, health status, or public assistance status.

CareSource provides free aids and services to people with disabilities to communicate effectively with us, such as: (1) qualified sign language interpreters, and (2) written information in other formats (large print, audio, accessible electronic formats, other formats). In addition, CareSource provides free language services to people whose primary language is not English, such as: (1) qualified interpreters, and (2) information written in other languages. If you need these services, please call 1-800-488-0134 (TTY: 1-800-750-0750 or 711).

If you believe that CareSource has failed to provide the above mentioned services to you or discriminated in another way on the basis of age, gender, gender identity, color, race, disability, national origin, marital status, sexual preference, religious affiliation, health status, or public assistance status, you may file a grievance, with:

CareSource  
Attn: Civil Rights Coordinator  
P.O. Box 1947, Dayton, Ohio 45401  
1-800-488-0134 (TTY: 1-800-750-0750 or 711)  
Fax: 1-844-417-6254

CivilRightsCoordinator@CareSource.com

You can file a grievance by mail, fax, or email. If you need help filing a grievance, the Civil Rights Coordinator is available to help you.

You may also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office of Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

U.S. Department of Health and Human Services  
200 Independence Avenue, SW Room 509F  
HHH Building Washington, D.C. 20201  
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.



## ENGLISH

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-800-488-0134 (TTY: 1-800-750-0750 or 711).

## SPANISH

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-488-0134 (TTY: 1-800-750-0750 or 711).

## CHINESE

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-488-0134 (TTY: 1-800-750-0750 or 711)。

## GERMAN

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-488-0134 (TTY: 1-800-750-0750 or 711).

## ARABIC

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة

اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-488-0134

(رقم هاتف الصم والبكم: 711 أو 1-800-750-0750)

## PENNSYLVANIA DUTCH

Wann du Deitsch schwetzscht, kannscht du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: Call 1-800-488-0134 (TTY: 1-800-750-0750 or 711).

## RUSSIAN

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-488-0134 (телетайп: 1-800-750-0750 or 711).

## FRENCH

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-488-0134 (ATS :1-800-750-0750 or 711).

## VIETNAMESE

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-488-0134 (TTY: 1-800-750-0750 or 711).

## CUSHITE/OROMO

XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-800-488-0134 (TTY: 1-800-750-0750 or 711).

## KOREAN

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-488-0134 (TTY: 1-800-750-0750 or 711). 번으로 전화해 주십시오.

## ITALIAN

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-800-488-0134 (TTY: 1-800-750-0750 or 711).

## JAPANESE

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-800-488-0134 (TTY:1-800-750-0750 or 711) まで、お電話にてご連絡ください。

## DUTCH

AANDACHT: Als u nederlands spreekt, kunt u gratis gebruikmaken van de taalkundige diensten. Bel 1-800-488-0134 (TTY: 1-800-750-0750 or 711).

## UKRAINIAN

УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 1-800-488-0134 (телетайп: 1-800-750-0750 or 711).

## ROMANIAN

ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii de asistență lingvistică, gratuit. Sunați la 1-800-488-0134 (TTY: 1-800-750-0750 or 711).

## NEPALI

ध्यान दिनुहोस्: तपाइंले नेपाली बोल्नुहुन्छ भने तपाइंको नमिति भाषा सहायता सेवाहरु निःशुल्क रूपमा उपलब्ध छ । फोने गर्नुहोस् 1-800-488-0134 (1-800-750-0750 टटिवाइ:711) ।

## SOMALI

DIGTOONI: Haddii aad ku hadasho Af Soomaali, adeegyada caawimada luqada, oo lacag la'aan ah, ayaa lagu heli karaa adiga. Wac 1-800-488-0134 (TTY: 1-800-750-0750 or 711).

  
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CareSource.com

1-800-488-0134 (TTY: 1-800-750-0750 or 711)

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