

**Via Email**

August 10, 2012

Jay Easterling  
Office of Legal & Acquisition Services, Office of Contracts & Acquisitions  
ATTN: RFA/RLB Unit  
Ohio Department of Job and Family Services  
30 East Broad Street, 31<sup>st</sup> Floor  
Columbus, OH 43215-3414

RE: Request for information: JFSR1213-07-8038 - ICDS

Dear Mr. Easterling:

In response to your request for information dated August 8, 2012, Buckeye Community Health Plan (Buckeye) respectfully submits the following information related to our behavioral health experience in Ohio represented in Appendix B, Part 1 of the Request for Applications (RFA) #JFSR 1213-07-8038.

The April 24, 2012, RFA asked about applicants' experience related to behavioral health. Appendix B of the RFA (Attachment 1, page 2 and 3) defines behavioral health as:

**“Providing access to mental health and substance abuse services including, but not limited to, acute/sub-acute psychiatric inpatient, medication management, day/ residential rehabilitation, intensive outpatient, day treatment, partial hospitalization, crisis stabilization, opioid maintenance therapy. For more information, please see Appendix E of Attachment 1 of this RFA: Ohio’s Demonstration Proposal to Integrate Care for Medicare-Medicaid Enrollees.”**

Appendix E of Attachment 1 of the RFA lists the following behavioral health services (Attachment 2, page 46):

- Comprehensive assessment and treatment planning
- Pharmacological management
- Case management services, including in-community case management
- Psychotherapy services
- Assertive Community Treatment (ACT)
- 24 hour on-call availability
- Emergency Services
- Inpatient Services – Including those provided in ODMH-operated psychiatric hospitals.

- Partial Hospital
- Day Treatment
- Treatment of substance use disorders, including individuals with co-morbid psychiatric and substance use disorders

For our Ohio Medicaid experience, Buckeye asserts that we are under contract with ODJFS to provide and arrange all behavioral health services listed in the RFA. The ODJFS Provider Agreement states that managed care plans:

“must ensure that members have access to **all** medically-necessary behavioral health services **covered by the FFS program** and are responsible for coordinating those services with other medical and support services, including the publicly funded community behavioral health system..... MCPs must provide Medicaid-covered behavioral health services for members who are unable to timely access services or are unwilling to access services through the publicly funded community behavioral health system as specified below.”

(Page 4 to 6 of Appendix G of the Provider Agreement, found online at [http://www.ifs.ohio.gov/ohp/bmhc/documents/pdf/Generic\\_Provider\\_Agreement\\_7.1.12.pdf](http://www.ifs.ohio.gov/ohp/bmhc/documents/pdf/Generic_Provider_Agreement_7.1.12.pdf))

While we are not responsible for paying for certain behavioral health services such as partial hospitalization under the existing Ohio Medicaid contract (i.e., we do not receive payment from ODJFS for these services.), Buckeye does receive payment for providing outpatient wrap-around behavioral health services and is also responsible for arranging and helping coordinate all the necessary behavioral health services. In an effort to provide the right amount of care timely in the least restrictive setting, Buckeye (with approval from ODJFS) has routinely paid for alternate behavioral health services from our capitation. These payments are made to providers offering services consistent with state-funded community services, but not receiving state funds for them. This has improved patient outcomes while demonstrating fiscal responsibility. A couple examples of these situations include the following:

- Buckeye has a contract with the Stricklin Crisis Stabilization Unit in Cleveland, Ohio. This 15-bed facility is a short-term alternative to inpatient psychiatric hospitalization for persons experiencing a psychiatric crisis. Services include: mental health assessments, pharmacologic management, crisis intervention services (e.g., group support sessions, activity therapies, individual counseling), residential treatment, and partial hospitalization services, etc.
- Buckeye has a contract with the Orca House in Cleveland, Ohio, a facility that provides a halfway house (residential) and intensive outpatient treatment focused on substance abuse treatment.
  - A specific example of how care was delivered in this setting included a member who had a four-month wait for a Medicaid-covered residential program. We opted for placement at the Orca House immediately. An assessment was done while the member was still in an inpatient psychiatric facility and once discharged to Orca, the member received

intensive counseling and services during a 30-day admission. Once discharged, it was arranged for the member to return to his intensive outpatient treatment program at his local Community Mental Health Center.

The ODJFS Question and Answer document dated May 10, 2012 stated in question 162, that applicants can only indicate having experience if the applicant was "under contract to provide and received payment for providing behavioral health services." Question 74 further clarified that the "service rendered must include all the core services listed in the definition" in order to check the applicable box (Attachment 3, pages 9 and 11).

Buckeye asserts that we do receive ODJFS payment for providing behavioral health services under the Ohio Medicaid program, and have provided the core benefits, albeit some on a limited basis. As such, we provide or arrange for all listed services and therefore should receive credit for Ohio Medicaid Behavioral health.

For our Ohio Medicare experience, our Ohio Medicare Special Needs Plan covers all traditional Medicare services. We have included Attachment 4, our current Evidence of Coverage, which details the following covered benefits:

- Page 46 – inpatient mental health services
- Page 49 – physician services which would include psychiatrist services
- Page 51 – outpatient mental health services, partial hospitalization services, and outpatient substance abuse services

As such, we provide or arrange for all listed services and therefore should receive credit for Ohio Medicare Behavioral health.

If you need documents that define these in more detail, please feel free to contact me.

If you need any further clarification, please contact me at 614-220-4900, extension 24108 or by email at [damerine@centene.com](mailto:damerine@centene.com).

Respectfully,



David B. Amerine  
Vice President, Regulatory Affairs

## APPENDIX B

### APPLICANT'S CONTRACT/COMPLIANCE EXPERIENCE

Appendix B documents an Applicant's experience and compliance history that ODJFS believes is relevant to providing the type and level of services necessary to care for Ohio's population of Medicare-Medicaid enrollees. An Applicant must report experience and compliance as required in this Appendix. This may include the experience/compliance of the Applicant and/or any entity within its corporate family and/or a partner as defined in Section III.A of this RFA.

This Appendix is divided into two parts: Part I requests information regarding Applicant's statewide experience with Medicare and Medicaid, and Part II requests information regarding current health plan operations for Medicare Advantage, Medicaid, and commercial insurance in those regions for which an Applicant is applying. Appendix B will produce a separate score for each region for which the Applicant has applied. The final score for Appendix B will be a combination of the score from Part I and the score for Part II associated with a particular region. For example, if an Applicant applied for the Central and East Central regions, ODJFS would calculate two Appendix B scores; one score for the Central region and one score for the East Central Region. Each of the scores would be comprised of the score from Part I and the score from Part II associated solely with the region being applied for.

#### **Part I: Statewide Experience (Maximum Points: 5,000)**

(1) Applicants must submit no more than a total of **five (5)** "Applicant Contract /Compliance Experience Forms" that reflect combined information regarding Medicare and Medicaid lines of business related to the Applicant and/or any entity within its corporate family and/or its partner within the selected state; and

(2) If an Applicant operates Medicare and/or Medicaid lines of business in more than 5 states then the Applicant may choose which five states' experience to report; and

(3) If an Applicant does not operate a Medicare and/or Medicaid lines of business in at least five states then the Applicant must complete and submit forms representing Medicare and/or Medicaid business in all states in which it operates these lines of business.

#### **INSTRUCTIONS FOR COMPLETING AN "APPLICANT STATEWIDE CONTRACT/COMPLIANCE EXPERIENCE FORM"**

The following are instructions for each section of the form by item number:

**Item 1: Name of Applicant** – The name of the health insuring corporation(s) as it appears on the Certificate of Authority issued, or the Certificate of Authority application currently under review, by the Ohio Department of Insurance (ODI). **Name of Individual Completing This Form** – The name of the individual completing the form.

**Item 2: Name of State** – One of the fifty states or federal district of the United States of America where the Applicant or a member of its corporate family or its partner was/is contracted to provide the managed care services for the line of business reported in this copy of the form.

**Item 3: Calendar Year (CY)** – Enter the total number of months for each of the indicated calendar years that the Applicant or a member of its corporate family or its partner provided services. Partial months should not be counted. For example, if the Applicant began services to members under the reported health plan in October 1, 2009 through the issuance date of this RFA (April 24, 2012) then the applicant would report CY 2008 = 0 months, CY 2009 = 3 months, CY 2010 = 12 months, and CY 2011 = 12 months.

**Item 4: Coverage & Line of Business** – Check all applicable boxes. If the Applicant provided services during the identified calendar year under contract for any of the following lines of business (i.e. Medicaid, Medicare) then check the appropriate box.

- a. Medicaid – See Section III.A Definitions of this RFA.
- b. Medicare – Medicare as defined in Section III.A Definitions of the RFA and are coordinated care plans (such as health maintenance organization (HMO), provider sponsored association (PSO), and/or preferred provider organization (PPO) plans).

The following definitions apply to the services:

**Hospital:** Inpatient and outpatient health care services that are generally and customarily provided by hospitals.

**Primary Care/Specialty Care:** Primary care includes outpatient routine and preventive services that are generally provided by an individual physician (M.D. or D.O.), certain physician group practice/clinic (Primary Care Clinics [PCCs]), or an advanced practice nurse (APN) as defined in Ohio Revised Code § 4723.43 or advanced practice nurse group practice within an acceptable specialty. Acceptable specialty types for services provided by primary care providers (PCPs) include family/general practice and internal medicine. Acceptable PCCs include Federally Qualified Health Clinics (FQHCs), Rural Health Clinics (RHCs), and the acceptable group practices/clinics specified by ODJFS. Specialty care includes health care provided by physicians whose training focused primarily on a specific field, such as neurology, cardiology, rheumatology, dermatology, oncology, orthopedics, ophthalmology, and other specialized fields.

**Home Health:** Home health services include home health nursing, home health aide and skilled therapies.

**Pharmacy:** Pharmacy services include generic and brand name drugs.

**Dental:** Dental services include examinations, diagnostic services, preventive services, restorative, endodontic, periodontic, orthodontic, oral surgery and other dental services.

**Vision:** Vision care services include examinations, fittings, and dispensing of ophthalmic materials (including contact lenses, low vision aids, etc.).

**Behavioral Health:** Providing access to mental health and substance abuse services including, but not limited to, acute/sub-acute psychiatric inpatient, medication management, day/residential rehabilitation, intensive outpatient, day treatment, partial hospitalization,

crisis stabilization, opioid maintenance therapy. For more information, please see Appendix E of Attachment 1 of this RFA: Ohio's Demonstration Proposal to Integrate Care for Medicare-Medicaid Enrollees.

**LTC Institutional:** Long-term nursing facility services which are designed to meet an individual's medical, personal, social and safety needs.

**Home- and Community-Based Services (HCBS):** A range of home and community services and supports designed to meet an individual's medical, personal and safety needs as an alternative to long term nursing facility care to enable a person to live as independently as possible.

**Durable Medical Equipment:** Includes medical supply, durable medical equipment, orthosis, prosthesis, or related services.

**Item 5: ABD Medicaid** – If the Medicaid experience being reported includes experience providing services the ABD Medicaid population then check the box for the appropriate year(s). See Section III.A Definitions of this RFA.

**Item 6: Member Months** – A member month is defined as 1 member being enrolled for 1 complete month. For example, an individual who is a member of a plan for a full year generates 12 member months and a family of 5 enrolled for 6 months generates (5 X 6) 30 member months. The Applicant is to provide the total number of member months for each of the calendar years for the line of business that is being reported.

**Item 7: Administrative Expense Ratio** – Applicant is to report the Administrative Expense Ratio for CY 2011 or if there is no experience reported for CY 2011 then the most current calendar year for which there is experience must be reported. The Administrative Expense Ratio is calculated by dividing total non-medical expense by total revenue (Administration Expense/Revenue). Expenses for activities that improve health quality should not be considered as “non-medical expense” for this purpose. Any pass-through, portion of a sales or HIC tax that is reimbursed back to the Applicant by a state agency should not be included in either the non-medical expense or the total revenue (e.g., Ohio's managed care sales and use tax collected by the Ohio Department of Taxation or the HIC tax collected by the Ohio Department of Insurance). Applicant should report the Medicare and Medicaid lines of business as separate administrative expense ratios, if applicable.

**Item 8: Participant-Directed Care** – Is a model for individuals who receive long term services and supports that allows the enrollee greater choice and control along a continuum of hiring, firing, training, supervising or paying independent providers. If the Applicant had experience entering into and administering participant-directed care arrangements, then check the one box that best represents the number of months experience since January 2009.

**Item 9: Accreditation** – Check the appropriate box if the Applicant for the reported state has a current accreditation level of Accredited, Commendable or Excellent with the National Committee for Quality Assurance (NCQA). If there are multiple product lines with various levels of accreditation then report only the highest level of accreditation for the reported state.

**Item 10: Applicant subject to any official governmental action revoking/proposing to revoke its licensure or exclude it from participation.** Check “Yes” if a government entity issued a notice since January 1, 2007 stating it will, or may, revoke a license of one of the health plans for which experience is being reported on Appendix B, or, if a state or federal agency took action since January 1, 2008 excluding the Applicant from participation in Medicaid or Medicare for one of the health plans for which experience is being reported on Appendix B.

**Item 11: New Member Freeze** – If a government entity barred enrollment of new consumers or forced disenrollment of existing consumers into the health plan for reasons related to poor/unacceptable performance in delivering services, then place a check in the boxes when the freeze/reduction was in effect. Do not check a box if a reduction/freeze was the result of market share or other reason not directly related to negative performance of the corporate family or its delegated entity. For example, Ohio Medicaid has the right to freeze an MCP’s membership based on inadequate performance.

**Item 12: Proposed Contract Termination/Nonrenewal** – The Applicant must check this box if a state or the federal government proposed in a written/typed communication to terminate or not renew its contract with the Applicant or member of the corporate family for reasons related to negative performance of the corporate family or its delegated entity.

**Item 13: Contract Denial/Termination/Nonrenewal** - The Applicant must check this box if a state or the federal government initiated and executed a denial or termination or nonrenewal of its contract with the Applicant or member of the corporate family for reasons related to negative performance of the corporate family or its delegated entity.

**Item 14: Sanctions imposed under 42 CFR 438.730 or 42 CFR 422.510** – The Applicant must check this box for the applicable year(s) the Center for Medicare and Medicaid Services (CMS) issued a sanction under 42 Code of Federal Regulation 438.730 or termination of contract under 42 CFR 422.510 that affected any part of the experience reported on the form.

## Applicant Statewide Contract/Compliance Experience Form

A separate form for each state

**Item 1: Name of Applicant:** \_\_\_\_\_

**Name of Individual Completing the Form:** \_\_\_\_\_

**Item 2: Name of State:** \_\_\_\_\_

<b>Item 3: Calendar Year (CY)</b>	CY 2009 Full Months: _____	CY 2010 Full Months: _____	CY 2011 Full Months: _____
<b>Item 4: Coverage</b>	<b>Line of Business</b>	<b>Line of Business</b>	<b>Line of Business</b>
Hospital (includes inpatient and outpatient services)	<input type="checkbox"/> Medicaid <input type="checkbox"/> Medicare	<input type="checkbox"/> Medicaid <input type="checkbox"/> Medicare	<input type="checkbox"/> Medicaid <input type="checkbox"/> Medicare
Primary Care	<input type="checkbox"/> Medicaid <input type="checkbox"/> Medicare	<input type="checkbox"/> Medicaid <input type="checkbox"/> Medicare	<input type="checkbox"/> Medicaid <input type="checkbox"/> Medicare
Specialty Care	<input type="checkbox"/> Medicaid <input type="checkbox"/> Medicare	<input type="checkbox"/> Medicaid <input type="checkbox"/> Medicare	<input type="checkbox"/> Medicaid <input type="checkbox"/> Medicare
Home Health	<input type="checkbox"/> Medicaid <input type="checkbox"/> Medicare	<input type="checkbox"/> Medicaid <input type="checkbox"/> Medicare	<input type="checkbox"/> Medicaid <input type="checkbox"/> Medicare
Pharmacy	<input type="checkbox"/> Medicaid <input type="checkbox"/> Medicare	<input type="checkbox"/> Medicaid <input type="checkbox"/> Medicare	<input type="checkbox"/> Medicaid <input type="checkbox"/> Medicare
Dental	<input type="checkbox"/> Medicaid <input type="checkbox"/> Medicare	<input type="checkbox"/> Medicaid <input type="checkbox"/> Medicare	<input type="checkbox"/> Medicaid <input type="checkbox"/> Medicare

Vision	<input type="checkbox"/> Medicaid <input type="checkbox"/> Medicare	<input type="checkbox"/> Medicaid <input type="checkbox"/> Medicare	<input type="checkbox"/> Medicaid <input type="checkbox"/> Medicare
Behavioral Health	<input type="checkbox"/> Medicaid <input type="checkbox"/> Medicare	<input type="checkbox"/> Medicaid <input type="checkbox"/> Medicare	<input type="checkbox"/> Medicaid <input type="checkbox"/> Medicare
LTC Institutional	<input type="checkbox"/> Medicaid <input type="checkbox"/> Medicare	<input type="checkbox"/> Medicaid <input type="checkbox"/> Medicare	<input type="checkbox"/> Medicaid <input type="checkbox"/> Medicare
HCBS	<input type="checkbox"/> Medicaid <input type="checkbox"/> Medicare	<input type="checkbox"/> Medicaid <input type="checkbox"/> Medicare	<input type="checkbox"/> Medicaid <input type="checkbox"/> Medicare
Durable Medical Equipment	<input type="checkbox"/> Medicaid <input type="checkbox"/> Medicare	<input type="checkbox"/> Medicaid <input type="checkbox"/> Medicare	<input type="checkbox"/> Medicaid <input type="checkbox"/> Medicare
<b>Item 5: ABD Medicaid</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Item 6: Member Months</b>			
Medicaid	_____	_____	_____
Medicare	_____	_____	_____
<b>Item 7: Administrative Expense Ratio and Reporting Year</b>	Medicare: _____                      Medicaid: _____ Year: _____                              Year: _____		
<b>Item 8: Participant-Directed Care</b>	<b>(check no more than one box)</b> More than 12 months <input type="checkbox"/> 1 – 12 months <input type="checkbox"/>		
<b>Item 9: Accreditation</b>	<b>NCQA</b> <input type="checkbox"/> • Accredited <input type="checkbox"/> • Commendable <input type="checkbox"/> • Excellent <input type="checkbox"/>		

**Item 10:** Since January 1, 2007, was Applicant subject to any official governmental action for the state and population identified on this form:

a. revoking its licensure  Yes or  No

b. proposing to revoke its license  Yes or  No

**Items 11, 12, 13 & 14:**

Was the health plan subject to any of the following regulatory actions?  Yes  No

**If Yes,** check the applicable action for the calendar year(s) that the action was in effect:

Item:		CY 2009	CY 2010	CY 2011
11	New Member Freeze <small>*Due to performance not market share</small>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12	Proposed Contract Termination/Nonrenewal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13	Contract Denial/ Termination/Nonrenewal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14	Sanctions/termination imposed under 42 CFR 438.730 or 42 CFR 422.510	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Provide the primary contact information, including the name, telephone and fax numbers, for the agency that proposed and/or assessed the above regulatory action(s).

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**ODJFS reserves the right to contact Applicants subsequent to application submission for clarification.**

**Part II: Applicant Regional Experience (Maximum Points: 15,000)**

For those regions an Applicant is applying, mark all the areas of coverage for each of the counties for which Applicant, as of April 1, 2012, has an active membership and provides health plan services to that membership.

**Region: Central**

		Area(s) of Coverage (check all that apply)		
County	Region	Medicare Advantage	Medicaid	Commercial
Delaware	CEN	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Franklin	CEN	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Madison	CEN	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pickaway	CEN	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Union	CEN	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Region: East Central**

		Area(s) of Coverage (check all that apply)		
County	Region	Medicare Advantage	Medicaid	Commercial
Portage	EC	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stark	EC	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Summit	EC	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Wayne	EC	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Region: Northeast**

		Area(s) of Coverage (check all that apply)		
County	Region	Medicare Advantage	Medicaid	Commercial
Cuyahoga	NE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Geauga	NE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lake	NE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lorain	NE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Medina	NE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Region: Northeast Central**

		Area(s) of Coverage (check all that apply)		
County	Region	Medicare Advantage	Medicaid	Commercial
Columbiana	NEC	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mahoning	NEC	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Trumbull	NEC	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Region: Northwest**

		Area(s) of Coverage (check all that apply)		
County	Region	Medicare Advantage	Medicaid	Commercial
Fulton	NW	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lucas	NW	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ottawa	NW	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Wood	NW	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Region: Southwest**

		Area(s) of Coverage (check all that apply)		
County	Region	Medicare Advantage	Medicaid	Commercial
Butler	SW	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Clermont	SW	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Clinton	SW	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hamilton	SW	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Warren	SW	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Region: West Central**

		Area(s) of Coverage (check all that apply)		
County	Region	Medicare Advantage	Medicaid	Commercial
Clark	WC	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Greene	WC	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Montgomery	WC	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

## **Appendix B**

### **Applicant's Contract/Compliance Experience**

### **Scoring Methodology**

The remainder of this Appendix is a description of the process that will be used by ODJFS in scoring an Applicant's responses to the questions in this Appendix. Applicants are not to fill in and return this section with their applications. However, ODJFS strongly encourages applicants to use these pages to evaluate the quality and responsiveness of their application packets prior to submission.

This appendix produces a score for each region for which the Applicant has applied. A regional score is equal to the score from Part I plus the score for the particular region calculated in Part II.

#### **PART I: Scoring Methodology**

##### **Overview:**

- Step 1: ODJFS will score each individual state Appendix B form independently not to exceed a total of 5,000 points for each state form. See below Step 1: Scoring of Individual Forms.
- Step 2: Each individual state form will be combined by multiplying individual state form scores by a set factor to derive a single score for the Applicant not to exceed 5,000. See below Step 2: Combining Individual Forms Into a Final Score.

##### **Step 1: Scoring of Individual State Forms**

1. To start, Applicants receive points for each calendar year for each line of business (LOB) by checking various boxes of "**Item 4: Coverage**". The value for each box checked is indicated in Exhibit B-1. The score is tallied by calendar year.
2. If an Applicant reports less than three (3) months of experience for any calendar year then the zero points will be given for that calendar year.
3. **Item 6: Member Months** – For each calendar year, the member months reported for the three lines of business (i.e. Medicaid, Medicare and Medicare-Medicaid) are totaled. If this total is less than 36,000 Member Months then zero points will be given for that particular calendar year.
4. Individual calendar year points are added together to produce a single preliminary score for the form.

5. The preliminary score (hereafter referred to as “score”) is multiplied by the following factors in the following order:
  - a. **Item 7:** Administrative Expense Ratio - the Medicaid and Medicare ratios reported for CY 2011, or the most recent calendar year reported on the form are compared to the administrative expense ratio provided in Exhibit B-1. If any one of the reported ratios is greater than 15% then the score is reduced by the percentage set forth in Exhibit B-1.
  - b. **Item 8:** Participant Directed Care – If the Applicant reports participant-directed care then the score is increased by the percentage indicated in Exhibit B-1.
  - c. **Item 9:** Accreditation – If the Applicant reports accreditation then the score is increased by the percentage indicated in Exhibit B-1.
  - d. **Item 10:** Subject to Official Government Action – checking the “YES” box will result in a decrease to the score as set forth in Exhibit B-1
  - e. **Items 11, 12, 13 & 14:** New Member Freeze; Proposed Contract Termination/Nonrenewal; Contract Termination/Nonrenewal; 42 CFR 438.730 Sanction – Should any of the boxes be checked in for any year and for any item then the score will be decreased by the percentage indicated in Exhibit B-1. Even if multiple boxes are checked, the score shall only be reduced once by 30%.
6. If the score for the individual form is greater than 5,000 then the final score for the individual form shall be 5,000. Otherwise, the preliminary form score is the final score for the individual form.

## **Step 2: Combining Individual Forms into a Final Score**

The Applicant’s individual form scores are derived by following Step 1 and are combined into one weighted score by assigning a weight to each individual state form based on the most recently reported Member Months as follows (See Exhibit B-2 for an example):

1. Member Months from CY 2011, or the most recent calendar year reported, on the Applicant’s individual state forms are totaled (Total Member Months);
2. For each Applicant, the reported Member Months for CY 2011, or the most recent calendar year reported on the individual state form, is divided by the Applicant’s Total Member Months to get a weight for the individual state form;
3. The score for Part I, Step 1 from each Applicant’s individual “Applicant Statewide Contract/Compliance Experience Form” is multiplied by its weight as calculated in item 2 above to get a weighted score;
4. All weighted scores calculated in item 3 above are added together to get a single, preliminary weighted score for Part I for each Applicant.

## PART II: Scoring Methodology

Applicants will be individually scored for each region. For each region an applicant may not score more than the maximum points of 15,000. For each region, if the applicant checked only one of the three boxes for a county (Medicare Advantage, Medicaid, and Commercial) then the score associated with the check box is the score for the county. If the applicant checked multiple boxes for a county then the checked box that awards the highest score is counted. For example, if applicant for the Central region checked the Medicare Advantage, Medicaid, and Commercial boxes for Delaware County then the Applicant would receive a score of 3,000 for Central region/Delaware County. The county points are totaled for a total score for Part II of this appendix for the specific region.

### Region: Central

County	Region	Area(s) of Coverage		
		Medicare Advantage	Medicaid	Commercial
Delaware	CEN	3,000	2,400	1,500
Franklin	CEN	3,000	2,400	1,500
Madison	CEN	3,000	2,400	1,500
Pickaway	CEN	3,000	2,400	1,500
Union	CEN	3,000	2,400	1,500

### Region: East Central

County	Region	Area(s) of Coverage		
		Medicare Advantage	Medicaid	Commercial
Portage	EC	3,750	3,000	1,875
Stark	EC	3,750	3,000	1,875
Summit	EC	3,750	3,000	1,875
Wayne	EC	3,750	3,000	1,875

### Region: Northeast

County	Region	Area(s) of Coverage		
		Medicare Advantage	Medicaid	Commercial
Cuyahoga	NE	3,000	2,400	1,500
Geauga	NE	3,000	2,400	1,500
Lake	NE	3,000	2,400	1,500
Lorain	NE	3,000	2,400	1,500
Medina	NE	3,000	2,400	1,500

**Region: Northeast Central**

		Area(s) of Coverage		
County	Region	Medicare Advantage	Medicaid	Commercial
Columbiana	NEC	5,000	4,000	2,500
Mahoning	NEC	5,000	4,000	2,500
Trumbull	NEC	5,000	4,000	2,500

**Region: Northwest**

		Area(s) of Coverage		
County	Region	Medicare Advantage	Medicaid	Commercial
Fulton	NW	3,750	3,000	1,875
Lucas	NW	3,750	3,000	1,875
Ottawa	NW	3,750	3,000	1,875
Wood	NW	3,750	3,000	1,875

**Region: Southwest**

		Area(s) of Coverage		
County	Region	Medicare Advantage	Medicaid	Commercial
Butler	SW	3,000	2,400	1,500
Clermont	SW	3,000	2,400	1,500
Clinton	SW	3,000	2,400	1,500
Hamilton	SW	3,000	2,400	1,500
Warren	SW	3,000	2,400	1,500

**Region: West Central**

		Area(s) of Coverage		
County	Region	Medicare Advantage	Medicaid	Commercial
Clark	WC	5,000	4,000	2,500
Greene	WC	5,000	4,000	2,500
Montgomery	WC	5,000	4,000	2,500



**Department of  
Job and Family Services**

**John R. Kasich**, Governor  
**Michael B. Colbert**, Director

April 2, 2012

Melanie Bella  
Medicare-Medicaid Coordination Office  
Centers for Medicare and Medicaid Services  
200 Independence Avenue SW  
Mail Stop Room 315-H  
Washington, DC 20201

Dear Ms. Bella:

I am pleased to submit Ohio's Capitated Financial Alignment Demonstration Proposal for Medicare-Medicaid Enrollees, responding to the Medicare-Medicaid Coordination Office letter of July 8, 2011. This proposal documents the combined effort of multiple state agencies at the direction of Governor Kasich and Ohio's Office of Health Transformation. The proposal design includes contributions from Medicare-Medicaid enrollees, providers and advocates across Ohio during an intensive year-long stakeholder engagement process. The model demonstrates Ohio's commitment to improving access to cost-effective, coordinated health and long-term care services that promotes individuals living in the setting of their choice and their independence.

This proposal builds on Ohio's experience with capitated Medicaid models, and significant participation among Ohio's Medicare population in Medicare Advantage Plans. Competitively selected health plans will manage a comprehensive benefit package for Medicare-Medicaid enrollees, utilizing a variety of care management tools to ensure that services are coordinated. The "Integrated Care Delivery System" (ICDS) presented here will improve care for Medicare-Medicaid enrollees over age 18 whose medical, behavioral health and functional service needs can be better coordinated by a single entity responsible for the efficient delivery of all services within a single organization responsible for complete and integrated service coordination. Ohio will select ICDS organizations whose competencies include successful care coordination for Medicare and Medicaid enrollees, as well as experience with long-term care providers, services, and supports. The ICDS care management model will incorporate behavioral health homes targeting the unique needs of enrollees with serious and persistent mental illness, and will build a competent and integrated care system for individuals with chronic illnesses.

30 East Broad Street  
Columbus, Ohio 43215  
[jfs.ohio.gov](http://jfs.ohio.gov)

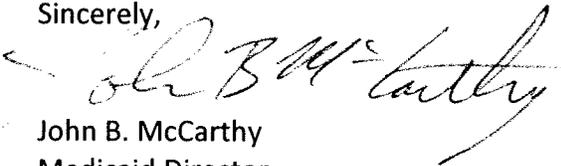
An Equal Opportunity Employer and Service Provider

Ohio's leadership strongly believes this model will improve health and long-term care outcomes, reduce costs and enhance satisfaction among enrollees. Integrated financing and service delivery will allow Ohio to measure the impact of care processes across payers and service settings. It will enhance provider relationships across traditionally broken lines of communication, promoting creative and enrollee-centered community-based care. It will eliminate the current system's cost-shifting incentives and costly service duplication.

This proposal reflects the administrative and policy recommendations from Ohio Medicaid, Departments of Mental Health, Alcohol and Drug Addiction Services, Aging, Developmental Disabilities and Health. It incorporates concerns and ideas from over 24 stakeholder groups, including health plans and health care delivery systems; care management and care coordination companies; physician and other provider associations; the Ohio Association of Area Agencies on Aging; social service and advocacy organizations and over 500 enrollees of Medicare, Medicaid or both programs. Letters of support from some of those organizations are included as evidence that Ohio is prepared to move forward.

I am anxious to begin discussions with your office to finalize Ohio's proposal and establish the terms of a 3-way contract for implementation in January 2013. Please let me know what additional information you may require. I look forward to working swiftly to achieve the goals of this proposal on behalf of Ohio's Medicare-Medicaid enrollees.

Sincerely,

A handwritten signature in cursive script, appearing to read "John B. McCarthy". The signature is written in black ink and is positioned to the right of the typed name.

John B. McCarthy  
Medicaid Director

**STATE OF OHIO**  
**OHIO DEPARTMENT OF JOB AND FAMILY SERVICES**  
**OFFICE OF OHIO HEALTH PLANS**

**STATE DEMONSTRATION TO INTEGRATE CARE FOR**  
**MEDICARE-MEDICAID ENROLLEES**

**PROPOSAL TO THE CENTER FOR MEDICARE**  
**AND MEDICAID INNOVATION**



**April 2, 2012**

## **A. Executive Summary**

Over 182,000 Ohioans are enrolled in both Medicare and Medicaid, but the two programs are designed and managed with almost no connection to one another. With no single point of accountability, long-term care services and supports, behavioral health services, and physical health services are poorly coordinated. The result is diminished quality of care for Medicare-Medicaid enrollees and unnecessarily high costs for taxpayers. Medicare-Medicaid full benefit enrollees make up only 9 percent of total Ohio Medicaid enrollment, but they account for more than 30 percent of total Medicaid spending.

This proposal presents a new approach to meeting the needs of individuals who are eligible for both Medicaid and Medicare benefits. Ohio has chosen the capitated managed care model offered by CMS in a July 8, 2011 Medicaid Director's letter. Through the Centers for Medicare and Medicaid Services' (CMS) Medicare-Medicaid Demonstration Program, Ohio will develop a fully integrated care system that comprehensively manages the full continuum of Medicare and Medicaid benefits for Medicare-Medicaid Enrollees, including Long Term Services and Supports (LTSS). Ohio's Integrated Care Delivery System (ICDS) Program will be implemented in selected regions across the state, beginning in January 2013.

Under Ohio's Demonstration Proposal, competitively selected ICDS health plans will manage a comprehensive benefit package for Medicare-Medicaid enrollees, utilizing a variety of care management tools to ensure that services are coordinated. The ICDS plans will:

- arrange for care and services by specialists, hospitals, and providers of LTSS and other non-Medicaid community-based services and supports;
- allocate increased resources to primary and preventive services in order to reduce utilization of more costly Medicare and Medicaid benefits, including institutional services;
- cover all administrative processes, including consumer engagement, which includes outreach and education functions, grievances, and appeals;
- use a person-centered care coordination model that promotes an individual's ability to live independently through a process that includes the individual in the development of their care plan; and
- utilize a payment structure that blends Medicare and Medicaid funding and mitigates the conflicting incentives that exist between Medicare and Medicaid.

Ohio's vision for the ICDS program is to create a fully integrated system of care that provides comprehensive services to Medicare-Medicaid Enrollees across the full continuum of Medicare and Medicaid benefits. Ohio anticipates that the reduction in costs through this model will enable more Medicare-Medicaid Enrollees to receive the medical and supportive services they need in their own homes and other community-based settings, rather than in more costly institutional settings. Ohio will demonstrate that its model of integrated care and financing will:

- keep people living in the community;
- increase individuals' independence;
- improve the delivery of quality care;
- reduce health disparities across all populations;
- improve health and functional outcomes;

- reduce costs for individuals by reducing or avoiding preventable hospital stays, nursing facility admissions, emergency room utilization; and
- improve transitions across care settings.

The reduction in costs through this model allows Ohio to continue to expand its investment in home- and community-based services as evidenced by the exclusion of enrollment caps on home- and community-based waiver participation in this proposal.

Ohio will continue to engage with and incorporate feedback from stakeholders during the implementation and operational phases of the Demonstration. Ohio intends to conduct an ongoing process of monitoring individual and provider experiences through a variety of means, including surveys, focus groups, and data analysis. In addition, Ohio will require that ICDS plans develop meaningful consumer input processes as part of their ongoing operations, as well as systems for measuring and monitoring the quality of service and care delivered to eligible individuals.

### Overview of the Ohio Integrated Care Delivery System Demonstration

<i>Target population</i>	<i>Individuals fully eligible to receive Medicare and Medicaid benefits</i>
<i>Total Number of Full Benefit Medicare-Medicaid Enrollees Statewide (Average dual eligibles per month, SFY 2011)</i>	182,328
<i>Total Number of Full Benefit Medicare-Medicaid Enrollees Living in the Geographic Service Area and eligible for the Demonstration (Average dual eligibles per month, SFY 2011)</i>	114,972
<i>Geographic Service Area</i>	<i>Seven regions of 3-5 counties each</i>
<i>Summary of Covered Benefits</i>	<i>Medicare Parts A,B, and D, Medicaid State Plan including all Community-based Behavioral Health Services and Nursing Facility Services, Medicaid Waiver Services</i>
<i>Financing Model</i>	<i>The capitated financial alignment model offered in the 7/8/11 State Medicaid Director Letter</i>
<i>Summary of Stakeholder Engagement/Input</i>	<ul style="list-style-type: none"> <li>• Vision for ICDS released Feb 2011;</li> <li>• ICDS proposal submitted to CMS Feb 2011;</li> <li>• Request for Information Sep 2011;</li> <li>• Five statewide consumer- caregiver forums. Jan 24, Jan 31, Feb 3, Feb 7, Feb 14</li> <li>• A statewide consumer conference call Feb 17;</li> <li>• An on-line consumer survey Feb 2012;</li> <li>• Two public hearings for Medicare-Medicaid enrollees, providers, and other stakeholders Mar 13 and Mar 20</li> </ul>
<i>Proposed Implementation Date</i>	<i>January 2013</i>

## B. Background

### i. Overall Vision and Barriers to Integration

Ohio's vision for the ICDS program is to create a fully integrated system of care that provides comprehensive services to Medicare-Medicaid Enrollees across the full continuum of Medicare and Medicaid benefits, including LTSS, which supports people maximizing their independence and living in the setting of their choice. Prior demonstrations of fully integrated health care systems for Medicare-Medicaid Enrollees in other states have demonstrated improved outcomes for consumers as well as more efficient utilization of Medicare and Medicaid benefits. The objective of the ICDS program is to provide higher quality and more person-centered care while also addressing the inefficiencies and incorrect incentives of the existing Medicare and Medicaid fee-for-service systems. Through the ICDS program, Ohio anticipates that more Medicare-Medicaid Enrollees will be able to receive the medical and supportive services they need in their own homes and other community settings, rather than in more costly institutional settings.

Ohio's ICDS program is one critical component of a broader effort underway to improve Ohio's overall health system performance. On January 13, 2011, just three days after taking office, Ohio Governor John Kasich established the Office of Health Transformation (OHT) to modernize Medicaid, streamline health and human services, and improve overall system performance. OHT quickly identified Medicare-Medicaid Enrollees as a high-cost population in the Medicaid program, as well as one that was poorly served by a fragmented health care system.<sup>1</sup> OHT applied for but did not receive one of the 15 demonstration grants offered by the Medicare-Medicaid Coordination Office to support planning activities for a demonstration program.<sup>2</sup> Nonetheless, Ohio proceeded with its own planning activities and submitted a Letter of Intent in October 2011 to CMS, conveying Ohio's intention to participate in CMS' Medicare-Medicaid Demonstration Initiative.

Earlier this year, Governor Kasich and the Office of Health Transformation made Ohio's Integrated Care Delivery System (ICDS) program for Medicare-Medicaid Enrollees the number one health care priority to be undertaken by the state in 2012. This decision reflects a readiness to take Ohio's experience with Medicaid managed care to the next level, and to use the ICDS program model to overcome barriers to delivery system integration that have resulted in Ohio lagging behind other states in providing meaningful alternatives to institutional placements and coordinating long-term services and supports.

Ohio created its Medicaid managed care program in 1978, first as an optional program for children and parents in a limited number of counties, but then expanding the program to mandatory enrollment statewide in 2006. Since 2006, the program also has been mandatory for physical health care services for the aged, blind and disabled (ABD) Medicaid population.<sup>3</sup> However, because of barriers in the current delivery system, certain subsets of the ABD population were exempted, including:

- Individuals who are institutionalized;
- Individuals who become Medicaid eligible through spending down their income;

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<sup>1</sup> Ohio Office of Health Transformation, **Medicaid Program Background** at [www.healthtransformation.ohio.gov](http://www.healthtransformation.ohio.gov).

<sup>2</sup> Ohio Office of Health Transformation, **Ohio's Demonstration Model to Integrate Care for Dual Eligibles**, February 1, 2011, found at: [www.healthtransformation.ohio.gov](http://www.healthtransformation.ohio.gov).

<sup>3</sup> Ohio 5111.16 Care Management System

- Individuals who are receiving services in a Medicaid 1915(c) Home- and Community-Based Services waiver, and;
- Individuals who are dually enrolled in both the Medicare and Medicaid programs.<sup>4</sup>

Thus, the delivery of services to the ABD population through a managed care model is not new in the Ohio Medicaid program, but the exemption has caused the approximately 182,000 full-benefit Medicare-Medicaid Enrollees in Ohio to be provided Medicare and Medicaid benefits primarily through the existing fee-for-service system.

Managed care for the Medicare-only population also is not a new concept in Ohio. According to The Kaiser Family Foundation's StateHealthFacts.org website, Ohio has the sixth highest Medicare enrollment in the United States (1,909,462 Medicare enrollees in 2011) and ranks fifth in Medicare Advantage (MA) enrollment (640,245 MA enrollees). Ohio's MA enrollment is presented in Appendix A. Based on those enrollment numbers, the percent of Medicare enrollees in a MA plan in 2011 was 34%, significantly higher than the national average of 26%. While the percentage of Medicare-only enrollees in Ohio in MA plans is higher than the national average, managed care enrollment among Medicare-Medicaid Enrollees is very low. Only between 2-3% of Medicare-Medicaid enrollees are enrolled in Special Needs Plans.

Over the last ten years, with significant investments in Medicaid home- and community-based services (HCBS) waiver programs, Ohio has made considerable progress towards rebalancing its LTSS system.<sup>5</sup> Ohio's HCBS waiver for individuals with a nursing facility level of care over the age of 60, called PASSPORT, provides services to over 30,000 individuals daily across the state, and is the third largest HCBS waiver program in the nation. This expansion in HCBS services has had a clear impact on reducing nursing home use in the state. Despite significant growth in the aged population over the last decade, the average daily census of persons receiving Medicaid-financed nursing home care has declined by about 5%.

However, more progress needs to be made. Ohio's LTSS System remains out of balance, tilted heavily towards institutional service settings. Ohio lags behind other states in its rebalancing efforts. Medicaid spending per capita for nursing home care in Ohio still ranks in the top quintile of all states, and the relative proportion of Medicaid spending for institutional care versus community-based care is well above the national average. If Ohio is going to address the rapid growth of its aged population over the coming decades, it will have to develop new program models for meeting both the health and long-term support needs of this population more efficiently. The ICDS program is an important step toward developing a higher quality, lower cost program model for individuals who qualify for both Medicare and Medicaid benefits.

## *ii. Detailed Description of Target Population*

The population that will be eligible to participate in the ICDS program is limited to "Full Benefit" Medicare-Medicaid Enrollees only. Individuals who are only eligible for Medicare Savings Program

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<sup>4</sup> Individuals under 21 years of age also were excluded from Medicaid managed care, but the exemption was recently removed and, beginning in January 2013, these individuals will be served in a managed care delivery system.

<sup>5</sup> Mehdizadeh et al, *Coming of Age: Tracking the Progress and Challenges of Delivery Long-Term Services and Supports in Ohio*. Scripps Gerontology Center, June 2011.

benefits (QMB-only, SLMB-only, and QI-1) will not be eligible. Additionally, the following specified populations will also be excluded from participating in the ICDS program:

- Individuals with Intellectual Disabilities (ID) and other Developmental Disabilities (DD) who are served through an IDD 1915(c) HCBS waiver or an ICF-IDD;
- Individuals enrolled in PACE;
- Individuals enrolled in both Medicare and Medicaid who have other third party creditable health care coverage;
- Individuals under the age of 18, and;
- Individuals who are Medicare and Medicaid eligible and are on a delayed Medicaid spend down.

Medicare-Medicaid Enrollees with Intellectual Disabilities (ID) and other Developmental Disabilities (DD) who are not served through an IDD 1915(c) HCBS waiver or an ICF-IDD may opt into the ICDS program.

Individuals with serious and persistent mental illness (SPMI) will be included in the ICDS program. Ohio Medicaid is currently working with CMS on a Medicaid state plan amendment to create Medicaid Health Homes for individuals with SPMI that will enhance the traditional patient-centered medical home to better coordinate physical and behavioral health services. Community behavioral health centers (CBHCs) will be eligible to apply to become Medicaid health homes for individuals with SPMI. The assumption in this proposal is that the SPMI Health Home initiative will be implemented in October 2012. At a later date, Ohio Medicaid will implement Medicaid Health Homes focusing on individuals with qualifying chronic physical health conditions. Ohio is proposing that ICDS plans will be required to partner and collaborate with approved Medicaid Health Homes.

The target population is further reduced because Ohio is proposing to implement the ICDS program in seven regions of 3-5 counties each. A map of the proposed geographic areas is shown in Appendix B. Based on the eligibility criteria stated above and the regions that are being proposed, Ohio estimates that approximately 114,972 Medicare-Medicaid Enrollees will be eligible to participate in the ICDS Program. Appendix C provides detailed estimates of the number of Medicare-Medicaid Enrollees eligible to participate in the ICDS Program, by region.

Ohio has conducted preliminary analyses of Medicaid spending for the ICDS target population. It is estimated that in FY 2011, Ohio Medicaid spent approximately \$2.5 billion providing services to Medicare-Medicaid Enrollees in the ICDS target population. Of this total, \$1.6 billion (65%) was for Medicaid-covered nursing home stays, while approximately \$560 million (another 23%) was spent for PASSPORT and other home- and community-based services. The remaining \$307 million (12%) was spent on Medicare cost-sharing services and other Medicaid benefits not available through the Medicare program. Thus, in all, 88% of Medicaid spending for the target population is for Long-Term Services and Supports, either in institutional or community-based settings. More detailed analysis of current Medicaid spending for the target population will be developed through the rate development process.

## **C. Care Model Overview**

### *i. Description of Proposed Delivery System*

Ohio will implement a comprehensive, fully-capitated, competitive model for the ICDS program. Through a competitive procurement, the state will select two competing health plans to serve Medicare-

Medicaid Enrollees in each of the designated regions except for the Northeast Region where three plans will be chosen. Medicare-Medicaid Enrollees will be able to choose to enroll in an ICDS plan in the region where they reside. In order to improve health outcomes and promote independent living the model:

- Emphasizes individual choice and control in the delivery of their care and services;
- Supports an individual's right to live independently, and;
- Recognizes an individual's right to dignity of risk.

*(a) Geographic Service Areas*

The ICDS program will be implemented in seven geographic regions of 3-5 counties each (see Appendix B). Each of the seven regions includes a metropolitan area, with most also serving a rural area. Six of the regions have at least four MA plans currently serving Medicare enrollees in the region, and the Northwest Region has at least three MA plans currently serving Medicare enrollees. The presence of established MA plans was influential in the choice of regions. All eligible Medicare-Medicaid Enrollees in the designated counties will be enrolled in the ICDS program in 2013.

*(b) Enrollment Method*

Enrollment in the ICDS Program will be mandatory for Medicaid-covered benefits. For Medicare-covered benefits, Ohio proposes to implement an "opt out" enrollment process. During late summer of 2012 Medicare-Medicaid Enrollees in the targeted geographic regions will be notified of their selection for the ICDS program. Not less than 60 days prior to enrollment into the ICDS program, a letter of notification will inform individuals that they will be enrolled in their plan of choice for both their Medicaid-covered benefits and their Medicare-covered benefits. If the individual does not choose an ICDS plan, the individual will be auto-enrolled into one of the plans.

Once enrolled in one of the two ICDS plans, individuals will be offered the option of switching plans during the first 90 days of enrollment with an annual open enrollment period, consistent with the current Medicaid Managed Care enrollment process. While there is no "lock in" for the Medicare program, Medicaid services will be provided in all circumstances through the ICDS. Individuals may disenroll from ICDS plans for their Medicare-covered benefits after 90 days of enrollment in the ICDS. Individuals may re-enroll in the Medicare component of the ICDS at any time upon request.

If eligible participants elect to opt out of the ICDS program for their Medicare-covered benefits, they will remain enrolled in the ICDS program for their Medicaid-covered services. There will no longer be a fee-for-service Medicaid option in the ICDS program.

*(c) Available Medical and Supportive Service Providers*

Because the geographic regions chosen include large urban areas in Ohio, access to both medical and supportive service providers is enhanced. More importantly, these areas are home to some of the nation's most comprehensive and integrated health care systems for both inpatient and outpatient care. Additionally, the ICDS regions are consistent with Ohio's Area Agencies on Aging networks, and the model envisions that those services also can be accessed for non-medical supports for this population.

Selected ICDS plans will be required to demonstrate adequate provider capacity to meet the CMS Panel Adequacy requirements for the region(s) for which they have applied. Plans will be required to maintain a network adequate to provide for those Medicaid benefits that exceed Medicare, such as dental and vision services providers. Plans will also be required to include providers whose physical locations and diagnostic equipment will accommodate individuals with disabilities.

Also as part of Medicaid waiver programs, Medicaid currently enrolls both agencies and independent providers, who do not work for an agency, to provide in-home waiver services. Because these providers are not certified by traditional processes, Medicaid reviews applications against a set of Ohio-specific requirements. ICDS plans will be required to develop contractual relationships with home- and community-service providers certified by the Ohio Department of Health and/or the Department of Aging as well as those which Medicaid has approved for the provision of home- and community-based services. ICDS plans must accommodate individual preference when developing provider networks.

*(d) LTSS Consumer Enrollment and Transition*

The state recognizes that consumer enrollment and transition into the ICDS will differ between those individuals who are dually eligible for Medicaid and Medicare who present a need for LTSS, and those who do not require such interventions. The ICDS model represents a significant shift in the LTSS delivery system and Medicaid is sensitive to the magnitude of the proposed changes for individuals. Ohio is committed to implementing this program in a manner that allows for the safe transition of individuals, emphasizing continuity of care, and minimizing service disruption.

Individuals enrolling in the ICDS will first enroll and receive Medicaid state plan services through the traditional Medicaid fee-for-service program. HCBS waiver services will be obtained through an approved HCBS waiver serving consumers with a nursing facility Level of Care (LOC). As a result, individuals will follow the State's existing processes for enrollment in Medicaid and HCBS services. After Medicaid enrollment, these individuals will transition into the ICDS and begin receiving both care management and LTSS through the ICDS.

Prior to the individual's enrollment in the ICDS program, the following will be performed by the PASSPORT Administration Agencies (PAA) or a state contracted case management agency depending on the waiver in which the individual is applying for enrollment:

- Information, Assistance, & Referral;
- Screening;
- Pre-Admission and Resident Review (PAA's only);
- Long-Term Care Consultation (PAA's only);
- Initial Assessment for HCBS waiver services;
- LOC Determination;
- State Funded Waiver Program Administration (PASSPORT and Assisted Living only), and;
- Service Plan Development for new waiver enrollees.

During the initial fee-for-service enrollment period, if the individual is enrolled on a HCBS waiver, the case management entity under contract with the state will develop a service plan. Individuals will continue to receive services through fee-for-service until they are enrolled in the ICDS.

After enrollment in the ICDS, the ICDS plan will be responsible for performing future assessments of consumer need and modifying care plans according to assessed needs. Once enrolled, the ICDS plan will authorize, monitor and purchase LTSS according to the service plan in a manner consistent with Ohio's quality strategy and federal waiver assurances. Plans will provide LTSS coordination using mechanisms that maximize individual choice and control. ICDS plans will be required to offer continuation of LTSS coordination. Pre-admission and resident review activities and LOC determinations will be performed outside of the ICDS.

To effectively implement the ICDS and transition individuals, at the time of enrollment in the ICDS (beginning the month in which the ICDS plan assumes responsibility for care coordination of the beneficiary) the ICDS plans will be required to adhere to specific transition requirements outlined in the table in Appendix D.

*ii. Description of Proposed Benefit Design*

Ohio will implement a fully-integrated model delivering all Medicaid-covered services and Medicare-covered services. No Medicaid benefit carve-outs are proposed. The baseline design requirement is that ICDS plans administer Medicare and Medicaid benefits jointly such that participants experience their coverage as a single, integrated care program. The program will cover:

- All Medicare benefits,
- All Medicaid state plan benefits including Medicare cost-sharing and,
- All Medicaid community-based behavioral health services (see Appendix E), and;
- All Medicaid home- and community-based services that are currently provided in one of the five nursing facility level of care HCBS waivers (see Appendix E).

The ICDS program will not cover habilitation services.

The vision of the ICDS program is to significantly enhance the individual's experience with the entire health care system, across all providers and services. The purpose of the ICDS system is to create a "seamless" health care system in which individuals no longer experience the frustration of accessing services from a host of disparate providers, who may not communicate effectively with one another about the individual's condition or treatment plan. Rather, in the ICDS program, the individual's experience with both the medical system and the LTSS system would be greatly simplified through his or her affiliation with a single ICDS plan and care manager that is responsible for the complete continuum of care for that individual including links to non-Medicaid covered social services.

The concept of a seamless health care system also applies to the providers in the ICDS plan's provider network. There will be no coinsurance amounts or deductibles applied to any claim. Additionally, providers will send a claim to the ICDS plan for services rendered without the requirement of a secondary claim as is currently required for services covered by both Medicare and Medicaid.

In the specifications included in the state's Request for Applications, the state will request that prospective ICDS health plans adopt a care management model that fundamentally transforms the manner in which health care is provided to persons who are dually eligible for Medicare and Medicaid, particularly those with high functional needs. Prior demonstrations of integrated care models for Medicare-Medicaid enrollees have shown that increased investments in primary and preventive services can produce high returns on investment in terms of reduced utilization of tertiary care, including

inpatient hospital services and extended nursing home stays. This transformation in care management includes extensive use of home visits, high use of physician substitutes such as physician assistants and nurse practitioners, and the employment of advanced pharmacy management programs to increase adherence and eliminate contra-indicated drug use. The state will enter into contracts with health plans that are willing to make the kinds of investments in primary and preventive services for Medicare-Medicaid enrollees that are needed to reduce inappropriate use of higher-cost services.

The ICDS plans will utilize care management models that are culturally sensitive to the Medicare-Medicaid enrollees they serve. During the plan selection process, culturally sensitive care management models that build provider networks to reflect the cultural characteristics of the ICDS plan's membership, will be considered. The state will also be looking for models that recruit providers capable of communicating with individuals in their primary language.

ICDS plans will be expected to provide care management services to monitor and coordinate the care for individuals. Individuals will have varying needs and require differing levels of interventions, interactions, engagement, and services. The care management model must incorporate individuals residing in all care settings, such as nursing facilities, hospitals, assisted living facilities, and at home. ICDS plans will be expected to implement a care management model for Ohio's Medicare-Medicaid enrollees that includes the following components:

- Use of mechanisms to identify and prioritize the timeframe by which individuals will receive a comprehensive assessment;
- Completion of a comprehensive assessment of an enrollee's medical, condition-specific, behavioral health, LTSS, environmental and social needs with input from the enrollee, family members, caregiver, and providers;
- Assignment of the enrollee to an appropriate risk/acuity level based on the results of the identification and assessment processes;
- Development of an integrated, person-centered care plan by the individual, family members, caregiver(s) and provider(s) that addresses needs identified in the comprehensive assessment with corresponding goals, interventions, and expected outcomes;
- Ongoing monitoring of the care plan to determine adherence to evidence-based practice, barriers to care, transitions across settings, service utilization, and quality of services in order to achieve progress toward person-centered goals and outcomes;
- Formulation of a trans-disciplinary care management team designed to effectively manage the individual's services. The team shall consist of the individual, the primary care provider, the care manager, and other providers as appropriate;
- Use of innovative communication methods;
- A comprehensive approach to managing care transitions, including admissions and discharges from hospitals, nursing facilities, and other settings to ensure communication among providers,

primary care follow up, medication reconciliation, timely provision of formal and informal in-home supports, etc.

- Ongoing-medication reconciliation and employment of advanced pharmacy management programs, including medication therapy management, to increase adherence and eliminate contra-indicated drug use, and;
- Use of a care management system that captures the assessment and care plan content and is linked to other databases or systems that are used to maintain information about the individual.

Medicaid will assign care management staffing ratios using a risk stratification methodology. The expectation is the care management model will improve health outcomes as well as reduce unnecessary utilization of healthcare services. Ohio will implement a care management survey to assess quality and individual satisfaction with ICDS care management processes.

The coordination of home- and community-based services is extremely important to keeping an individual in the community. It has also been found that the relationship between the individual and their service coordinator has a large impact on outcomes. Ohio recognizes both the right for the individual to choose his or her service coordinator for home- and community-based services and the importance of the role entities in the state have already played in the coordination of these services. Thus, in order to maintain continuity of care and assist in transition, the ICDS plans will be required to subcontract with an outside entity to provide service coordination of what is known traditionally as 1915(c) home- and community-based waiver services. Furthermore, because of the role PASSPORT Administrative Agencies (PAA) have played in ensuring people are able to live in the community, the ICDS plan will be required to contract with the PAA in the region that is being served for service coordination of home- and community-based waiver services and may contract with other entities that provide this service (e.g. Centers for Independent Living).

Individuals will be given the right to choose both the entity that will provide service coordination for traditional 1915(c) home- and community-based waiver services, and who their service coordinator is. For individuals age sixty and older that do not choose a service coordinator, they will be assigned a service coordinator from the PAA that serves the region where the individual resides.

### *iii. Description of Supplemental Benefits and Ancillary Services.*

Other features of the ICDS that will be required include:

- Expert wheelchair fitting, purchase, maintenance and repair, including professional evaluation, home assessment, skilled wheelchair technicians, pick-up and delivery, timely repairs (in the home or repair shop), training, demonstration, and loaner chairs.
- Specialists in pressure ulcer prevention and intervention, who assess all ICDS enrollees to identify those at risk and coordinate care.
- Promotion of social/education/artistic activities to combat isolation.
- A requirement to conduct home visits with members so that individuals can be observed and assessed in their own home environment. Individuals with more significant health and

functional needs will be required to be visited more frequently than individuals in relatively good health and with no functional impairments.

- Twenty-four hour in-person coverage for all individuals, such that if a person calls at any time of day, a trained health care professional with access to the individual's records will be available to assess their situation and take an appropriate course of action.
- A pharmacy management program that includes the pharmacists in the pharmacy where the individual obtains their prescriptions. This program must continually monitor the proper adherence of individuals to fill prescriptions and take medications in accordance with the prescriber's instructions.
- A comprehensive and aggressive process to review all hospital admissions and nursing home placements to identify admissions/placements that were inappropriate and avoidable and to develop systemic approaches to reducing inappropriate use of high-cost tertiary services.
- A comprehensive behavioral health management program that integrates physical and behavioral health services and that has the staff and resources to develop interventions for individuals with cognitive impairments and behavioral issues, including the ability to rapidly respond to acute episodes for individuals with severe mental illnesses. Pending successful implementation, this will be based on a health home model of delivery for persons with serious mental illness.
- A culturally sensitive approach to care management, such that individuals have an opportunity to communicate with their health care practitioners in their primary language, either directly or through interpreters, and to receive care that is sensitive to their cultural background and preferences.
- A common or centralized record, provided by the ICDS, for each individual, whose care is coordinated by the ICDS, that is accessible to each individual and all health care practitioners involved in managing the individual's care, so that all encounters with the individual by any practitioner can be shared across the ICDS.

While Ohio intends to provide specifications for the framework of the care management model for ICDS members in its Request for Applications and/or contracts, the state also recognizes that the organizations bidding for ICDS health plan contracts will bring to the table their own care management models for effectively managing care for Medicare-Medicaid Enrollees. Thus, the care management model provided to individuals in the ICDS program will reflect a balance of state requirements and contractor competencies. Further, the state wishes to establish a truly competitive market environment in which ICDS health plans compete for members based upon the quality of the services they provide. The state also fully expects that care management models will evolve and improve over time as the ICDS program gains real world experience.

#### *iv. Discussion of employment of evidence-based practices*

Quality improvement efforts in Ohio are designed to close the gap between the latest research and practice. Evidence-based practices are the cornerstone of Ohio's Medicaid Quality Strategy (Quality

Strategy) which governs the Ohio Medicaid program. ICDS plans will be expected to fully participate in the state's efforts, and meet the associated requirements and expected outcomes established in the Quality Strategy, to improve the health and quality of care for Ohio's Medicaid population.

Ohio's Medicaid Quality Strategy is based on the U.S. Department of Health and Human Services' *National Strategy for Quality Improvement in Health Care* and is implemented across delivery systems in all of Ohio's Medicaid programs. The Quality Strategy (attached as Appendix F) serves as a framework to communicate Ohio's approach for ensuring that timely access to high quality health care is provided in a cost-effective, coordinated manner across the continuum of care for Medicaid individuals. The Quality Strategy is based on continuous quality improvement with evidence-based guidelines, transparency, accountability, informed choices, value and consistency/continuity. Ohio's efforts to improve the quality are consistent with the National Strategy's broad aims to: 1) improve the overall quality of care by making health care more person-centered, reliable, accessible and safe; 2) improve the health of the Ohio Medicaid population by supporting proven interventions to address behavioral, social, and environmental determinants of health; and 3) facilitate the implementation of best clinical practices to Medicaid providers through collaboration and improvement science approaches.

Priorities have been established to advance these broad aims and are based on the latest research to rapidly improve health outcomes and increase effectiveness of care. Goals have been selected in each of the priority areas and will focus Ohio's efforts in the next three years. Ohio Medicaid's key priorities and examples of supporting initiatives are described below:

*Priority: Make care safer by eliminating preventable health-care acquired conditions and errors.*

- The Ohio Hospital Association (OHA) in partnership with the Ohio Patient Safety Institute was awarded a two year contract in December 2011 by the U.S. Department of Health and Human Services to implement change packages related to improving patient care in eleven (11) clinical areas including pressure ulcers, surgical site infections, ventilator associated pneumonia, and catheter associated urinary tract infections. The OHA contract will bring together hospitals and providers in the state to participate in collaboratives and learning networks.
- Multiple state departments have come together to lead a consortium of public and private entities to address the escalating deaths and harms related to prescription pain medications. Numerous strategies have been employed to drive the appropriate utilization of these medications based on the analysis of state data and the evidence in medical and behavioral health literature. The development of Emergency Department Prescribing Guidelines, the formation of a Solace support group, the implementation of a lock-in program and a public awareness campaign are all outcomes of this effort. State subject matter experts are currently gathering to establish and clarify promising practices related to the prescribing of controlled substances including the role of Suboxone. Ongoing monitoring and feedback of the utilization of high risk medications are part of the continuous improvement cycle.

*Priority: Improving care coordination by creating a system that is less fragmented, where communication is clear, and patients and providers have access to information in order to optimize care.*

- Ohio has developed a collaborative of Patient Centered Medical Homes (PCMHs) that meet regularly to accelerate adoption and disseminate innovation at the practice level. Existing and emerging PCMHs will be used as the foundation for the Medicaid Health Home initiative which is designed to better coordinate medical and behavioral health care consistent with the needs of the individuals with severe and/or multiple chronic illnesses. A Health Home will offer an intense form of care management across settings and the continuum of care which includes a comprehensive set of services and meaningful use of health information technology. Nationally recognized measures will be used to evaluate the Medicaid Health Home initiative including reductions in unnecessary hospital readmissions and inappropriate emergency department visits, improvements in chronic disease management and patient satisfaction, and increased access to preventive services.
- Ohio Medicaid initiated a quality improvement effort called IMPROVE (Implement Medicaid Programs for the Reduction of Avoidable Visits to the Emergency Department) that demonstrated promising results in the reduction of unnecessary emergency department visits in five major cities in Ohio. Community collaboratives consisting of a broad array of stakeholders were formed in each area that tackled local needs with person centered interventions. Ohio Medicaid is planning on building on this success by using the network to help develop other innovative models of care.

*Priority: Promoting evidence-based prevention and treatment practices by preventing and reducing harm associated with high cost, prevalent conditions which include high risk pregnancy/premature births, behavioral health, cardiovascular disease, diabetes, asthma, upper respiratory infections and musculoskeletal health.*

- Ohio Medicaid uses national performance measurement sets, like the National Committee for Quality Assurance's (NCQA's) Healthcare Effectiveness Data and Information Set (HEDIS), in order to assess health plan performance on important dimensions of care and service. Performance results are compared to national benchmarks and standards in order to hold health plans accountable for improving the quality of care. Ohio Medicaid uses a system of incentives and sanctions to ensure program compliance and continuous quality improvement.
- For the ICDS program, Ohio will select national measures, as appropriate and available, and consumer satisfaction surveys in order to monitor and evaluate the improvements in outcomes (e.g., health, satisfaction and functional status) experienced by Medicare-Medicaid individuals. As necessary, Ohio plans to develop several measures that reflect rebalancing, diversion, and long term services and supports. For a complete list of proposed quality measures for the ICDS program, please refer to Appendix G. In addition, Ohio will develop meaningful long-term care measures, including the ratio of individuals receiving services in long-term care facilities versus home- and community-based settings. All measures will be publicly reported.

*Priority: Supporting person- and family-centered care by integrating patient/family feedback on preferences, desired outcomes, and experiences into all care settings and delivery.*

- Meaningful engagement of individuals in the delivery of their health care—from selecting providers to choosing the best treatment option—has the amazing potential to transform

health care systems. Ohio Medicaid sponsors several surveys, like the CAHPS consumer satisfaction survey, quality of life survey, and the Ohio Family Health Survey, that are intended to collect information about individual's experiences with and perceptions of care. Survey results are provided to health plans and providers in order to modify and change care processes.

*Priority: Ensuring effective and efficient administration by sustaining a quality-focused, continuous learning organization.*

- Ohio Medicaid requires that contracting health plans obtain an acceptable level of accreditation from the National Committee for Quality Assurance. NCQA's accreditation is the industry "gold standard" for ensuring that health plan's structure, processes, and outcomes yield improvements in quality health care and consumer experiences. ICDS plans will be expected to achieve accreditation for the Medicare product line.
- Medicaid health plans are required to adhere to the Quality Assessment and Performance Improvement (QAPI) Program federal regulations (42 CFR 438) which are designed to help the plan establish an approach for assessing and improving quality. In its most basic form, the QAPI includes performance improvement projects, performance measure reporting, assessment of utilization of services, and an assessment of the quality and appropriateness of care furnished to individuals with special health care needs. The plan is expected to implement corrective actions or quality improvement initiatives when negative trends in health care are detected. ICDS plans will be expected to adhere to the QAPI regulations contained in 42 CFR 438.

As stated previously, the ICDS plans and their providers must apply national evidence-based clinical practice guidelines relevant to populations with chronic conditions, and relating to the detection and ongoing management of cardiovascular disease, diabetes, depression, obstructive lung disease and substance use. However, many individuals with complex needs may require flexibility in treatment approaches. In developing person-centered care plans, evidence-based practice will be appropriately balanced by an approach to care that considers an individual's needs.

*v. How the proposed care model fits with:*

*(a) Current Medicaid waivers and state plan services*

Ohio's current array of Medicaid State Plan and Waiver Services will be maintained in the ICDS and will be enhanced by the care coordination opportunities provided by this model.

*(b) Existing managed long-term care programs.*

As stated previously, Ohio has mandatory Medicaid managed care for health services for covered families and children (CFC) and aged, blind and disabled (ABD) populations excluding individuals who reside in a facility, receive services from a 1915(c) HCBS waiver, or are dually enrolled in both the Medicare and Medicaid programs. Ohio does not currently use a managed care delivery model for long-term care programs or services.

*(c) Existing Specialty Behavioral Health Plans*

Ohio does not currently contract with specialty behavioral health plans.

*(d) Integrated Program via MA Special Needs Plans (SNPs) or PACE programs*

Individuals will be required to choose one of the ICDS plans in a region. Thus, if the SNP is not one of the ICDS plans, the individual will be disenrolled from the SNP and given the choice of one of the ICDS plans.

Individuals enrolled in the PACE program will be excluded from the ICDS program.

*(e) Other State Payment Delivery Efforts*

The top priority of Ohio Medicaid, improving health outcomes, is monitored and encouraged through a variety of methods, including Ohio's managed care plan accountability and pay-for-performance (P4P) system. In addition to the strategies identified below, Ohio Medicaid continues to pursue promising strategies that increase the value of health care by using payment reform as a means to reward the delivery of high quality person centered health care. For example, Ohio Medicaid was the first state Medicaid program to join Catalyst for Payment Reform (CPR), a private-sector payment reform initiative to coordinate efforts among the participants to improve value in health care purchasing. CPR's guiding principles can be found at <http://www.catalyzepaymentreform.org/Principles.html>.

*(f) Other Strategic Partnerships*

Some organizations have more experience in providing acute care services to this target population, including hospital care, post-acute care, specialty services, physician services, and behavioral health services. Other organizations have more experience in providing LTSS to the target population, including personal care, in-home services, nursing home care, assisted living services, and other home- and community-based services. The ICDS program will involve strategic partnerships among organizations with these two different skill sets, and through contract requirements set clear expectations that these organizations will form a collaborative structure that can efficiently manage the full continuum of Medicare and Medicaid benefits that will be covered under the ICDS contract with the state and CMS.

**D. Stakeholder Engagement and Individual Protections**

*i. Description of stakeholder engagement in planning.*

Beginning in January 2011, Ohio formally sought internal and external stakeholder input into the design of an ICDS program. Over the past year, the State has conducted numerous activities to solicit this input and has given serious consideration to stakeholders' concerns and expectations in making key decisions about the program design. These activities include:

- A Request for Information and summary of responses;
- Testimony of the Ohio Medicaid Director before the Ohio Legislature;
- Establishment of an advisory group made up of internal and external stakeholders;
- Presentation of a concept paper to the State's Unified Long Term Care Systems Advisory Workgroup;

- Development of a Question & Answer document and fact sheet associated with the concept paper;
- Development of a individual questionnaire and summary of responses, and;
- A series of public meetings and statewide conference call.

In addition, the Governor's Office of Health Transformation launched a website with a description of the initiative and links to key information about the stakeholder engagement activities listed above and documents such as the concept paper and associated Q&A and fact sheet. The Office of Health Transformation will be posting a compendium of Stakeholder Engagement activities related to the ICDS Initiative entitled: *"The Ohio Integrated Care Delivery System Demonstration Proposal to Better Serve Medicare-Medicaid Enrollees: Stakeholder Engagement Process and Summary of Findings"* as a companion document to this Demonstration proposal.

Appendix H shows the sequence of activities described above that the State has conducted to obtain stakeholder input. As shown, the ICDS concept was first made public in early 2011 with the release of a vision statement and proposal submitted to the Centers for Medicare & Medicaid Services to compete for a contract to design an integrated program.<sup>6</sup> The first formal step in stakeholder engagement was the release of a Request for Information (RFI) in September of 2011. Ohio released the RFI to solicit input from "those most affected by and interested in the provision of care to" Medicare-Medicaid Enrollees. Stakeholders were given one month to submit responses, and were encouraged to address a standard set of questions designed to elicit proposals and descriptions of best practices. Ohio received responses from 24 stakeholder groups, including: health plans and health care delivery systems; care management and care coordination companies; provider associations; the Ohio Association of Area Agencies on Aging; social service and advocacy organizations; and others.

In September 2011, December 2011, and February 2012, Medicaid Director John McCarthy testified before the Ohio Joint Legislative Committee for Unified Long-Term Care Services and Supports on the integration of care and services for Medicare-Medicaid Enrollees and other state Health Transformation initiatives. In addition, the State contracted with researchers to conduct key informant interviews with several members of Ohio's Unified Long-Term Care Systems Advisory Workgroup to obtain their input on an ICDS program. This Workgroup, first established in 2007, is charged with developing strategies to unify the State Long-Term Care Services System and better address the needs of a growing population of older adults and individuals with disabilities.

In late December 2011, State staff met with advocates for consumers and family caregivers to formulate a strategy to obtain input directly from individuals and other interested stakeholders in their communities. Based on recommendations from that meeting, during January and February 2012 state staff participated in five regional meetings in Athens, Cleveland, Columbus, Dayton, and Toledo. Over 180 individuals attended these meetings. A statewide teleconference was held February 17, with over 70 individuals participating. Three more public hearings were held in March 2012, including a presentation of the demonstration proposal to the Unified Long-Term Care System Advisory Workgroup.

To complement the public meetings, the State developed a questionnaire for Medicare-Medicaid Enrollees and Medicaid Waiver Participants to obtain input on their current health and LTSS service delivery, service use, experience with care coordination and care during transitions from inpatient

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<sup>6</sup>Ohio Office of Health Transformation, **Ohio's Demonstration Model to Integrate Care for Dual Eligibles**, February 21, 2011.

settings, and gaps in services. The questionnaire also solicited comments on how services could be improved. The Ohio Olmstead Task Force and Ohio Association of Area Agencies on Aging helped the state disseminate the questionnaire to interested Ohioans. The questionnaire was posted online on the Governor's Office of Health Transformation website in early February, with options to complete the questionnaire online or download it and mail it in. All responses received by February 20th were reviewed and considered in developing the demonstration proposal. Over 500 questionnaire responses were submitted, with Medicare-Medicaid Enrollees comprising roughly a quarter of the respondents. The Ohio Olmstead Task Force contributed specific recommendations regarding the ICDS design and continues to participate in ongoing design and discussions.

*(a) Themes from Stakeholder Engagement Activities*

Stakeholder feedback fell mainly into five major categories: delivery system structure; care management and other individual points of contact; role of local infrastructure and providers; benefits and groups covered; and the process of developing and implementing the program. A report summarizing the stakeholder input received to-date will be posted to the Office of Health Transformation website. Comments on these general themes are summarized briefly below:

*Type of Delivery System.* Stakeholders expressed a wide range of views on the best type of delivery system to achieve the goals identified in the RFI. The most common delivery systems proposed were: full-risk managed care; and various hybrid, "managed" fee-for-service (FFS) approaches. Among supporters of the former approach, stakeholders differed on whether the model should be based on MA Plans, Special Needs Plans, or Medicaid managed care plans. To achieve scale, most managed care entities supported automatic enrollment of Medicare-Medicaid Enrollees with the ability to opt out for Medicare services. Many proponents of the managed FFS approach favored building on care coordination currently provided by community-based organizations in conjunction with a primary care physician or interdisciplinary team within a medical health home.

*Care Management and Individual Point of Contact.* Stakeholders were overwhelmingly supportive of a single point-of-entry system and enhanced care coordination that would be more tailored to individuals' needs and preferences. Numerous groups provided very specific proposals for meeting these goals based on their current product lines or model programs in other states. At the public forums, Medicare-Medicaid Enrollees and their caregivers described a number of obstacles to receiving high-quality, person-centered care; many of which could be addressed through effective care coordination and linkages, a central point of contact, and greater flexibility in service coverage.

*Role of Local Providers and Infrastructure.* Many of the concerns stakeholders had related to a full-risk managed care approach was the potential for managed care organizations to cut out or reduce the role of the existing community-based infrastructure. A number of the managed care organizations identified strategic alliances with these organizations to be essential to their success in serving the Medicare-Medicaid Enrollees. Stakeholders disagreed regarding the type of organizations best suited to work with patient-centered health homes to coordinate care. In general, supporters of an integrated managed care approach preferred health plans be responsible for care coordination. Supporters of a managed fee-for-service approach preferred that current waiver care management organizations, namely Area Agencies on Aging, have this responsibility.

*Benefits and Groups Covered.* Broad support was expressed for health management and prevention programs to encourage individuals to be involved in their health and functioning. In addition, several

stakeholders expressed support for benefits not currently covered by Medicare or Medicaid that could be provided on a cost effective basis by preventing re-hospitalizations and long-term nursing facility placement. Many individuals expressed frustration that services and equipment that are critically important to them tend to be unreliable and of poor quality. In some cases, these concerns extended to personal care and home health workers. At the same time, many waiver participants are satisfied with their services and are fearful they will be disrupted by a new program.

*Process.* While some stakeholders understand the proposed ICDS timeline within the context of the CMS initiatives, others are concerned that important milestones, such as the release of a Request for Application, might occur without sufficient stakeholder input. Stakeholders agreed on a need for continued interaction between the state, individuals, service providers, health plans, and other groups as program design continues. Several stakeholders proposed a phased-in approach and specified regions they thought should be included in the initial phase of implementation.

*(b) How Stakeholder Input Was Incorporated into the ICDS Program Design*

A theme that came through loud and clear from many stakeholders was the desire to leverage the expertise and experience within the existing aging, disability, and LTSS infrastructure. Accordingly, the program design emphasizes strategic partnerships among integrated care entities and local aging and disability resources and LTSS providers.

Another strong message was the importance of including behavioral health services and providers with this expertise in the program because mental health and substance abuse issues are often co-occurring with physical and cognitive conditions. The current ICDS program design includes the full range of Medicare and Medicaid services, including behavioral health for individuals with needs for these services. Medicare-Medicaid Enrollees with a primary diagnosis of serious mental illness will be included in the ICDS and will have access to the State's Health Home model targeted to this population when operational in the ICDS regions.

*ii. Individual Protections*

Ohio's approach to establishing a quality management infrastructure for the ICDS Program is to ensure that individuals enrolled in the program have access to the medical and support services they need, and that the services they are provided are of the highest quality possible. The program will require strong quality management controls to offset any incentives for ICDS plans to reduce or limit access to medically necessary services or ability to live independently in the community. The individual protections provided in the ICDS program will be no less than the protections provided to members of MA plans, Medicaid-only plans, and individuals enrolled in 1915(c) home- and community-based waiver services or in any other affected setting. Further, Ohio intends to work collaboratively with CMS to develop quality and performance measures that are specifically tailored to the needs and characteristics of Medicare-Medicaid Enrollees. Individual protections that are built into the ICDS program model include the following:

*Competitive Program Model.* Individuals will be guaranteed a choice between competing ICDS plans in their geographic region. It is expected that plans which provide higher quality services to their members will gain reputations for doing so, and will be selected by a higher proportion of Medicare-Medicaid Enrollees in the region. The process for selecting ICDS plans to participate in the program is also competitive. Among the multiple bidders which may submit proposals to participate in the ICDS

Program, Ohio (and CMS) will select those plans which have the best track record for providing high quality services to their members, and which demonstrate the competence and ability to meet the diverse service needs of a population with high medical and support needs.

*Individual Choice.* Medicare-Medicaid individuals will be allowed to choose the ICDS plan which provides the higher quality service and which best meets their individualized needs. For Medicare, individuals will be allowed to receive their Medicare-covered benefits through their ICDS plan, or to opt out of the program and continue to receive services through the traditional fee-for-service system or a MA plan. Further, if individuals are not satisfied with the quality of the services they are receiving in their current plan, they will be allowed to switch plans annually.

*Provider Choice.* Except as specified in Appendix D Medicare-Medicaid Enrollees will be required to receive services within the designated networks of each ICDS plan, individuals will be allowed to have freedom of choice of providers within the networks, including choice of LTSS providers such as personal care aides. Individual choice extends to the selection of each member's designated care manager. If a member is dissatisfied with his or her assigned care manager, he or she will be allowed to request an alternate care manager.

*Cost Sharing Protections.* ICDS plans must require that participating providers accept the payment from the ICDS as payment in full unless patient liability applies.

*Participant-Directed Services.* During the stakeholder engagement process, consumers identified "Participant-Directed" services as a valued LTSS benefit. ICDS plans will be required to provide Participant-Directed services as a service option within their LTSS benefit package. This service allows ICDS members to select their own LTSS providers within an established individualized budget, including the option to pay family members as personal care attendants. Ohio Medicaid is considering the option of contracting with a single fiscal agent to manage this benefit for all participating ICDS plans, to reduce the administrative costs related to this service option.

*Timely Approval of Prior Authorizations.* Many of the individuals served by the ICDS plan will be receiving home- and community-based services. The ICDS plan will be required to have an expedited process to review changes in plans of care that must take into account the goal of having people live in the community as independently as possible. Thus, if an individual's needs change, a plan of care must be changed to meet those needs in an expeditious manner. Independent living may not be impeded by the ICDS plan's prior authorization timeframes. For example, an individual who uses a wheelchair for mobility in the community cannot wait three or more days on a prior authorization approval for a wheelchair repair.

*Consumer Participation in ICDS Governance.* All ICDS plans will be required to have local governance bodies in each geographic region. These local bodies will have input into policies and protocols utilized by the local ICDS plans (as also governed by contractual requirements and the plans' corporate policies). At least 20% of the members of the local governance bodies will be ICDS plan members.

*Meetings with ICDS Plan Members.* Every ICDS plan will be required to convene meetings with their members at least semi-annually to fully document all grievances raised by individuals at the meetings, to keep comprehensive minutes of all member meetings that are made available to all individuals, and to provide written responses to all articulated grievances prior to the convening of the next member meeting. The ICDS will notify all members at least 15 days prior to each meeting regarding the date and

location of the meeting, and offer to assist with transportation to the meeting if the member cannot travel independently.

*Grievances and Appeals.* Each ICDS will administer Grievance and first-level Appeals process, by which individuals can appeal any decision made by the ICDS to reduce or deny access to covered benefits. An appeal filed within 15 days of a decision by the ICDS will require the continuation of benefits during the appeals process. Subsequent appeals will be filed according to procedures of the program having jurisdiction over the benefit.

*Contact Information for Oversight Agencies.* The ICDS health plan will provide each individual with contact information for regulatory agencies. In the case of individuals receiving long-term care services and supports, the ICDS will provide contact information for the Office of the State Long-Term Care Ombudsman.

### *iii. Ongoing Stakeholder Engagement*

Ohio will continue to engage with and incorporate feedback from stakeholders during the implementation and operational phases of the Demonstration. This will be accomplished through an ongoing process of public meetings, monitoring individual and provider experiences through a variety of means, including surveys, focus groups, website updates, and data analysis. In addition, Ohio will require that ICDS plans develop meaningful consumer input processes as part of their ongoing operations, as well as systems for measuring and monitoring the quality of service and care delivered to eligible individuals. Ohio will also develop consumer notices and related materials about the ICDS program that are easily understood by persons with limited English proficiency, and will translate materials into prevalent languages as determined by the State.

## **E. Financing and Payment**

### *i. State-Level Payment Reforms*

Ongoing initiatives include:

*Nursing and Aide Services rate reform.* As a result of the passage of Ohio House Bill 153, Ohio's biennial budget bill for state fiscal year 2012/2013, Medicaid is engaged in a process of examining and revising the current rate structure for both state plan and waiver nursing and aide services. Stakeholder engagement is on-going as well as work with the state of Ohio's actuary. Changes to the rate setting methodology may take place as early as July 2012.

*New pay for performance initiative for managed care.* A recently revamped quality program for the managed care program has put Ohio Medicaid in the forefront of programs emphasizing quality as a key component of plan reimbursement. Plans can earn bonus funds for meeting quality targets that have been carefully designed to emphasize patient-centered, evidence-based care. This new reimbursement structure emphasizes the State's intention that "reimbursement rewards value."

*Reformed nursing facility reimbursement.* Ohio Medicaid has recently transitioned from a cost-based Medicaid payment system for nursing homes to a price based system, a change that was initiated by the legislature in 2005 (HB 66) to reward efficiency. More of the Medicaid payment is now linked to direct care for residents and quality. The new system increases Medicaid quality incentive payments for

nursing homes from 1.7 percent of the average Medicaid nursing home rate in 2011 to 9.7 percent in 2013, and increases the actual amount spent on average for resident services from \$93.04 to \$102.96 per person per day. The Ohio General Assembly established a Unified Long-Term Care Systems Advisory Workgroup to assist in the implementation of these reforms.

The State's reimbursement goals of emphasizing quality, transparency, patient-centeredness, and value will be carried through the ICDS program reimbursement structure as well. The capitation-based reimbursement model will be designed to produce ICDS plan incentives to provide high quality, coordinated care that will reduce overall system costs. The blended capitation payment structure is expected to provide plans the flexibility to utilize the most appropriate cost effective service for the enrollee, eliminating incentives to shift costs between Medicare and Medicaid. Furthermore, ICDS plans must develop innovative performance-based reimbursement with their network providers.

#### *ii. Payments to ICDS Health Plans*

Ohio Medicaid and Medicare will make prospective capitation payments to ICDS plans, which are responsible for providing all Medicare and Medicaid services and coordinating care. Capitation payments will include costs associated with the medical, behavioral health, and LTSS provided to individuals, as well as the non-medical expenses required to provide and coordinate those services. Any savings will be shared proportionately between the two programs. The capitation structure will include carefully-designed rate cells and may include other components such as risk adjustment, risk sharing, and pay-for-performance.

*Rate cell structure.* Appropriate payment structures start with a foundation of well-designed rate cells. Rate cells stratify the target population into homogenous risk groups, so that payments to ICDS Plans can be aligned with the mix of risk they enroll. Ohio and its actuaries are in the process of evaluating potential rate cell structures for use in the ICDS program. Selected rate cells will be based on objective, measureable characteristics of the target population that correlate with expected risk. Careful consideration will be given to ensure that the selected structure appropriately compensates ICDS Plans while encouraging the provision of sufficient, coordinated, cost effective services needed by their enrollees.

*Risk adjustment.* Risk adjustment techniques acknowledge the potential for different ICDS plans to attract different mixes of risk among their enrollees, which may happen even within carefully constructed rate cells. When this happens, an appropriate average rate for a given rate cell can overpay some health plans while underpaying others. Significant misalignment in this manner is not conducive to a stable, cost-effective program. While effective risk adjustment models for managed long-term care populations are in their infancy, Ohio and its actuaries will work with stakeholders, potential vendors, and CMS to evaluate the need for additional risk adjustment techniques in the ICDS program.

*Pay-for-performance.* Ohio's philosophy that reimbursement should reward value will be incorporated into a financial incentive program within the ICDS reimbursement structure. ICDS plans that produce overall system savings while providing high quality care should have the opportunity to share in those savings. As noted above, Ohio has recently updated the pay for performance incentive structure within its existing acute care managed care program. Under the CMS proposed financial model, participating plans will be subject to an increasing quality withhold (1, 2, 3 percent in years 1, 2, and 3 of the demonstration). Quality thresholds will be established for each year. Plans will be able to earn back the withheld capitation revenue if they meet quality thresholds. Ohio will work with CMS to construct a

withhold-based quality incentive program that incorporates quality indicators that have been tailored specifically for the dual eligible population and are based on Ohio Medicaid's Quality Strategy. Furthermore, because providers are the key to improved health outcomes, there will be a requirement that at least 50% of the quality withhold is passed on to those providers whose performance led to improvements in quality measures. ICDS contracts with providers will establish this arrangement.

Ohio is also expecting new innovative models of pay-for-performance among the ICDS plans and providers in their networks. Simply paying on a Medicare or Medicaid fee-for-service basis will not provide the right incentives. Plans that propose innovative reimbursement methodologies will be awarded higher scores in the procurement process.

### *iii. Payments to Providers*

In order to maintain an adequate provider network and provide for continuity of care during the transition (as outlined in Appendix D), ICDS plans will be required to make arrangements to allow individuals to continue to receive services from their current or existing providers. This may be accomplished through a variety of mechanisms such as single case agreements, contracts, out-of-network authorization, etc.. Additionally, during the transition period, ICDS plans may not reduce reimbursement rates for services (unless agreed to by both the provider and the ICDS plan) for the following providers that are actively providing services to individuals enrolled in the ICDS program when the program goes live in the region: Medicaid 1915(c) waiver providers, state plan home health and private duty nursing providers, nursing facilities, primary care physicians, PASSPORT PAAs, and Department of Mental Health and Department of Alcohol and Drug Abuse Services certified behavioral health service providers. Additionally, the Medicaid program will have the authority to review all provider contracts and rates before they can be implemented.

Each ICDS will have a process to accept claims electronically and will provide electronic funds transfer for claims payment when requested. Prompt payment requirements will be developed and penalties will be assessed for any ICDS plan that does not comply with these standards. Providers must submit claims within 365 days of the date of service and ICDS plans will issue any overpayment findings within 365 days of the date of payment. However, shorter claims submission timeframes may be required for provider incentive programs. Claims submitted 90 days after the date of service do not have to be considered for provider incentive payments. ICDS Plans must locate provider relations and claims support staff in each region to educate and assist providers in claims submission processes and resolve issues with claims payment.

ICDS plans will be required to complete prior authorization requests in accordance with timeframes established by the state. If the ICDS plan does not meet the standards, the plan will first be assessed a monetary penalty. If the plan continues to not meet the standards, auto-enrollment into the plan will be halted. Additionally, plans will not be allowed to retroactively deny payments for services that were prior authorized, unless the individual's enrollment with the ICDS plan was retro-actively terminated by Ohio Medicaid or Medicare

## **F. Expected Outcomes**

Ohio expects the ICDS program to result in an entirely different consumer experience for ICDS program members, as well as significantly different service utilization patterns. The outcomes observed in previous demonstrations to fully integrate Medicare and Medicaid benefits have shown that integrated

plans have used the flexibility of pooled capitation to make increased investments in primary and preventive care services. Thus, in the ICDS program, we would expect to see increased use of primary care practitioners, increased use of home visits, increased monitoring of medication adherence, increased focus on post-hospital follow-up care, increased family/caregiver support, and increased use of behavioral health services. Ohio also expects to see decreased nursing home admissions, reduced lengths of stay for nursing home episodes, reduced hospital readmissions rates, reduced emergency room visits, a reduction in duplicative unnecessary tests, and more appropriate use of specialty services. Realistically, Ohio does not expect to observe these kinds of outcomes immediately because it will take time for ICDS health plans to put the care management models into place to achieve these results.

Ohio also expects to see significant improvement in individuals' experience with the health care system in the ICDS program. This would include improvements in the quality of nursing facilities and HCBS providers, increased cultural sensitivity to members' social and ethnic backgrounds, increased consumer participation in his or her own plan of care, improved communication with providers about treatment and medications, and a greater sense of control over how and where long-term care services are provided. These consumer-based outcomes will be objectively measured as part of the state's overall Quality Strategy.

As part of the revamped Quality Management strategy, Ohio developed a new set of performance measures and standards to hold Medicaid managed care plans more accountable, including the adoption of national performance measures specifically tailored to the Aged, Blind, and Disabled (ABD) Medicaid adult population. Ohio will build on its existing Medicaid Quality Management framework to design and implement a comprehensive quality management strategy for the ICDS program, but adapt the ICDS version to reflect the needs of Medicare-Medicaid Enrollees, particularly those receiving LTSS.

Ohio also recognizes that the Quality Management strategy adopted for the ICDS program must include quality oversight of Medicare-covered benefits as well as Medicaid-covered benefits. The ICDS plans participating in the Demonstration will be required to meet both Medicaid *and* Medicare standards and requirements. However, it is also recognized that one of the objectives of the Medicare-Medicaid Demonstration as a whole is to unify and simplify the requirements that fully integrated health systems must meet in serving Medicare-Medicaid Enrollees. For example, in its recent guidance to organizations considering participation as fully capitated plans in the Demonstration, CMS states that "CMS and States shall determine applicable standards, and jointly conduct a single comprehensive quality management process and consolidated reporting process."<sup>7</sup> Ohio is committed and looks forward to working with CMS in developing a comprehensive quality management process for the ICDS program that programmatically combines as well as streamlines Medicare and Medicaid reporting requirements.

#### *vi. Reporting Requirements*

Monthly enrollment figures and other operational reporting (e.g., utilization data, incident reporting, nursing facility census) will be posted on Ohio's Medicaid website. For all data collected from ICDS plans, Ohio will present the information by plan and region.

The State will require each plan to submit comprehensive encounter data on all service utilization for enrolled individuals in a manner that enables the State to assess performance by plan, by region, and

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<sup>7</sup>Centers for Medicare and Medicaid Services, **Guidance for Organizations Interested in Offering Capitated Financial Alignment Demonstration Plans**, January 25, 2012.

Statewide, and in a manner that permits aggregation of data to assess trends and to facilitate targeted and broad based quality improvement activities. The State will ensure that sufficient mechanisms and infrastructure is in place for the collection, reporting, and analysis of encounter data provided by the plans. The State will have a process in place to assure encounter data from each plan is timely, complete, and accurate, and take appropriate action to identify and correct deficiencies identified in the collection of encounter data. The State will develop specific data requirements and require contractual provisions to impose financial penalties if accurate data are not submitted in a timely fashion.

## **G. Infrastructure and Implementation**

### *i. State capacity to implement and oversee the proposed demonstration*

Overall responsibility for development of the ICDS program model and implementation plan rests with the Ohio Medicaid Director, who will Chair of the ICDS Management Team and serve as the main point of contact for the Medicare-Medicaid Coordination Office at CMS regarding CMS-Ohio collaboration in the ICDS program. The Governor's Office of Health Transformation (see Appendix I) will provide high-level policy input into the ICDS Program and serve as the primary communication channel to Governor Kasich, who named the ICDS program his Administration's number one health policy priority in 2012. Ohio Medicaid will establish an ICDS Management Team that includes staff from the program areas needed to design and implement the ICDS program:

- John McCarthy, Ohio Medicaid Director, is responsible for overall ICDS program development and implementation, and will serve as the chair of the ICDS Management Team and point of contact for the CMS Medicare-Medicaid Coordination Office;
- Patrick Beatty, Assistant Deputy Director for Medicaid Policy, has overarching responsibility for all of Ohio's Medicaid Managed Care Programs;
- Dr. Mary Applegate, Medical Director, is the lead on clinical policy and quality management;
- Harry Saxe, ICDS Project Manager, is the lead staff person on the initiative and devoted full time to the ICDS program;
- Mitali Ghatak, Chief of Fiscal Planning and Management, has lead development for actuarial analysis and rate development, supervising the work of Ohio's actuarial contractor, currently Mercer Government Services;
- Jon Barley, Chief of Health Services Research, oversees Quality Management in Ohio's Medicaid programs; and
- Dale Lehman, Chief of Managed Care Contract Administration, has lead responsibility for monitoring of Medicaid contracts.
- Kim Donica, Matt Hobbs, and Susan Fredman provide technical support to the Management Team in regard to Long-Term Services and Supports issues in the ICDS program, and Rafiat Eshett, Christi Pepe and David Dorsky provide additional technical support to the Management Team.

The members of the ICDS Management Team will chair additional workgroups devoted to specific components of the program, such as the ICDS plan selection process, individual enrollment and protections, IT systems modifications, rate development, quality management, and CMS collaborations (e.g. development of the Memorandum of Understanding).

In order to ensure oversight of the implementation and ongoing operations of the ICDS program, a Quality Oversight Committee (QOC) will be created that will meet monthly or more frequently if needed as decided by the Medicaid Director. The QOC membership will consist of:

1. Ohio Medicaid – The Medicaid Director, the Medical Director, and six staff members
2. Department of Aging – The Director (or designee) and three staff members
3. Department of Mental Health - The Director (or designee) and three staff members
4. Department of Alcohol and Drug Addiction Services - The Director (or designee) and three staff members
5. One enrollee from each plan in each region for a total of fifteen people
6. ICDS Plan – The Chief Executive Officer, the Chief Operation Officer, and the ICDS Program Director

Ohio has also secured outside consulting support for development of the ICDS program. The State has two separate engagements with Mercer Government Services, one to provide actuarial support in the rate development process, and one to provide general consulting support. Ohio has also engaged Thomson Reuters to provide consulting support in the development and implementation of the model.

Ohio Medicaid has received Medicare data for Parts A, B and D for the Medicare-Medicaid enrollee population. Ohio Medicaid will house the data internally and use both internal and external resources to perform analysis to support ICDS operations and the delivery of services to ICDS individuals.

#### *ii. Implementation strategy and anticipated timeline*

Appendix J presents a detailed implementation timeline for the ICDS program, including the completion and posting of this Draft Demonstration Proposal. Many of the details of the implementation timeline have been discussed in previous sections of this proposal. While the timeline is ambitious, Ohio is on track to begin enrollment of Medicare-Medicaid Enrollees beginning January 2013.

#### *(a) Initial Enrollment of Medicare-Medicaid Enrollees into the ICDS Program*

The initial enrollment of individuals into the ICDS Program is a significant undertaking, and must be conducted in a manner that results in minimal disruption of existing services and supports to ICDS members. Ohio Medicaid will establish an ICDS Enrollment Workgroup to develop a detailed implementation plan for the initial launch of the ICDS program. The Enrollment Workgroup will be tasked with the following responsibilities:

- Establish explicit criteria for determining who will be enrolled in the ICDS program and who will not (e.g. exclusion criteria for persons served by the Ohio Department of Developmental Disabilities);
- Work with Ohio's enrollment broker to assure accurate information and enrollment processes for prospective Medicare-Medicaid Enrollees in each targeted region;
- Develop a comprehensive communications plan for communicating with Medicare-Medicaid Enrollees regarding the implementation of the ICDS program, and informing Medicare-Medicaid Enrollees of their enrollment options;
- Coordinate with the selected ICDS health plans in each of the geographic regions to implement as seamless an enrollment process as possible;

- Coordinate with the selected ICDS health plans regarding marketing materials that will be made available to prospective ICDS enrollees to facilitate their choice of an ICDS plan in their region;
- Develop the specific language for the initial enrollment letter that will go out to all eligible enrollees;
- Develop specific policies for allowing consumers to opt out of the Medicare side of the ICDS program, and;
- Work with ICDS health plans on the development of initial enrollment packets for ICDS consumers regarding their rights and benefits under the ICDS program.

The Enrollment Workgroup will be established in mid-May 2012 and report directly to the Medicaid Director, who has day-to-day operational responsibility for the implementation of the ICDS program. The Enrollment Workgroup will include consumer representatives to ensure that the consumer perspective is reflected in ICDS enrollment policies. The Enrollment Workgroup will continue its work throughout all of 2012 until the ICDS program is launched in January 2013.

As previously discussed, there are many details to the initial enrollment process that are yet to be worked out, but a basic structure of the initial enrollment process is outlined below:

- Medicare-Medicaid Enrollees will be sent an initial “information” letter in the summer of 2012 letting them know about the launch of the ICDS program in their region, and informing them of their need to choose an ICDS health plan during the upcoming enrollment period in the fall of 2012. All informational and marketing procedures and materials will be jointly developed by Medicare and Medicaid during the summer of 2012.
- Letters will be mailed to all Medicare-Medicaid Enrollees no less than 60 days prior to the effective date of enrollment into the ICDS program, asking them to choose one of the ICDS health plans in their region, and communicating information about their right to opt out of the Medicare side of ICDS.
- Medicare-Medicaid Enrollees who have not made a choice of ICDS health plans 30 days prior to the effective date of enrollment will be mailed a reminder letter giving them 14 days to make a choice of plans.
- ICDS enrollees who have not made a plan selection will be automatically assigned to one of the ICDS health plans in their region.
- Medicare-Medicaid Enrollees will be transitioned into their chosen ICDS plan in the first two (2) quarters of 2013 in accordance with the following regional phase-in schedule:
  - February 1, 2013 – Northwest, Northeast Central and East Central;
  - April 1, 2013 – Northeast;
  - May 1, 2013 – Central, West Central and Southwest
- Medicare-Medicaid Enrollees will be mailed information packets from the ICDS plan of their choice in the month prior to their enrollment in the plan.

### *(b) Selecting ICDS Health Plans*

Ohio Medicaid intends to select ICDS health plans through a competitive procurement process. Contracts will be awarded to those organizations that can best meet the criteria established by Ohio Medicaid for a truly integrated care delivery system for individuals. It is anticipated that Ohio Medicaid will issue a Request for Application (RFA) in April 2012. Potential bidders will be allowed to submit questions through an on-line process shortly after release of the RFA. Ohio Medicaid will also respond in writing to all technical and business questions submitted by potential bidders. Bidders will be given approximately five weeks to prepare a response to the RFA.

It is anticipated that the bid review process will be conducted in two phases. Proposals that adequately meet all of the criteria specified in the RFA will advance to phase two of the process. Ohio Medicaid may then direct additional technical and business questions to remaining applicants in each target region in order to support final selections. Applicants may also be requested to make oral presentations to the ICDS selection committee, which will include representation from CMS. If no quality bids are submitted in a target region, Ohio Medicaid reserves the right to rebid or combine regions to facilitate implementation.

## **H. Feasibility and Sustainability**

### *i. Potential Barriers and Challenges*

Ohio does not underestimate the amount of work that needs to be accomplished between now and January 2013, in order to bring the ICDS program up and running. Governor Kasich has designated the launch of the ICDS program as his number one health priority in 2012, and all available resources will be dedicated to the effort. The implementation effort will be managed by the ICDS Management Team under the day-to-day direction of the state Medicaid Director. The health care leadership in the state, including the Governor's office to the Office of Health Transformation and Ohio Medicaid, is fully focused on implementation of the ICDS program.

Neither does Ohio underestimate the political challenges it faces during the ICDS implementation process. The shift in the state's purchasing strategy from a fee-for-service model to a fully capitated model for Medicare-Medicaid Enrollees will result in an entirely new flow of Medicare and Medicaid dollars to the provider community. The shift is not trivial—the magnitude of the shift is measured in the billions of dollars. These kinds of shifts naturally create significant anxieties among the organizations that provide services to Medicare-Medicaid enrollees.

From the consumer perspective, similar anxieties arise. There are underlying concerns that the shift from a fee-for-service model to a capitated approach will result in service disruptions for some or many consumers. The state is committed to engaging in an ongoing dialogue with consumers to understand their concerns regarding the ICDS program, and to discuss both the potential advantages and disadvantages of integrated health care systems for Medicare-Medicaid enrollees. Further, as described earlier in this proposal, the state is committed to implementing the ICDS program in a manner that ensures existing service arrangements for Medicare-Medicaid Enrollees are not disrupted.

## *ii. Remaining Statutory or Regulatory Challenges*

There are no Ohio statutory or regulatory barriers to the full implementation of the ICDS program. Ohio Medicaid has full authority to move forward on the implementation of the ICDS program. The state recognizes the need for CMS approval for the Medicare-Medicaid Demonstration Proposal, including the authority to mandate the enrollment of Medicare-Medicaid Enrollees into managed care. The state is fully committed to working with the Medicare-Medicaid Coordination Office to utilize the most appropriate authorities needed for ICDS program implementation.

## *iii. Funding Commitments or Contracting Processes Needed*

Over the next 10 months, Ohio will be undertaking a number of contracting processes to support the launch of the ICDS program. These contracting processes include:

- A competitive procurement to select at least two ICDS health plans in each of the seven targeted geographic regions for the ICDS program. The scheduled release of the Request for Applications is April 16, with a proposal due date from bidders on May 25, 2012. The proposal review process will be conducted jointly with CMS and will result in the negotiation of three-way contracts, ready for final signature on September 20, 2012.
- Ohio Medicaid has existing contracts in place for consulting and actuarial support from Mercer Government Services and Thomson Reuters. Mercer will be providing actuarial support in the rate development process as well as general consulting support for the ICDS implementation process. Thomson Reuters is also providing consulting support on program design issues and implementation processes.
- Ohio Medicaid will be working with the state's Managed Care Enrollment Broker, Automated Health Systems, Inc., to design and implement the initial enrollment of Medicare-Medicaid Enrollees into the ICDS health plans.
- Ohio Medicaid and the Department on Aging are considering new contracts with the Aging and Disability Resource Networks to serve as initial one-stop enrollment agencies for the ICDS program.

## *iv. Scalability and Replicability*

The ICDS Program Demonstration already includes approximately 60% of the eligible Medicare-Medicaid Enrolled population in the state. Expansion to the more rural areas of the state in non-Demonstration counties beyond the three-year Demonstration period will depend upon the success of the Demonstration in meeting its objectives, and the feasibility of replicating the ICDS care management model in less populated regions. The Ohio ICDS program model should be highly replicable in other states. As a Demonstration state, Ohio is willing and interested in sharing the experience gained in the implementation and management of the Ohio ICDS program with other states also wishing to provide better care for Medicare-Medicaid Enrollees.

## *v. Letters of Support*

Please see appendix K for letters of support.

## **I. Additional Documentation**

Ohio Medicaid will work with CMS to develop an administrative budget request for implementation and ongoing operational costs of the project during the development of the Memorandum of Understanding.

## **J. Interaction with Other HHS/CMS Initiatives**

ICDS plans will be required to participate and include providers in their networks to coordinate HHS and CMS initiatives aimed at improving health and health care, including but not limited to the Partnership for Patients, Million Hearts Campaign, HHS Action Plan to Reduce Racial and Ethnic Health Disparities, and Community Based Care Transition Program Grants. In addition, and concurrent with the ICDS initiative, Ohio is implementing several other initiatives to streamline the administration and delivery of LTSS in the state and to improve consumer outcomes, including a consolidated HCBS waiver initiative, front door reform, and a Money Follows the Person (MFP) Demonstration grant. This section discusses how these initiatives will be coordinated with the ICDS program.

### *(a) Reducing Racial and Ethnic Health Disparities*

Reducing racial and ethnic health disparities is one of Ohio's goals to improve health outcomes. In order to achieve improvement in this area, Ohio Medicaid joined the Ohio Department of Health in applying for a grant for technical assistance from the National Academy of State Health Policy (NASHP). NASHP chose Ohio for the project, and Ohio signed the agreement for the project in October 2011. Attached in Appendix L is the application Ohio submitted along with the work plan that was developed after the award. The objectives of this project include:

- Implementing Health Homes and Patient Centered Medical Homes in such a way that also addresses social determinants through integrated care services.
- Designing Health Homes to directly address key findings of the *2010 Healthcare Disparities Report* (Agency for Healthcare Research and Quality).
- Develop and implement learning opportunities for healthcare providers which include cultural and linguistic competency. This will empower health care providers to better serve diverse communities. Additionally, this will also help healthcare providers understand their role in eliminating healthcare disparities.
- Use data to identify the best locations to establish new Health Homes and/or Patient Centered Medical Homes, especially in areas that are considered "medical hotspots".
- Address healthcare workforce diversity to improve provide patient/provider relationships.

The ICDS will implement performance improvement plans to target areas of biggest variations and poor outcomes in disparate populations.

*(b) Consolidated HCBS Waiver Initiative*

In January 2011, the Governor's Office of Health Transformation initiated a consolidation of existing HCBS waiver programs that will be coordinated with the ICDS initiative.<sup>8</sup> Under the Consolidated HCBS Waiver, Ohio's five NF-based HCBS waivers will be consolidated into one waiver. These five HCBS waivers include: (1) the PASSPORT waiver, (2) the Assisted Living Waiver, (3) Choices waiver, (4) the Ohio Home Care Waiver, and (5) the Transitions II Aging Carve-Out Waiver. The new Consolidated Waiver will serve all persons with physical disabilities age 18 through 64 and all persons age 65 and over who are eligible for HCBS services. Children under the age of 18, and persons who receive services from waivers administered by the Ohio Department of Developmental Disabilities will not be served in the Consolidated Waiver.

The majority of individuals who received LTSS services through Ohio's NF-based HCBS waiver programs are Medicare-Medicaid Enrollees. As the ICDS program is rolled out throughout the entire state of Ohio, it is expected that the ICDS program will be the primary program model for providing all Long-Term Services and Supports in Ohio, both institutional services and HCBS services. Persons who otherwise qualify for LTSS but who are not Medicare-Medicaid Enrollees will receive their LTSS services under the Consolidated HCBS Waiver Program.

*(c) Balancing Incentive Payment Program*

Ohio is also contemplating how other LTSS structural reforms can be built into the LTSS delivery system. In support of these efforts, Ohio is considering applying for the federal Balancing Incentive Payment Program, which requires a single entry point system, a uniform assessment tool, and conflict free case management. Ohio Medicaid, in conjunction with other stakeholders, is working toward a system of long-term care that maximizes choice and promotes community integration. For the past two years, Ohio Medicaid has been revising and reforming the state's current Medicaid level of care (LOC) determination process. Current work has centered on making short-term LOC process changes and clarifying policy and procedures. The next phase of LOC work is long-term reform of the current, fragmented, paper-based LOC determination process. Another component of this work is the development of a new assessment tool that will be used to determine eligibility for an array of Medicaid programs that serve individuals with a nursing facility LOC.

*(d) Money Follows the Person Demonstration Grant*

Ohio has a robust relocation program operated through its MFP demonstration grant. ICDS plans are expected to coordinate transition activities for individuals who are institutionalized with MFP efforts. Housing is an integral component of serving individuals in Ohio holistically. Because Medicaid cannot pay for housing directly, the agency (through its MFP demonstration program, HOME Choice) develops strategic partnerships with many of the agencies responsible for the development of housing and the issuance of rent subsidies. These partnering agencies include the Ohio Housing Finance Agency, Ohio Department of Development, and many of the nearly 80 Public Housing Authorities throughout the state. As a result, Ohio Medicaid has secured over 200 vouchers specifically for individuals with disabilities and advocated for new waiting lists with Public Housing Authorities that prioritize individuals with disabilities. The agency is also creating set-aside units at the development stage for HOME Choice

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<sup>8</sup> ODJFS. **Concept Paper for the Centers for Medicare and Medicaid Services (CMS) Regarding Ohio's Unified Long-Term Services and Supports Medicaid Waiver**, January 20, 2012.

participants, including those who may be eligible for both Medicare and Medicaid. In the next year, Ohio Medicaid and HOME Choice will explore the development of a system of referral and coordination that will allow for a permanent set-aside of 5-10 percent of all new affordable housing units for individuals with low-incomes and disabilities, including Medicare-Medicaid Enrollees. These housing units will be made available to ICDS health plans as alternative residential placements for persons who need housing assistance, but not the level of care required in a nursing home setting.

# **APPENDIX A**

## Appendix A

### Total Medicare Advantage Plan Enrollment in Ohio, 2006 through 2011

Year	Total MA Enrollment	Percent Change
2006	273,775	
2007	315,607	15%
2008	453,920	44%
2009	487,578	7%
2010	620,138	27%
2011	640,245	3%

Source: StateHealthFacts.org

## **APPENDIX B**



## **APPENDIX C**

**Appendix C**  
**Proposed ICDS Target Populations by Region**

	NW Region		WC Region		SW Region		Central Region		NE Region		EC Region		NEC Region	Total		
	In Demo	Not In Demo	In Demo	Not In Demo	In Demo	Not In Demo	In Demo	Not In Demo	In Demo	Not In Demo	In Demo	Not In Demo	In Demo	In Demo	Not In Demo	Total
<b>Total Full Benefit Medicare-Medicaid Enrollees</b>	11,117	8,742	13,418	3,692	21,506	2,867	18,158	30,374	34,642	4,146	18,224	5,468	9,975	127,040	55,288	182,328
<b>Enrollees 65+</b>	5,342	4,569	7,171	2,050	10,625	1,624	8,952	16,284	19,444	2,064	9,974	3,046	5,347	66,855	29,638	96,493
<b>Enrollees 18-64</b>	5,765	4,169	6,244	1,640	10,866	1,242	9,173	14,069	15,148	2,081	8,237	2,421	4,624	60,057	25,622	85,679
<b>Enrollees with SMI over 18</b>	1,162	740	1,292	258	2,287	198	1,624	2,311	3,601	495	1,670	402	691	12,326	4,405	16,731
<b>Excluded Enrollees</b>																
<b>Enrollees with ID (DD waiver, ICF-MR )</b>	1,223	920	1,034	441	2,035	133	2,096	1,919	2,881	255	1,986	488	686	11,941	4,156	16,097
<b>Enrollees &lt; 18</b>	10	4	3	2	15	0	33	20	50	1	12	1	4	127	28	155
<b>Total MMEs Eligible for ICDS Program</b>	9,884	7,818	12,381	3,249	19,456	2,734	16,029	28,435	31,711	3,890	16,226	4,979	9,285	114,972	51,104	166,076

Source: ODJFS/DDS Average Enrollment March 30, 2012

Individuals enrolled in PACE, receiving delayed spend down, or with retroactive or backdated enrollment are excluded.

## **APPENDIX D**

## Appendix D

### Transition Requirements

<b>Transition Requirements</b>	<b>Waiver Consumers</b>	<b>Non-Waiver Consumers with LTC Needs (HH and PDN use)</b>	<b>NF Consumers AL Consumers</b>	<b>No LTC Need Consumers</b>
<b>Physician</b>	90 day transition for individuals identified for high risk care management; 365 days for all others	90 day transition for individuals identified for high risk care management; 365 days for all others	90 day transition for individuals identified for high risk care management; 365 days for all others	90 day transition for individuals identified for high risk care management; 365 days for all others
<b>Pharmacy</b>	90 day transition	90 day transition	90 day transition	90 day transition
<b>Medicaid DME</b>	Must honor PA's when item has not been delivered and must review ongoing PA's for medical necessity	Must honor PA's when item has not been delivered and must review ongoing PA's for medical necessity	Must honor PA's when item has not been delivered and must review ongoing PA's for medical necessity	Must honor PA's when item has not been delivered and must review ongoing PA's for medical necessity
<b>Scheduled Surgeries</b>	Must honor specified provider			
<b>Chemo/Radiation</b>	Treatment initiated prior to enrollment must be authorized through the course of treatment with the specified provider	Treatment initiated prior to enrollment must be authorized through the course of treatment with the specified provider	Treatment initiated prior to enrollment must be authorized through the course of treatment with the specified provider	Treatment initiated prior to enrollment must be authorized through the course of treatment with the specified provider
<b>Organ, Bone Marrow, Hematopoietic Stem Cell Transplant</b>	Must honor specified provider			
<b>Medicaid Vision and Dental</b>	Must honor PA's when item has not been delivered	Must honor PA's when item has not been delivered	Must honor PA's when item has not been delivered	Must honor PA's when item has not been delivered

Transition Requirements	Waiver Consumers	Non-Waiver Consumers with LTC Needs (HH and PDN use)	NF Consumers AL Consumers	No LTC Need Consumers
<b>Home Health and PDN</b>	<p>Maintain service at current level and with current providers at current Medicaid reimbursement rates. Changes may not occur unless:</p> <p>A significant change occurs as defined in OAC 5101:3-45-01 ; or Individuals expresses a desire to self-direct services; or after 365 days.</p>	Sustain existing service for 90 days and then review for medical necessity after an in-person assessment that includes provider observation	For AL: Sustain existing service for 90 days and then review for medical necessity after an in-person assessment that includes provider observation	N/A
<b>Waiver Services-Direct Care</b> <ul style="list-style-type: none"> <li>• Personal Care Assistance</li> <li>• Waiver Nursing</li> <li>• Home Care Attendant</li> <li>• Respite</li> <li>• Enhanced Community Living</li> <li>• Adult Day Services</li> <li>• Social Work/Counseling</li> <li>• Independent Living Skills Training</li> </ul>	<p>Maintain service at current level and with current providers at current Medicaid reimbursement rates. Changes may not occur unless:</p> <p>A significant change occurs as defined in OAC 5101:3-45-01 ; or Individuals expresses a desire to self-direct services; or after 365 days.</p>	N/A	N/A	N/A

<b>Transition Requirements</b>	<b>Waiver Consumers</b>	<b>Non-Waiver Consumers with LTC Needs (HH and PDN use)</b>	<b>NF Consumers AL Consumers</b>	<b>No LTC Need Consumers</b>
<b>Waiver Services-All other</b>	Maintain service at current level for 365 days and existing service provider for 90 days. Plan initiated change in service provider can only occur after an in-home assessment and plan for the transition to a new provider.	N/A	N/A	N/A

During the transition period referenced above, change from the existing provider can only occur in the following circumstances:

- 1) Consumer requests a change,
- 2) Provider gives appropriate notice of intent to discontinue services to a consumer or
- 3) Provider performance issues are identified that affect an individual's health and welfare.

# **APPENDIX E**

# **Appendix E**

## **Home- and Community-Based Services**

### **And**

## **Behavioral Health Services**

#### Home- and Community-Based Services:

- Out of Home Respite Services
- Adult Day Health Services
- Supplemental Adaptive and Assistive Device Services/Specialized Medical Equipment and Supplies
- Supplemental Transportation Services/Non-Medical Transportation
- Transportation
- Chore Services
- Social Work Counseling
- Emergency Response Services/Personal Emergency Response Systems Home Modification Services/Environmental Accessibility Adaptations
- Personal Care Aide Services/Homemaker/Personal Care
- Waiver Nursing Services
- Home Delivered Meals Alternate meals service
- Pest Control
- Assisted Living Services
- Home Care Attendant Enhanced Community Living
- Nutritional Consultation
- Independent Living Assistance
- Community Transition

#### Behavioral Health Services:

- Comprehensive assessment and treatment planning
- Pharmacological management
- Case management services, including in-community case management
- Psychotherapy services
- Assertive Community Treatment (ACT)
- 24 hour on-call availability
- Emergency Services
- Inpatient Services – Including those provided in ODMH-operated psychiatric hospitals.
- Partial Hospital
- Day Treatment
- Treatment of substance use disorders, including individuals with co-morbid psychiatric and substance use disorders

Continuity of care will be assured to maintain patient and community well-being and safety. Any patient referred to a new provider shall have a minimum of ninety (90) days to transition to a new provider, and longer if transfer presents a substantial risk to the patient or community. New providers will receive and review records prior to commencing treatment and confirm ability to meet patient needs with minimal chance of decompensation and harm to patient and community.

In situations where patient and/or community needs and safety cannot be met with in-network resources (such as with court-ordered treatment or forensic patients), or if transfer to a new provider represents a substantial risk of clinical deterioration and consequent risk to the patient/community, provisions shall be made for the patient to continue in treatment with his/her existing provider and reimbursement shall be at standard Ohio Medicaid rates. Any treatment which is court-ordered shall be approved as a clinically necessary service.

## **APPENDIX F**

**Appendix F  
Ohio Medicaid Quality Strategy**

Medicaid Aims

1. Better Care: Improve the overall quality, by making health care more patient-centered, reliable, accessible, and safe.
2. Healthy People/Healthy Communities: Improve the health of the Ohio Medicaid population by supporting proven interventions to address behavioral, social and, environmental determinants of health.
3. Practice Best Evidence Medicine: Facilitate the implementation of best clinical practices to Medicaid providers through collaboration and improvement science approaches.

Medicaid Priorities, Goals, & Initiatives

Priorities:				
Make Care Safer	Improve Care Coordination	Promote Evidence-Based Prevention and Treatment Practices	Support Person and Family Centered Care	Ensure Effective and Efficient Administration
Goals:				
Eliminate preventable health-care acquired conditions and errors.	Create a delivery system that is less fragmented, where communication is clear, and patients and providers have access to information in order to optimize care.	Prevent and reduce the harm caused by high cost, prevalent conditions. These Clinical Focus Areas* include: 1. High Risk Pregnancy / Premature Births 2. Behavioral Health 3. Cardiovascular Disease 4. Diabetes 5. Asthma 6. Upper Respiratory Infections 7. Musculoskeletal Health (Duals)	Integrate patient/ family feedback on preferences, desired outcomes, and experiences into all care settings and delivery.	Sustain a quality focused, continuous learning organization.
Current Initiatives Supporting Goals*:				
<ul style="list-style-type: none"> <li>• Change hospital payment policy for never events &amp; hospital-acquired infections (P)</li> <li>• Eliminate blood stream catheter infections in Neonatal Intensive Care Units (QIS)</li> <li>• Human milk feeding to premature infants (QIS)</li> <li>• Solutions for Patient Safety (SPS) - Adverse Drug Events - Surgical Site Infections - Serious Safety Events (QIS)</li> <li>• Retrospective Drug Utilization Review (AF)</li> <li>• Meaningful Use: - Electronic Prescribing - Drug Interaction - Drug Allergies - Computerized Provider Order Entry (I)</li> </ul>	<ul style="list-style-type: none"> <li>• Managed Care Plan Delivery System - Access to services in a timely manner - Availability of a robust provider network - Care management - 24/7 Nurse Advice Line (AF) - IMPROVE Collaborative (QIS) - Behavioral Health Collaborative (COL)</li> <li>• Health Homes – Intense care management of chronically ill consumers using <i>Patient-Centered Medical Homes</i> as the foundation (COL)</li> <li>• Integration of dual eligibles (UD)</li> <li>• Accountable Care Organizations (UD)</li> <li>• MC enrollment efficiency (P)</li> <li>• Presumptive eligibility for pregnant women and newborns (P)</li> <li>• Meaningful Use: - Facilitating appropriate medical information communication (DSS)</li> </ul>	<ul style="list-style-type: none"> <li>• MCP Quality Accountability System: - Process &amp; outcome measures for each of the six Clinical Focus Areas above (NRM) - Pay-for-Performance (I)</li> <li>• Age appropriate preventive services - Adult Preventive Visit Benefit (P) - EPSDT Performance Improvement Project (QIS)</li> <li>• Obstetrical - Eliminating scheduled deliveries prior to 39 weeks - Antenatal steroids for high-risk mothers (QIS)</li> <li>• Implementation and spread of Pediatric Psychiatric Network (QIS)</li> <li>• Safety net consortium to improve diabetes care and outcomes (QIS)</li> <li>• QI Infrastructure Investment - Information System for data collection, analysis, &amp; feedback - Quality improvement coordinators (QIS)</li> <li>• Meaningful use: - Clinical Decision Support (DSS)</li> </ul>	<ul style="list-style-type: none"> <li>• NCQA CAHPS Consumer Satisfaction Survey (CS)</li> <li>• Review MCP Grievance/ Appeals/ Complaints / State Hearings (AF)</li> <li>• MCP Consumer Quality of Life Surveys (CS)</li> <li>• MCP Consumer Care Management Survey (CS)</li> <li>• Ohio Family Health Survey (CS)</li> <li>• Engage Patient in QI Process (CS) - OPQC - SPS - IMPROVE</li> <li>• Meaningful use: - Patient empowerment/ access to medical information (DSS)</li> </ul>	<ul style="list-style-type: none"> <li>• Quality Assessment and Performance Improvement (QAPI) Program: - Performance Improvement Projects (QIS) - Performance Measure reporting (NRM) - Over/under utilization Assessment (AF) - Special health care needs quality and appropriateness of care assessment (AF)</li> <li>• MCP Compliance Monitoring (AF)</li> <li>• Member Services (AF)</li> <li>• Provider Services (AF)</li> <li>• Program Integrity (AF)</li> <li>• MITS (AF)</li> <li>• Meaningful Use: - Consumer Decision Support - Provider Decision Support (DSS)</li> </ul>
Cross Cutting Issues: Integration of Physical and Behavioral Health, Elimination of Health Care Disparities				
How:	P = Policy QIS = Quality Improvement Science COL = Collaborative	I = Incentives CS = Consumer Survey DSS = Decision Support System	NRM = Nationally Recognized Measurement Sets AF = Administrative Function UD = Under Development	

\* The Clinical Focus Areas and Current Initiatives were developed for the CFC & ABD consumers who are not on a waiver or in an institution, or dually eligible. A separate evaluation will be completed to determine the Clinical Focus Areas and Current Initiatives for these populations.

## **APPENDIX G**

# Appendix G

## Integrated Care Delivery System Quality Measures

### April 2, 2012

Description of Measure				Clinical Focus Area	Quality Strategy Priority Area	
Number	Name	Source of Nationally-Recognized Measure	Other Ohio Programs Using Measure*			
1	Follow-Up After Hospitalization for Mental Illness - 7-day Follow-Up	NCQA/HEDIS	AHRQ, CHIPRA, HH, MC	Behavioral Health	Promote Evidence Based Prevention and Treatment Practices	
2	Anti-Depressant Medication Management - New Episode of Depression: (a) Optimal Practitioner Contacts for Medication Management	NCQA/HEDIS				
3	Anti-Depressant Medication Management - New Episode of Depression: (b) Effective Acute Phase Treatment	NCQA/HEDIS	AHRQ, EHR			
4	Anti-Depressant Medication Management - New Episode of Depression: (c) Effective Continuation Phase Treatment	NCQA/HEDIS	AHRQ, EHR			
5	Initiation and Engagement of Alcohol and Other Drug (AOD) Dependence Treatment- Engagement of AOD Treatment, Total	NCQA/HEDIS	AHRQ, EHR, HH, MC			
6	Initiation and Engagement of Alcohol and Other Drug (AOD) Dependence Treatment- Initiation of AOD Treatment, Total	NCQA/HEDIS	AHRQ, EHR, HH			
7	Cholesterol Management for Patients With Cardiovascular Conditions - LDL-C Screening and LDL-C Control (<100 mg/dL)	NCQA/HEDIS	EHR, MC, HH	Cardiovascular Disease		
8	Persistence of Beta-Blocker Treatment After a Heart Attack	NCQA/HEDIS	MC			
9	Controlling High Blood Pressure	NCQA/HEDIS	AHRQ, EHR, HH, MC			
10	Comprehensive Diabetes Care - HbA1c Control (<8.0%)	NCQA/HEDIS	EHR, HH, MC	Diabetes		
11	Comprehensive Diabetes Care - Blood Pressure Control (<140/90 mm Hg)	NCQA/HEDIS	EHR, MC			
12	Comprehensive Diabetes Care - LDL-C <100	NCQA/HEDIS	EHR, HH			
13	Pharmacotherapy Management of COPD Exacerbation (PCE), 40 and Older	NCQA/HEDIS		Asthma/COPD		
14	Osteoporosis Management in Women Who had a Fracture	NCQA/HEDIS		Musculoskeletal Health		
15	Pneumonia Vaccination Status for Older Adults ≥ 65 Years of Age (HEDIS CAHPS Survey)	NCQA/HEDIS	EHR			Improve Care Coordination
16	Medication Reconciliation Post-Discharge	NCQA/HEDIS	HH			
17	Use of High-risk Medications in the Elderly	NCQA/HEDIS				
18	Adults' Access to Preventive/Ambulatory Health Services - Total	NCQA/HEDIS	HH, MC			
19	Care for Older Adults - Medication Review, Advance Care Planning, Functional Status Assessment, Pain Screening, 66 & Older	NCQA/HEDIS				Support Person and Family Centered Care
20	Diversion measure TBD					
21	Rebalancing measure TBD					
22	Longterm Care measures TBD					

**\* Other Program Key**

AHRQ AHRQ Adult Core  
 CHIPRA CHIPRA  
 HH Ohio's Health Homes Program  
 MC Ohio's Medicaid Managed Care Program  
 EHR Meaningful Use Electronic Health Records

# **APPENDIX H**

# Appendix H

## Timeline of Stakeholder Activities

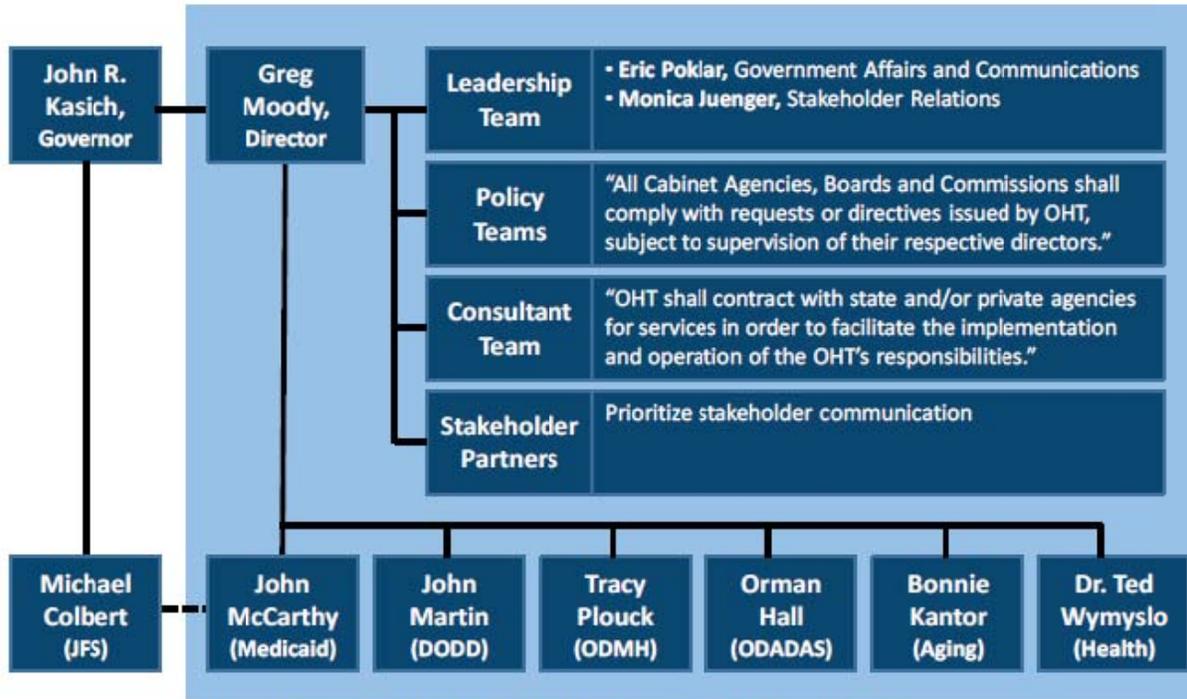
Stakeholder Engagement Activity	2011												2012					
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	
Vision for Integrated Healthcare Delivery System for Medicare-Medicaid Enrollees released by Governor Kasich's Office of Health Transformation		◆																
Proposal submitted to CMS to develop an integrated care delivery system (ICDS) for Medicare-Medicaid enrollees (not selected)		◆																
Governor Kasich's Jobs Budget authorizes the State to seek federal approval to implement an ICDS						◆												
Letter of Intent submitted to CMS to design a Medicare-Medicaid enrollee fiscal alignment model									◆									
Request For Information (RFI) released to Stakeholders regarding an ICDS for Medicare-Medicaid Enrollees									◆									
24 stakeholder groups submit responses to RFI									■									
Medicaid Director, John McCarthy, testified before Ohio Legislature									◆			◆		◆				
Independent researchers interview several members of State's Unified Long-Term Care System Advisory Workgroup											◆							
Stakeholder Advisory Group for ICDS formed											◆							
Meeting with consumers and consumer advocates to plan for a strategy to solicit public input on ICDS												◆						
ICDS concept paper presented to Unified Long-Term Care System Advisory Workgroup, ICDS FAQs and fact sheet													◆					
Public input meeting - Toledo													◆					
Public input meeting - Columbus													◆					
Public input meeting - Dayton														◆				
Public input meeting - Cleveland															◆			
Beneficiary Questionnaire																→		
Public input meeting - Athens (rural area)																◆		
Statewide public input conference call																◆		
State posts ICDS proposal on Ohio Office of Health Transformation website for public comment																■		
ICDS Proposal presented to Unified Long-Term Care System Advisory Workgroup																	◆	
2 additional public input meetings (locations TBD)																	◆ ◆	
CMS publishes ICDS proposal in federal register for public comment																	■	

# **APPENDIX I**

# Appendix I



Governor's Office of Health Transformation



Source: Ohio Governor John R. Kasich, Executive Order 2011-02K (January 13, 2011)

# **APPENDIX J**

**Appendix J**  
**Ohio Integrated Care Delivery System (ICDS)**  
**Design and Implementation Timeframe**

<b>Target Date</b>	<b>Phase I: Getting Organized</b>	<b>On Website</b>
02/01/2011	OHT applies for a CMMI Medicare-Medicaid integration demonstration grant	Yes
06/30/2011	The Jobs Budget (HB 153) creates authority (ORC 5111.944) for Ohio to implement ICDS	Yes
07/08/2011	CMMI releases financial models to support Medicare-Medicaid integration	Yes
08/11/2011	Public meeting: Unified Long-Term Care System (ULTCS) Advisory Group	Yes
09/08/2011	Public meeting: ULTCS Advisory Group	Yes
09/16/2011	Ohio submits a Letter of Intent to CMMI to participate in an ICDS program	Yes
09/20/2011	Ohio Medicaid releases a request for information (RFI) for input on ICDS design options	Yes
09/28/2011	Public meeting: Joint Legislative Committee on ULTCS	Yes
10/14/2011	RFI responses due and considered for incorporation into an ICDS Concept Paper	Yes
11/28/2011	Public meeting: ULTCS Advisory Group	Yes
12/20/2011	Public meeting: Joint Legislative Committee for ULTCS	Yes
<b>Phase II: ICDS Concept Paper and Public Comment</b>		
01/10/2012	ICDS Concept Paper posted for public review (50 day public comment period begins)	Yes
01/12/2012	Public meeting: ULTCS Advisory Group	Yes
01/24/2012- 02/14/2012	Regional meetings to facilitate consumer and family caregiver public comment held in Toledo (1/24), Columbus (1/31), Dayton (2/3), Cleveland (2/7), and Athens (2/14)	Yes
02/06/2012	Additional stakeholder meetings with LTC facilities and health plans	Yes
02/08/2012	Consumer questionnaire posted to facilitate public comment	Yes
02/17/2012	Statewide conference call to facilitate public comment	Yes
02/20/2012	Public comments due and considered for incorporation into an ICDS Draft Proposal	Yes
<b>Phase III: ICDS Proposal and Public Comment</b>		
02/27/2012	ICDS Draft Proposal posted for public review (30 day public comment period begins)	Yes
03/08/2012	Public meeting: ULTCS Advisory Group	Yes
03/13/2012	First public hearing: Rhodes State Office Tower	Yes
03/20/2012	Second public hearing: Rhodes State Office Tower	Yes
03/27/2012	Public comments due and considered for incorporation into a final ICDS Proposal	Yes
03/30/2012	Ohio submits ICDS Proposal to CMMI	
04/02/2012	CMS posts Ohio Proposal for public review (30 day public comment period begins)	
05/01/2012	Public comments due and CMS/Ohio begin review of public comments	
05/15/2012	CMS/Ohio complete review public comment and make final revisions to the Proposal	

<b>Target Date</b>	<b>Phase IV: ICDS Implementation</b>	<b>On Website</b>
04/16/2012	Ohio releases a request for applications (RFA)	
04/23/2012	RFA questions are due on-line question & answer	
05/04/2012	CMS and Ohio begin negotiation on Memorandum of Understanding (MOU)	
05/25/2012	RFAs due	
06/04/2012	ICDS applicants submit proposed benefit packages	
06/30/2012	CMS and Ohio sign a Memorandum of Understanding (MOU)	
07/02/2012	CMS and Ohio finalize the content of a 3-way contract (CMS/Ohio/ICDS)	
07/30/2012	CMS/Ohio ICDS plan selection complete	
08/01/2012	Readiness review	
09/20/2012	CMS, Ohio, and ICDS plans sign 3-way contracts	
<b>Phase V: ICDS Enrollment</b>		
08/23/2012	Initial information letter sent to Medicare-Medicaid individuals in target regions	
60 days prior to enrollment	Notification letters sent to ICDS individuals	
30 days prior to enrollment	Second notification letter sent to ICDS individuals	
15 days prior to enrollment	Auto-assignment for individuals who have not enrolled in an ICDS plan	
During the month prior to enrollment	ICDS plans send enrollment packets to ICDS individuals	
02/01/2013	Initial enrollment into ICDS plans	
90 days after enrollment	Medicare opt-out option ongoing	

## **APPENDIX K**



JOHN R. KASICH  
GOVERNOR  
STATE OF OHIO

February 21, 2012

Melanie Bella, Director  
Medicare-Medicaid Coordination Office  
Centers for Medicare & Medicaid Services  
7500 Security Boulevard  
Baltimore, Maryland 21244

Dear Ms. Bella,

As Governor of the State of Ohio, one of my highest priorities is to improve overall health system performance. In January 2011, during my first week as Governor, I created the Office of Health Transformation to pursue an aggressive reform agenda, including the integration of care for Medicare-Medicaid enrollees.

Nearly 200,000 Ohioans are enrolled in both Medicare and Medicaid, but the two programs are designed and managed with almost no connection to each other. As a result of poor coordination among physical health, behavioral health and long-term care services, quality of care is diminished and costs are too high. Medicare-Medicaid enrollees make up only 14 percent of total Ohio Medicaid enrollment, but they account for 46 percent of Medicaid long-term care spending.

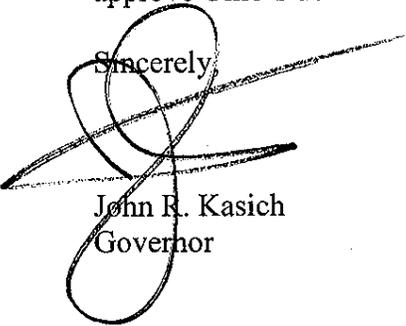
Ohio needs better and more flexible tools to reverse the trends of diminishing quality and increasing cost. For that reason, Medicare-Medicaid integration has been a priority from the outset of my Administration and I am committed to seeing it through.

On June 18, 2011, I met with President Obama and discussed Ohio's urgency to integrate care for Medicare-Medicaid enrollees. On November 30, 2011, I met with Republican Governors from around the country and singled out Medicare-Medicaid integration as our greatest opportunity for constructive engagement with the federal government.

Today, I am requesting your favorable consideration of Ohio's proposal to create an Integrated Care Delivery System for Medicare-Medicaid Eligibles (attached). I have committed the resources necessary to engage your office in program design, support a competitive procurement, and implement Ohio's demonstration in January 2013. John McCarthy, Ohio's Medicaid Director, can provide whatever you need to make your decision.

Thank you for your leadership in moving the states' integration projects forward. Without Medicare-Medicaid integration, Ohioans will continue to suffer the ill effects of a fragmented system and taxpayers will bear otherwise avoidable costs. I appreciate your working with us to approve Ohio's demonstration.

Sincerely,



John R. Kasich  
Governor



Department of  
Aging

**John Kasich**, Governor  
**Bonnie Kantor-Burman**, Director

March 30, 2012

Melanie Bella, Director  
Medicare-Medicaid Coordination Office  
Centers for Medicare & Medicaid Services  
7500 Security Boulevard  
Baltimore, Maryland 21244

Dear Ms. Bella:

I am writing to express my support for Ohio's proposal to create an Integrated Care Delivery System for Medicare-Medicaid enrollees. As Governor Kasich has stated, Ohio needs better, more flexible tools to reverse the trends of diminishing quality and increasing costs in our healthcare delivery system. In my capacity as the Director of the Ohio Department of Aging, I am acutely aware of the need for greater integration and coordination of healthcare services provided to beneficiaries by Medicare and Medicaid.

The existence of poor coordination among physical health, behavioral health and long-term care services, results in diminished quality of care and contributes to an upward spiral in cost growth. While Medicare-Medicaid enrollees make up only 14 percent of total Ohio Medicaid enrollment, they account for 46 percent of Medicaid long-term care spending.

The integration of services provided by Medicare-Medicaid will significantly contribute to our goal of enhancing quality and decreasing costs. I am therefore requesting your favorable consideration of Ohio's Demonstration Proposal to create an Integrated Care Delivery System.

Thank you for your leadership on this critically important topic.

Sincerely,

A handwritten signature in black ink that reads "Bonnie Kantor-Burman". The signature is written in a cursive, flowing style.

Bonnie Kantor-Burman  
Director



# OHIO DEPARTMENT OF HEALTH

246 North High Street  
Columbus, Ohio 43215

614/466-3543  
[www.odh.ohio.gov](http://www.odh.ohio.gov)

John R. Kasich / Governor

Theodore E. Wymyslo, M.D. / Director of Health

March 29, 2012

Melanie Bella, Director  
Medicare-Medicaid Coordination Office  
Centers for Medicare & Medicaid Services  
7500 Security Boulevard  
Baltimore, Maryland 21244

Dear Ms. Bella:

I am writing to express my support for Ohio's proposal to create an Integrated Care Delivery System for Medicare-Medicaid enrollees. As Governor Kasich has stated, Ohio needs better, more flexible tools to reverse the trends of diminishing quality and increasing costs in our healthcare delivery system. In my capacity as the Director of the Ohio Department of Health (ODH), I am acutely aware of the need for greater integration and coordination of healthcare services provided to beneficiaries eligible for services provided by Medicare and Medicaid. ODH has been encouraging the expansion of a Patient-Centered Medical Home model of care as one approach to facilitating partnerships that are structured to achieve the same effect.

The existence of poor coordination among physical health, behavioral health and long-term care services, results in diminished quality of care and contributes to an upward spiral in cost growth. While Medicare-Medicaid enrollees make up only 14 percent of total Ohio Medicaid enrollment, they account for 46 percent of Medicaid long-term care spending.

The integration of services provided by Medicare-Medicaid will significantly contribute to our goal of enhancing quality and decreasing costs. I am therefore requesting your favorable consideration of Ohio's Demonstration Proposal to create an Integrated Care Delivery System.

Thank you for your leadership on this critically important topic.

Sincerely

A handwritten signature in black ink that reads "Theodore E. Wymyslo M.D." with a stylized flourish at the end.

Theodore E. Wymyslo, M.D.  
Director

**John R. Kasich**, Governor  
**Mary Taylor**, Lieutenant Governor  
**Orman Hall**, Director

March 30, 2012

Melanie Bella, Director  
Medicare-Medicaid Coordination Office  
Centers for Medicare & Medicaid Services  
7500 Security Boulevard  
Baltimore, Maryland 21244

Dear Ms. Bella:

I am writing to express my support for Ohio's proposal to create an Integrated Care Delivery System for Medicare-Medicaid enrollees. As Governor Kasich has stated, Ohio needs better, more flexible tools to reverse the trends of diminishing quality and increasing costs in our healthcare delivery system. In my capacity as the Director of the Ohio Department of Alcohol and Drug Addiction Services, I am acutely aware of the need for greater integration and coordination of healthcare services provided to beneficiaries eligible for services provided by Medicare and Medicaid.

The existence of poor coordination among physical health, behavioral health and long-term care services, results in diminished quality of care and contributes to an upward spiral in cost growth. While Medicare-Medicaid enrollees make up only 14 percent of total Ohio Medicaid enrollment, they account for 46 percent of Medicaid long-term care spending.

The integration of services provided by Medicare-Medicaid will significantly contribute to our goal of enhancing quality and decreasing costs. I am therefore requesting your favorable consideration of Ohio's Demonstration Proposal to create an Integrated Care Delivery System.

Thank you for your leadership on this critically important topic.

Sincerely,



Orman Hall, Director  
Ohio Department of  
Alcohol and Drug Addiction Services



Department of  
Mental Health

John R. Kasich, Governor  
Tracy J. Plouck, Director

March 30, 2012

Melanie Bella, Director  
Medicare-Medicaid Coordination Office  
Centers for Medicare & Medicaid Services  
7500 Security Boulevard  
Baltimore, Maryland 21244

*Melanie*  
Dear Ms. Bella:

I am writing to express my support for Ohio's proposal to create an Integrated Care Delivery System for Medicare-Medicaid enrollees. As Governor Kasich has stated, Ohio needs better, more flexible tools to reverse the trends of diminishing quality and increasing costs in our healthcare delivery system. In my capacity as the Director of the Ohio Department of Mental Health, I am acutely aware of the need for greater integration and coordination of healthcare services provided to beneficiaries by Medicare and Medicaid, particularly those with mental illness.

The existence of poor coordination among physical health, behavioral health and long-term care services, results in diminished quality of care and contributes to an upward spiral in cost growth. While Medicare-Medicaid enrollees make up only 14 percent of total Ohio Medicaid enrollment, they account for 46 percent of Medicaid long-term care spending.

The integration of services provided by Medicare-Medicaid will significantly contribute to our goal of enhancing quality and decreasing costs. I am therefore requesting your favorable consideration of Ohio's Demonstration Proposal to create an Integrated Care Delivery System.

Thank you for your leadership on this critically important topic.

Sincerely,

Tracy J. Plouck  
Director  
Ohio Department of Mental Health

Establishing mental health as a cornerstone of overall health

30 East Broad Street  
Columbus, Ohio 43215  
mentalhealth.ohio.gov

614 | 466-2297  
614 | 752-9696 TTY  
614 | 752-9453 Fax

# **APPENDIX L**

# State of Ohio

## Advance Health Equity through State Implementation of Health Reform

### Application for Technical Assistance

#### Ohio Core team

##### ***Team Member (Medicaid)***

Name: **John McCarthy** Primary Contact: **Yes**  No   
Title: **Director, Ohio Medicaid** Phone: **(614) 752-3739**  
Agency: **Ohio Dept. Job & Family Services** E-mail: **John.McCarthy@jfs.ohio.gov**  
Assistant (if applicable): Assistant's e-mail:

##### ***Team member (Public Health)***

Name: **Johnnie (Chip) Allen, MPH** Primary Contact: **Yes**  No   
Title: **Health Equity Coordinator** Phone: **(614) 728-6919**  
Agency: **Ohio Department of Health** E-mail: **Chip.Allen@odh.ohio.gov**  
Assistant (if applicable): Assistant's e-mail: **Robyn.Taylor@odh.ohio.gov**

##### ***Team member (Minority Health)***

Name: **Angela C. Dawson, MS,LPC** Primary Contact: **Yes**  No   
Title: **Executive Director** Phone (614) **466-4000**  
Agency: **Ohio Commission on Minority Health** E-mail: **Angela.Dawson@mih.ohio.gov**

---

#### **1. Role of Core Team Members in Ohio Health Reform Efforts**

The depth and complexity of the ACA requires government, private sector and community-based organizations to collaborate in new and innovative ways to take full advantage of provisions outlined in the ACA. One important step in this process is to outline what state cabinet-level agencies are doing to provide leadership, coordination and support of this effort. Below are brief descriptions of what core team agencies/members are doing to implement ACA in Ohio.

##### **Ohio Medicaid**

Ohio Medicaid is actively taking steps to implement Section 2703 of the ACA which includes the state option to provide Health Homes. This particular initiative is based on the Patient-Centered Medical Home model and is connected to new funding/match opportunities from the Center for Medicaid Services. Key elements of this initiative include:

- Focusing on patients with multiple chronic and complex conditions. This includes Medicaid consumers with two or more of the following conditions: mental health, substance abuse, asthma, diabetes, heart disease and obesity (BMI>25).
- Coordination across medical, behavioral and long-term care.
- Building linkages to community, support and recovery services which also address social determinants of health.

Ohio Medicaid claims/encounter data reveal that there are over 325,000 Medicaid consumers who qualify for this initiative. Moreover, a disproportionate number of these individuals are from racial and ethnic minority groups and Ohio's Appalachia region.

### **Ohio Department of Health (ODH)**

The Ohio Department of Health is the state's lead public health agency whose mission is to protect and improve the health of all Ohioans. ODH's core philosophy centers on promoting and demonstrating equity and social justice in our actions, as we engage communities in achieving optimal health for all Ohioans. ODH has a dedicated Office of Health Equity which is responsible for coordinating health equity policy initiatives throughout the agency and among state cabinet-level agencies. To this end, ODH has also applied for membership on the forthcoming Region V HHS Health Equity Council.

ODH has actively worked to address various provisions of the ACA which include Sections 10334 (Minority Health), 3101 (Data Collection, Analysis and Quality), Section 1946 (Addressing Health Care Disparities) and Section 4201 (Community Transformation Grants). Examples of state initiatives include:

- Establishment of a health equity office in 2008 to coordinate health equity efforts throughout the agency and cabinet-level organizations (ACA, Section 10034).
- Infusion of health disparity elimination strategies in all grants from ODH with a focus on social determinants.
- Inclusion of OBM race and ethnicity standards in all new data systems and health information exchanges.
- Statewide implementation of Ohio House Bill 198. This bill authorizes the implementation of a statewide Patient Centered Medical Home Education Pilot Project throughout Ohio which also addresses healthcare disparities (ACA, Sections 2703 and 1946).

### **Ohio Commission on Minority Health (OCMH)**

Created in 1987, the OCMH is an autonomous state agency designed to address the disparity that exists between the health status of minority and non-minority populations. The OCMH is dedicated to eliminating racial and ethnic health disparities through innovative strategies, financial opportunities (grants), public health promotion, legislative action, public policy and systems change. The OCMH is responsible for addressing the following ACA Sections:

- Increasing the supply of a highly qualified healthcare workforce to improve access and health care delivery through certified community health workers (ACA, Section 1946- Addressing Health Care Disparities).

- Implementation of the Research and Evaluation Enhancement Program (REEP) to assess quality, grant integrity and efficacy of minority demonstration projects throughout Ohio (ACA Section 5307, Cultural Competency, Public Health, & Individuals with Disabilities Training).
- Funding to over 100 community-based organizations and health departments for innovative and culturally specific projects designed to address health inequities (Grants to Promote Positive Health Behaviors and Outcomes).

## **2. State Agency & Stakeholder Involvement in Health Reform/Equity Initiatives**

Ohio is very fortunate to have a strong coalition of stakeholders who actively participate in the planning and implementation of health reform activities. Examples of stakeholder involvement are described below:

- The Ohio Medicaid Health Homes Program is led by Ohio Medicaid at the Department of Job & Family Services. Since June 20, 2011 at least eight (8) stakeholder meetings were conducted to obtain input on the design of the program. Stakeholders include community-based organizations, Managed-Care Plans (MCP), health policy research firms, primary health care organizations and large hospital systems.
- In support of the Ohio Medicaid Health Homes, the Ohio Department of Health has implemented the Patient Centered Medical Home Initiative based on recent legislation (Ohio House Bill 198). This is different than the Ohio Medicaid Health Homes Program in that is more comprehensive, because HB 198 is not limited to the Medicaid population and engages multiple payer sources. In addition to enlisting the consultation of national experts, various stakeholders have been engaged including consumer groups, the Ohio Hospital Association, Commission on Minority Health, insurance companies and community-based organizations.
- The Ohio Commission on Minority Health (OCMH) participated in the National Partnership for Action (NPA) Local Conversation Initiative of the U.S. Department of Health and Human Services, Office of Minority Health. The OCMH conducted nineteen (19) local conversations which included stakeholders and partners from public and private sectors. As a result, regional plans/strategies were developed to shape policies designed to eliminate health disparities. These plans will be published and disseminated throughout the Ohio in December 2011.
- The OCMH received funding from the U.S. Department of Health & Human Services (HHS) to increase statewide awareness and implementation of the *HHS Action Plan to Reduce Racial and Ethnic Health Disparities*. This initiative includes working with a variety of statewide organizations to determine their capacity and level of readiness to implement various aspects of the plan.
- The OCMH, in partnership with the Ohio Department of Health, submitted a joint application to the Centers for Disease Control and Prevention for the Community Transformation Grant. The focus of this proposal mobilizes and assists communities and coalitions to implement policy, environmental, programmatic and infrastructure changes to 83 primarily rural counties. The overall goal is to reduce risk factors for leading causes of death and disability and to prevent and control chronic diseases. Moreover, this application has a significant focus on social determinants of health and identifying segments of Ohio's population who experience chronic disease health disparities (ACA, Section 4201).

### 3. Prioritize the Top Three Priority Areas for Technical Assistance

The three priorities for technical assistance include *Emphasize Coordination of Care, Promote Quality & Efficiency from the Health Care System*, and *Use Your Data* categories. Objectives and rationale for these choices include the following:

#### Emphasize Coordination of Care

Ohio's efforts to establish Health Homes have been outlined in Question #2. Process and impact health equity objectives associated with this priority include:

- Implementing Health Homes and Patient Centered Medical Homes in such a way which also addresses social determinants through integrated care services.
- Designing Health Homes which directly address key findings of the *2010 Healthcare Disparities Report* (Agency for Healthcare Research and Quality).
- Develop and implement learning opportunities for healthcare providers which include cultural and linguistic competency. This will empower health care providers to better serve diverse communities. Additionally, this will also help healthcare providers understand their role in eliminating healthcare disparities.
- Use data to identify the best locations to establish new Health Homes and/or Patient Centered Medical Homes, especially in areas that are considered "medical hotspots".
- Address healthcare workforce diversity to improve provide patient/provider relationships.

#### Promote Quality & Efficiency from the Health Care System

- Develop payment reform demonstrations to improve care for populations that are disproportionately impacted by chronic conditions.
- Investigate the feasibility of using Managed Care Plans or other entities as administrators for greater efficiency.
- Develop payment reform strategies which demonstrate significant cost savings based on the findings within the *Economic Burden of Health Inequalities in the United States* (The Joint Center for Political & Economic Studies).

#### Use Your Data

- Maximize meaningful use of Health Information Technology (HIT) to incorporate metrics identified in the *2010 Healthcare Disparities Report* into routine patient care protocols of Health Homes. This will function to directly respond to eliminate healthcare disparities.
- Develop methodologies to maximize HIT to include, for instance, combining public health data, aggregated data from Electronic Medical Records and geospatial market research data. This will help formulate a multi-dimensional snapshot of healthcare issues in Ohio to develop health disparity elimination solutions that are proactive in nature.
- Review Electronic Medical Record systems and identify data elements that should be collected to measure the impact of Health Homes on healthcare disparities.
- Develop evaluation measures based on aggregated data from Electronic Medical Records to determine progress in eliminating healthcare disparities. This data would then be converted to dashboard indicators to share with various stakeholders.

#### **4. Describe the Type of Technical Assistance Most Helpful to You.**

Health equity is a difficult concept to grasp and even more difficult to put into practice. The core team represents three governmental agencies with different orientations to address health issues. With this in mind, technical assistance is needed to strengthen our adoption of a syndemic orientation for the selected priority areas. Syndemic orientation is defined by the Centers for Disease Control and Prevention as a way to focus on connections among health-related problems, considering those connections when developing health policies, and aligning with other avenues of social change to ensure the conditions in which all people can be healthy. This is extremely important since the determinants of health which result in health disparities largely occur outside of the healthcare setting.

Development of a syndemic orientation must be coupled with technical assistance to implement and sustain structural solutions within the priority areas identified. This includes, for instance, designing Health Homes which address key quality care measures outlined in the 2011 Healthcare Disparities Report as routine practice (as opposed to an afterthought). The inability to develop structural solutions on how healthcare is rendered and/or evaluated will result in persistent health disparities for years to come.

Technical assistance is also needed to introduce new models of payment reform and demonstrate how these models improve health outcomes and reduce health disparities. It would be particularly useful to show how payment reform could help address and overcome findings outlined in the *Economic Burden of Health Inequalities in the United States* (Joint Center for Political & Economic Studies). It is obvious that what gets funded gets done. Successful models of payment reform will make it much easier to convince decision-makers on the proper allocation of resources for programs which function to eliminate health disparities.

Lastly, we want to fully operationalize the concept of “meaningful use of data”. This includes the development of policies and procedures to collect appropriate data on race and ethnicity, access to healthcare, quality of healthcare and evidence of healthcare disparities. We must also improve the manner in which we turn data into information to make data-driven decisions. This includes using evaluation strategies to assess the extent that Ohio is making process to eliminate healthcare disparities in pursuit of health equity.



Advancing Health Equity through Implementation of Health Reform  
**State Health Equity Work Plan**  
October 2011- May 2012

The purpose of the State Health Equity Workplan is to guide your state team's efforts to advance health equity throughout your participation in the NASHP Health Equity Learning Collaborative. During the 8-month technical assistance period, you will participate in peer-learning activities and expert conference calls that will help you progress on your health equity work.

With this in mind, and considering your state's priorities as they relate to advancing health equity, please use this work plan to indicate the health equity action steps your state will take over the 8-month period of the Learning Collaborative. Your team is free to draw upon the proposed activities described in your RFA application, but please keep in mind that the Learning Collaborative's technical assistance activities will be focused on the following policy areas:

- 1) *Building Provider and Health Systems Capacity: Cultural Competency Training to Improve Providers' and/or Policymakers' Capacity to Implement the ACA through a Health Equity Lens*
- 2) *Improving Eligibility and Enrollment Systems to Foster Participation of Racially and Ethnically Diverse Populations*
- 3) *Engaging Racial and Ethnic Minority Communities in Policy Development and Implementation*
- 4) *Cultural Competency in Establishing Health Homes to Improve Health Outcomes for Racial and Ethnic Minorities*
- 5) *Use Your Data: Measuring Health Equity*
- 6) *Medicaid Managed Care Contract Standards that Advance Health Equity*

Please consider the above topics as your team develops your work plan for the 8-month TA period. We hope that you will include at least 3 of these policy initiatives in your work plan. Using the template below, please:

- Provide a timeline by which you plan to accomplish your team's policy priorities
- A brief description of the project activity/action step your state will take to advance health equity in your state
- Any milestones/deliverables that will be used to document your progress on the project activity/action step, and
- A designated member of your team responsible for the project activity and accompanying deliverable

State of Ohio NASHP Health Equity Workplan

**NATIONAL ACADEMY**  
*for STATE HEALTH POLICY*

State of Ohio NASHP Workplan

<b>Policy Initiative</b>	<b>Project Activity/Action Step</b>	<b>Timeline</b> (Ex: Oct 2011- Jan 2012)	<b>Milestone/Outcome</b>	<b>State Team Member Responsible</b>
1) <i>Medicaid Managed Care Contract Standards that Advance Health Equity</i>	Review contracts with Equity/Disparity lens and subsequent regional culturally competent approach	New contracts for July 2012	OUTCOME: Development/implementation of effective, standard contract language/ deliverables which compel Medicaid Managed Care Organizations to explicitly address health care disparities with a focus on metrics and improving health outcomes	Jon Barley, Carol Ware, Dale Lehmann
1) <i>Improving Eligibility and Enrollment Systems to Foster Participation of Racially and Ethnically Diverse Populations and mandate the reporting of quality indicators by race and ethnicity</i>  Racial and ethnic minority consumer input into policy development.	Eligibility system replacement (CRIS-E): Upgrades/replacement to current information/technology systems to ensure we have accurate (and mandatory) data to proactively respond to health disparities and health care disparities.	Uncertain but in this next 18 months	OUTCOME: Enhanced ability to identify minority and impoverished populations who experience health disparities and health care disparities.  The interoperability of systems to facilitate the efficient sharing of information with sister service agencies.  The ability to determine the impact (both positive and negative)—on disparities.	Jon Barley and Mary Applegate (with help from Patrick Beatty and Mel Borkan who specialize in this work at Ohio Medicaid) Angela Cornelius Dawson Chip Allen will enlist the help of Dr. Robert Campbell

**NATIONAL ACADEMY**  
*for STATE HEALTH POLICY*

<p>Agency Quality Strategy</p>	<p>Develop a set of health disparity and health equity metrics that can be tracked in a visible way (e.g., dashboard indicators) as part of day-to-day operations. This could include using the Agency for Healthcare Research &amp; Quality (AHRQ) 2010 Health Care Disparity Report as a guide for metrics.</p>	<p>By July 2012</p>	<p>Metrics to identify progress on addressing health care disparities. RATIONALE: We may need other ways to track this until the new eligibility system is functional. Several agencies are already involved in the Family Health Survey. If we cannot use claims data, TA could be helpful in how best to get at this information Each agency may need to target a specific condition or population in the short term to accomplish this (E.g. Infant mortality or prematurity by disparate population)</p>	<p>Mary Applegate, Robyn Taylor</p>
<p><i>Use Your Data: Measuring Health Equity</i></p>	<p>Develop integrated metrics which include Medicaid and public health surveillance data-sets to determine future strategies to eliminate health disparities.</p> <p>Use of aggregated data extracted from electronic medical records to identify geographic locations to illustrate high concentrations of Medicaid recipients with disparate health outcomes.</p>	<p>July</p>	<p>Outcome: Capacity to determine the impact of clinical services on health care disparities and the effect of local social determinants of health on health outcomes.</p> <p>Outcome: Cross sector public/private partnerships to develop integrated solutions which simultaneously address health care disparities and positively impact the social, environmental and economic conditions.</p>	<p>Core Team Members</p>
<p><i>Cultural Competency in Establishing Health Homes to Improve</i></p>	<p>Make sure Health Homes (HH) and Patient Centered Medical Homes (PCMH) efforts are appropriately</p>	<p>By July 2012</p>	<p>Outcomes: Establishment of HH and PCMH in areas where there are persistent health care and health disparities</p>	<p>Core Team</p>

**NATIONAL ACADEMY**  
*for* STATE HEALTH POLICY

<p><i>Health Outcomes for Racial and Ethnic Minorities</i></p>	<p>educated and provide services in a culturally sensitive manner</p>		<p>(Medical Hot Spots).</p> <p>Patient Centered Medical Homes and Health Homes that have the capacity to serve diverse patient populations:</p> <p>Policies that ensure HH and PCMH workforce routinely train in the area of cultural and linguistic competency.</p> <p>Recruitment and retention of minority physicians, certified community health workers</p> <p>Establish educational pipeline policies to increase capacity to reach diverse populations and to improve patient/provider relationships</p>	
	<p>Encourage the development of Health homes and PCMH in high disparate population neighborhoods</p>		<p>Routine /use of GIS Mapping tools to help determine Hotspots and incorporate social determinants of health data into decision-making for the placement of Health Homes and Patient Centered Medical Homes</p>	<p>John McCarthy/Dr. Wymslo/Chip Allen/ Robyn Taylor</p>
	<p>Include/develop disparity elimination strategies &amp; metrics as identified in the <i>IOM's Unequal Treatment</i> and AHRQ measures of effectiveness in physical and mental health homes</p>		<p>RATIONALE: TA related to disparity measures that may be utilized throughout our program over a protracted period of time to measure progress.</p>	<p>Core Team</p>
	<p>Identify health care service</p>	<p>By July 2012</p>	<p>Outcome: Increase diversity of the</p>	<p>Mina Chang &amp; Angela</p>

**NATIONAL ACADEMY**  
*for* STATE HEALTH POLICY

MEDTAPP Access Initiative	<p>candidates (nurses, physicians and other health care workers) to represent and serve disparate populations and support their placement in high need areas</p>		<p>health care workforce as compared to predetermined baseline measurements.</p> <p>RATIONALE: TA could be helpful with candidate identification, appropriate support to serve in a high need area.</p>	Cornelius, Chip Allen & Robyn Taylor
Electronic Health Record Vendor Engagement	<p>Systematically educate (and require) vendors to include data fields to race, ethnicity and income to capture disparities for regional improvement initiatives and evaluation that may inform policy</p> <p>Examine vendor protocols for EMR and incorporate uniform data elements that would align the EMR to measure the impact of HH and PCMH on healthcare disparities</p>	Ongoing	<p>Outcome: Ability to extract aggregate summary measures on quality and health outcomes by race, ethnicity and income from EMRs on selected health disparity metrics.</p> <p>RATIONALE: TA to gather national efforts and innovation around this topic would be helpful.</p>	Mark Vidmar
<p>Promote Quality and Efficiency from the Health Care System</p> <p>Develop ACO Health Disparities Strike Teams (HDST)</p>	<p>Development of recruitment and payment reform strategies for Accountable Care Organizations that maintain high expectations for quality and ensure adequate representation of diverse patient Populations and health care</p>		<p>Outcome:</p> <p>Development of HDST to work with ACOs who do not achieve target health disparity elimination outcomes.</p> <p>Better quality and outcomes across the board without segregating</p>	Core Team Members

**NATIONAL ACADEMY**  
*for* **STATE HEALTH POLICY**

	systems.		<p>patients to certain ACOs</p> <p>RATIONALE: ACO's which serve large minority populations or low income individuals will initially face challenges in containing costs and positively influencing better health outcomes because these populations they tend to be sicker and present more challenges. If outcomes and quality drive costs, ACOs may inadvertently segregate minority and/or low income patients into certain ACOs that do not have the capacity to lower costs and improve quality because of the inavailability of resources. Caring for patient populations who experience disparities may initially impact an ACO's health care outcomes. TA is needed to understand how to avoid segregating minorities in ACOs which are low-performing and/or unwilling to make investments to address/overcome health care disparities.</p>	
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## 2012 Evidence of Coverage



**January 1 – December 31, 2012**

## **Evidence of Coverage**

### **Your Medicare Health Benefits and Services and Prescription Drug Coverage as a Member of Advantage by Buckeye Community Health Plan (HMO SNP)**

This booklet gives you the details about your Medicare health care and prescription drug coverage from January 1 – December 31, 2012. It explains how to get the health care and prescription drugs you need covered. This is an important legal document. Please keep it in a safe place.

This plan, Advantage by Buckeye Community Health Plan (Buckeye), is offered by Buckeye Community Health Plan. (When this Evidence of Coverage says “we,” “us,” or “our,” it means Buckeye. When it says “plan” or “our plan,” it means Buckeye.)

Buckeye is a Coordinated Care plan with a Medicare Advantage contract and a contract with the Ohio Medicaid program.

This information is available for free in other languages. Please contact our Member Services number at 866-389-7690 for additional information. (TTY users should call 800-750-0750). Hours are Monday through Sunday 8:00AM to 8:00PM. Member Services also has free language interpreter services available for non-English speakers.

Esta información está disponible gratuitamente en otros idiomas. Póngase en contacto con nuestro número de servicios al miembro al 866-389-7690 para obtener información adicional. (Los usuarios de TTY deben llamar 800-750-0750). Horas son de lunes a domingo de 8:00 AM a 8:00 PM. Servicio al miembros también tiene servicios de intérprete de lengua libre disponibles para no hablantes de inglés.

Benefits, formulary, pharmacy network, premium, deductible, and/or copayments/coinsurance may change on January 1, 2013.

## **2012 Evidence of Coverage**

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## **SECTION 1      Introduction**

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<b>Section 1.1      You are enrolled in Buckeye, which is a specialized Medicare Advantage Plan (Special Needs Plan)</b>
--

You are covered by both Medicare and Medicaid:

- **Medicare** is the Federal health insurance program for people 65 years of age or older, some people under age 65 with certain disabilities, and people with end-stage renal disease (kidney failure).
- **Medicaid** is a joint Federal and state government program that helps with medical costs for certain people with limited incomes and resources. Medicaid coverage varies depending on the state and the type of Medicaid you have. Some people with Medicaid get help paying for their Medicare premiums and other costs. Other people also get coverage for additional services and drugs that are not covered by Medicare.

You have chosen to get your Medicare health care and your prescription drug coverage through our plan, Buckeye.

There are different types of Medicare health plans. Buckeye is a specialized Medicare Advantage Plan (a Medicare “Special Needs Plan”), which means its benefits are designed for people with special health care needs. Buckeye is designed specifically for people who have Medicare and who are also entitled to assistance from Medicaid.

Because you get assistance from Medicaid, you will pay less for some of your Medicare health care services. Medicaid also provides other benefits to you by covering health care services that are not usually covered under Medicare. You will also receive Extra Help from Medicare to pay for the costs of your Medicare prescription drugs. Buckeye will help manage all of these benefits for you, so that you get the health care services and payment assistance that you are entitled to.

Buckeye is run by a private company. Like all Medicare Advantage Plans, this Medicare Special Needs Plan is approved by Medicare. The plan also has a contract with the Ohio Medicaid program to coordinate your Medicaid benefits. We are pleased to be providing your Medicare health care coverage, including your prescription drug coverage.

<b>Section 1.2      What is the Evidence of Coverage booklet about?</b>
---

This Evidence of Coverage booklet tells you how to get your Medicare and prescription drugs covered through our plan. This booklet explains your rights and responsibilities, what is covered, and what you pay as a member of the plan.

This plan, Buckeye, is offered by Buckeye Community Health Plan. (When this Evidence of Coverage says “we,” “us,” or “our,” it means Buckeye. When it says “plan” or “our plan,” it means Buckeye.)

The word “coverage” and “covered services” refers to the medical care and services and the prescription drugs available to you as a member of Buckeye.

### **Section 1.3      What does this Chapter tell you?**

Look through Chapter 1 of this Evidence of Coverage to learn:

- What makes you eligible to be a plan member?
- What is your plan’s service area?
- What materials will you get from us?
- What is your plan premium and how can you pay it?
- How do you keep the information in your membership record up to date?

### **Section 1.4      What if you are new to Buckeye?**

If you are a new member, then it’s important for you to learn how the plan operates – what the rules are and what services are available to you. We encourage you to set aside some time to look through this Evidence of Coverage booklet.

If you are confused or concerned or just have a question, please contact our plan’s Member Services (contact information is on the back cover of this booklet).

### **Section 1.5      Legal information about the Evidence of Coverage**

#### **It’s part of our contract with you**

This Evidence of Coverage is part of our contract with you about how Buckeye covers your care. Other parts of this contract include your enrollment form, the List of Covered Drugs (Formulary), and any notices you receive from us about changes to your coverage or conditions that affect your coverage. These notices are sometimes called “riders” or “amendments.”

The contract is in effect for months in which you are enrolled in Buckeye between January 1, 2012 and December 31, 2012.

#### **Medicare must approve our plan each year**

Medicare (the Centers for Medicare & Medicaid Services) must approve Buckeye each year. You can continue to get Medicare coverage as a member of our plan only as long as we choose

to continue to offer the plan for the year in question and the Centers for Medicare & Medicaid Services renews its approval of the plan.

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## **SECTION 2      What makes you eligible to be a plan member?**

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<b>Section 2.1      Your eligibility requirements</b>
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You are eligible for membership in our plan as long as:

- You live in our geographic service area (section 2.3 below describes our service area)
- -- and -- you are entitled to Medicare Part A
- -- and -- you are enrolled in Medicare Part B
- -- and -- you do not have End-Stage Renal Disease (ESRD), with limited exceptions, such as if you develop ESRD when you are already a member of a plan that we offer, or you were a member of a different plan that was terminated.
- and -- you meet the special eligibility requirements described below.

### **Special eligibility requirements for our plan**

Our plan is designed to meet the needs of people who receive certain Medicaid benefits. (Medicaid is a joint Federal and state government program that helps with medical costs for certain people with limited incomes and resources.) To be eligible for our plan you must be eligible for both Medicare and full Medicaid Benefits.

<b>Section 2.2      What are Medicare Part A and Medicare Part B?</b>
---

When you originally signed up for Medicare, you received information about how to get Medicare Part A and Medicare Part B. Remember:

- Medicare Part A generally covers services furnished by institutional providers such as hospitals, skilled nursing facilities, or home health agencies.
- Medicare Part B is for most other medical services (such as physician's services and other outpatient services) and certain items (such as durable medical equipment and supplies).

<b>Section 2.3      What is Medicaid?</b>
---

Medicaid is a joint Federal and state government program that helps with medical costs for certain people who have limited incomes and resources. Each state decides what counts as income and resources, who is eligible, what services are covered, and the cost for services. States also can decide how to run their program as long as they follow the Federal guidelines.

In addition, there are programs offered through Medicaid that help people with Medicare pay their Medicare costs, such as their Medicare premiums. These programs help people with limited income and resources save money each year:

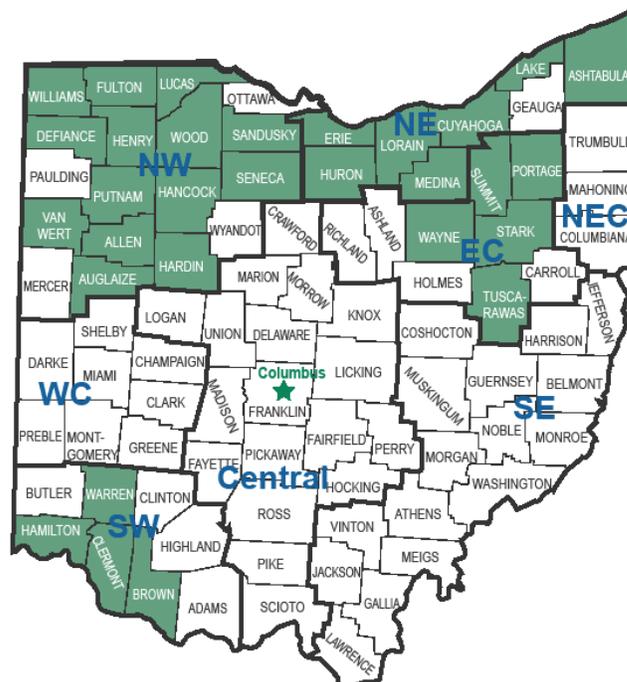
- **Qualified Medicare Beneficiary (QMB) Plus Medicaid:** Helps pay Medicare Part A and Part B premiums, and other cost sharing (like deductibles, coinsurance, and co-payments) for individuals with Medicaid.
- **Specified Low-Income Medicare Beneficiary (SLMB) Plus Medicaid:** Helps pay Part B premiums for individuals with Medicaid.

**Section 2.4 Here is the plan service area for Buckeye**

Although Medicare is a Federal program, Buckeye is available only to individuals who live in our plan service area. To remain a member of our plan, you must keep living in this service area. The service area is described below.

Our service area includes these counties in Ohio: Allen, Ashtabula, Auglaize, Brown, Clermont, Cuyahoga, Defiance, Erie, Fulton, Hamilton, Hancock, Hardin, Henry, Huron, Lake, Lorain, Lucas, Medina, Portage, Putnam, Sandusky, Seneca, Stark, Summit, Tuscarawas, Van Wert, Warren, Wayne, Williams, and Wood.

**Buckeye Community Health Plan Advantage  
Medicare Counties of Operation**



If you plan to move out of the service area, please contact Member Services. When you move, you will have a Special Enrollment Period that will allow you to switch to Original Medicare or enroll in a Medicare health or drug plan that is available in your new location.

## SECTION 3 What other materials will you get from us?

### Section 3.1 Your plan membership card – Use it to get all covered care and prescription drugs

While you are a member of our plan, you must use your membership card for our plan whenever you get any services covered by this plan and for prescription drugs you get at network pharmacies. Here's a sample membership card to show you what yours will look like:



As long as you are a member of our plan you must **not** use your red, white, and blue Medicare card to get covered medical services (with the exception of routine clinical research studies and hospice services). Keep your red, white, and blue Medicare card in a safe place in case you need it later.

**Here's why this is so important:** If you get covered services using your red, white, and blue Medicare card instead of using your Buckeye membership card while you are a plan member, you may have to pay the full cost yourself.

If your plan membership card is damaged, lost, or stolen, call Member Services right away and we will send you a new card.

### Section 3.2 The Provider Directory: Your guide to all providers in the plan's network

Every year that you are a member of our plan, we will send you either a new Provider Directory or an update to your Provider Directory. This directory lists our network providers.

**What are "network providers"?**

**Network providers** are the doctors and other health care professionals, medical groups, hospitals, and other health care facilities that have an agreement with us to accept our payment and any plan cost sharing as payment in full. We have arranged for these providers to deliver covered services to members in our plan.

### **Why do you need to know which providers are part of our network?**

It is important to know which providers are part of our network because, with limited exceptions, while you are a member of our plan you must use network providers to get your medical care and services. The only exceptions are emergencies, urgently needed care when the network is not available (generally, when you are out of the area), out-of-area dialysis services, and cases in which Buckeye authorizes use of out-of-network providers. See Chapter 3 (Using the plan's coverage for your medical services) for more specific information about emergency, out-of-network, and out-of-area coverage.

If you don't have your copy of the Provider Directory, you can request a copy from Member Services. You may ask Member Services for more information about our network providers, including their qualifications. You can also see the Provider Directory at [www.bchpohio.com](http://www.bchpohio.com), or download it from this website. Both Member Services and the website can give you the most up-to-date information about changes in our network providers.

### **Section 3.3 The plan's List of Covered Drugs (Formulary)**

The plan has a List of Covered Drugs (Formulary). We call it the "Drug List" for short. It tells which Part D prescription drugs are covered by Buckeye. The drugs on this list are selected by the plan with the help of a team of doctors and pharmacists. The list must meet requirements set by Medicare. Medicare has approved the Buckeye Drug List.

The Drug List also tells you if there are any rules that restrict coverage for your drugs.

We will send you a copy of the Drug List. The Drug List we send to you includes information for the covered drugs that are most commonly used by our members. However, we cover additional drugs that are not included in the printed Drug List. If one of your drugs is not listed in the Drug List, you should visit our website or contact Member Services to find out if we cover it. To get the most complete and current information about which drugs are covered, you can visit the plan's website ([www.bchpohio.com](http://www.bchpohio.com)) or call Member Services (phone numbers are on the back cover of this booklet).

### **Section 3.4 The Explanation of Benefits (the "EOB"): Reports with a summary of payments made for your Part D prescription drugs**

When you use your Part D prescription drug benefits, we will send you a summary report to help you understand and keep track of payments for your Part D prescription drugs. This summary report is called the Explanation of Benefits (or the "EOB").

The Explanation of Benefits tells you the total amount you have spent on your Part D prescription drugs and the total amount we have paid for each of your Part D prescription drugs during the month. Chapter 6 (What you pay for your Part D prescription drugs) gives more information about the Explanation of Benefits and how it can help you keep track of your drug coverage.

An Explanation of Benefits summary is also available upon request. To get a copy, please contact Member Services.

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## **SECTION 4      Your monthly premium for Buckeye**

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<b>Section 4.1      How much is your plan premium?</b>
--

You do not pay a separate monthly plan premium for Buckeye. You must continue to pay your Medicare Part B premium (unless your Part B premium is paid for you by Medicaid or another third party).

### **Some members are required to pay other Medicare premiums**

As explained in Section 2 above, in order to be eligible for our plan, you must maintain your eligibility for Medicaid as well as be entitled to Medicare Part A and enrolled in Medicare Part B. For most Buckeye members, Medicaid pays for your Part A premium (if you don't qualify for it automatically) and for your Part B premium. If Medicaid is not paying your Medicare premiums for you, you must continue to pay your Medicare premiums to remain a member of the plan.

- Your copy of Medicare & You 2012 gives information about these premiums in the section called "2012 Medicare Costs." This explains how the Part B premium differs for people with different incomes.
- Everyone with Medicare receives a copy of Medicare & You each year in the fall. Those new to Medicare receive it within a month after first signing up. You can also download a copy of Medicare & You 2012 from the Medicare website (<http://www.medicare.gov>). Or, you can order a printed copy by phone at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users call 1-877-486-2048.

<b>Section 4.2      Can we change your monthly plan premium during the year?</b>
--

**No.** We are not allowed to begin charging a monthly plan premium during the year. If the monthly plan premium changes for next year we will tell you in September and the change will take effect on January 1.

However, in some cases, you may need to start paying or may be able to stop paying a Late Enrollment Penalty. (The Late Enrollment Penalty may apply if you had a continuous period of 63 days or more when you didn't have "creditable" prescription drug coverage.) This could

happen if you become eligible for the Extra Help program or if you lose your eligibility for the Extra Help program during the year:

- If you currently pay the penalty and become eligible for Extra Help during the year, you would no longer pay your penalty.
- If the Extra Help program is currently paying your Late Enrollment Penalty and you lose your eligibility during the year, you would need to start paying your penalty.

You can find out more about the Extra Help program in Chapter 2, Section 7.

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## **SECTION 5      Please keep your plan membership record up to date**

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<b>Section 5.1      How to help make sure that we have accurate information about you</b>
---

Your membership record has information from your enrollment form, including your address and telephone number. It shows your specific plan coverage including your Primary Care Provider.

The doctors, hospitals, pharmacists, and other providers in the plan's network need to have correct information about you. **These network providers use your membership record to know what services and drugs are covered for you.** Because of this, it is very important that you help us keep your information up to date.

### **Let us know about these changes:**

- Changes to your name, your address, or your phone number
- Changes in any other health insurance coverage you have (such as from your employer, your spouse's employer, workers' compensation, or Medicaid)
- If you have any liability claims, such as claims from an automobile accident
- If you have been admitted to a nursing home
- If your designated responsible party (such as a caregiver) changes
- If you are participating in a clinical research study

If any of this information changes, please let us know by calling Member Services (phone numbers are on the back cover of this booklet). You should also contact Social Security and Ohio Medicaid so that your address can be updated with Medicare and Medicaid (contact information can be found in Chapter 2, Sections 5 and 6).

**Read over the information we send you about any other insurance coverage you have**

Medicare requires that we collect information from you about any other medical or drug insurance coverage that you have. That's because we must coordinate any other coverage you have with your benefits under our plan. (For more information about how our coverage works when you have other insurance, see Section 7 in this chapter.)

Once each year, we will send you a letter that lists any other medical or drug insurance coverage that we know about. Please read over this information carefully. If it is correct, you don't need to do anything. If the information is incorrect, or if you have other coverage that is not listed, please call Member Services (phone numbers are on the back cover of this booklet).

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## **SECTION 6      We protect the privacy of your personal health information**

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<b>Section 6.1      We make sure that your health information is protected</b>
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Federal and state laws protect the privacy of your medical records and personal health information. We protect your personal health information as required by these laws.

For more information about how we protect your personal health information, please go to Chapter 8, Section 1.4 of this booklet.

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## **SECTION 7      How other insurance works with our plan**

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<b>Section 7.1      Which plan pays first when you have other insurance?</b>
--

When you have other insurance (like employer group health coverage), there are rules set by Medicare that decide whether our plan or your other insurance pays first. The insurance that pays first is called the "primary payer" and pays up to the limits of its coverage. The one that pays second, called the "secondary payer," only pays if there are costs left uncovered by the primary coverage. The secondary payer may not pay all of the uncovered costs.

These rules apply for employer or union group health plan coverage:

- If you have retiree coverage, Medicare pays first.
- If your group health plan coverage is based on your or a family member's current employment, who pays first depends on your age, the size of the employer, and whether you have Medicare based on age, disability, or End-stage Renal Disease (ESRD):
  - If you're under 65 and disabled and you or your family member is still working, your plan pays first if the employer has 100 or more employees or at least one employer in a multiple employer plan has more than 100 employees.

- If you're over 65 and you or your spouse is still working, the plan pays first if the employer has 20 or more employees or at least one employer in a multiple employer plan has more than 20 employees.
- If you have Medicare because of ESRD, your group health plan will pay first for the first 30 months after you become eligible for Medicare.

These types of coverage usually pay first for services related to each type:

- No-fault insurance (including automobile insurance)
- Liability (including automobile insurance)
- Black lung benefits
- Workers' compensation

Medicaid and TRICARE never pay first for Medicare-covered services. They only pay after Medicare, employer group health plans, and/or Medigap have paid.

If you have other insurance, tell your doctor, hospital, and pharmacy. If you have questions about who pays first, or you need to update your other insurance information, call Member Services (phone numbers are on the back cover of this booklet.) You may need to give your plan member ID number to your other insurers (once you have confirmed their identity) so your bills are paid correctly and on time.

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## **SECTION 1      Buckeye contacts** (how to contact us, including how to reach Member Services at the plan)

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### **How to contact our plan's Member Services**

For assistance with claims, billing or member card questions, please call or write to Buckeye Member Services. We will be happy to help you.

<b>Member Services</b>	
<b>CALL</b>	866-389-7690  Calls to this number are free. Monday through Sunday 8:00AM to 8:00PM.  Member Services also has free language interpreter services available for non-English speakers.
<b>TTY</b>	800-750-0750  This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.  Calls to this number are free. Monday through Sunday 8:00AM to 8:00PM.
<b>FAX</b>	866-786-1036
<b>WRITE</b>	175 S. 3 <sup>rd</sup> Street, Suite 1200, Columbus, Ohio 43215
<b>WEBSITE</b>	<a href="http://www.bchpohio.com">www.bchpohio.com</a>

### **How to contact us when you are asking for a coverage decision about your medical care and Part D prescription drugs**

A coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your medical services. For more information on asking for coverage decisions about your medical care, see Chapter 9 (What to do if you have a problem or complaint (coverage decisions, appeals, complaints)).

You may call us if you have questions about our coverage decision process.

<b>Coverage Decisions for Medical Care and Part D Prescription Drugs</b>	
<b>CALL</b>	866-389-7690  Calls to this number are free.
<b>TTY</b>	800-750-0750  This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.  Calls to this number are free.
<b>FAX</b>	866-786-1036
<b>WRITE</b>	175 S. 3 <sup>rd</sup> Street, Suite 1200, Columbus, Ohio 43215
<b>WEBSITE</b>	<a href="http://www.bchpohio.com">www.bchpohio.com</a>

### **How to contact us when you are making an appeal about your medical care and Part D prescription drugs**

An appeal is a formal way of asking us to review and change a coverage decision we have made. For more information on making an appeal about your medical care, see Chapter 9 (What to do if you have a problem or complaint (coverage decisions, appeals, complaints)).

<b>Appeals for Medical Care and Part D Prescription Drugs</b>	
<b>CALL</b>	866-389-7690  Calls to this number are free.

<b>TTY</b>	800-750-0750  This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.  Calls to this number are free.
<b>FAX</b>	866-786-1036
<b>WRITE</b>	175 S. 3 <sup>rd</sup> Street, Suite 1200, Columbus, Ohio 43215
<b>WEBSITE</b>	<a href="http://www.bchpohio.com">www.bchpohio.com</a>

### **How to contact us when you are making a complaint about your medical care and Part D Prescription Drugs**

You can make a complaint about us or one of our network providers, including a complaint about the quality of your care. This type of complaint does not involve coverage or payment disputes. (If your problem is about the plan's coverage or payment, you should look at the section above about making an appeal.) For more information on making a complaint about your medical care, see Chapter 9 (What to do if you have a problem or complaint (coverage decisions, appeals, complaints)).

<b>Complaints about Medical Care</b>	
<b>CALL</b>	866-389-7690  Calls to this number are free.
<b>TTY</b>	800-750-0750  This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.  Calls to this number are free.
<b>FAX</b>	866-786-1036
<b>WRITE</b>	175 S. 3 <sup>rd</sup> Street, Suite 1200, Columbus, Ohio 43215

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## Where to send a request asking us to pay for our share of the cost for medical care or a drug you have received

For more information on situations in which you may need to ask us for reimbursement or to pay a bill you have received from a provider, see Chapter 7 (Asking us to pay our share of a bill you have received for covered medical services or drugs).

**Please note:** If you send us a payment request and we deny any part of your request, you can appeal our decision. See Chapter 9 (What to do if you have a problem or complaint (coverage decisions, appeals, complaints)) for more information.

Also, we cannot reimburse you for Medicaid covered services, but we can contact your provider on your behalf and ask them to bill Medicaid as appropriate.

Payment Requests	
<b>CALL</b>	866-389-7690  Calls to this number are free.
<b>TTY</b>	800-750-0750  This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.  Calls to this number are free.
<b>FAX</b>	866-704-3064
<b>WRITE</b>	175 S. 3 <sup>rd</sup> Street, Suite 1200, Columbus, Ohio 43215
<b>WEBSITE</b>	<a href="http://www.bchpohio.com">www.bchpohio.com</a>

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## SECTION 2 Medicare (how to get help and information directly from the Federal Medicare program)

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Medicare is the Federal health insurance program for people 65 years of age or older, some people under age 65 with disabilities, and people with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a kidney transplant).

The Federal agency in charge of Medicare is the Centers for Medicare & Medicaid Services (sometimes called “CMS”). This agency contracts with Medicare Advantage organizations including us.

<b>Medicare</b>	
<b>CALL</b>	<p>1-800-MEDICARE, or 1-800-633-4227</p> <p>Calls to this number are free.</p> <p>24 hours a day, 7 days a week.</p>
<b>TTY</b>	<p>1-877-486-2048</p> <p>This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.</p> <p>Calls to this number are free.</p>
<b>WEBSITE</b>	<p><a href="http://www.medicare.gov">http://www.medicare.gov</a></p> <p>This is the official government website for Medicare. It gives you up-to-date information about Medicare and current Medicare issues. It also has information about hospitals, nursing homes, physicians, home health agencies, and dialysis facilities. It includes booklets you can print directly from your computer. You can also find Medicare contacts in your state by selecting “Help and Support” and then clicking on “Useful Phone Numbers and Websites.”</p> <p>The Medicare website also has detailed information about your Medicare eligibility and enrollment options with the following tools:</p> <ul style="list-style-type: none"><li>• <b>Medicare Eligibility Tool:</b> Provides Medicare eligibility status information. Select “Find Out if You’re Eligible.”</li><li>• <b>Medicare Plan Finder:</b> Provides personalized information about available Medicare prescription drug plans, Medicare health plans, and Medigap (Medicare Supplement Insurance) policies in your area. Select “Health &amp; Drug Plans” and then “Compare Drug and Health Plans” or “Compare Medigap Policies.” These tools provide an estimate of what your out-of-pocket costs might be in different Medicare plans.</li></ul> <p>If you don’t have a computer, your local library or senior center may be able to help you visit this website using its computer. Or, you can call Medicare at the number above and tell them what information you are looking for. They will find the information on the website, print it out, and send it to you.</p>

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### **SECTION 3      State Health Insurance Assistance Program** (free help, information, and answers to your questions about Medicare)

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The State Health Insurance Assistance Program (SHIP) is a government program with trained counselors in every state. In Ohio, the SHIP is called the Ohio Senior Health Insurance Information Program (OSHIIP).

OSHIIP is independent (not connected with any insurance company or health plan). It is a state program that gets money from the Federal government to give free local health insurance counseling to people with Medicare.

OSHIIP counselors can help you with your Medicare questions or problems. They can help you understand your Medicare rights, help you make complaints about your medical care or treatment, and help you straighten out problems with your Medicare bills. OSHIIP counselors can also help you understand your Medicare plan choices and answer questions about switching plans.

<b>Ohio Senior Health Insurance Information Program</b>	
<b>CALL</b>	800-686-1578
<b>WRITE</b>	2110 Stella Court, Columbus, Ohio 43215

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### **SECTION 4      Quality Improvement Organization** (paid by Medicare to check on the quality of care for people with Medicare)

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There is a Quality Improvement Organization for each state. For Ohio, the Quality Improvement Organization is called KePro.

KePro has a group of doctors and other health care professionals who are paid by the Federal government. This organization is paid by Medicare to check on and help improve the quality of care for people with Medicare. KePro is an independent organization. It is not connected with our plan.

You should contact KePro in any of these situations:

- You have a complaint about the quality of care you have received.
- You think coverage for your hospital stay is ending too soon.
- You think coverage for your home health care, skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services are ending too soon.

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<b>KePro</b>	
<b>CALL</b>	800-589-7337
<b>WRITE</b>	Rock Run Center, 5700 Lombardo Center Drive, Suite 100, Seven Hills, Ohio 44131

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## **SECTION 5 Social Security**

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The Social Security Administration is responsible for determining eligibility and handling enrollment for Medicare. U.S. citizens who are 65 or older, or who have a disability or End-Stage Renal Disease and meet certain conditions, are eligible for Medicare. If you are already getting Social Security checks, enrollment into Medicare is automatic. If you are not getting Social Security checks, you have to enroll in Medicare. Social Security handles the enrollment process for Medicare. To apply for Medicare, you can call Social Security or visit your local Social Security office.

<b>Social Security Administration</b>	
<b>CALL</b>	1-800-772-1213  Calls to this number are free.  Available 7:00 am to 7:00 pm, Monday through Friday.  You can use Social Security's automated telephone services to get recorded information and conduct some business 24 hours a day.
<b>TTY</b>	1-800-325-0778  This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.  Calls to this number are free.  Available 7:00 am to 7:00 pm, Monday through Friday.
<b>WEBSITE</b>	<a href="http://www.ssa.gov">http://www.ssa.gov</a>

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## **SECTION 6      Medicaid** (a joint Federal and state program that helps with medical costs for some people with limited income and resources)

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Our plan is a special needs plan, which means all of our members are dually enrolled with both Medicare and Medicaid.

Medicaid is a joint Federal and state government program that helps with medical costs for certain people with limited incomes and resources.

In addition, there are programs offered through Medicaid that help people with Medicare pay their Medicare costs, such as their Medicare premiums. These programs help people with limited income and resources save money each year:

- **Qualified Medicare Beneficiary (QMB):** Helps pay Medicare Part A and Part B premiums, and other cost sharing (like deductibles, coinsurance, and copayments).
- **Specified Low-Income Medicare Beneficiary (SLMB) and Qualifying Individual (QI):** Helps pay Part B premiums.
- **Qualified Disabled & Working Individuals (QDWI):** Helps pay Part A premiums.

If you have questions about the assistance you get from Medicaid, contact the Ohio Department of Job and Family Services.

<b>Ohio Department of Job and Family Services</b>	
<b>CALL</b>	800-324-8680
<b>TTY</b>	800-292-3572  This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
<b>WRITE</b>	The phone number above can give the address for your particular county.
<b>WEBSITE</b>	<a href="http://www.jfs.ohio.gov/OHP/index.stm">www.jfs.ohio.gov/OHP/index.stm</a>

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## **SECTION 7      Information about programs to help people pay for their prescription drugs**

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### **Medicare's "Extra Help" Program**

Because you are eligible for Medicaid, you qualify for and are getting "Extra Help" from Medicare to pay for your prescription drug plan costs. You do not need to do anything further to get this Extra Help.

If you have questions about Extra Help, call:

- 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048, 24 hours a day, 7 days a week;
- The Social Security Office at 1-800-772-1213, between 7 am to 7 pm, Monday through Friday. TTY users should call 1-800-325-0778; or
- Your State Medicaid Office. (See Section 6 of this chapter for contact information)

If you believe that you are paying an incorrect cost-sharing amount when you get your prescription at a pharmacy, our plan has established a process that allows you to either request assistance in obtaining evidence of your proper co-payment level, or, if you already have the evidence, to provide this evidence to us.

Buckeye provides access to Part D drugs at the correct LIS level when provided with evidence of LIS eligibility regardless of whether or not the health plan and Centers for Medicare & Medicaid Services (CMS) systems match. Buckeye updates its system with the LIS status confirmed by the Best Available Evidence (BAE).

Buckeye accepts any of the following forms of evidence to establish the Low Income Subsidy (LIS) status of full benefit dual eligible beneficiaries:

- A copy of the beneficiary's Medicaid card that includes the beneficiary's name and an eligibility date \*
- A copy of a State document that confirms active Medicaid status. \*
- A print out form the State electronic enrollment file showing Medicaid status. \*
- A screen print from the State's Medicaid system showing Medicaid status. \*
- Other documentation provided by the State showing Medicaid status. \*
- For individuals who are not deemed eligible but who apply, and are determined LIS eligible, a copy of the Social Security Administration (SSA) award letter.

\* During a month after June of the previous calendar year.

Buckeye accepts any of the following forms of evidence to establish that a beneficiary is institutionalized and qualifies for zero cost sharing:

- A remittance from the facility confirming Medicaid payment for a full calendar month for the beneficiary. \*
- A copy of a State document that confirms Medicaid payment on behalf of the beneficiary to the facility for a full calendar month after June of the previous calendar year.
- A screen print from the State’s Medicaid system showing that the beneficiary’s institutionalized status based on at least a full calendar month stay for Medicaid payment purposes during a month after June of the previous calendar year.

\* During a month after June of the previous calendar year.

- When we receive the evidence showing your copayment level, we will update our system so that you can pay the correct copayment when you get your next prescription at the pharmacy. If you overpay your copayment, we will reimburse you. Either we will forward a check to you in the amount of your overpayment or we will offset future copayments. If the pharmacy hasn’t collected a copayment from you and is carrying your copayment as a debt owed by you, we may make the payment directly to the pharmacy. If a state paid on your behalf, we may make payment directly to the state. Please contact Member Services if you have questions.

### **Medicare Coverage Gap Discount Program**

Because you get “Extra Help” from Medicare to pay for your prescription drug plan costs, the Medicare Coverage Gap Discount Program does not apply to you. You already have coverage for your prescription drugs during the coverage gap through the Extra Help program.

### **State Pharmaceutical Assistance Programs**

Many states have State Pharmaceutical Assistance Programs that help some people pay for prescription drugs based on financial need, age, or medical condition. Each state has different rules to provide drug coverage to its members.

These programs provide limited income and medically needy seniors and individuals with disabilities financial help for prescription drugs. In Ohio, the State Pharmaceutical Assistance Program is Ohio’s Best Rx.

<b>Ohio’s Best Rx</b>	
<b>CALL</b>	866-923-7879
<b>WRITE</b>	PO Box 408, Twinsburg, Ohio 44087
<b>WEBSITE</b>	<a href="http://www.ohiobestrx.org">www.ohiobestrx.org</a>

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## **SECTION 8      How to contact the Railroad Retirement Board**

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The Railroad Retirement Board is an independent Federal agency that administers comprehensive benefit programs for the nation’s railroad workers and their families. If you have questions regarding your benefits from the Railroad Retirement Board, contact the agency.

<b>Railroad Retirement Board</b>	
<b>CALL</b>	1-877-772-5772  Calls to this number are free.  Available 9:00 am to 3:30 pm, Monday through Friday  If you have a touch-tone telephone, recorded information and automated services are available 24 hours a day, including weekends and holidays.
<b>TTY</b>	1-312-751-4701  This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.  Calls to this number are not free.
<b>WEBSITE</b>	<a href="http://www.rrb.gov">http://www.rrb.gov</a>

---

## **SECTION 9      Do you have “group insurance” or other health insurance from an employer?**

---

If you (or your spouse) get benefits from your (or your spouse’s) employer or retiree group, call the employer/union benefits administrator or Member Services if you have any questions. You can ask about your (or your spouse’s) employer or retiree health benefits, premiums, or the enrollment period.

If you have other prescription drug coverage through your (or your spouse’s) employer or retiree group, please contact **that group’s benefits administrator**. The benefits administrator can help you determine how your current prescription drug coverage will work with our plan.

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## **SECTION 1      Things to know about getting your medical care covered as a member of our plan**

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This chapter tells things you need to know about using the plan to get your medical care covered. It gives definitions of terms and explains the rules you will need to follow to get the medical treatments, services, and other medical care that are covered by the plan.

For the details on what medical care covered by our plan and how much you pay as your share of the cost when you get this care, use the benefits chart in the next chapter, Chapter 4 (Benefits Chart, what is covered and what you pay).

<b>Section 1.1      What are “network providers” and “covered services”?</b>
--

Here are some definitions that can help you understand how you get the care and services that are covered for you as a member of our plan:

- **“Providers”** are doctors and other health care professionals licensed by the state to provide medical services and care. The term “providers” also includes hospitals and other health care facilities.
- **“Network providers”** are the doctors and other health care professionals, medical groups, hospitals, and other health care facilities that have an agreement with us to accept our payment and your cost-sharing amount as payment in full. We have arranged for these providers to deliver covered services to members in our plan. The providers in our network generally bill us directly for care they give you. When you see a network provider, you usually pay only your share of the cost for covered services.
- **“Covered services”** include all the medical care, health care services, supplies, and equipment that are covered by our plan. Your covered services for medical care are listed in the benefits chart in Chapter 4.

<b>Section 1.2      Basic rules for getting your medical care covered by the plan</b>
---

As a Medicare health plan, Buckeye must cover all services covered by Original Medicare and must follow Original Medicare's coverage rules for these services.

Buckeye will generally cover your medical care as long as:

- **The care you receive is included in the plan's Benefits Chart** (this chart is in Chapter 4 of this booklet).
- **The care you receive is considered medically necessary.** “Medically necessary” means that the services, supplies, or drugs are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.

- **You have a network primary care provider (a PCP) who is providing and overseeing your care.** As a member of our plan, you must choose a network PCP (for more information about this, see Section 2.1 in this chapter).
  - In most situations, your network PCP must give you approval in advance before you can use other providers in the plan's network, such as specialists, hospitals, skilled nursing facilities, or home health care agencies. This is called giving you a "referral." For more information about this, see Section 2.3 of this chapter.
  - Referrals from your PCP are not required for emergency care or urgently needed care. There are also some other kinds of care you can get without having approval in advance from your PCP (for more information about this, see Section 2.2 of this chapter).
- **You must receive your care from a network provider** (for more information about this, see Section 2 in this chapter). In most cases, care you receive from an out-of-network provider (a provider who is not part of our plan's network) will not be covered. Here are three exceptions:
  - The plan covers emergency care or urgently needed care that you get from an out-of-network provider. For more information about this, and to see what emergency or urgently needed care means, see Section 3 in this chapter.
  - If you need medical care that Medicare requires our plan to cover and the providers in our network cannot provide this care, you can get this care from an out-of-network provider. However, an out of network authorization is always required prior to getting that care. This authorization must be obtained from the plan. Failure to obtain prior authorization when required for an out of network provider could result in you being responsible for the bill. In this situation, we will cover these services (if you obtain a prior authorization from us) as if you got the care from a network provider or at no cost to you. For information about getting approval to see an out-of-network doctor, see Section 2.4 in this chapter.
  - Kidney dialysis services that you get at a Medicare-certified dialysis facility when you are temporarily outside the plan's service area.

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## **SECTION 2      Use providers in the plan's network to get your medical care**

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<b>Section 2.1      You must choose a Primary Care Provider (PCP) to provide and oversee your care</b>
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### **What is a "PCP" and what does the PCP do for you?**

- What is a PCP? A primary care provider is responsible for your overall care and will direct your care and will refer you to any needed specialist.

- What types of providers may act as a PCP? A PCP is a family care physician, a general practitioner, a primary care clinic, or internal medicine physician practicing as primary care.
- Explain the role of a PCP in your plan. A PCP is your medical home and our partner in meeting your health care needs.
- What is the role of the PCP in coordinating covered services? Your PCP is to direct your care and make any referrals to outside providers as needed.
- What is the role of the PCP in making decisions about or obtaining prior authorization, if applicable? The PCP should make the referral to in network specialist when needed or obtain prior authorization for out of network specialist.

### **How do you choose your PCP?**

Please review our Provider Directory or call Member Services for assistance in choosing a PCP.

### **Changing your PCP**

You may change your PCP for any reason, at any time. Also, it's possible that your PCP might leave our plan's network of providers and you would have to find a new PCP.

If you wish to change PCP's please call Member Services at (866-389-7690) Monday through Sunday 8:00AM to 8:00PM or TTY Users call (800-750-0750) and request a change. You will be issued a new ID card showing the new PCP within 2 weeks. The change will be reflected in the system with a few days.

<b>Section 2.2</b>	<b>What kinds of medical care can you get without getting approval in advance from your PCP?</b>
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You can get the services listed below without getting approval in advance from your PCP.

- Routine women's health care, which includes breast exams, screening mammograms (x-rays of the breast), Pap tests, and pelvic exams as long as you get them from a network provider.
- Flu shots and pneumonia vaccinations as long as you get them from a network provider.
- Emergency services from network providers or from out-of-network providers.
- Urgently needed care from in-network providers or from out-of-network providers when network providers are temporarily unavailable or inaccessible, e.g., when you are temporarily outside of the plan's service area.
- Kidney dialysis services that you get at a Medicare-certified dialysis facility when you are temporarily outside the plan's service area. (If possible, please call Member Services before you leave the service area so we can help arrange for you to have maintenance dialysis while you are away.)

### **Section 2.3      How to get care from specialists and other network providers**

A specialist is a doctor who provides health care services for a specific disease or part of the body. There are many kinds of specialists. Here are a few examples:

- Oncologists, who care for patients with cancer.
- Cardiologists, who care for patients with heart conditions.
- Orthopedists, who care for patients with certain bone, joint, or muscle conditions.

**There are certain services your provider will need to get prior authorization from the plan. These include:**

- Experimental or investigative services
- Services from a non participating provider
- Inpatient facility admissions (e.g., acute care, rehabilitation, skilled nursing)
  - Outpatient facility services (Includes those that result in admission).
  - Outpatient surgery or ambulatory surgery services
  - Physical, occupational and speech therapy. (Excludes initial evaluation)
  - Cardiac rehabilitation. (Excludes initial evaluation)
  - Pulmonary rehabilitation. (Excludes initial evaluation)
  - Pain management services
  - Diagnostic tests (e.g., CT, MRI, MRA and PET scans, cardiac nuclear imaging, and sleep studies)
  - Observation services
- Home health care services
- DME, orthotics and prosthetics
- Certain specialist referrals
- Ambulance transportation

To get a service prior authorized, your provider must call our Medical Management Department at 866-246-4359 (fax 877-861-6722).

### **What if a specialist or another network provider leaves our plan?**

Sometimes a specialist, clinic, hospital or other network provider you are using might leave the plan. If this happens, you will have to switch to another provider who is part of our plan. Member Services can assist you in finding and selecting another provider.

### **Section 2.4      How to get care from out-of-network providers**

Buckeye must ensure that you have access to network providers sufficient to offer covered services with a reasonable distance to your home. If we are unable to locate a provider that is within a reasonable distance, we may authorize you to see a provider who is not part of our

network. You are also allowed to use out-of-network services without authorization in urgent and emergency situations as described below.

If you have any questions about finding a provider, please contact Member Services.

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## **SECTION 3      How to get covered services when you have an emergency or urgent need for care**

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<b>Section 3.1      Getting care if you have a medical emergency</b>
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### **What is a “medical emergency” and what should you do if you have one?**

A “**medical emergency**” is when you, or any other prudent layperson with an average knowledge of health and medicine, believe that you have medical symptoms that require immediate medical attention to prevent loss of life, loss of a limb, or loss of function of a limb. The medical symptoms may be an illness, injury, severe pain, or a medical condition that is quickly getting worse.

If you have a medical emergency:

- **Get help as quickly as possible.** Call 911 for help or go to the nearest emergency room, hospital, or urgent care center. Call for an ambulance if you need it. You do not need to get approval or a referral first from your PCP.
- **As soon as possible, make sure that our plan has been told about your emergency.** We need to follow up on your emergency care. You or someone else should call to tell us about your emergency care, usually within 48 hours. The phone number for Member Services can be found in the beginning of this booklet.

### **What is covered if you have a medical emergency?**

You may get covered emergency medical care whenever you need it, anywhere in the United States or its territories. Our plan does not provide for emergency medical care outside of the United States or its territories. Our plan covers ambulance services in situations where getting to the emergency room in any other way could endanger your health. For more information, see the Benefits Chart in Chapter 4 of this booklet.

If you have an emergency, we will talk with the doctors who are giving you emergency care to help manage and follow up on your care. The doctors who are giving you emergency care will decide when your condition is stable and the medical emergency is over.

After the emergency is over you are entitled to follow-up care to be sure your condition continues to be stable. Your follow-up care will be covered by our plan. If your emergency care is provided by out-of-network providers, we will try to arrange for network providers to take over your care as soon as your medical condition and the circumstances allow.

### **What if it wasn't a medical emergency?**

Sometimes it can be hard to know if you have a medical emergency. For example, you might go in for emergency care – thinking that your health is in serious danger – and the doctor may say that it wasn't a medical emergency after all. If it turns out that it was not an emergency, as long as you reasonably thought your health was in serious danger, we will cover your care.

However, after the doctor has said that it was not an emergency, we will cover additional care only if you get the additional care in one of these two ways:

- You go to a network provider to get the additional care.
- – or – the additional care you get is considered “urgently needed care” and you follow the rules for getting this urgent care (for more information about this, see Section 3.2 below).

<b>Section 3.2</b>	<b>Getting care when you have an urgent need for care</b>
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### **What is “urgently needed care”?**

“Urgently needed care” is a non-emergency, unforeseen medical illness, injury, or condition, that requires immediate medical care, but the plan's network of providers is temporarily unavailable or inaccessible. The unforeseen condition could, for example, be an unforeseen flare-up of a known condition that you have (for example, a flare-up of a chronic skin condition).

### **What if you are in the plan's service area when you have an urgent need for care?**

In most other situations, if you are in the plan's service area, we will cover urgently needed care only if you get this care from a network provider and follow the other rules described earlier in this chapter. However, if the circumstances are unusual or extraordinary, and network providers are temporarily unavailable or inaccessible, we will cover urgently needed care that you get from an out-of-network provider.

### **What if you are outside the plan's service area when you have an urgent need for care?**

When you are outside the service area and cannot get care from a network provider, our plan will cover urgently needed care that you get from any provider.

Our plan does not cover urgently needed care or any other any other care if you receive the care outside of the United States.

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## **SECTION 4      What if you are billed directly for the full cost of your covered services?**

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<b>Section 4.1      You can ask the plan to pay our share of the cost for your covered services</b>
---

In limited instances, you may be asked to pay the full cost of the service. Other times, you may find that you have paid more than you expected under the coverage rules of the plan. In either case, you will want our plan to pay our share of the costs by reimbursing you for the payments you have already made.

There may also be times when you get a bill from a provider for the full cost of medical care you have received. In many cases, you should send this bill to us so that we can pay our share of the costs for your covered medical services.

Buckeye cannot reimburse you or your provider for Medicaid covered services, but we can contract your provider and remind them to bill Ohio Medicaid as appropriate. If you have paid for Medicaid covered services inappropriately, we can work with your provider to have them issue you reimbursement.

If you have paid more than your share for covered services, or if you have received a bill for the full cost of covered medical services, go to Chapter 7 (Asking us to pay a bill you have received for covered medical services or drugs) for information about what to do.

<b>Section 4.2      What should you do if services are not covered by our plan?</b>
---

Buckeye covers all medical services that are medically necessary, are listed in the plan's Benefits Chart (this chart is in Chapter 4 of this booklet), and are obtained consistent with plan rules. You are responsible for paying the full cost of services that aren't covered by our plan, either because they are not plan covered services, or they were obtained out-of-network where not authorized.

If you have any questions about whether we will pay for any medical service or care that you are considering, you have the right to ask us whether we will cover it before you get it. If we say we will not cover your services, you have the right to appeal our decision not to cover your care.

Chapter 9 (What to do if you have a problem or complaint (coverage decisions, appeals, complaints)) has more information about what to do if you want a coverage decision from us or want to appeal a decision we have already made. You may also call Member Services at the number on the back cover of this booklet to get more information about how to do this.

For covered services that have a benefit limitation, you pay the full cost of any services you get after you have used up your benefit for that type of covered service. You can call Member

Services when you want to know how much of your benefit limit you have already used. They can also help you determine if you might be able to get additional services through Medicaid.

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## **SECTION 5      How are your medical services covered when you are in a “clinical research study”?**

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<b>Section 5.1      What is a “clinical research study”?</b>
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A clinical research study is a way that doctors and scientists test new types of medical care, like how well a new cancer drug works. They test new medical care procedures or drugs by asking for volunteers to help with the study. This kind of study is one of the final stages of a research process that helps doctors and scientists see if a new approach works and if it is safe.

Not all clinical research studies are open to members of our plan. Medicare first needs to approve the research study. If you participate in a study that Medicare has not approved, you will be responsible for paying all costs for your participation in the study.

Once Medicare approves the study, someone who works on the study will contact you to explain more about the study and see if you meet the requirements set by the scientists who are running the study. You can participate in the study as long as you meet the requirements for the study and you have a full understanding and acceptance of what is involved if you participate in the study.

If you participate in a Medicare-approved study, Original Medicare pays most of the costs for the covered services you receive as part of the study. When you are in a clinical research study, you may stay enrolled in our plan and continue to get the rest of your care (the care that is not related to the study) through our plan.

If you want to participate in a Medicare-approved clinical research study, you do not need to get approval from us or your PCP. The providers that deliver your care as part of the clinical research study do not need to be part of our plan's network of providers.

Although you do not need to get our plan's permission to be in a clinical research study, **you do need to tell us before you start participating in a clinical research study.** Here is why you need to tell us:

1. We can let you know whether the clinical research study is Medicare-approved.
2. We can tell you what services you will get from clinical research study providers instead of from our plan.

If you plan on participating in a clinical research study, contact Member Services (see Chapter 2, Section 1 of this Evidence of Coverage).

<b>Section 5.2</b>	<b>When you participate in a clinical research study, who pays for what?</b>
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Once you join a Medicare-approved clinical research study, you are covered for routine items and services you receive as part of the study, including:

- Room and board for a hospital stay that Medicare would pay for even if you weren't in a study.
- An operation or other medical procedure if it is part of the research study.
- Treatment of side effects and complications of the new care.

Original Medicare pays most of the cost of the covered services you receive as part of the study. After Medicare has paid its share of the cost for these services, our plan will also pay for part of the costs. We will pay the difference between the cost sharing in Original Medicare and your cost sharing as a member of our plan. This means you will pay the same amount for the services you receive as part of the study as you would if you received these services from our plan.

When you are part of a clinical research study, **neither Medicare nor our plan will pay for any of the following:**

- Generally, Medicare will not pay for the new item or service that the study is testing unless Medicare would cover the item or service even if you were not in a study.
- Items and services the study gives you or any participant for free.
- Items or services provided only to collect data, and not used in your direct health care. For example, Medicare would not pay for monthly CT scans done as part of the study if your condition would usually require only one CT scan.

### **Do you want to know more?**

You can get more information about joining a clinical research study by reading the publication "Medicare and Clinical Research Studies" on the Medicare website (<http://www.medicare.gov>). You can also call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

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## **SECTION 6**

### **Rules for getting care covered in a "religious non-medical health care institution"**

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<b>Section 6.1</b>	<b>What is a religious non-medical health care institution?</b>
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A religious non-medical health care institution is a facility that provides care for a condition that would ordinarily be treated in a hospital or skilled nursing facility care. If getting care in a hospital or a skilled nursing facility is against a member's religious beliefs, we will instead provide coverage for care in a religious non-medical health care institution. You may choose to pursue medical care at any time for any reason. This benefit is provided only for Part A inpatient services (non-medical health care services). Medicare will only pay for non-medical health care services provided by religious non-medical health care institutions.

<b>Section 6.2</b>	<b>What care from a religious non-medical health care institution is covered by our plan?</b>
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To get care from a religious non-medical health care institution, you must sign a legal document that says you are conscientiously opposed to getting medical treatment that is “non-excepted.”

- “Non-excepted” medical care or treatment is any medical care or treatment that is voluntary and not required by any federal, state, or local law.
- “Excepted” medical treatment is medical care or treatment that you get that is not voluntary or is required under federal, state, or local law.

To be covered by our plan, the care you get from a religious non-medical health care institution must meet the following conditions:

- The facility providing the care must be certified by Medicare.
- Our plan's coverage of services you receive is limited to non-religious aspects of care.
- If you get services from this institution that are provided to you in your home, our plan will cover these services only if your condition would ordinarily meet the conditions for coverage of services given by home health agencies that are not religious non-medical health care institutions.
- If you get services from this institution that are provided to you in a facility, the following conditions apply:
  - You must have a medical condition that would allow you to receive covered services for inpatient hospital care or skilled nursing facility care.
  - – and – you must get approval in advance from our plan before you are admitted to the facility or your stay will not be covered.

Please note: Medicare inpatient hospital coverage limits apply (see the benefits chart in Chapter 4 for more information).

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## **SECTION 7**      **Rules for ownership of durable medical equipment**

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<b>Section 7.1</b>	<b>Will you own your durable medical equipment after making a certain number of payments under our plan?</b>
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Durable medical equipment includes items such as oxygen equipment and supplies, wheelchairs, walkers, and hospital beds ordered by a provider for use in the home. Certain items, such as prosthetics, are always owned by the enrollee. In this section, we discuss other types of durable medical equipment that must be rented.

In Original Medicare, people who rent certain types of durable medical equipment own the equipment after paying co-payments for the item for 13 months. As a member of Buckeye, however, you usually will not acquire ownership of rented durable medical equipment items no matter how many copayments you make for the item while a member of our plan. Under certain

limited circumstances we will transfer ownership of the durable medical equipment item. Call member services (phone numbers are on the back cover of this booklet) to find out about the requirements you must meet and the documentation you need to provide.

**What happens to payments you have made for durable medical equipment if you switch to Original Medicare?**

If you switch to Original Medicare after being a member of our plan: If you did not acquire ownership of the durable medical equipment item while in our plan, you will have to make 13 new consecutive payments for the item while in Original Medicare in order to acquire ownership of the item. Your previous payments while in our plan do not count toward these new 13 consecutive payments.

If you made payments for the durable medical equipment item under Original Medicare before you joined our plan, these previous Original Medicare payments also do not count toward the new 13 consecutive payments. You will have to make 13 new consecutive payments for the item under Original Medicare in order to acquire ownership. There are no exceptions to this case when you return to Original Medicare.

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**Chapter 4. Benefits Chart (what is covered and what you pay)**

**SECTION 1 Understanding your out-of-pocket costs for covered services..... 39**

Section 1.1 What is the most you will pay for Medicare Part A and Part B covered medical services? .....39

**SECTION 2 Use the Benefits Chart to find out what is covered for you and how much you may pay..... 39**

Section 2.1 Your medical benefits and costs as a member of this plan .....39

**SECTION 3 What benefits are not covered by the plan or Medicare?..... 58**

Section 3.1 Benefits not covered by the plan or Medicare (exclusions).....58

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## **SECTION 1      Understanding your costs for covered services**

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This chapter focuses on what services are covered. It includes a Benefits Chart that gives a list of your covered services as a member of Buckeye. Later in this chapter, you can find information about medical services that are not covered.

<b>Section 1.1      What is the most you will pay for Medicare Part A and Part B covered medical services?</b>
--

Because you get assistance from Medicaid, you pay nothing for your covered services as long as you follow the plans' rules for getting your care and maintain full Medicaid eligibility. (See Chapter 3 for more information about the plans' rules for getting your care.)

Because you are enrolled in a Medicare Advantage Plan, there is a limit to how much you have to pay out-of-pocket each year for medical services that are covered by our plan (see the Medical Benefits Chart in Section 2, below). This limit is called the maximum out-of-pocket amount for medical services.

**Note:** Because our members also get assistance from Medicaid, very few members ever reach this out-of-pocket maximum.

As a member of Buckeye, the most you will have to pay out-of-pocket for covered Part A and Part B services in 2012 is \$3,400. The amounts you pay for deductibles, copayments, and coinsurance for covered services count toward this out-of-pocket amount. The amounts you pay for your Part D prescription drugs do not count toward your maximum out-of-pocket amount. If you reach the maximum out-of-pocket amount of \$3,400, you will not have to pay any out-of-pocket costs for the rest of the year for covered Part A and Part B services. However, you must continue to pay the Medicare Part B premium (unless your Part B premium is paid for you by Medicaid or another third party).

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## **SECTION 2      Use the Benefits Chart to find out what is covered for you and how much you will pay**

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<b>Section 2.1      Your medical benefits and costs as a member of the plan</b>
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The Benefits Chart on the following pages lists the services Buckeye covers and what you may pay out-of-pocket for each service. The services listed in the Benefits Chart are covered only when the following coverage requirements are met:

- Your Medicare covered services must be provided according to the coverage guidelines established by Medicare.
- Your services (including medical care, services, supplies, and equipment) must be medically necessary. "Medically necessary" means that the services, supplies, or drugs

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are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.

- You receive your care from a network provider. In most cases, care you receive from an out-of-network provider will not be covered. Chapter 3 provides more information about requirements for using network providers and the situations when we will cover services from an out-of-network provider.
- You have a primary care provider (a PCP) who is providing and overseeing your care. In most situations, your PCP must give you approval in advance before you can see other providers in the plan's network. This is called giving you a "referral." Chapter 3 provides more information about getting a referral and the situations when you do not need a referral.
- Some of the services listed in the Benefits Chart are covered only if your doctor or other network provider gets approval in advance (sometimes called "prior authorization") from us. Covered services that need approval in advance are marked in the Benefits Chart by an asterisk.
- For all preventive services that are covered at no cost under Original Medicare, we also cover the service at no cost to you.

For a listing of Medicaid-covered services, please see Section IV of your Summary of Benefits or call the state Medicaid program (contact information found in Section 6 of Chapter 2).

## Benefits Chart

Services that are covered for you	What you must pay when you get these services
<b>Inpatient Care</b>	
<p><b>Inpatient hospital care</b>                      Covered services include:</p> <ul style="list-style-type: none"> <li>• Semi-private room (or a private room if medically necessary)</li> <li>• Meals including special diets</li> <li>• Regular nursing services</li> <li>• Costs of special care units (such as intensive care or coronary care units)</li> <li>• Drugs and medications</li> <li>• Lab tests</li> <li>• X-rays and other radiology services</li> <li>• Necessary surgical and medical supplies</li> <li>• Use of appliances, such as wheelchairs</li> <li>• Operating and recovery room costs</li> <li>• Physical, occupational, and speech language therapy</li> <li>• Inpatient substance abuse services</li> <li>• Under certain conditions, the following types of transplants are covered: corneal, kidney, kidney-pancreatic, heart, liver, lung, heart/lung, bone marrow, stem cell, and intestinal/multivisceral. If you need a transplant, we will arrange to have your case reviewed by a Medicare-approved transplant center that will decide whether you are a candidate for a transplant. If Buckeye provides transplant services at this distant location (farther away than the normal community patterns of care) and you chose to obtain transplants at this distant location, we may arrange or pay for appropriate lodging and transportation costs for you and a companion.</li> <li>• Blood - including storage and administration. Coverage of whole blood and packed red cells begins only with the fourth pint of blood that you need - you pay for the first 3 pints of unreplaced blood. All other components of blood are covered beginning with the first pint used.</li> <li>• Physician services</li> </ul>	<p>For each benefit period in 2011, there was an enrollee copayment of:                      Days 1–60: \$1,132 deductible                      Days 61–90: \$283 per day                      Days 91–150: \$566 per lifetime reserve day                      *These costs increased for 2012.</p> <p><i>All costs are paid by Medicaid if you have full Medicaid.</i></p> <p>A “benefit period” starts the day you go into a hospital or skilled nursing unit. It ends when you go 60 days in a row without hospital or skilled nursing care. If you go into the hospital after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods you can have.</p> <p>If you get authorized inpatient care at an out-of-network hospital after your emergency condition is stabilized, your cost is the cost-</p>

<p><b>Services that are covered for you</b></p>	<p><b>What you must pay when you get these services</b></p>
<p><b>Note:</b> To be an inpatient, your provider must write an order to admit you to the hospital. Even if you stay in the hospital overnight, you might still be considered an “outpatient.” If you are not sure if you are an inpatient, you should ask the hospital staff.</p> <p>You can also find more information in a Medicare fact sheet called “Are You a Hospital Inpatient or Outpatient? If You Have Medicare – Ask!” This fact sheet is available on the Web at <a href="http://www.medicare.gov/Publications/Pubs/pdf/11435.pdf">http://www.medicare.gov/Publications/Pubs/pdf/11435.pdf</a> or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. You can call these numbers for free, 24 hours a day, 7 days a week.</p>	<p>sharing you would pay at a network hospital.</p>
<p><b>Inpatient mental health care</b></p> <ul style="list-style-type: none"> <li>• Covered services include mental health care services that require a hospital stay. There is a 190-day lifetime limit for inpatient services in a psychiatric hospital. The 190-day limit does not apply to Mental Health services provided in a psychiatric unit of a general hospital.</li> </ul>	<p>Same deductible and co-pay as inpatient hospital care above.</p>
<p><b>Skilled nursing facility (SNF) care</b></p> <p>(For a definition of “skilled nursing facility care,” see Chapter 12 of this booklet. Skilled nursing facilities are sometimes called “SNFs.”)</p> <p>Covered services include:</p> <ul style="list-style-type: none"> <li>• Semiprivate room (or a private room if medically necessary)</li> <li>• Meals, including special diets</li> <li>• Regular nursing services</li> <li>• Physical therapy, occupational therapy, and speech therapy</li> <li>• Drugs administered to you as part of your plan of care (This includes substances that are naturally present in the body, such as blood clotting factors.)</li> <li>• Blood - including storage and administration. Coverage of whole blood and packed red cells begins only with the fourth pint of blood that you need - you pay for the first 3 pints of unreplaced blood. All other components of blood are covered beginning with</li> </ul>	<p>For each benefit period in 2011, there was an enrollee copayment of:                      Days 1–20: \$0 per day                      Days 21-100: \$141.50 per day <i>*This cost increased for 2012.</i></p> <p><i>All costs are paid by Medicaid if you have full Medicaid.</i></p> <p>No prior hospital stay is required.</p>

<p><b>Services that are covered for you</b></p>	<p><b>What you must pay when you get these services</b></p>
<p>the first pint used.</p> <ul style="list-style-type: none"> <li>• Medical and surgical supplies ordinarily provided by SNFs</li> <li>• Laboratory tests ordinarily provided by SNFs</li> <li>• X-rays and other radiology services ordinarily provided by SNFs</li> <li>• Use of appliances such as wheelchairs ordinarily provided by SNFs</li> <li>• Physician services</li> </ul> <p>Generally, you will get your SNF care from plan facilities. However, under certain conditions listed below, you may be able to get your care from a facility that isn't a plan provider, if the facility accepts our plan's amounts for payment.</p> <ul style="list-style-type: none"> <li>• A nursing home or continuing care retirement community where you were living right before you went to the hospital (as long as it provides skilled nursing facility care).</li> <li>• A SNF where your spouse is living at the time you leave the hospital.</li> </ul>	<p>There are 100 days covered for each benefit period.</p> <p>A "benefit period" starts the day you go into a hospital or skilled nursing unit. It ends when you go 60 days in a row without hospital or skilled nursing care. If you go into the hospital after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods you can have.</p>
<p><b>Inpatient services covered during a non-covered inpatient stay</b></p> <p>If you have exhausted your inpatient benefits or if the inpatient stay is not reasonable and necessary, we will not cover your inpatient stay. However, in some cases, we will cover certain services you receive while you are in the hospital or the skilled nursing facility (SNF) stay. Covered services include but are not limited to:</p> <ul style="list-style-type: none"> <li>• Physician services</li> <li>• Diagnostic tests (like lab tests)</li> <li>• X-ray, radium, and isotope therapy including technician materials and services</li> <li>• Surgical dressings</li> <li>• Splints, casts and other devices used to reduce fractures and dislocations</li> <li>• Prosthetics and orthotics devices (other than dental) that replace all or part of an internal body organ (including contiguous tissue), or all or part of the function of a permanently inoperative</li> </ul>	<p>For covered services, you must pay the standard co-pay or coinsurance. For example, you must pay 20% of the costs for physician services (see later section, "Physician Services").</p> <p><i>All costs are paid by Medicaid if you have full Medicaid.</i></p> <p>For all other services, you must pay 100% once the benefit period has been exhausted or if the service has been denied by the plan – unless the service is covered by Medicaid and</p>

<p><b>Services that are covered for you</b></p>	<p><b>What you must pay when you get these services</b></p>
<p>or malfunctioning internal body organ, including replacement or repairs of such devices</p> <ul style="list-style-type: none"> <li>• Leg, arm, back, and neck braces; trusses, and artificial legs, arms, and eyes including adjustments, repairs, and replacements required because of breakage, wear, loss, or a change in the patient’s physical condition</li> <li>• Physical therapy, speech therapy, and occupational therapy</li> </ul>	<p>has not been denied for medical necessity.</p>
<p><b>Home health agency care</b></p> <p>Covered services include:</p> <ul style="list-style-type: none"> <li>• Part-time or intermittent skilled nursing and home health aide services (To be covered under the home health care benefit, your skilled nursing and home health aide services combined must total fewer than 8 hours per day and 35 hours per week)</li> <li>• Physical therapy, occupational therapy, and speech therapy</li> <li>• Medical and social services</li> <li>• Medical equipment and supplies</li> </ul>	<p>There is no cost for Medicare-covered home health visits.</p>
<p><b>Hospice care</b></p> <p>You may receive care from any Medicare-certified hospice program. Your hospice doctor can be a network provider or an out-of-network provider.</p> <p>Original Medicare (rather than our plan) will pay for your hospice services and any Part A and Part B services related to your terminal condition. While you are in the hospice program, your hospice provider will bill Original Medicare for the services that Original Medicare pays for.</p> <p>Covered services include:</p> <ul style="list-style-type: none"> <li>• Drugs for symptom control and pain relief</li> <li>• Short-term respite care</li> <li>• Home care</li> </ul> <p>You are still a member of our plan. If you need non-hospice care (care that is not related to your terminal condition), you have two options:</p>	<p>When you enroll in a Medicare-certified hospice program, your hospice services and your Part A and Part B services related to your terminal condition are paid for by Original Medicare, not Buckeye.</p> <p>For the one-time consultation, 20% of the costs for the doctor visit.</p> <p><i>All costs are paid by Medicaid if you have full Medicaid.</i></p>

Services that are covered for you	What you must pay when you get these services
<ul style="list-style-type: none"> <li>You can obtain your non-hospice care from plan providers. In this case, you only pay plan allowed cost sharing</li> <li>--or-- You can get your care covered by Original Medicare. In this case, you must pay the cost-sharing amounts under Original Medicare, except for emergency or urgently needed care. However, after payment, you can ask us to pay you back for the difference between the cost sharing in our plan and the cost sharing under Original Medicare.</li> </ul> <p><b>Note:</b> If you need non-hospice care (care that is not related to your terminal condition), you should contact us to arrange the services. Getting your non-hospice care through our network providers will lower your share of the costs for the services.</p> <p>Our plan covers hospice consultation services (one time only) for a terminally ill person who hasn't elected the hospice benefit.</p>	
Outpatient Services	
<p><b>Physician services, including doctor's office visits</b></p> <p>Covered services include:</p> <ul style="list-style-type: none"> <li>Medically-necessary medical or surgical services furnished in a physician's office, certified ambulatory surgical center, hospital outpatient department, or any other location</li> <li>Consultation, diagnosis, and treatment by a specialist</li> <li>Basic hearing and balance exams performed, if your doctor orders it to see if you need medical treatment</li> <li>Tele-health office visits including consultation, diagnosis and treatment by a specialist</li> <li>Second opinion by another network provider prior to surgery</li> <li>Non-routine dental care (covered services are limited to surgery of the jaw or related structures, setting fractures of the jaw or facial bones, extraction of teeth to prepare the jaw for radiation treatments of neoplastic cancer disease, or services that would be covered when provided by a physician). For additional covered dental services, refer to the end of this chart.</li> </ul>	<p>20% of the costs for each in-network <b>primary care doctor</b> visit for Medicare covered services.</p> <p>20% of the costs for each in-network <b>specialist*</b> visit for Medicare covered services.</p> <p>20% of the costs for each in-network <b>urgent care</b> visit for Medicare covered services.</p> <p><i>All costs are paid by Medicaid if you have full Medicaid.</i></p>

<p><b>Services that are covered for you</b></p>	<p><b>What you must pay when you get these services</b></p>
<p><b>Outpatient hospital services</b></p> <p>We cover medically-necessary services you get in the outpatient department of a hospital for diagnosis or treatment of an illness or injury.</p> <p>Covered services include:</p> <ul style="list-style-type: none"> <li>• Services in an emergency department or outpatient clinic, including same-day surgery</li> <li>• Laboratory tests billed by the hospital</li> <li>• Mental health care, including care in a partial-hospitalization program, if a doctor certifies that inpatient treatment would be required without it</li> <li>• X-rays and other radiology services billed by the hospital</li> <li>• Medical supplies such as splints and casts</li> <li>• Certain screenings and preventive services</li> <li>• Certain drugs and biologicals that you can't give yourself</li> </ul> <p><b>Note:</b> Unless the provider has written an order to admit you as an inpatient to the hospital, you are an outpatient and pay the cost-sharing amounts for outpatient hospital services. Even if you stay in the hospital overnight, you might still be considered an "outpatient." If you are not sure if you are an outpatient, you should ask the hospital staff.</p> <p>You can also find more information in a Medicare fact sheet called "Are You a Hospital Inpatient or Outpatient? If You Have Medicare – Ask!" This fact sheet is available on the Web at <a href="http://www.medicare.gov/Publications/Pubs/pdf/11435.pdf">http://www.medicare.gov/Publications/Pubs/pdf/11435.pdf</a> or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. You can call these numbers for free, 24 hours a day, 7 days a week.</p>	<p>20% of the costs for each in-network outpatient hospital facility visit for Medicare covered services.</p> <p><i>All costs are paid by Medicaid if you have full Medicaid.</i></p>
<p><b>Chiropractic services</b></p> <p>Covered services include:</p> <ul style="list-style-type: none"> <li>• We cover only manual manipulation of the spine to correct subluxation</li> </ul>	<p>20% of the costs for each chiropractic visit for Medicare covered services.</p> <p><i>All costs are paid by Medicaid if you have full Medicaid.</i></p>

<b>Services that are covered for you</b>	<b>What you must pay when you get these services</b>
<p><b>Podiatry services</b></p> <p>Covered services include:</p> <ul style="list-style-type: none"> <li>• Treatment of injuries and diseases of the feet (such as hammer toe or heel spurs).</li> <li>• Routine foot care for members with certain medical conditions affecting the lower limbs.</li> </ul>	<p>20% of the costs for each podiatry visit for Medicare covered services. <i>All costs are paid by Medicaid if you have full Medicaid.</i></p>
<p><b>Outpatient mental health care</b></p> <p>Covered services include:</p> <p>Mental health services provided by a doctor, clinical psychologist, clinical social worker, clinical nurse specialist, nurse practitioner, physician assistant, or other Medicare-qualified mental health care professional as allowed under applicable state laws.</p>	<p>45% of the costs for each Medicare covered visit. <i>All costs are paid by Medicaid if you have full Medicaid.</i></p>
<p><b>Partial hospitalization services</b></p> <p>“Partial hospitalization” is a structured program of active psychiatric treatment provided in a hospital outpatient setting or by a community mental health center, that is more intense than the care received in your doctor’s or therapist’s office and is an alternative to inpatient hospitalization.</p>	<p>20% of the costs for each Medicare covered visit. <i>All costs are paid by Medicaid if you have full Medicaid.</i></p>
<p><b>Outpatient substance abuse services</b></p>	<p>45% of the costs for each Medicare covered visit. <i>All costs are paid by Medicaid if you have full Medicaid.</i></p>
<p><b>Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers</b></p> <p><b>Note:</b> If you are having surgery in a hospital, you should check with your provider about whether you will be an inpatient or outpatient. Unless the provider writes an order to admit you as an inpatient to the hospital, you are an outpatient and pay the cost-sharing amounts for outpatient surgery. Even if you stay in the hospital overnight, you might still be considered an “outpatient.”</p>	<p>20% of the costs for each Medicare covered ambulatory surgical center or outpatient hospital facility visit. <i>All costs are paid by Medicaid if you have full Medicaid.</i></p>

<p><b>Services that are covered for you</b></p>	<p><b>What you must pay when you get these services</b></p>
<p><b>Ambulance services</b></p> <ul style="list-style-type: none"> <li>• Covered ambulance services include fixed wing, rotary wing, and ground ambulance services, to the nearest appropriate facility that can provide care only if they are furnished to a member whose medical condition is such that other means of transportation are contraindicated (could endanger the person's health) or if authorized by the plan. The member's condition must require both the ambulance transportation itself and the level of service provided in order for the billed service to be considered medically necessary.</li> <li>• Non-emergency transportation by ambulance is appropriate if it is documented that the member's condition is such that other means of transportation are contraindicated (could endanger the person's health) and that transportation by ambulance is medically required.</li> </ul>	<p>20% of the cost of Medicare covered ambulance benefit.</p> <p><i>All costs are paid by Medicaid if you have full Medicaid.</i></p>
<p><b>Emergency care</b></p> <p>Emergency care is care that is needed to evaluate or stabilize an emergency medical condition.</p> <p>A medical emergency is when you, or any other prudent layperson with an average knowledge of health and medicine, believe that you have medical symptoms that require immediate medical attention to prevent loss of life, loss of a limb, or loss of function of a limb. The medical symptoms may be an illness, injury, severe pain, or a medical condition that is quickly getting worse. Medicare only covers emergency care within the United States or its territories.</p>	<p>20% of the cost (up to \$50) for Medicare covered emergency room visits, which is waived if you are admitted within 3 days.</p> <p><i>All costs are paid by Medicaid if you have full Medicaid.</i></p>
<p><b>Urgently needed care</b></p> <p>Urgently needed care is care provided to treat a non-emergency, unforeseen medical illness, injury, or condition, that requires immediate medical care, but the plan's network of providers is temporarily unavailable or inaccessible. Medicare only covers urgently needed care within the United States or its territories.</p>	<p>20% of the cost for Medicare covered urgently needed care.</p> <p><i>All costs are paid by Medicaid if you have full Medicaid.</i></p>

<b>Services that are covered for you</b>	<b>What you must pay when you get these services</b>
<p><b>Outpatient rehabilitation services</b></p> <p>Covered services include: physical therapy, occupational therapy, and speech language therapy. Outpatient rehabilitation services are provided in various outpatient settings, such as hospital outpatient departments, independent therapist offices, and Comprehensive Outpatient Rehabilitation Facilities (CORFs).</p>	<p>20% of the cost for Medicare covered benefits.  <i>All costs are paid by Medicaid if you have full Medicaid.</i></p>
<p><b>Cardiac rehabilitation services</b></p> <p>Comprehensive programs that include exercise, education, and counseling are covered for members who meet certain conditions with a doctor’s order. The plan also covers intensive cardiac rehabilitation programs that are typically more rigorous or more intense than cardiac rehabilitation programs.</p>	<p>20% of the cost for Medicare covered benefits.  <i>All costs are paid by Medicaid if you have full Medicaid.</i></p>
<p><b>Pulmonary rehabilitation services</b></p> <p>Comprehensive programs of pulmonary rehabilitation are covered for members who have moderate to very severe chronic obstructive pulmonary disease (COPD) and an order for pulmonary rehabilitation from the doctor treating their chronic respiratory disease.</p>	<p>20% of the cost for Medicare covered benefits.  <i>All costs are paid by Medicaid if you have full Medicaid.</i></p>
<p><b>Durable medical equipment and related supplies</b></p> <p>(For a definition of “durable medical equipment,” see Chapter 12 of this booklet.)</p> <p>Covered items include, but are not limited to: wheelchairs, crutches, hospital bed, IV infusion pump, oxygen equipment, nebulizer, and walker.</p>	<p>20% of the cost for Medicare covered benefits.  <i>All costs are paid by Medicaid if you have full Medicaid.</i></p>
<p><b>Prosthetic devices and related supplies</b></p> <p>Devices (other than dental) that replace a body part or function. These include, but are not limited to: colostomy bags and supplies directly related to colostomy care, pacemakers, braces, prosthetic shoes, artificial limbs, and breast prostheses (including a surgical brassiere after a mastectomy). Includes certain supplies related to prosthetic devices, and repair and/or replacement of prosthetic devices. Also includes some coverage following cataract removal or cataract surgery – see “Vision Care” later in this section for more detail.</p>	<p>20% of the cost for Medicare covered benefits.  <i>All costs are paid by Medicaid if you have full Medicaid.</i></p>

<p><b>Services that are covered for you</b></p>	<p><b>What you must pay when you get these services</b></p>
<p><b>Diabetes self-management training, diabetic services and supplies</b></p> <p>For all people who have diabetes (insulin and non-insulin users). Covered services include:</p> <ul style="list-style-type: none"> <li>• Blood glucose monitor, blood glucose test strips, lancet devices and lancets, and glucose-control solutions for checking the accuracy of test strips and monitors.</li> <li>• For people with diabetes who have severe diabetic foot disease: One pair per calendar year of therapeutic custom-molded shoes (including inserts provided with such shoes) and two additional pairs of inserts, or one pair of depth shoes and three pairs of inserts (not including the non-customized removable inserts provided with such shoes). Coverage includes fitting.</li> <li>• Diabetes self-management training is covered under certain conditions.</li> </ul>	<p>0% of the cost for diabetes self-monitoring training.</p> <p>20% of the cost for Medicare covered diabetes supplies.</p> <p><i>All costs are paid by Medicaid if you have full Medicaid.</i></p>
<p><b>Outpatient diagnostic tests and therapeutic services and supplies</b></p> <p>Covered services include, but are not limited to:</p> <ul style="list-style-type: none"> <li>• X-rays</li> <li>• Radiation (radium and isotope) therapy including technician materials and supplies</li> <li>• Surgical supplies, such as dressings</li> <li>• Splints, casts and other devices used to reduce fractures and dislocations</li> <li>• Laboratory tests</li> <li>• Blood. Coverage begins with the fourth pint of blood that you need – you pay for the first 3 pints of unreplaced blood. Coverage of storage and administration begins with the first pint of blood that you need.</li> <li>• Other outpatient diagnostic tests</li> </ul>	<p>0% of the cost for Medicare-covered lab, cardiovascular screening, and EKG screening services.</p> <p>20% of the cost for other Medicare covered diagnostic tests and therapeutic services.</p> <p><i>All costs are paid by Medicaid if you have full Medicaid.</i></p>

<b>Services that are covered for you</b>	<b>What you must pay when you get these services</b>
<p><b>Vision care</b></p> <p>Covered services include:</p> <ul style="list-style-type: none"> <li>• Outpatient physician services for the diagnosis and treatment of diseases and conditions of the eye. Original Medicare doesn't cover routine eye exams (eye refractions) for eyeglasses/contacts.</li> <li>• For people who are at high risk of glaucoma, such as people with a family history of glaucoma, people with diabetes, and African-Americans who are age 50 and older: glaucoma screening once per year.</li> <li>• One pair of eyeglasses or contact lenses after each cataract surgery that includes insertion of an intraocular lens. (If you have two separate cataract operations, you cannot reserve the benefit after the first surgery and purchase two eyeglasses after the second surgery.) Corrective lenses/frames (and replacements) needed after a cataract removal without a lens implant.</li> <li>• Our plan covers additional vision benefits – see Additional Benefits section at the end of this chart.</li> </ul>	<p>20% of the cost for Medicare covered benefits.</p> <p><i>All costs are paid by Medicaid if you have full Medicaid.</i></p>
<p><b>Preventive Services</b></p>	
<p>For all preventive services that are covered at no cost under Original Medicare, we also cover the service at no cost to you.</p>	
<p><b>Abdominal aortic aneurysm screening</b></p> <p>A one-time screening ultrasound for people at risk. The plan only covers this screening if you get a referral for it as a result of your "Welcome to Medicare" physical exam.</p>	<p>0% of the cost for Medicare covered benefits.</p>

<p><b>Services that are covered for you</b></p>	<p><b>What you must pay when you get these services</b></p>
<p><b>Bone mass measurement</b></p> <p>For qualified individuals (generally, this means people at risk of losing bone mass or at risk of osteoporosis), the following services are covered every 24 months or more frequently if medically necessary: procedures to identify bone mass, detect bone loss, or determine bone quality, including a physician’s interpretation of the results.</p>	<p>0% of the cost for Medicare covered benefits.</p>
<p><b>Colorectal cancer screening</b></p> <p>For people 50 and older, the following are covered:</p> <ul style="list-style-type: none"> <li>• Flexible sigmoidoscopy (or screening barium enema as an alternative) every 48 months</li> <li>• Fecal occult blood test, every 12 months</li> </ul> <p>For people at high risk of colorectal cancer, we cover:</p> <ul style="list-style-type: none"> <li>• Screening colonoscopy (or screening barium enema as an alternative) every 24 months</li> </ul> <p>For people not at high risk of colorectal cancer, we cover:</p> <ul style="list-style-type: none"> <li>• Screening colonoscopy every 10 years (120 months), but not within 48 months of a screening sigmoidoscopy</li> </ul>	<p>0% of the cost for Medicare covered benefit</p>
<p><b>HIV screening</b></p> <p>For people who ask for an HIV screening test or who are at increased risk for HIV infection, we cover:</p> <ul style="list-style-type: none"> <li>• One screening exam every 12 months</li> </ul> <p>For women who are pregnant, we cover:</p> <ul style="list-style-type: none"> <li>• Up to three screening exams during a pregnancy</li> </ul>	<p>0% of the cost for Medicare covered benefits</p>
<p><b>Immunizations</b></p> <p>Covered Medicare Part B services include:</p> <ul style="list-style-type: none"> <li>• Pneumonia vaccine</li> <li>• Flu shots, once a year in the fall or winter</li> <li>• Hepatitis B vaccine if you are at high or intermediate risk of getting Hepatitis B</li> <li>• Other vaccines if you are at risk and they meet Medicare Part B coverage rules</li> </ul> <p>We also cover some vaccines under our Part D prescription drug benefit.</p>	<p>0% of the cost for Medicare covered benefits.</p>

<b>Services that are covered for you</b>	<b>What you must pay when you get these services</b>
<p><b>Breast cancer screening (mammograms)</b></p> <p>Covered services include:</p> <ul style="list-style-type: none"> <li>• One baseline mammogram between the ages of 35 and 39</li> <li>• One screening mammogram every 12 months for women age 40 and older</li> <li>• Clinical breast exams once every 24 months</li> </ul>	<p>0% of the cost for Medicare covered benefits.</p>
<p><b>Cervical and vaginal cancer screening</b></p> <p>Covered services include:</p> <ul style="list-style-type: none"> <li>• For all women: Pap tests and pelvic exams are covered once every 24 months</li> <li>• If you are at high risk of cervical cancer or have had an abnormal Pap test and are of childbearing age: one Pap test every 12 months</li> </ul>	<p>0% of the cost for Medicare covered benefits</p>
<p><b>Prostate cancer screening exams</b></p> <p>For men age 50 and older, covered services include the following - once every 12 months:</p> <ul style="list-style-type: none"> <li>• Digital rectal exam</li> <li>• Prostate Specific Antigen (PSA) test</li> </ul>	<p>0% of the cost for Medicare covered benefits</p>
<p><b>Cardiovascular disease testing</b></p> <p>Blood tests for the detection of cardiovascular disease (or abnormalities associated with an elevated risk of cardiovascular disease) once every 5 years (60 months).</p>	<p>0% of the cost for Medicare covered benefits.</p>
<p><b>“Welcome to Medicare” physical exam</b></p> <p>The plan covers a one-time “Welcome to Medicare” physical exam, which includes a review of your health, as well as education and counseling about the preventive services you need (including certain screenings and shots), and referrals for other care if needed.</p> <p><b>Important:</b> You must have the physical exam within the first 12 months you have Medicare Part B. When you make your appointment, let your doctor’s office know you would like to schedule your “Welcome to Medicare” physical exam.</p>	<p>There is no coinsurance, copayment, or deductible for the Welcome to Medicare exam.</p>

<p><b>Services that are covered for you</b></p>	<p><b>What you must pay when you get these services</b></p>
<p><b>Annual wellness visit</b></p> <p>If you've had Part B for longer than 12 months, you can get an annual wellness visit to develop or update a personalized prevention plan based on your current health and risk factors. This is covered once every 12 months.</p> <p><b>Note:</b> Your first annual wellness visit can't take place within 12 months of your "Welcome to Medicare" exam. However, you don't need to have had a "Welcome to Medicare" exam to be covered for annual wellness visits after you've had Part B for 12 months.</p>	<p>There is no coinsurance, copayment, or deductible for the annual wellness visit.</p>
<p><b>Diabetes screening</b></p> <p>We cover this screening (includes fasting glucose tests) if you have any of the following risk factors: high blood pressure (hypertension), history of abnormal cholesterol and triglyceride levels (dyslipidemia), obesity, or a history of high blood sugar (glucose). Tests may also be covered if you meet other requirements, like being overweight and having a family history of diabetes.</p> <p>Based on the results of these tests, you may be eligible for up to two diabetes screenings every 12 months.</p>	<p>0% of the cost for Medicare covered benefits</p>
<p><b>Medical nutrition therapy</b></p> <p>This benefit is for people with diabetes, renal (kidney) disease (but not on dialysis), or after a transplant when ordered by your doctor.</p> <p>We cover 3 hours of one-on-one counseling services during your first year that you receive medical nutrition therapy services under Medicare (this includes our plan, any other Medicare Advantage plan, or Original Medicare), and 2 hours each year after that. If your condition, treatment, or diagnosis changes, you may be able to receive more hours of treatment with a physician's order. A physician must prescribe these services and renew their order yearly if your treatment is needed into another calendar year.</p>	<p>0% of the cost for Medicare covered benefits</p>

<p><b>Services that are covered for you</b></p>	<p><b>What you must pay when you get these services</b></p>
<p><b>Smoking and tobacco use cessation (counseling to stop smoking)</b></p> <p>If you use tobacco, but do not have signs or symptoms of tobacco-related disease: we cover two counseling quit attempts within a 12-month period. Each counseling attempt includes up to four face-to-face visits.</p> <p>If you use tobacco and have been diagnosed with a tobacco-related disease or are taking medicine that may be affected by tobacco: we cover cessation counseling services. We cover two counseling quit attempts within a 12-month period. Each counseling attempt includes up to four face-to-face visits, however, you will pay the applicable inpatient or outpatient cost sharing.</p>	<p>If you haven't been diagnosed with an illness caused or complicated by tobacco use:                      0% of the cost for Medicare covered benefits</p> <p>If you have been diagnosed with an illness caused or complicated by tobacco use, or you take a medicine that is affected by tobacco:                      0% of the cost for Medicare covered benefits</p>
<p><b>Other Services</b></p>	
<p><b>Services to treat kidney disease and conditions</b></p> <p>Covered services include:</p> <ul style="list-style-type: none"> <li>• Kidney disease education services to teach kidney care and help members make informed decisions about their care. For members with stage IV chronic kidney disease when referred by their doctor, we cover up to six sessions of kidney disease education services per lifetime.</li> <li>• Outpatient dialysis treatments (including dialysis treatments when temporarily out of the service area, as explained in Chapter 3)</li> <li>• Inpatient dialysis treatments (if you are admitted as an inpatient to a hospital for special care)</li> <li>• Self-dialysis training (includes training for you and anyone helping you with your home dialysis treatments)</li> <li>• Home dialysis equipment and supplies</li> <li>• Certain home support services (such as, when necessary, visits by trained dialysis workers to check on your home dialysis, to help in emergencies, and check your dialysis equipment and water supply)</li> </ul> <p>Certain drugs for dialysis are covered under your Medicare Part B drug benefit. For information about coverage for Part B Drugs, please go to the section below, "Medicare Part B prescription drugs."</p>	<p>20% of the cost for renal dialysis.</p> <p>0% of the cost for nutritional therapy for end stage renal disease.</p> <p><i>All costs are paid by Medicaid if you have full Medicaid.</i></p>

<b>Services that are covered for you</b>	<b>What you must pay when you get these services</b>
<p><b>Medicare Part B prescription drugs</b></p> <p>These drugs are covered under Part B of Original Medicare. Members of our plan receive coverage for these drugs through our plan. Covered drugs include:</p> <ul style="list-style-type: none"> <li>• Drugs that usually aren't self-administered by the patient and are injected or infused while you are getting physician, hospital outpatient, or ambulatory surgical center services</li> <li>• Drugs you take using durable medical equipment (such as nebulizers) that was authorized by the plan</li> <li>• Clotting factors you give yourself by injection if you have hemophilia</li> <li>• Immunosuppressive drugs, if you were enrolled in Medicare Part A at the time of the organ transplant</li> <li>• Injectable osteoporosis drugs, if you are homebound, have a bone fracture that a doctor certifies was related to post-menopausal osteoporosis, and cannot self-administer the drug</li> <li>• Antigens</li> <li>• Certain oral anti-cancer drugs and anti-nausea drugs</li> <li>• Certain drugs for home dialysis, including heparin, the antidote for heparin when medically necessary, topical anesthetics, and erythropoiesis-stimulating agents (such as Epogen®, Procrit®, Epoetin Alfa, Aranesp®, or Darbepoetin Alfa)</li> <li>• Intravenous Immune Globulin for the home treatment of primary immune deficiency diseases</li> </ul> <p>Chapter 5 explains the Part D prescription drug benefit, including rules you must follow to have prescriptions covered. What you pay for your Part D prescription drugs through our plan is listed in Chapter 6.</p>	<p>20% of the cost for Medicare covered Part B prescription drugs.</p> <p><i>All costs are paid by Medicaid if you have full Medicaid.</i></p>
<p><b>Additional Medicare Benefits</b></p>	
<p><b>Dental services</b></p> <p>Covered services include:</p> <ul style="list-style-type: none"> <li>• One oral exam and cleaning every year.</li> <li>• Comprehensive restorative amalgam or resin-based composite fillings once per tooth per year.</li> </ul>	<p>There is no copayment for these services.</p>

<b>Services that are covered for you</b>	<b>What you must pay when you get these services</b>
<p><b>Hearing services</b></p> <p>Covered services include:</p> <ul style="list-style-type: none"> <li>• Basic hearing evaluations performed by your provider are covered as outpatient care when furnished by a physician, audiologist, or other qualified provider.</li> <li>• Up to \$750 for a hearing aid every year.</li> </ul>	<p>There is no copayment for these services.</p>
<p><b>Vision care</b></p> <p>Covered services include:</p> <ul style="list-style-type: none"> <li>• One routine eye exam every year.</li> <li>• Up to \$300 every two years for eyewear including lenses, frames, contacts, and upgrades.</li> </ul>	<p>There is no copayment for these services.</p>
<p><b>Health and wellness education programs</b></p> <ul style="list-style-type: none"> <li>• Health Club Membership/Fitness Classes: Up to \$250 reimbursement per year for health club membership fees.</li> <li>• NurseWise: a free 24-hour information line staffed with registered nurses available to answer health questions.</li> <li>• Care Management Programs: Buckeye has many care management programs for people with serious conditions such as asthma, diabetes, congestive heart failure, coronary artery disease, etc.</li> </ul>	<p>There is no copayment for these services.</p>
<p><b>Transportation</b></p> <ul style="list-style-type: none"> <li>• 30 round trips (60 one-way) per year to plan approved locations such as Medicare medical appointments and ODJFS Medicaid redetermination appointments.</li> </ul>	<p>There is no copayment for these services.</p>
<p><b>Over-the-counter (OTC) supplies</b></p> <p>Covered services include up to \$25 per month for certain supplies shipped free to your home from our mail order pharmacy, Rx Direct. Contact Member Services for an order form and assistance with ordering supplies or go online to <a href="http://www.bchpohio.com">www.bchpohio.com</a></p>	<p>There is no copayment for these services.</p>
<p><b>Emergency Medical Response System</b></p> <p>Covered services include a pendant that gives members an easy way to call for help at any time of the day or night.</p>	<p>There is no copayment for these services.</p>

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## **SECTION 3      What benefits are not covered by the plan?**

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<b>Section 3.1      Benefits not covered by the plan or Medicare (exclusions)</b>
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This section tells you what kinds of benefits are “excluded” by Medicare. Excluded means that the plan doesn’t cover these benefits. In some cases, Medicaid covers items or services that are excluded by Medicare. For more information about Medicaid benefits, call Member Services (phone numbers are on the back cover of this booklet).

The list below describes some services and items that aren’t covered by the plan under any conditions and some that are excluded by the plan only under specific conditions.

We won’t pay for the excluded medical benefits listed in this section (or elsewhere in this booklet), and neither will Original Medicare. The only exception: if a benefit on the exclusion list is found upon appeal to be a medical benefit that we should have paid for or covered because of your specific situation. (For information about appealing a decision we have made to not cover a medical service, go to Chapter 9, Section 6.3 in this booklet.)

In addition to any exclusions or limitations described in the Benefits Chart, or anywhere else in this Evidence of Coverage, **the following items and services aren’t covered under Original Medicare or by our plan.**

- Services considered not reasonable and necessary, according to the standards of Original Medicare, unless these services are listed by our plan as covered services.
- Experimental medical and surgical procedures, equipment and medications, unless covered by Original Medicare or under a Medicare-approved clinical research study. (See Chapter 3, Section 5 for more information on clinical research studies.) Experimental procedures and items are those items and procedures determined by our plan and Original Medicare to not be generally accepted by the medical community.
- Surgical treatment for morbid obesity, except when it is considered medically necessary and covered under Original Medicare.
- Private room in a hospital, except when it is considered medically necessary.
- Private duty nurses.
- Personal items in your room at a hospital or a skilled nursing facility, such as a telephone or a television.
- Full-time nursing care in your home.
- Custodial care, unless it is provided with covered skilled nursing care and/or skilled rehabilitation services. Custodial care, or non-skilled care, is care that helps you with activities of daily living, such as bathing or dressing.
- Homemaker services include basic household assistance, including light housekeeping or light meal preparation.

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- Fees charged by your immediate relatives or members of your household.
  - Meals delivered to your home.
  - Elective or voluntary enhancement procedures or services (including weight loss, hair growth, sexual performance, athletic performance, cosmetic purposes, anti-aging and mental performance), except when medically necessary.
  - Cosmetic surgery or procedures, unless because of an accidental injury or to improve a malformed part of the body. However, all stages of reconstruction are covered for a breast after a mastectomy, as well as for the unaffected breast to produce a symmetrical appearance.
  - Routine dental care, such as cleanings, fillings or dentures, beyond the annual visit and fillings as detailed in the table above. However, non-routine dental care required to treat illness or injury may be covered as inpatient or outpatient care.
  - Chiropractic care, other than manual manipulation of the spine consistent with Medicare coverage guidelines.
  - Routine foot care, except for the limited coverage provided according to Medicare guidelines.
  - Orthopedic shoes, unless the shoes are part of a leg brace and are included in the cost of the brace or the shoes are for a person with diabetic foot disease.
  - Supportive devices for the feet, except for orthopedic or therapeutic shoes for people with diabetic foot disease.
  - Routine hearing exams, hearing aids, or exams to fit hearing aids beyond the annual exam and hearing aid coverage detailed above (\$750 annual limit).
  - Eyeglasses, routine eye examinations, radial keratotomy, LASIK surgery, vision therapy and other low vision aids beyond the annual eye exam and eyewear covered as detailed above (\$300 annual limit). However, eyeglasses are covered for people after cataract surgery.
  - Reversal of sterilization procedures, sex change operations, and non-prescription contraceptive supplies.
  - Acupuncture.
  - Naturopath services (uses natural or alternative treatments).
  - Services provided to veterans in Veterans Affairs (VA) facilities. However, when emergency services are received at VA hospital and the VA cost sharing is more than the cost sharing under our plan, we will reimburse veterans for the difference. Members are still responsible for our cost-sharing amounts.

The plan will not cover the excluded services listed above. Even if you receive the services at an emergency facility, the excluded services are still not covered.

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## **Chapter 5. Using the plan's coverage for your Part D prescription drugs**

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## How can you get information about your drug costs?

Because you are eligible for Medicaid, you qualify for and are getting “Extra Help” from Medicare to pay for your prescription drug plan costs. Because you are in the Extra Help program, **some information in this Evidence of Coverage about the costs for Part D prescription drugs may not apply to you.** We have included a separate insert, called the “Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs” (LIS Rider), which tells you about your drug coverage. If you don't have this insert, please call Member Services and ask for the “Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs” (LIS Rider). Phone numbers for Member Services are on the back cover of this booklet.

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## SECTION 1 Introduction

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<b>Section 1.1 This chapter describes your coverage for Part D drugs</b>
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This chapter explains rules for using your coverage for Part D drugs. The next chapter tells what you pay for Part D drugs (Chapter 6, What you pay for your Part D prescription drugs).

In addition to your coverage for Part D drugs, Buckeye also covers some drugs under the plan's medical benefits:

- The plan covers drugs you are given during covered stays in the hospital or in a skilled nursing facility. Chapter 4 (Benefits Chart, what is covered and what you pay) tells about the benefits and costs for drugs during a covered hospital or skilled nursing facility stay.
- Medicare Part B also provides benefits for some drugs. Part B drugs include certain chemotherapy drugs, certain drug injections you are given during an office visit, and drugs you are given at a dialysis facility. Chapter 4 (Benefits Chart, what is covered and what you pay) tells about the coverage and costs for Part B drugs.

In addition to the drugs covered by Medicare, some prescription drugs are covered for you under your Medicaid benefits. For more information about Medicaid benefits, call ODJFS Medicaid (contact information can be found in Section 6 of Chapter 2).

**This chapter explains rules for using your coverage for Medicare Part D drugs.** The next chapter tells what you pay for Part D drugs (Chapter 6, What you pay for your Part D prescription drugs).

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<b>Section 1.2</b>	<b>Basic rules for the plan's Part D drug coverage</b>
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The plan will generally cover your drugs as long as you follow these basic rules:

- You must use a network pharmacy to fill your prescription. (See Section 2, Fill your prescriptions at a network pharmacy or through the plan's mail-order service.)
- Your drug must be on the plan's List of Covered Drugs (Formulary) (we call it the "Drug List" for short). (See Section 3, Your drugs need to be on the plan's "Drug List.")
- Your drug must be used for a medically accepted indication. A "medically accepted indication" is a use of the drug that is either approved by the Food and Drug Administration or supported by certain reference books. (See Section 3 for more information about a medically accepted indication.)

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<b>SECTION 2</b>	<b>Fill your prescription at a network pharmacy or through the plan's mail-order service</b>
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<b>Section 2.1</b>	<b>To have your prescription covered, use a network pharmacy</b>
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In most cases, your prescriptions are covered only if they are filled at the plan's network pharmacies. (See Section 2.5 for information about when we would cover prescriptions filled at out-of-network pharmacies.)

A network pharmacy is a pharmacy that has a contract with the plan to provide your covered prescription drugs. The term "covered drugs" means all of the Part D prescription drugs that are covered on the plan's Drug List.

<b>Section 2.2</b>	<b>Finding network pharmacies</b>
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### **How do you find a network pharmacy in your area?**

To find a network pharmacy, you can look in your Provider Directory, visit our website ([www.bchpohio.com](http://www.bchpohio.com)), or call Member Services (phone numbers are on the back cover of this booklet). Choose whatever is easiest for you.

You may go to any of our network pharmacies. If you switch from one network pharmacy to another, and you need a refill of a drug you have been taking, you can ask either to have a new prescription written by a provider or to have your prescription transferred to your new network pharmacy.

### **What if the pharmacy you have been using leaves the network?**

If the pharmacy you have been using leaves the plan's network, you will have to find a new pharmacy that is in the network. To find another network pharmacy in your area, you can get help from Member Services (phone numbers are on the back cover of this booklet) or use the Provider Directory.

### **What if you need a specialized pharmacy?**

Sometimes prescriptions must be filled at a specialized pharmacy. Specialized pharmacies include:

- Pharmacies that supply drugs for home infusion therapy.
- Pharmacies that supply drugs for residents of a long-term care facility. Usually, a long-term care facility (such as a nursing home) has its own pharmacy. Residents may get prescription drugs through the facility's pharmacy as long as it is part of our network. If your long-term care pharmacy is not in our network, please contact Member Services.
- Pharmacies that serve the Indian Health Service / Tribal / Urban Indian Health Program (not available in Puerto Rico). Except in emergencies, only Native Americans or Alaska Natives have access to these pharmacies in our network.
- Pharmacies that dispense drugs that are restricted by the FDA to certain locations or that require special handling, provider coordination, or education on their use. (Note: This scenario should happen rarely.)

To locate a specialized pharmacy, look in your Provider Directory or call Member Services.

<b>Section 2.3      Using the plan's mail-order services</b>
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For certain kinds of drugs, you can use the plan's network mail-order services. Generally, the drugs available through mail order are drugs that you take on a regular basis, for a chronic or long-term medical condition.

Our plan's mail-order service requires you to order a **90-day supply**.

To get order forms and information about filling your prescriptions by mail call Member Services at 866-389-7690 or TTY Users 800-750-0750 from 8:00AM to 8:00PM, 7 days a week.

Usually a mail-order pharmacy order will get to you in no more than 16 days. Contact member services if the order is delayed.

## **Section 2.4      How can you get a long-term supply of drugs?**

When you get a long-term supply of drugs, your cost sharing may be lower. The plan offers two ways to get a long-term supply of “mail-order” drugs on our plan’s Drug List. (Mail-order drugs are drugs that you take on a regular basis, for a chronic or long-term medical condition.)

1. **Some retail pharmacies** in our network allow you to get a long-term supply of mail-order drugs. Some of these retail pharmacies may agree to accept a lower cost-sharing amount for a long-term supply of mail-order drugs. Other retail pharmacies may not agree to accept the lower cost-sharing amounts for a long-term supply of mail-order drugs. In this case you will be responsible for the difference in price. Your Provider Directory tells you which pharmacies in our network can give you a long-term supply of mail-order drugs. You can also call Member Services for more information.
2. For certain kinds of drugs, you can use the plan’s network **mail-order services**. Our plan’s mail-order service requires you to order a 90-day supply of the drug. See Section 2.3 for more information about using our mail-order services.

## **Section 2.5      When can you use a pharmacy that is not in the plan’s network?**

### **Your prescription may be covered in certain situations**

Generally, we cover drugs filled at an out-of-network pharmacy only when you are not able to use a network pharmacy. Here are the circumstances when we would cover prescriptions filled at an out-of-network pharmacy:

- When you are out of the area, require a prescription filled, and are unable to obtain medications at local in-network pharmacy.
- Generally, we only cover drugs filled at an out-of-network pharmacy in limited, non-routine circumstances when a network pharmacy is not available.

In these situations, **please check first with Member Services** to see if there is a network pharmacy nearby.

### **How do you ask for reimbursement from the plan?**

If you must use an out-of-network pharmacy, you will generally have to pay the full cost (rather than your normal share of the cost) when you fill your prescription. You can ask us to reimburse you for our share of the cost. (Chapter 7, Section 2.1 explains how to ask the plan to pay you back.)

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## **SECTION 3      Your drugs need to be on the plan's "Drug List"**

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<b>Section 3.1      The "Drug List" tells which Part D drugs are covered</b>
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The plan has a "List of Covered Drugs (Formulary)." In this Evidence of Coverage, **we call it the "Drug List" for short.**

The drugs on this list are selected by the plan with the help of a team of doctors and pharmacists. The list must meet requirements set by Medicare. Medicare has approved the plan's Drug List.

We will generally cover a drug on the plan's Drug List as long as you follow the other coverage rules explained in this chapter and the use of the drug is a medically accepted indication. A "medically accepted indication" is a use of the drug that is either:

- Approved by the Food and Drug Administration. (That is, the Food and Drug Administration has approved the drug for the diagnosis or condition for which it is being prescribed.)
- -- or -- supported by certain reference books. (These reference books are the American Hospital Formulary Service Drug Information, the DRUGDEX Information System, and the USPDI or its successor.)

### **The Drug List includes both brand name and generic drugs**

A generic drug is a prescription drug that has the same active ingredients as the brand name drug. Generally, it works just as well as the brand name drug and usually costs less. There are generic drug substitutes available for many brand name drugs.

### **What is not on the Drug List?**

The plan does not cover all prescription drugs.

- In some cases, the law does not allow any Medicare plan to cover certain types of drugs (for more information about this, see Section 7.1 in this chapter).
- In other cases, we have decided not to include a particular drug on the Drug List.

<b>Section 3.2      There are four (4) "cost-sharing tiers" for drugs on the Drug List</b>
--

Every drug on the plan's Drug List is in one of four (4) cost-sharing tiers. In general, the higher the cost-sharing tier, the higher your cost for the drug:

- Tier 1 includes generic drugs on the formulary.
- Tier 2 includes preferred brand name drugs on the formulary.

- Tier 3 includes non-preferred brand name drugs on the formulary.
- Tier 4 includes injectable medications on the formulary.

To find out which cost-sharing tier your drug is in, look it up in the plan's Drug List.

The amount you pay for drugs in each cost-sharing tier is shown in Chapter 6 (What you pay for your Part D prescription drugs).

### **Section 3.3      How can you find out if a specific drug is on the Drug List?**

You have three ways to find out:

1. Check the most recent Drug List we sent you in the mail.
2. Visit the plan's website ([www.bchpohio.com](http://www.bchpohio.com)). The Drug List on the website is always the most current.
3. Call Member Services to find out if a particular drug is on the plan's Drug List or to ask for a copy of the list. Phone numbers for Member Services are on the back cover of this booklet.

## **SECTION 4      There are restrictions on coverage for some drugs**

### **Section 4.1      Why do some drugs have restrictions?**

For certain prescription drugs, special rules restrict how and when the plan covers them. A team of doctors and pharmacists developed these rules to help our members use drugs in the most effective ways. These special rules also help control overall drug costs, which keeps your drug coverage more affordable.

In general, our rules encourage you to get a drug that works for your medical condition and is safe and effective. Whenever a safe, lower-cost drug will work medically just as well as a higher-cost drug, the plan's rules are designed to encourage you and your provider to use that lower-cost option. We also need to comply with Medicare's rules and regulations for drug coverage and cost sharing.

**If there is a restriction for your drug, it usually means that you or your provider will have to take extra steps in order for us to cover the drug.** If you want us to waive the restriction for you, you will need to use the formal appeals process and ask us to make an exception. We may or may not agree to waive the restriction for you. (See Chapter 9, Section 7.2 for information about asking for exceptions.)

## Section 4.2 What kinds of restrictions?

Our plan uses different types of restrictions to help our members use drugs in the most effective ways. The sections below tell you more about the types of restrictions we use for certain drugs.

### Restricting brand name drugs when a generic version is available

Generally, a “generic” drug works the same as a brand name drug and usually costs less. **In most cases, when a generic version of a brand name drug is available, our network pharmacies will provide you the generic version.** We usually will not cover the brand name drug when a generic version is available. However, if your provider has told us the medical reason that neither the generic drug nor other covered drugs that treat the same condition will work for you, then we will cover the brand name drug. (Your share of the cost may be greater for the brand name drug than for the generic drug.)

### Getting plan approval in advance

For certain drugs, you or your provider need to get approval from the plan before we will agree to cover the drug for you. This is called “**prior authorization.**” Sometimes the requirement for getting approval in advance helps guide appropriate use of certain drugs. If you do not get this approval, your drug might not be covered by the plan.

### Quantity limits

For certain drugs, we limit the amount of the drug that you can have. For example, the plan might limit how many refills you can get, or how much of a drug you can get each time you fill your prescription. For example, if it is normally considered safe to take only one pill per day for a certain drug, we may limit coverage for your prescription to no more than one pill per day.

## Section 4.3 Do any of these restrictions apply to your drugs?

The plan's Drug List includes information about the restrictions described above. To find out if any of these restrictions apply to a drug you take or want to take, check the Drug List. For the most up-to-date information, call Member Services (phone numbers are on the back cover of this booklet) or check our website ([www.bchpohio.com](http://www.bchpohio.com)).

**If there is a restriction for your drug, it usually means that you or your provider will have to take extra steps in order for us to cover the drug.** If there is a restriction on the drug you want to take, you should contact Member Services to learn what you or your provider would need to do to get coverage for the drug. If you want us to waive the restriction for you, you will need to use the formal appeals process and ask us to make an exception. We may or may not agree to waive the restriction for you. (See Chapter 9, Section 7.2 for information about asking for exceptions.)

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## **SECTION 5      What if one of your drugs is not covered in the way you'd like it to be covered?**

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<b>Section 5.1      There are things you can do if your drug is not covered in the way you'd like it to be covered</b>
--

Suppose there is a prescription drug you are currently taking, or one that you and your provider think you should be taking. We hope that your drug coverage will work well for you, but it's possible that you might have a problem. For example:

- **What if the drug you want to take is not covered by the plan?** For example, the drug might not be covered at all. Or maybe a generic version of the drug is covered but the brand name version you want to take is not covered.
- **What if the drug is covered, but there are extra rules or restrictions on coverage for that drug?** As explained in Section 4, some of the drugs covered by the plan have extra rules to restrict their use. For example, there might be limits on what amount of the drug (number of pills, etc.) is covered during a particular time period. In some cases, you may want us to waive the restriction for you. For example, you may want us to cover more of a drug (number of pills, etc.) than we normally will cover.
- **What if the drug is covered, but it is in a cost-sharing tier that makes your cost sharing more expensive than you think it should be?** The plan puts each covered drug into one of four (4) different cost-sharing tiers. How much you pay for your prescription depends in part on which cost-sharing tier your drug is in.

There are things you can do if your drug is not covered in the way that you'd like it to be covered. Your options depend on what type of problem you have:

- If your drug is not on the Drug List or if your drug is restricted, go to Section 5.2 to learn what you can do.

<b>Section 5.2      What can you do if your drug is not on the Drug List or if the drug is restricted in some way?</b>
--

If your drug is not on the Drug List or is restricted, here are things you can do:

- You may be able to get a temporary supply of the drug (only members in certain situations can get a temporary supply). This will give you and your provider time to change to another drug or to file a request to have the drug covered.
- You can change to another drug.
- You can request an exception and ask the plan to cover the drug or remove restrictions from the drug.

## You may be able to get a temporary supply

Under certain circumstances, the plan can offer a temporary supply of a drug to you when your drug is not on the Drug List or when it is restricted in some way. Doing this gives you time to talk with your provider about the change in coverage and figure out what to do.

To be eligible for a temporary supply, you must meet the two requirements below:

### 1. The change to your drug coverage must be one of the following types of changes:

- The drug you have been taking is **no longer on the plan's Drug List**.
- -- or -- the drug you have been taking is **now restricted in some way** (Section 4 in this chapter tells about restrictions).

### 2. You must be in one of the situations described below:

- **For those members who were in the plan last year and aren't in a long-term care facility:**

We will cover a temporary supply of your drug **one time only during the first 90 days of the calendar year**. This temporary supply will be for a maximum of a 30-day supply, or less if your prescription is written for fewer days. The prescription must be filled at a network pharmacy.

- **For those members who are new to the plan and aren't in a long-term care facility:**

We will cover a temporary supply of your drug **one time only during the first 90 days of your membership** in the plan. This temporary supply will be for a maximum of a 30-day supply, or less if your prescription is written for fewer days. The prescription must be filled at a network pharmacy.

- **For those members who are new to the plan and reside in a long-term care facility:**

We will cover a temporary supply of your drug **during the first 90 days of your membership** in the plan. The first supply will be for a maximum of a 31-day supply, or less if your prescription is written for fewer days. If needed, we will cover additional refills during your first 90 days in the plan.

- **For those members who have been in the plan for more than 90 days and reside in a long-term care facility and need a supply right away:**

We will cover one a 31-day supply, or less if your prescription is written for fewer days. This is in addition to the above long-term care transition supply.

To ask for a temporary supply, call Member Services (phone numbers are on the back cover of this booklet).

During the time when you are getting a temporary supply of a drug, you should talk with your provider to decide what to do when your temporary supply runs out. You can either switch to a different drug covered by the plan or ask the plan to make an exception for you and cover your current drug. The sections below tell you more about these options.

### **You can change to another drug**

Start by talking with your provider. Perhaps there is a different drug covered by the plan that might work just as well for you. You can call Member Services to ask for a list of covered drugs that treat the same medical condition. This list can help your provider find a covered drug that might work for you.

### **You can ask for an exception**

You and your provider can ask the plan to make an exception for you and cover the drug in the way you would like it to be covered. If your provider says that you have medical reasons that justify asking us for an exception, your provider can help you request an exception to the rule. For example, you can ask the plan to cover a drug even though it is not on the plan's Drug List. Or you can ask the plan to make an exception and cover the drug without restrictions.

If you are a current member and a drug you are taking will be removed from the formulary or restricted in some way for next year, we will allow you to request a formulary exception in advance for next year. We will tell you about any change in the coverage for your drug for the following year. You can then ask us to make an exception and cover the drug in the way you would like it to be covered for the following year. We will give you an answer to your request for an exception before the change takes effect.

If you and your provider want to ask for an exception, Chapter 9, Section 7.4 tells what to do. It explains the procedures and deadlines that have been set by Medicare to make sure your request is handled promptly and fairly.

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## **SECTION 6      What if your coverage changes for one of your drugs?**

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<b>Section 6.1      The Drug List can change during the year</b>
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Most of the changes in drug coverage happen at the beginning of each year (January 1). However, during the year, the plan might make many kinds of changes to the Drug List. For example, the plan might:

- **Add or remove drugs from the Drug List.** New drugs become available, including new generic drugs. Perhaps the government has given approval to a new use for an existing drug. Sometimes, a drug gets recalled and we decide not to cover it. Or we might remove a drug from the list because it has been found to be ineffective.

- **Move a drug to a higher or lower cost-sharing tier.**
- **Add or remove a restriction on coverage for a drug** (for more information about restrictions to coverage, see Section 5 in this chapter).
- **Replace a brand name drug with a generic drug.**

In almost all cases, we must get approval from Medicare for changes we make to the plan's Drug List.

## **Section 6.2      What happens if coverage changes for a drug you are taking?**

### **How will you find out if your drug's coverage has been changed?**

If there is a change to coverage for a drug you are taking, the plan will send you a notice to tell you. Normally, **we will let you know at least 60 days ahead of time.**

Once in a while, a drug is **suddenly recalled** because it's been found to be unsafe or for other reasons. If this happens, the plan will immediately remove the drug from the Drug List. We will let you know of this change right away. Your provider will also know about this change, and can work with you to find another drug for your condition.

### **Do changes to your drug coverage affect you right away?**

If any of the following types of changes affect a drug you are taking, the change will not affect you until January 1 of the next year if you stay in the plan:

- If we move your drug into a higher cost-sharing tier.
- If we put a new restriction on your use of the drug.
- If we remove your drug from the Drug List, but not because of a sudden recall or because a new generic drug has replaced it.

If any of these changes happens for a drug you are taking, then the change won't affect your use or what you pay as your share of the cost until January 1 of the next year. Until that date, you probably won't see any increase in your payments or any added restriction to your use of the drug. However, on January 1 of the next year, the changes will affect you.

In some cases, you will be affected by the coverage change before January 1:

- If a **brand name drug you are taking is replaced by a new generic drug**, the plan must give you at least 60 days' notice or give you a 60-day refill of your brand name drug at a network pharmacy.
  - During this 60-day period, you should be working with your provider to switch to the generic or to a different drug that we cover.

- Or you and your provider can ask the plan to make an exception and continue to cover the brand name drug for you. For information on how to ask for an exception, see Chapter 9 (What to do if you have a problem or complaint (coverage decisions, appeals, complaints)).
- Again, if a drug is **suddenly recalled** because it's been found to be unsafe or for other reasons, the plan will immediately remove the drug from the Drug List. We will let you know of this change right away.
  - Your provider will also know about this change, and can work with you to find another drug for your condition.

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## **SECTION 7      What types of drugs are not covered by the plan?**

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<b>Section 7.1      Types of drugs we do not cover</b>
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This section tells you what kinds of prescription drugs are “excluded.” This means Medicare does not pay for these drugs.

We won't pay for the drugs that are listed in this section. The only exception: If the requested drug is found upon appeal to be a drug that is not excluded under Part D and we should have paid for or covered it because of your specific situation. (For information about appealing a decision we have made to not cover a drug, go to Chapter 9, Section 7.5 in this booklet.) If the drug is excluded, you must pay for it yourself.

Here are three general rules about drugs that Medicare drug plans will not cover under Part D:

- Our plan's Part D drug coverage cannot cover a drug that would be covered under Medicare Part A or Part B.
- Our plan cannot cover a drug purchased outside the United States and its territories.
- Our plan usually cannot cover off-label use. “Off-label use” is any use of the drug other than those indicated on a drug's label as approved by the Food and Drug Administration.
  - Generally, coverage for “off-label use” is allowed only when the use is supported by certain reference books. These reference books are the American Hospital Formulary Service Drug Information, the DRUGDEX Information System, and the USPDI or its successor. If the use is not supported by any of these reference books, then our plan cannot cover its “off-label use.”

Also, by law, the categories of drugs listed below are not covered by Medicare unless. However, some of these drugs may be covered for you under your Medicaid drug coverage. For more information about Medicaid coverage, contact ODJFS (contact information listed in Section 6 of Chapter 2).

- Non-prescription drugs (also called over-the-counter drugs)
- Drugs when used to promote fertility
- Drugs when used for the relief of cough or cold symptoms
- Drugs when used for cosmetic purposes or to promote hair growth
- Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations
- Drugs when used for the treatment of sexual or erectile dysfunction, such as Viagra, Cialis, Levitra, and Caverject
- Drugs when used for treatment of anorexia, weight loss, or weight gain
- Outpatient drugs for which the manufacturer seeks to require that associated tests or monitoring services be purchased exclusively from the manufacturer as a condition of sale
- Barbiturates and Benzodiazepines

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## **SECTION 8      Show your plan membership card when you fill a prescription**

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<b>Section 8.1      Show your membership card</b>
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To fill your prescription, show your plan membership card at the network pharmacy you choose. When you show your plan membership card, the network pharmacy will automatically bill the plan for our share of the costs of your covered prescription drug. You will need to pay the pharmacy your share of the cost when you pick up your prescription.

<b>Section 8.2      What if you don't have your membership card with you?</b>
---

If you don't have your plan membership card with you when you fill your prescription, ask the pharmacy to call the plan to get the necessary information.

If the pharmacy is not able to get the necessary information, **you may have to pay the full cost of the prescription when you pick it up.** (You can then **ask us to reimburse you** for our share. See Chapter 7, Section 2.1 for information about how to ask the plan for reimbursement.)

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## **SECTION 9      Part D drug coverage in special situations**

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<b>Section 9.1      What if you're in a hospital or a skilled nursing facility for a stay that is covered by the plan?</b>
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If you are admitted to a hospital or to a skilled nursing facility for a stay covered by the plan, we will generally cover the cost of your prescription drugs during your stay. Once you leave the hospital or skilled nursing facility, the plan will cover your drugs as long as the drugs meet all of our rules for coverage. See the previous parts of this section that tell about the rules for getting drug coverage. Chapter 6 (What you pay for your Part D prescription drugs) gives more information about drug coverage and what you pay.

<b>Section 9.2      What if you're a resident in a long-term care facility?</b>
---

Usually, a long-term care facility (such as a nursing home) has its own pharmacy, or a pharmacy that supplies drugs for all of its residents. If you are a resident of a long-term care facility, you may get your prescription drugs through the facility's pharmacy as long as it is part of our network.

Check your Provider Directory to find out if your long-term care facility's pharmacy is part of our network. If it isn't, or if you need more information, please contact Member Services.

### **What if you're a resident in a long-term care facility and become a new member of the plan?**

If you need a drug that is not on our Drug List or is restricted in some way, the plan will cover a **temporary supply** of your drug during the first 90 days of your membership. The first supply will be for a maximum of 31-day supply, or less if your prescription is written for fewer days. If needed, we will cover additional refills during your first 90 days in the plan.

If you have been a member of the plan for more than 90 days and need a drug that is not on our Drug List or if the plan has any restriction on the drug's coverage, we will cover one a 31-day supply, or less if your prescription is written for fewer days.

During the time when you are getting a temporary supply of a drug, you should talk with your provider to decide what to do when your temporary supply runs out. Perhaps there is a different drug covered by the plan that might work just as well for you. Or you and your provider can ask the plan to make an exception for you and cover the drug in the way you would like it to be covered. If you and your provider want to ask for an exception, Chapter 9, Section 7.4 tells what to do.

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<b>Section 9.3</b>	<b>What if you're also getting drug coverage from an employer or retiree group plan?</b>
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Do you currently have other prescription drug coverage through your (or your spouse's) employer or retiree group? If so, please contact **that group's benefits administrator**. He or she can help you determine how your current prescription drug coverage will work with our plan.

In general, if you are currently employed, the prescription drug coverage you get from us will be secondary to your employer or retiree group coverage. That means your group coverage would pay first.

**Special note about 'creditable coverage':**

Each year your employer or retiree group should send you a notice that tells if your prescription drug coverage for the next calendar year is "creditable" and the choices you have for drug coverage.

If the coverage from the group plan is "**creditable**," it means that the plan has drug coverage that is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage.

**Keep these notices about creditable coverage**, because you may need them later. If you enroll in a Medicare plan that includes Part D drug coverage, you may need these notices to show that you have maintained creditable coverage. If you didn't get a notice about creditable coverage from your employer or retiree group plan, you can get a copy from your employer or retiree plan's benefits administrator or the employer or union.

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**SECTION 10**      **Programs on drug safety and managing medications**

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<b>Section 10.1</b>	<b>Programs to help members use drugs safely</b>
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We conduct drug use reviews for our members to help make sure that they are getting safe and appropriate care. These reviews are especially important for members who have more than one provider who prescribes their drugs.

We do a review each time you fill a prescription. We also review our records on a regular basis. During these reviews, we look for potential problems such as:

- Possible medication errors
- Drugs that may not be necessary because you are taking another drug to treat the same medical condition
- Drugs that may not be safe or appropriate because of your age or gender

- Certain combinations of drugs that could harm you if taken at the same time
- Prescriptions written for drugs that have ingredients you are allergic to
- Possible errors in the amount (dosage) of a drug you are taking.

If we see a possible problem in your use of medications, we will work with your provider to correct the problem.

## **Section 10 .2      Programs to help members manage their medications**

We have programs that can help our members with special situations. For example, some members have several complex medical conditions or they may need to take many drugs at the same time, or they could have very high drug costs.

These programs are voluntary and free to members. A team of pharmacists and doctors developed the programs for us. The programs can help make sure that our members are using the drugs that work best to treat their medical conditions and help us identify possible medication errors.

If we have a program that fits your needs, we will automatically enroll you in the program and send you information. If you decide not to participate, please notify us and we will withdraw you from the program. If you have any questions about these programs, please contact Member Services (phone numbers are on the back cover of this booklet).

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## **Chapter 6. What you pay for your Part D prescription drugs**

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## How can you get information about your drug costs?

Because you are eligible for Medicaid, you qualify for and are getting “Extra Help” from Medicare to pay for your prescription drug plan costs. Because you are in the Extra Help program, **some information in this Evidence of Coverage about the costs for Part D prescription drugs: may not apply to you.** We have included a separate insert, called the “Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs” (LIS Rider), which tells you about your drug coverage. If you don’t have this insert, please call Member Services and ask for the “Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs” (LIS Rider). Phone numbers for Member Services are on the back cover of this booklet.

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## SECTION 1 Introduction

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<b>Section 1.1</b>	<b>Use this chapter together with other materials that explain your drug coverage</b>
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This chapter focuses on what you pay for your Part D prescription drugs. To keep things simple, we use “drug” in this chapter to mean a Part D prescription drug. As explained in Chapter 5, not all drugs are Part D drugs – some drugs are excluded from Part D coverage by law. Some of the drugs excluded from Part D coverage are covered under Medicare Part A or Part B. To understand the payment information we give you in this chapter, you need to know the basics of what drugs are covered, where to fill your prescriptions, and what rules to follow when you get your covered drugs. Here are materials that explain these basics:

- **The plan’s List of Covered Drugs (Formulary).** To keep things simple, we call this the “Drug List.”
  - This Drug List tells which drugs are covered for you.
  - It also tells which of the four (4) “cost-sharing tiers” the drug is in and whether there are any restrictions on your coverage for the drug.
  - If you need a copy of the Drug List, call Member Services (phone numbers are on the back cover of this booklet). You can also find the Drug List on our website at [www.bchpohio.com](http://www.bchpohio.com). The Drug List on the website is always the most current.
- **Chapter 5 of this booklet.** Chapter 5 gives the details about your prescription drug coverage, including rules you need to follow when you get your covered drugs. Chapter 5 also tells which types of prescription drugs are not covered by our plan.
- **The plan’s Provider Directory.** In most situations you must use a network pharmacy to get your covered drugs (see Chapter 5 for the details). The Provider Directory has a list of

pharmacies in the plan’s network. It also explains how you can get a long-term supply of a drug (such as filling a prescription for a three-month’s supply).

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**SECTION 2      What you pay for a drug depends on which “drug payment stage” you are in when you get the drug**

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**Section 2.1      What are the drug payment stages for Buckeye members?**

As shown in the table below, there are “drug payment stages” for your Medicare Part D prescription drug coverage. How much you pay for a drug depends on which of these stages you are in at the time you get a prescription filled or refilled. Keep in mind you are always responsible for the plan’s monthly premium regardless of the drug payment stage.

<b>Stage 1</b> Yearly Deductible Stage	<b>Stage 2</b> Initial Coverage Stage	<b>Stage 3</b> Coverage Gap Stage	<b>Stage 4</b> Catastrophic Coverage Stage
Because there is no deductible for the plan, this payment stage does not apply to you.  If you receive Extra Help to pay your prescription drugs, this payment stage does not apply to you.	You begin in this stage when you fill your first prescription of the year.  During this stage, the plan pays its share of the cost of your drugs and <b>you pay your share of the cost.</b>	Because there is no coverage gap for the plan, this payment stage does not apply to you.	During this stage, <b>the plan will pay most of the costs</b> of your drugs for the rest of the calendar year (through December 31, 2012).  (Details are in Section 7 of this chapter.)

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**SECTION 3      We send you reports that explain payments for your drugs and which payment stage you are in**

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**Section 3.1      We send you a monthly report called the “Explanation of Benefits” (the “EOB”)**

Our plan keeps track of the costs of your prescription drugs and the payments you have made when you get your prescriptions filled or refilled at the pharmacy. This way, we can tell you when you have moved from one drug payment stage to the next. In particular, there are two types of costs we keep track of:

- We keep track of how much you have paid. This is called your “**out-of-pocket**” cost.

- We keep track of your “**total drug costs.**” This is the amount you pay out-of-pocket or others pay on your behalf plus the amount paid by the plan.

Our plan will prepare a written report called the Explanation of Benefits (it is sometimes called the “EOB”) when you have had one or more prescriptions filled through the plan during the previous month. It includes:

- **Information for that month.** This report gives the payment details about the prescriptions you have filled during the previous month. It shows the total drug costs, what the plan paid, and what you and others on your behalf paid.
- **Totals for the year since January 1.** This is called “year-to-date” information. It shows you the total drug costs and total payments for your drugs since the year began.

<b>Section 3.2</b>	<b>Help us keep our information about your drug payments up to date</b>
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To keep track of your drug costs and the payments you make for drugs, we use records we get from pharmacies. Here is how you can help us keep your information correct and up to date:

- **Show your membership card when you get a prescription filled.** To make sure we know about the prescriptions you are filling and what you are paying, show your plan membership card every time you get a prescription filled.
- **Make sure we have the information we need.** There are times you may pay for prescription drugs when we will not automatically get the information we need to keep track of your out-of-pocket costs. To help us keep track of your out-of-pocket costs, you may give us copies of receipts for drugs that you have purchased. (If you are billed for a covered drug, you can ask our plan to pay our share of the cost for the drug. For instructions on how to do this, go to Chapter 7, Section 2 of this booklet.) Here are some types of situations when you may want to give us copies of your drug receipts to be sure we have a complete record of what you have spent for your drugs:
  - When you purchase a covered drug at a network pharmacy at a special price or using a discount card that is not part of our plan’s benefit.
  - When you made a co-payment for drugs that are provided under a drug manufacturer patient assistance program.
  - Any time you have purchased covered drugs at out-of-network pharmacies or other times you have paid the full price for a covered drug under special circumstances.
- **Send us information about the payments others have made for you.** Payments made by certain other individuals and organizations also count toward your out-of-pocket costs and help qualify you for catastrophic coverage. For example, payments made by a State Pharmaceutical Assistance Program, an AIDS drug assistance program, the Indian Health Service, and most charities count toward your out-of-pocket costs. You should keep a record of these payments and send them to us so we can track your costs.

- **Check the written report we send you.** When you receive an Explanation of Benefits (an EOB) in the mail, please look it over to be sure the information is complete and correct. If you think something is missing from the report, or you have any questions, please call us at Member Services (phone numbers are on the back cover of this booklet). Be sure to keep these reports. They are an important record of your drug expenses.

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## **SECTION 4      There is no deductible for Buckeye**

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<b>Section 4.1      You do not pay a deductible for your Part D drugs</b>
---

There is no deductible for Buckeye. You begin in the Initial Coverage Stage when you fill your first prescription of the year. See Section 5 for information about your coverage in the Initial Coverage Stage.

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## **SECTION 5      During the Initial Coverage Stage, the plan pays its share of your drug costs and you pay your share**

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<b>Section 5.1      What you pay for a drug depends on the drug and where you fill your prescription</b>
--

During the Initial Coverage Stage, the plan pays its share of the cost of your covered prescription drugs, and you pay your share. Your share of the cost will vary depending on the drug and where you fill your prescription.

### **The plan has four (4) cost-sharing tiers**

Every drug on the plan's Drug List is in one of four (4) cost-sharing tiers. In general, the higher the cost-sharing tier number, the higher your cost for the drug:

- Tier 1 includes generic drugs on the formulary. Co-pays for generic medications are \$0.
- Tier 2 includes preferred brand name drugs on the formulary. Co-pays for brand name drugs are \$3.30 or \$6.50, depending on your level of Medicaid coverage.
- Tier 3 includes non-preferred brand name drugs on the formulary. Co-pays for non-preferred brand name drugs are \$3.30 or \$6.50, depending on your level of Medicaid coverage.
- Tier 4 includes injectable medications on the formulary. Co-pays for generic injectable medications are \$0. Co-pays for non-generic injectable medications are \$3.30 or \$6.50, depending on your level of Medicaid coverage.

To find out which cost-sharing tier your drug is in, look it up in the plan's Drug List.

## Your pharmacy choices

How much you pay for a drug depends on whether you get the drug from:

- A retail pharmacy that is in our plan's network
- A pharmacy that is not in the plan's network
- The plan's mail-order pharmacy

For more information about these pharmacy choices and filling your prescriptions, see Chapter 5 in this booklet and the plan's Provider Directory.

<b>Section 5.2</b>	<b>A table that shows your costs for a one-month supply of a drug</b>
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During the Initial Coverage Stage, your share of the cost of a covered drug will be either a co-payment.

- **“Co-payment”** means that you pay a fixed amount each time you fill a prescription.

As shown in the table below, the amount of the co-payment depends on which cost-sharing tier your drug is in. Please note:

- If your covered drug costs less than the co-payment amount listed in the chart, you will pay that lower price for the drug. You pay either the full price of the drug or the co-payment amount, whichever is lower.
- We cover prescriptions filled at out-of-network pharmacies in only limited situations. Please see Chapter 5, Section 2.5 for information about when we will cover a prescription filled at an out-of-network pharmacy.

**Your share of the cost when you get a one-month supply (or less) of a covered Part D prescription drug from:**

	<b>Network pharmacy</b> (up to a 30-day supply)	<b>The plan's mail-order service</b> (up to a 90-day supply)	<b>Network long-term care pharmacy</b> (up to a 31-day supply)	<b>Out-of-network pharmacy</b> (Coverage is limited to certain situations; see Chapter 5 for details.) (up to a 30-day supply)
<b>Cost-Sharing Tier 1</b> Generic Drugs	\$0	\$0	\$0	\$0
<b>Cost-Sharing Tier 2</b> Brand	\$3.30 to \$6.50	\$3.30 to \$6.50	\$3.30 to \$6.50	\$3.30 to \$6.50
<b>Cost-Sharing Tier 3</b> Non-Preferred Brand	\$3.30 to \$6.50	\$3.30 to \$6.50	\$3.30 to \$6.50	\$3.30 to \$6.50
<b>Cost-Sharing Tier 4</b> Injectables	\$0 for generic; \$3.30 to \$6.50 for non-generic	\$0 for generic; \$3.30 to \$6.50 for non-generic	\$0 for generic; \$3.30 to \$6.50 for non-generic	\$0 for generic; \$3.30 to \$6.50 for non-generic

**Section 5.3 A table that shows your costs for a long-term (up to a 90-day supply of a drug)**

For some drugs, you can get a long-term supply (also called an “extended supply”) when you fill your prescription. A long-term supply is up to a 90-day supply. (For details on where and how to get a long-term supply of a drug, see Chapter 5.)

The table below shows what you pay when you get a long-term up to a 90-day supply of a drug.

**Your share of the cost when you get a long-term supply of a covered Part D prescription drug from:**

	<b>Network pharmacy</b> (up to a 90-day supply)	<b>The plan's mail-order service</b> (up to a 90-day supply)
<b>Cost-Sharing Tier 1</b> Generic	\$0	\$0
<b>Cost-Sharing Tier 2</b> Brand	\$3.30 to \$6.50 Some pharmacies may not accept the lower co-pay, in which case you would be responsible for the difference	\$3.30 to \$6.50
<b>Cost-Sharing Tier 3</b> Non-preferred brand	\$3.30 to \$6.50 Some pharmacies may not accept the lower co-pay, in which case you would be responsible for the difference	\$3.30 to \$6.50
<b>Cost-Sharing Tier 4</b> Injectables	\$0 for generic and \$3.30 or \$6.50 for non-generic Some pharmacies may not accept the lower co-pay, in which case you would be responsible for the difference	\$0 for generic and \$3.30 or \$6.50 for non-generic

**Section 5.4 You stay in the Initial Coverage Stage until your out-of-pocket costs for the year reach \$4,700**

You stay in the Initial Coverage Stage until your total out-of-pocket costs reach \$4,700. Medicare has rules about what counts and what does not count as your out-of-pocket costs. (See Section 5.5 for information about how Medicare counts your out-of-pocket costs.) When you reach an out-of-pocket limit of \$4,700, you leave the Initial Coverage Gap and move on to the Catastrophic Coverage Stage.

Your total drug cost is based on adding together what you have paid and what any Part D plan has paid:

- **What you have paid** for all the covered drugs you have gotten since you started with your first drug purchase of the year. (See Section 5.5 for more information about how Medicare calculates your out-of-pocket costs.) This includes:
  - The total you paid as your share of the cost for your drugs during the Initial Coverage Stage.

- **What the plan has paid** as its share of the cost for your drugs during the Initial Coverage Stage. (If you were enrolled in a different Part D plan at any time during 2012, the amount that plan paid during the Initial Coverage Stage also counts toward your total drug costs.)

Section 5.5 tells you more about what counts toward your out-of-pocket costs.

The Explanation of Benefits (EOB) that we send to you will help you keep track of how much you and the plan have spent for your drugs during the year. Many people do not reach the \$4,700 limit in a year.

We will let you know if you reach this \$4,700 amount. If you do reach this amount, you will leave the Initial Coverage Stage and move on to the Catastrophic Coverage Stage.

<b>Section 5.5</b>	<b>How Medicare calculates your out-of-pocket costs for prescription drugs</b>
--------------------	--

Medicare has rules about what counts and what does not count as your out-of-pocket costs. When you reach an out-of-pocket limit of \$4,700, you leave the Initial Coverage Stage and move on to the Catastrophic Coverage Stage.

Here are Medicare's rules that we must follow when we keep track of your out-of-pocket costs for your drugs.

These payments **are included** in your out-of-pocket costs

When you add up your out-of-pocket costs, **you can include** the payments listed below (as long as they are for Part D covered drugs and you followed the rules for drug coverage that are explained in Chapter 5 of this booklet):

- The amount you pay for drugs when you are in any of the following drug payment stages:
  - The Initial Coverage Stage.
- Any payments you made during this calendar year as a member of a different Medicare prescription drug plan before you joined our plan.

**It matters who pays:**

- If you make these payments **yourself**, they are included in your out-of-pocket costs.
- These payments are also included if they are made on your behalf by **certain other individuals or organizations**. This includes payments for your drugs made by a friend or relative, by most charities, by AIDS drug assistance programs, by a State Pharmaceutical Assistance Program that is qualified by Medicare, or by the Indian Health Service. Payments made by Medicare's "Extra Help" Program are also included.

**Moving on to the Catastrophic Coverage Stage:**

When you (or those paying on your behalf) have spent a total of \$4,700 in out-of-pocket costs within the calendar year, you will move from the Initial Coverage Stage to the Catastrophic Coverage Stage.

These payments are **not included**  
in your out-of-pocket costs

When you add up your out-of-pocket costs, you are **not allowed to include** any of these types of payments for prescription drugs:

- The amount you pay for your monthly premium.
- Drugs you buy outside the United States and its territories.
- Drugs that are not covered by our plan.
- Drugs you get at an out-of-network pharmacy that do not meet the plan's requirements for out-of-network coverage.
- Drugs covered by Medicaid only.
- Non-Part D drugs, including prescription drugs covered by Part A or Part B and other drugs excluded from coverage by Medicare.
- Payments you make toward prescription drugs not normally covered in a Medicare Prescription Drug Plan.
- Payments made by the plan for your generic drugs while in the Coverage Gap.
- Payments for your drugs that are made by group health plans including employer health plans.
- Payments for your drugs that are made by certain insurance plans and government-funded health programs such as TRICARE and the Veteran's Administration.
- Payments for your drugs made by a third-party with a legal obligation to pay for prescription costs (for example, Worker's Compensation).

Reminder: If any other organization such as the ones listed above pays part or all of your out-of-pocket costs for drugs, you are required to tell our plan. Call Member Services to let us know (phone numbers are on the back cover of this booklet).

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## How can you keep track of your out-of-pocket total?

- **We will help you.** The Explanation of Benefits (EOB) report we send to you includes the current amount of your out-of-pocket costs (Section 3 in this chapter tells about this report). When you reach a total of \$4,700 in out-of-pocket costs for the year, this report will tell you that you have left the Initial Coverage Stage and have moved on to the Catastrophic Coverage Stage.
- **Make sure we have the information we need.** Section 3.2 tells what you can do to help make sure that our records of what you have spent are complete and up to date.

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## SECTION 6 There is no coverage gap for Buckeye members

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<b>Section 6.1</b>	<b>You do not have a coverage gap for your Part D drugs.</b>
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There is no coverage gap for Buckeye. Once you leave the Initial Coverage Stage, you move on to the Catastrophic Coverage Stage. See Section 7 for information about your coverage in the Catastrophic Coverage Stage.

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## SECTION 7 During the Catastrophic Coverage Stage, the plan pays most of the costs for your drugs

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<b>Section 7.1</b>	<b>Once you are in the Catastrophic Coverage Stage, you will stay in this stage for the rest of the year</b>
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You qualify for the Catastrophic Coverage Stage when your out-of-pocket costs have reached the \$4,700 limit for the calendar year. Once you are in the Catastrophic Coverage Stage, you will stay in this payment stage until the end of the calendar year.

**During this stage, the plan will pay all of the costs for your drugs.**

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## SECTION 8 What you pay for vaccinations covered by Part D depends on how and where you get them

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<b>Section 8.1</b>	<b>Our plan has separate coverage for the Part D vaccine medication itself and for the cost of giving you the vaccination shot</b>
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Our plan provides coverage of a number of Part D vaccines. We also cover vaccines that are considered medical benefits. You can find out about coverage of these vaccines by going to the Benefits Chart in Chapter 4, Section 2.1.

There are two parts to our coverage of Part D vaccinations:

- The first part of coverage is the cost of **the vaccine medication itself**. The vaccine is a prescription medication.
- The second part of coverage is for the cost of **giving you the vaccination shot**. (This is sometimes called the “administration” of the vaccine.)

### What do you pay for a Part D vaccination?

What you pay for a Part D vaccination depends on three things:

- 1. The type of vaccine** (what you are being vaccinated for).
  - Some vaccines are considered medical benefits. You can find out about your coverage of these vaccines by going to Chapter 4, Benefits Chart (what is covered and what you pay).
  - Other vaccines are considered Part D drugs. You can find these vaccines listed in the plan’s List of Covered Drugs (Formulary).
- 2. Where you get the vaccine medication.**
- 3. Who gives you the vaccination shot.**

What you pay at the time you get the Part D vaccination can vary depending on the circumstances. For example:

- Sometimes when you get your vaccination shot, you will have to pay the entire cost for both the vaccine medication and for getting the vaccination shot. You can ask our plan to pay you back for our share of the cost.
- Other times, when you get the vaccine medication or the vaccination shot, you will pay only your share of the cost.

To show how this works, here are three common ways you might get a Part D vaccination shot.

Situation 1: You buy the Part D vaccine at the pharmacy and you get your vaccination shot at the network pharmacy. (Whether you have this choice depends on where you live. Some states do not allow pharmacies to administer a vaccination.)

- You will have to pay the pharmacy the amount of your copayment for the vaccine itself.
- Our plan will pay for the cost of giving you the vaccination shot.

Situation 2: You get the Part D vaccination at your doctor’s office.

- When you get the vaccination, you will pay for the entire cost of the vaccine and its administration.
- You can then ask our plan to pay you back for our share of the cost by using the procedures that are described in Chapter 7 of this booklet

(Asking us to pay our share of a bill you have received for covered medical services or drugs).

- You will be reimbursed the amount you paid less your normal copayment for the vaccine (including administration).
- Situation 3: You buy the Part D vaccine at your pharmacy, and then take it to your doctor's office where they give you the vaccination shot.
- You will have to pay the pharmacy the amount of your copayment for the vaccine itself.
- When your doctor gives you the vaccination shot, you will pay the entire cost for this service. You can then ask our plan to pay you back for our share of the cost by using the procedures described in Chapter 7 of this booklet.
- You will be reimbursed the amount charged by the doctor for administering the vaccine.

<b>Section 9.2</b>	<b>You may want to call us at Member Services before you get a vaccination</b>
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The rules for coverage of vaccinations are complicated. We are here to help. We recommend that you call us first at Member Services whenever you are planning to get a vaccination (phone numbers are on the back cover of this booklet).

- We can tell you about how your vaccination is covered by our plan and explain your share of the cost.
- We can tell you how to keep your own cost down by using providers and pharmacies in our network.
- If you are not able to use a network provider and pharmacy, we can tell you what you need to do to ask us to pay you back for our share of the cost.

**Chapter 7. Asking us to pay our share a bill you have received for covered medical services or drugs**

**SECTION 1 Situations in which you should ask us to pay for your covered services or drugs ..... 94**

Section 1.1 If you pay for your covered services or drugs, or if you receive a bill, you can ask us for payment.....94

**SECTION 2 How to ask us to pay you back or to pay a bill you have received ..... 96**

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**SECTION 4 Other situations in which you should save your receipts and send copies to us..... 98**

Section 4.1 In some cases, you should send copies of your receipts to us to help us track your out-of-pocket drug costs .....98

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**SECTION 1      Situations in which you should ask us to pay for your covered services or drugs**

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<b>Section 1.1      If you pay for your covered services or drugs, or if you receive a bill, you can ask us for payment</b>
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Our network providers bill the plan directly for your covered services and drugs – you should not receive a bill for covered services or drugs. If you get a bill for medical care or drugs you have received, you should send this bill to us so that we can pay it. When you send us the bill, we will look at the bill and decide whether the services should be covered. If we decide they should be covered, we will pay the provider directly.

If you have already paid for services or drugs covered by the plan, you can ask our plan to pay you back (paying you back is often called “reimbursing” you). It is your right to be paid back by our plan whenever you’ve paid more than your share of the cost for medical services or drugs that are covered by our plan. When you send us a bill you have already paid, we will look at the bill and decide whether the services or drugs should be covered. If we decide they should be covered, we will pay you back for the services or drugs.

Here are examples of situations in which you may need to ask our plan to pay you back or to pay a bill you have received.

**1. When you’ve received emergency or urgently needed medical care from a provider who is not in our plan’s network**

You can receive emergency services from any provider, whether or not the provider is a part of our network. When you receive emergency or urgently needed care from a provider who is not part of our network, you should ask the provider to bill the plan.

- If you pay the entire amount yourself at the time you receive the care, you need to ask us to pay you back for our share of the cost. Send us the bill, along with documentation of any payments you have made.
- At times you may get a bill from the provider asking for payment that you think you do not owe. Send us this bill, along with documentation of any payments you have already made.
  - If the provider is owed anything, we will pay the provider directly.
  - If you have already paid more than your share of the cost for the service, we will determine how much you owed and pay you back for our share of the cost.

**2. When a network provider sends you a bill you think you should not pay**

Network providers should always bill the plan directly. But sometimes they make mistakes, and ask you to pay for your services.

- Whenever you get a bill from a network provider that you think is more than you should pay, send us the bill. We will contact the provider directly and resolve the billing problem.
- If you have already paid a bill to a network provider, but you feel that you paid too much, send us the bill along with documentation of any payment you have made. You should ask us to pay you back for your covered services.

### **3. If you are retroactively enrolled in our plan.**

Sometimes a person's enrollment in the plan is retroactive. (Retroactive means that the first day of their enrollment has already past. The enrollment date may even have occurred last year.)

If you were retroactively enrolled in our plan and you paid out-of-pocket for any of your covered services or drugs after your enrollment date, you can ask us to pay you back for our share of the costs. You will need to submit paperwork for us to handle the reimbursement.

- Please contact Member Services for additional information about how to ask us to pay you back and deadlines for making your request.

### **4. When you use an out-of-network pharmacy to get a prescription filled**

If you go to an out-of-network pharmacy and try to use your membership card to fill a prescription, the pharmacy may not be able to submit the claim directly to us. When that happens, you will have to pay the full cost of your prescription. (We cover prescriptions filled at out-of-network pharmacies only in a few special situations. Please go to Chapter 5, Sec. 2.5 to learn more.)

- Save your receipt and send a copy to us when you ask us to pay you back for our share of the cost.

### **5. When you pay the full cost for a prescription because you don't have your plan membership card with you**

If you do not have your plan membership card with you, you can ask the pharmacy to call the plan or to look up your plan enrollment information. However, if the pharmacy cannot get the enrollment information they need right away, you may need to pay the full cost of the prescription yourself.

- Save your receipt and send a copy to us when you ask us to pay you back for our share of the cost.

### **6. When you pay the full cost for a prescription in other situations**

You may pay the full cost of the prescription because you find that the drug is not covered for some reason.

- For example, the drug may not be on the plan's List of Covered Drugs (Formulary); or it could have a requirement or restriction that you didn't know about or don't think

should apply to you. If you decide to get the drug immediately, you may need to pay the full cost for it.

- Save your receipt and send a copy to us when you ask us to pay you back. In some situations, we may need to get more information from your doctor in order to pay you back for our share of the cost of the drug.

When you send us a request for payment, we will review your request and decide whether the service or drug should be covered. This is called making a “coverage decision.” If we decide it should be covered, we will pay for our share of the cost for the service or drug. If we deny your request for payment, you can appeal our decision. Chapter 9 of this booklet (What to do if you have a problem or complaint (coverage decisions, appeals, complaints)) has information about how to make an appeal.

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## **SECTION 2      How to ask us to pay you back or to pay a bill you have received**

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<b>Section 2.1      How and where to send us your request for payment</b>
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Send us your request for payment, along with your bill and documentation of any payment you have made. It’s a good idea to make a copy of your bill and receipts for your records.

To make sure you are giving us all the information we need to make a decision, you can fill out our claim form to make your request for payment.

- You don’t have to use the form, but it will help us process the information faster.
- Either download a copy of the form from our website ([www.bchpohio.com](http://www.bchpohio.com)) or call Member Services and ask for the form. The phone numbers for Member Services are on the back cover of this booklet.

Mail your request for payment together with any bills or receipts to us at this address:

Buckeye Community Health Plan  
Compliance-Appeals/Grievances  
175 S. 3<sup>rd</sup> Street, Suite 1200  
Columbus, Ohio 43215

Please be sure to contact Member Services if you have any questions. If you don’t know what you should have paid, or you receive bills and you don’t know what to do about those bills, we can help. You can also call if you want to give us more information about a request for payment you have already sent to us.

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**SECTION 3      We will consider your request for payment and say yes or no**

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<b>Section 3.1</b>	<b>We check to see whether we should cover the service or drug and how much we owe</b>
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When we receive your request for payment, we will let you know if we need any additional information from you. Otherwise, we will consider your request and make a coverage decision.

- If we decide that the medical care or drug is covered and you followed all the rules for getting the care or drug, we will pay for our share of the cost for the service. If you have already paid for the service or drug, we will mail your reimbursement of our share of the cost to you. If you have not paid for the service or drug yet, we will mail the payment directly to the provider. (Chapter 3 explains the rules you need to follow for getting your medical services covered. Chapter 5 explains the rules you need to follow for getting your Part D prescription drugs covered.)
- If we decide that the medical care or drug is not covered, or you did not follow all the rules, we will not pay for our share of the cost of the care or drug. Instead, we will send you a letter that explains the reasons why we are not sending the payment you have requested and your rights to appeal that decision.

<b>Section 3.2</b>	<b>If we tell you that we will not pay for all or part of the medical care or drug, you can make an appeal</b>
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If you think we have made a mistake in turning down your request for payment or you don't agree with the amount we are paying, you can make an appeal. If you make an appeal, it means you are asking us to change the decision we made when we turned down your request for payment.

For the details on how to make this appeal, go to Chapter 9 of this booklet (What to do if you have a problem or complaint (coverage decisions, appeals, complaints)). The appeals process is a formal process with detailed procedures and important deadlines. If making an appeal is new to you, you will find it helpful to start by reading Section 5 of Chapter 9. Section 5 is an introductory section that explains the process for coverage decisions and appeals and gives definitions of terms such as "appeal." Then after you have read Section 5, you can go to the section in Chapter 9 that tells what to do for your situation:

- If you want to make an appeal about getting paid back for a medical service, go to Section 6.3 in Chapter 9.
- If you want to make an appeal about getting paid back for a drug, go to Section 7.5 of Chapter 9.

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**SECTION 4 Other situations in which you should save your receipts and send copies to us**

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<b>Section 4.1</b>	<b>In some cases, you should send copies of your receipts to us to help us track your out-of-pocket drug costs</b>
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There are some situations when you should let us know about payments you have made for your drugs. In these cases, you are not asking us for payment. Instead, you are telling us about your payments so that we can calculate your out-of-pocket costs correctly. This may help you to qualify for the Catastrophic Coverage Stage more quickly.

Below is an example of a situation when you should send us copies of receipts to let us know about payments you have made for your drugs:

**When you get a drug through a patient assistance program offered by a drug manufacturer**

Some members are enrolled in a patient assistance program offered by a drug manufacturer that is outside the plan benefits. If you get any drugs through a program offered by a drug manufacturer, you may pay a copayment to the patient assistance program.

- Save your receipt and send a copy to us so that we can have your out-of-pocket expenses count toward qualifying you for the Catastrophic Coverage Stage.
- **Please note:** Because you are getting your drug through the patient assistance program and not through the plan's benefits, we will not pay for any share of these drug costs. But sending a copy of the receipt allows us to calculate your out-of-pocket costs correctly and may help you qualify for the Catastrophic Coverage Stage more quickly.

Since you are not asking for payment in the case described above, this situation is not considered a coverage decision. Therefore, you cannot make an appeal if you disagree with our decision.

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## **Chapter 8. Your rights and responsibilities**

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## **SECTION 1      Our plan must honor your rights as a member of the plan**

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<b>Section 1.1</b>	<b>We must provide information in a way that works for you (in languages other than English, in Braille, in large print, or other alternate formats, etc.)</b>
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To get information from us in a way that works for you, please call Member Services (phone numbers are on the back cover of this booklet).

Our plan has people and free language interpreter services available to answer questions from non-English speaking members. We can also give you information in Braille, in large print, or other alternate formats if you need it. If you are eligible for Medicare because of a disability, we are required to give you information about the plan's benefits that is accessible and appropriate for you.

If you have any trouble getting information from our plan because of problems related to language or a disability, please call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week, and tell them that you want to file a complaint. TTY users call 1-877-486-2048.

<b>Section 1.2</b>	<b>We must treat you with fairness and respect at all times</b>
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Our plan must obey laws that protect you from discrimination or unfair treatment. **We do not discriminate** based on a person's race, ethnicity, national origin, religion, gender, age, mental or physical disability, health status, claims experience, medical history, genetic information, evidence of insurability, or geographic location within the service area.

If you want more information or have concerns about discrimination or unfair treatment, please call the Department of Health and Human Services' **Office for Civil Rights** 1-800-368-1019 (TTY 1-800-537-7697) or your local Office for Civil Rights.

If you have a disability and need help with access to care, please call us at Member Services (phone numbers are on the back cover of this booklet). If you have a complaint, such as a problem with wheelchair access, Member Services can help.

<b>Section 1.3</b>	<b>We must ensure that you get timely access to your covered services and drugs</b>
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As a member of our plan, you have the right to choose a primary care provider (PCP) in the plan's network to provide and arrange for your covered services (Chapter 3 explains more about this). Call Member Services to learn which doctors are accepting new patients (phone numbers are on the back cover of this booklet). We do not require referrals to go to network providers.

As a plan member, you have the right to get appointments and covered services from the plan's network of providers within a reasonable amount of time. This includes the right to get timely services from specialists when you need that care. You also have the right to get your prescriptions filled or refilled at any of our network pharmacies without long delays.

If you think that you are not getting your medical care or Part D drugs within a reasonable amount of time, Chapter 9, Section 11 of this booklet tells what you can do. (If we have denied coverage for your medical care or drugs and you don't agree with our decision, Chapter 9, Section 5 tells what you can do.)

<b>Section 1.4</b>	<b>We must protect the privacy of your personal health information</b>
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Federal and state laws protect the privacy of your medical records and personal health information. We protect your personal health information as required by these laws.

- Your “personal health information” includes the personal information you gave us when you enrolled in this plan as well as your medical records and other medical and health information.
- The laws that protect your privacy give you rights related to getting information and controlling how your health information is used. We give you a written notice, called a “Notice of Privacy Practice,” that tells about these rights and explains how we protect the privacy of your health information.

### **How do we protect the privacy of your health information?**

- We make sure that unauthorized people don't see or change your records.
- In most situations, if we give your health information to anyone who isn't providing your care or paying for your care, we are required to get written permission from you first. Written permission can be given by you or by someone you have given legal power to make decisions for you.
- There are certain exceptions that do not require us to get your written permission first. These exceptions are allowed or required by law.
  - For example, we are required to release health information to government agencies that are checking on quality of care.
  - Because you are a member of our plan through Medicare, we are required to give Medicare your health information including information about your Part D prescription drugs. If Medicare releases your information for research or other uses, this will be done according to Federal statutes and regulations.

### **You can see the information in your records and know how it has been shared with others**

You have the right to look at your medical records held at the plan, and to get a copy of your records. You also have the right to ask us to make additions or corrections to your medical records. If you ask us to do this, we will work with your healthcare provider to decide whether the changes should be made.

You have the right to know how your health information has been shared with others for any purposes that are not routine.

If you have questions or concerns about the privacy of your personal health information, please call Member Services (phone numbers are on the back cover of this booklet).

<b>Section 1.5</b>	<b>We must give you information about the plan, its network of providers, and your covered services</b>
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As a member of our plan, you have the right to get several kinds of information from us. (As explained above in Section 1.1, you have the right to get information from us in a way that works for you. This includes getting the information in languages other than English and in large print or other alternate formats.)

If you want any of the following kinds of information, please call Member Services (phone numbers are on the back cover of this booklet):

- **Information about our plan.** This includes, for example, information about the plan's financial condition. It also includes information about the number of appeals made by members and the plan's performance ratings, including how it has been rated by plan members and how it compares to other Medicare health plans.
- **Information about our network providers including our network pharmacies.**
  - For example, you have the right to get information from us about the qualifications of the providers and pharmacies in our network and how we pay the providers in our network.
  - For a list of the providers and or pharmacies in the plan's network, see the Provider Directory.
  - For more detailed information about our providers or pharmacies, you can call Member Services (phone numbers are on the back cover of this booklet) or visit our website at [www.bchpohio.com](http://www.bchpohio.com).
- **Information about your coverage and rules you must follow when using your coverage.**
  - In Chapters 3 and 4 of this booklet, we explain what medical services are covered for you, any restrictions to your coverage, and what rules you must follow to get your covered medical services.

- To get the details on your Part D prescription drug coverage, see Chapters 5 and 6 of this booklet plus the plan's List of Covered Drugs (Formulary). These chapters, together with the List of Covered Drugs (Formulary), tell you what drugs are covered and explain the rules you must follow and the restrictions to your coverage for certain drugs.
- If you have questions about the rules or restrictions, please call Member Services (phone numbers are on the back cover of this booklet).
- **Information about why something is not covered and what you can do about it.**
  - If a medical service or Part D drug is not covered for you, or if your coverage is restricted in some way, you can ask us for a written explanation. You have the right to this explanation even if you received the medical service or drug from an out-of-network provider or pharmacy.
  - If you are not happy or if you disagree with a decision we make about what medical care or Part D drug is covered for you, you have the right to ask us to change the decision. You can ask us to change the decision by making an appeal. For details on what to do if something is not covered for you in the way you think it should be covered, see Chapter 9 of this booklet. It gives you the details about how to make an appeal if you want us to change our decision. (Chapter 9 also tells about how to make a complaint about quality of care, waiting times, and other concerns.)
  - If you want to ask our plan to pay our share of a bill you have received for medical care or a Part D prescription drug, see Chapter 7 of this booklet.

<b>Section 1.6</b>	<b>We must support your right to make decisions about your care</b>
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### **You have the right to know your treatment options and participate in decisions about your health care**

You have the right to get full information from your doctors and other health care providers when you go for medical care. Your providers must explain your medical condition and your treatment choices in a way that you can understand.

You also have the right to participate fully in decisions about your health care. To help you make decisions with your doctors about what treatment is best for you, your rights include the following:

- **To know about all of your choices.** This means that you have the right to be told about all of the treatment options that are recommended for your condition, no matter what they cost or whether they are covered by our plan. It also includes being told about programs our plan offers to help members manage their medications and use drugs safely.

- **To know about the risks.** You have the right to be told about any risks involved in your care. You must be told in advance if any proposed medical care or treatment is part of a research experiment. You always have the choice to refuse any experimental treatments.
- **The right to say “no.”** You have the right to refuse any recommended treatment. This includes the right to leave a hospital or other medical facility, even if your doctor advises you not to leave. You also have the right to stop taking your medication. Of course, if you refuse treatment or stop taking medication, you accept full responsibility for what happens to your body as a result.
- **To receive an explanation if you are denied coverage for care.** You have the right to receive an explanation from us if a provider has denied care that you believe you should receive. To receive this explanation, you will need to ask us for a coverage decision. Chapter 9 of this booklet tells how to ask the plan for a coverage decision.

### **You have the right to give instructions about what is to be done if you are not able to make medical decisions for yourself**

Sometimes people become unable to make health care decisions for themselves due to accidents or serious illness. You have the right to say what you want to happen if you are in one of these situations. This means that, if you want to, you can:

- Fill out a written form to give **someone the legal authority to make medical decisions for you** if you ever become unable to make decisions for yourself.
- **Give your doctors written instructions** about how you want them to handle your medical care if you become unable to make decisions for yourself.

The legal documents that you can use to give your directions in advance in these situations are called “**advance directives**.” There are different types of advance directives and different names for them. Documents called “**living will**” and “**power of attorney for health care**” are examples of advance directives.

If you want to use an “advance directive” to give your instructions, here is what to do:

- **Get the form.** If you want to have an advance directive, you can get a form from your lawyer, from a social worker, or from some office supply stores. You can sometimes get advance directive forms from organizations that give people information about Medicare. You can also contact Member Services to ask for the forms (phone numbers are on the back cover of this booklet).
- **Fill it out and sign it.** Regardless of where you get this form, keep in mind that it is a legal document. You should consider having a lawyer help you prepare it.
- **Give copies to appropriate people.** You should give a copy of the form to your doctor and to the person you name on the form as the one to make decisions for you if you can’t. You may want to give copies to close friends or family members as well. Be sure to keep a copy at home.

If you know ahead of time that you are going to be hospitalized, and you have signed an advance directive, **take a copy with you to the hospital.**

- If you are admitted to the hospital, they will ask you whether you have signed an advance directive form and whether you have it with you.
- If you have not signed an advance directive form, the hospital has forms available and will ask if you want to sign one.

**Remember, it is your choice whether you want to fill out an advance directive** (including whether you want to sign one if you are in the hospital). According to law, no one can deny you care or discriminate against you based on whether or not you have signed an advance directive.

### **What if your instructions are not followed?**

If you have signed an advance directive, and you believe that a doctor or hospital hasn't followed the instructions in it, you may file a complaint with the Ohio Department of Health at 800-342-0553, Monday through Friday 8 a.m. to 5 p.m.

<b>Section 1.7</b>	<b>You have the right to make complaints and to ask us to reconsider decisions we have made</b>
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If you have any problems or concerns about your covered services or care, Chapter 9 of this booklet tells what you can do. It gives the details about how to deal with all types of problems and complaints.

As explained in Chapter 9, what you need to do to follow up on a problem or concern depends on the situation. You might need to ask our plan to make a coverage decision for you, make an appeal to us to change a coverage decision, or make a complaint. Whatever you do – ask for a coverage decision, make an appeal, or make a complaint – **we are required to treat you fairly.**

You have the right to get a summary of information about the appeals and complaints that other members have filed against our plan in the past. To get this information, please call Member Services (phone numbers are on the back cover of this booklet).

<b>Section 1.8</b>	<b>What can you do if you think you are being treated unfairly or your rights are not being respected?</b>
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### **If it is about discrimination, call the Office for Civil Rights**

If you think you have been treated unfairly or your rights have not been respected due to your race, disability, religion, sex, health, ethnicity, creed (beliefs), age, or national origin, you should call the Department of Health and Human Services' **Office for Civil Rights** at 1-800-368-1019 or TTY 1-800-537-7697, or call your local Office for Civil Rights.

## Is it about something else?

If you think you have been treated unfairly or your rights have not been respected, and it's not about discrimination, you can get help dealing with the problem you are having:

- You can **call Member Services** (phone numbers are on the back cover of this booklet).
- You can **call the State Health Insurance Assistance Program**. For details about this organization and how to contact it, go to Chapter 2, Section 3.
- Or, **you can call Medicare** at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

### Section 1.9 How to get more information about your rights

There are several places where you can get more information about your rights:

- You can **call Member Services** (phone numbers are on the back cover of this booklet).
- You can **call the State Health Insurance Assistance Program**. For details about this organization and how to contact it, go to Chapter 2, Section 3.
- You can contact **Medicare**.
  - You can visit the Medicare website to read or download the publication “Your Medicare Rights & Protections.” (The publication is available at: <http://www.medicare.gov/Publications/Pubs/pdf/10112.pdf>.)
  - Or, you can call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

## SECTION 2 You have some responsibilities as a member of the plan

### Section 2.1 What are your responsibilities?

Things you need to do as a member of the plan are listed below. If you have any questions, please call Member Services (phone numbers are on the back cover of this booklet). We're here to help.

- **Get familiar with your covered services and the rules you must follow to get these covered services.** Use this Evidence of Coverage booklet to learn what is covered for you and the rules you need to follow to get your covered services.
  - Chapters 3 and 4 give the details about your medical services, including what is covered, what is not covered, rules to follow, and what you pay.

- Chapters 5 and 6 give the details about your coverage for Part D prescription drugs.
- **If you have any other health insurance coverage or prescription drug coverage in addition to our plan, you are required to tell us.** Please call Member Services to let us know.
  - We are required to follow rules set by Medicare and Medicaid to make sure that you are using all of your coverage in combination when you get your covered services from our plan. This is called “**coordination of benefits**” because it involves coordinating the health and drug benefits you get from our plan with any other health and drug benefits available to you. We’ll help you coordinate your benefits. (For more information about coordination of benefits, go to Chapter 1, Section 7.)
- **Tell your doctor and other health care providers that you are enrolled in our plan.** Show your plan membership card whenever you get your medical care or Part D prescription drugs.
- **Help your doctors and other providers help you by giving them information, asking questions, and following through on your care.**
  - To help your doctors and other health providers give you the best care, learn as much as you are able to about your health problems and give them the information they need about you and your health. Follow the treatment plans and instructions that you and your doctors agree upon.
  - Make sure your doctors know all of the drugs you are taking, including over-the-counter drugs, vitamins, and supplements.
  - If you have any questions, be sure to ask. Your doctors and other health care providers are supposed to explain things in a way you can understand. If you ask a question and you don’t understand the answer you are given, ask again.
- **Be considerate.** We expect all our members to respect the rights of other patients. We also expect you to act in a way that helps the smooth running of your doctor’s office, hospitals, and other offices.
- **Pay what you owe.** As a plan member, you are responsible for these payments:
  - In order to be eligible for our plan, you must be entitled to Medicare Part A and enrolled in Medicare Part B. For most Buckeye members, Medicaid pays for your Part A premium (if you don’t qualify for it automatically) and for your Part B premium. If Medicaid is not paying your Medicare premiums for you, you must continue to pay your Medicare premiums to remain a member of the plan.
  - For most of your medical services or drugs covered by the plan, you must pay your share of the cost when you get the service or drug. This will be a (a fixed amount) or coinsurance (a percentage of the total cost). Chapter 4 tells what you

must pay for your medical services. Chapter 6 tells what you must pay for your Part D prescription drugs.

- If you get any medical services or drugs that are not covered by our plan or by other insurance you may have, you must pay the full cost.
  - If you disagree with our decision to deny coverage for a service or drug, you can make an appeal. Please see Chapter 9 of this booklet for information about how to make an appeal.
- If you are required to pay a late enrollment penalty, you must pay the penalty to remain a member of the plan.
- **Tell us if you move.** If you are going to move, it's important to tell us right away. Call Member Services (phone numbers are on the back cover of this booklet).
  - **If you move outside of our plan service area, you cannot remain a member of our plan.** (Chapter 1 tells about our service area.) We can help you figure out whether you are moving outside our service area. If you are leaving our service area, we can let you know if we have a plan in your new area.
  - **If you move within our service area, we still need to know** so we can keep your membership record up to date and know how to contact you.
- **Call member services for help if you have questions or concerns.** We also welcome any suggestions you may have for improving our plan.
  - Phone numbers and calling hours for Member Services are on the back cover of this booklet.
  - For more information on how to reach us, including our mailing address, please see Chapter 2.

## **Chapter 9. What to do if you have a problem or complaint (coverage decisions, appeals, complaints)**

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## BACKGROUND

### SECTION 1 Introduction

#### Section 1.1 What to do if you have a problem or concern

This chapter explains the processes for handling problems and concerns. The process you use to handle your problem depends on two things:

1. Whether your problem is about benefits covered by **Medicare** or **Medicaid**. If you would like help deciding whether to use the Medicare process or the Medicaid process, or both, please contact Member Services. (Telephone numbers are on the back cover of this booklet.)
2. The type of problem you are having:
  - For some types of problems, you need to use the **process for coverage decisions and making appeals**.
  - For other types of problems, you need to use the **process for making complaints**.

These processes have been approved by Medicare. To ensure fairness and prompt handling of your problems, each process has a set of rules, procedures, and deadlines that must be followed by us and by you.

Which one do you use? The guide in Section 3 will help you identify the right process to use.

#### Section 1.2 What about the legal terms?

There are technical legal terms for some of the rules, procedures, and types of deadlines explained in this chapter. Many of these terms are unfamiliar to most people and can be hard to understand.

To keep things simple, this chapter explains the legal rules and procedures using simpler words in place of certain legal terms. For example, this chapter generally says “making a complaint” rather than “filing a grievance,” “coverage decision” rather than “organization determination” or “coverage determination,” and “Independent Review Organization” instead of “Independent Review Entity.” It also uses abbreviations as little as possible.

However, it can be helpful – and sometimes quite important – for you to know the correct legal terms for the situation you are in. Knowing which terms to use will help you communicate more clearly and accurately when you are dealing with your problem and get the right help or information for your situation. To help you know which terms to use, we include legal terms when we give the details for handling specific types of situations.

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**SECTION 2      You can get help from government organizations that are not connected with us**

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**Section 2.1      Where to get more information and personalized assistance**

Sometimes it can be confusing to start or follow through the process for dealing with a problem. This can be especially true if you do not feel well or have limited energy. Other times, you may not have the knowledge you need to take the next step.

**Get help from an independent government organization**

We are always available to help you. But in some situations you may also want help or guidance from someone who is not connected with us. You can always contact your **State Health Insurance Assistance Program (SHIP)**. This government program has trained counselors in every state. The program is not connected with us or with any insurance company or health plan. The counselors at this program can help you understand which process you should use to handle a problem you are having. They can also answer your questions, give you more information, and offer guidance on what to do.

The services of SHIP counselors are free. You will find phone numbers in Chapter 2, Section 3 of this booklet.

**You can also get help and information from Medicare**

For more information and help in handling a problem, you can also contact Medicare. Here are two ways to get information directly from Medicare:

- You can call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.
- You can visit the Medicare website (<http://www.medicare.gov>).

**You can also get help and information from Medicaid**

For information about how to contact Medicaid, see Section 6 of Chapter 2.

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**SECTION 3      To deal with your problem, which process should you use?**

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**Section 3.1      Should you use the process for Medicare benefits or Medicaid benefits?**

Because you have Medicare and get assistance from Medicaid, you have different processes that you can use to handle your problem or complaint. Which process you use depends on whether the problem is about Medicare benefits or Medicaid benefits. If your problem is about a benefit

covered by Medicare, then you should use the Medicare process. If your problem is about a benefit covered by Medicaid, then you should use the Medicaid process. If you would like help deciding whether to use the Medicare process or the Medicaid process, please contact Member Services. (Telephone numbers are on the back cover of this booklet.)

The Medicare process and Medicaid process are described in different parts of this chapter. To find out which part you should read, use the chart below.

To figure out which part of this chapter will help with your specific problem or concern, <b>START HERE</b>	
<b>Is your problem about Medicare benefits or Medicaid benefits?</b> (If you would like help deciding whether your problem is about Medicare benefits or Medicaid benefits, please contact Member Services.)	
My problem is about <b>Medicare</b> benefits.  Go to the next section of this chapter, <b>Section 4, “Handling problems about Medicare your benefits.”</b>	My problem is about <b>Medicaid</b> benefits.  Skip ahead to <b>Section 12</b> of this chapter, <b>“Handling problems about your Medicaid benefits.”</b>

## PROBLEMS ABOUT YOUR MEDICARE BENEFITS

### SECTION 4 Handling problems about your Medicare benefits

<b>Section 4.1</b>	<b>Should you use the process for coverage decisions and appeals? Or should you use the process for making complaints?</b>
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If you have a problem or concern, you only need to read the parts of this chapter that apply to your situation. The chart below will help you find the right section of this chapter for problems or complaints about **benefits covered by Medicare**.

To figure out which part of this chapter will help with your problem or concern about your **Medicare** benefits, use this chart:

**Is your problem or concern about your benefits or coverage?**

(This includes problems about whether particular medical care or prescription drugs are covered or not, the way in which they are covered, and problems related to payment for medical care or prescription drugs.)

**Yes.**

My problem is about benefits or coverage.

Go on to the next section of this chapter, **Section 5, “A guide to the basics of coverage decisions and making appeals.”**

**No.**

My problem is not about benefits or coverage.

Skip ahead to **Section 11** at the end of this chapter: **“How to make a complaint about quality of care, waiting times, customer service or other concerns.”**

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**SECTION 5      A guide to the basics of coverage decisions and appeals**

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**Section 5.1      Asking for coverage decisions and making appeals: the big picture**

The process for asking for coverage decisions and making appeals deals with problems related to your benefits and coverage, including problems related to payment. This is the process you use for issues such as whether something is covered or not and the way in which something is covered.

**Asking for coverage decisions**

A coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your medical services or drugs. We are making a coverage decision whenever we decide what is covered for you and how much we pay. For example, your plan network doctor makes a (favorable) coverage decision for you whenever you receive medical care from him or her or if your network doctor refers you to a medical specialist. You can also contact us and ask for a coverage decision if your doctor is unsure whether we will cover a particular medical

service or refuses to provide medical care you think that you need. In other words, if you want to know if we will cover a medical service before you receive it, you can ask us to make a coverage decision for you.

In some cases we might decide a service or drug is not covered or is no longer covered by Medicare for you. If you disagree with this coverage decision, you can make an appeal.

## **Making an appeal**

If we make a coverage decision and you are not satisfied with this decision, you can “appeal” the decision. An appeal is a formal way of asking us to review and change a coverage decision we have made.

When you make an appeal, we review the coverage decision we have made to check to see if we were following all of the rules properly. Your appeal is handled by different reviewers than those who made the original unfavorable decision. When we have completed the review we give you our decision.

If we say no to all or part of your Level 1 Appeal, you can go on to a Level 2 Appeal. The Level 2 Appeal is conducted by an independent organization that is not connected to us. (In some situations, your case will be automatically sent to the independent organization for a Level 2 Appeal. If this happens, we will let you know. In other situations, you will need to ask for a Level 2 Appeal.) If you are not satisfied with the decision at the Level 2 Appeal, you may be able to continue through several more levels of appeal.

<b>Section 5.2</b>	<b>How to get help when you are asking for a coverage decision or making an appeal</b>
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Would you like some help? Here are resources you may wish to use if you decide to ask for any kind of coverage decision or appeal a decision:

- You **can call us at Member Services** (phone numbers are on the back cover of this booklet).
- To **get free help from an independent organization** that is not connected with our plan, contact your State Health Insurance Assistance Program (see Section 2 of this chapter).
- **Your doctor or other provider can make a request for you.** Your doctor or other provider can request a coverage decision or a Level 1 Appeal on your behalf. To request any appeal after Level 1, your doctor or other provider must be appointed as your representative.
- **You can ask someone to act on your behalf.** If you want to, you can name another person to act for you as your “representative” to ask for a coverage decision or make an appeal.
  - There may be someone who is already legally authorized to act as your representative under State law.

- If you want a friend, relative, your doctor or other provider, or other person to be your representative, call Member Services and ask for the “Appointment of Representative” form. (The form is also available on Medicare’s website at <http://www.cms.hhs.gov/cmsforms/downloads/cms1696.pdf> or on our website at [www.bchpohio.com](http://www.bchpohio.com)). The form gives that person permission to act on your behalf. It must be signed by you and by the person who you would like to act on your behalf. You must give us a copy of the signed form.
- **You also have the right to hire a lawyer to act for you.** You may contact your own lawyer, or get the name of a lawyer from your local bar association or other referral service. There are also groups that will give you free legal services if you qualify. However, **you are not required to hire a lawyer** to ask for any kind of coverage decision or appeal a decision.

<b>Section 5.3</b>	<b>Which section of this chapter gives the details for <u>your</u> situation?</b>
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There are four different types of situations that involve coverage decisions and appeals. Since each situation has different rules and deadlines, we give the details for each one in a separate section:

- **Section 6** of this chapter: “Your medical care: How to ask for a coverage decision or make an appeal”
- **Section 7** of this chapter: “Your Part D prescription drugs: How to ask for a coverage decision or make an appeal”
- **Section 8** of this chapter: “How to ask us to cover a longer inpatient hospital stay if you think the doctor is discharging you too soon”
- **Section 9** of this chapter: “How to ask us to keep covering certain medical services if you think your coverage is ending too soon” (Applies to these services only: home health care, skilled nursing facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF) services)

If you’re not sure which section you should be using, please call Member Services (phone numbers are on the back cover of this booklet). You can also get help or information from government organizations such as your State Health Insurance Assistance Program (Chapter 2, Section 3, of this booklet has the phone numbers for this program).

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## **SECTION 6      Your medical care: How to ask for a coverage decision or make an appeal**

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Have you read Section 5 of this chapter (A guide to “the basics” of coverage decisions and appeals)?  
If not, you may want to read it before you start this section.

<b>Section 6.1</b>	<b>This section tells what to do if you have problems getting coverage for medical care or if you want us to pay you back for our share of the cost of your care</b>
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This section is about your benefits for medical care and services. These benefits are described in Chapter 4 of this booklet: Benefits Chart (what is covered). To keep things simple, we generally refer to “medical care coverage” or “medical care” in the rest of this section, instead of repeating “medical care or treatment or services” every time.

This section tells what you can do if you are in any of the five following situations:

1. You are not getting certain medical care you want, and you believe that this care is covered by our plan.
2. Our plan will not approve the medical care your doctor or other medical provider wants to give you, and you believe that this care is covered by the plan.
3. You have received medical care or services that you believe should be covered by the plan, but we have said we will not pay for this care.
4. You have received and paid for medical care or services that you believe should be covered by the plan, and you want to ask our plan to reimburse you for this care.
5. You are being told that coverage for certain medical care you have been getting that we previously approved will be reduced or stopped, and you believe that reducing or stopping this care could harm your health.

- **NOTE: If the coverage that will be stopped is for hospital care, home health care, skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services,** you need to read a separate section of this chapter because special rules apply to these types of care. Here’s what to read in those situations:
  - Chapter 9, Section 8: How to ask us for a longer hospital stay if you think you are being asked to leave the hospital too soon.
  - Chapter 9, Section 9: How to ask us to keep covering certain medical services if you think your coverage is ending too soon. This section is about three services only: home health care, skilled nursing facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF) services.
- For all other situations that involve being told that medical care you have been getting will be stopped, use this section (Section 6) as your guide for what to do.

<b>Which of these situations are you in?</b>	
<b>If you are in this situation:</b>	<b>This is what you can do:</b>
Do you want to find out whether we will cover the medical care or services you want?	You can ask us to make a coverage decision for you.  Go to the next section of this chapter, <b>Section 6.2</b> .
Have we already told you that we will not cover or pay for a medical service in the way that you want it to be covered or paid for?	You can make an <b>appeal</b> . (This means you are asking us to reconsider.)  Skip ahead to <b>Section 6.3</b> of this chapter.
Do you want to ask us to pay you back for medical care or services you have already received and paid for?	You can send us the bill.  Skip ahead to <b>Section 6.5</b> of this chapter.

**Section 6.2 Step-by-step: How to ask for a coverage decision (how to ask our plan to authorize or provide the medical care coverage you want)**

**Legal Terms** When a coverage decision involves your medical care, it is called an “**organization determination**.”

**Step 1:** You ask our plan to make a coverage decision on the medical care you are requesting. If your health requires a quick response, you should ask us to make a “**fast decision**.”

**Legal Terms** A “fast decision” is called an “**expedited determination**.”

How to request coverage for the medical care you want

- Start by calling, writing, or faxing our plan to make your request for us to provide coverage for the medical care you want. You, your doctor, or your representative can do this.
- For the details on how to contact us, go to Chapter 2, Section 1 and look for the section called, “How to contact us when you are asking for a coverage decision about your medical care.”

Generally we use the standard deadlines for giving you our decision

When we give you our decision, we will use the “standard” deadlines unless we have agreed to use the “fast” deadlines. **A standard decision means we will give you an answer within 14 days** after we receive your request.

- **However, we can take up to 14 more calendar days** if you ask for more time, or if we need information (such as medical records) that may benefit you. If we decide to take extra days to make the decision, we will tell you in writing.
- If you believe we should not take extra days, you can file a “fast complaint” about our decision to take extra days. When you file a fast complaint, we will give you an answer to your complaint within 24 hours. (The process for making a complaint is different from the process for coverage decisions and appeals. For more information about the process for making complaints, including fast complaints, see Section 11 of this chapter.)

If your health requires it, ask us to give you a “fast decision”

- **A fast decision means we will answer within 72 hours.**
  - **However, we can take up to 14 more calendar days** if we find that some information that may benefit you is missing, or if you need time to get information to us for the review. If we decide to take extra days, we will tell you in writing.
  - If you believe we should not take extra days, you can file a “fast complaint” about our decision to take extra days. (For more information about the process for making complaints, including fast complaints, see Section 11 of this chapter.) We will call you as soon as we make the decision.
- **To get a fast decision, you must meet two requirements:**
  - You can get a fast decision only if you are asking for coverage for medical care you have not yet received. (You cannot get a fast decision if your request is about payment for medical care you have already received.)
  - You can get a fast decision only if using the standard deadlines could cause serious harm to your health or hurt your ability to function.
- **If your doctor tells us that your health requires a “fast decision,” we will automatically agree to give you a fast decision.**
- If you ask for a fast decision on your own, without your doctor’s support, we will decide whether your health requires that we give you a fast decision.
  - If we decide that your medical condition does not meet the requirements for a fast decision, we will send you a letter that says so (and we will use the standard deadlines instead).
  - This letter will tell you that if your doctor asks for the fast decision, we will automatically give a fast decision.

- The letter will also tell how you can file a “fast complaint” about our decision to give you a standard decision instead of the fast decision you requested. (For more information about the process for making complaints, including fast complaints, see Section 11 of this chapter.)

**Step 2: We consider your request for medical care coverage and give you our answer.**

Deadlines for a “**fast**” coverage decision

- Generally, for a fast decision, we will give you our answer **within 72 hours**.
  - As explained above, we can take up to 14 more calendar days under certain circumstances. If we decide to take extra days to make the decision, we will tell you in writing.
  - If you believe we should not take extra days, you can file a “fast complaint” about our decision to take extra days. When you file a fast complaint, we will give you an answer to your complaint within 24 hours. (For more information about the process for making complaints, including fast complaints, see Section 11 of this chapter.)
  - If we do not give you our answer within 72 hours (or if there is an extended time period, by the end of that period), you have the right to appeal. Section 6.3 below tells how to make an appeal.
- **If our answer is yes to part or all of what you requested**, we must authorize or provide the medical care coverage we have agreed to provide within 72 hours after we received your request. If we extended the time needed to make our decision, we will provide the coverage by the end of that extended period.
- **If our answer is no to part or all of what you requested**, we will send you a written statement that explains why we said no.

Deadlines for a “**standard**” coverage decision

- Generally, for a standard decision, we will give you our answer **within 14 days of receiving your request**.
  - We can take up to 14 more calendar days (“an extended time period”) under certain circumstances. If we decide to take extra days to make the decision, we will tell you in writing.
  - If you believe we should not take extra days, you can file a “fast complaint” about our decision to take extra days. When you file a fast complaint, we will give you an answer to your complaint within 24 hours. (For more information about the process for making complaints, including fast complaints, see Section 11 of this chapter.)
  - If we do not give you our answer within 14 days (or if there is an extended time period, by the end of that period), you have the right to appeal. Section 6.3 below tells how to make an appeal.

- **If our answer is yes to part or all of what you requested**, we must authorize or provide the coverage we have agreed to provide within 14 days after we received your request. If we extended the time needed to make our decision, we will provide the coverage by the end of that extended period.
- **If our answer is no to part or all of what you requested**, we will send you a written statement that explains why we said no.

**Step 3: If we say no to your request for coverage for medical care, you decide if you want to make an appeal.**

- If we say no, you have the right to ask us to reconsider – and perhaps change – this decision by making an appeal. Making an appeal means making another try to get the medical care coverage you want.
- If you decide to make an appeal, it means you are going on to Level 1 of the appeals process (see Section 6.3 below).

<b>Section 6.3</b>	<b>Step-by-step: How to make a Level 1 Appeal (how to ask for a review of a medical care coverage decision made by our plan)</b>
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<b>Legal Terms</b>	An appeal to the plan about a medical care coverage decision is called a plan “ <b>reconsideration.</b> ”
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**Step 1: You contact us and make your appeal.** If your health requires a quick response, you must ask for a “**fast appeal.**”

What to do

- **To start an appeal you, your doctor, or your representative, must contact us.** For details on how to reach us for any purpose related to your appeal, go to Chapter 2, Section 1 look for section called, “How to contact us when you are making an appeal about your medical care.”
- **If you are asking for a standard appeal, make your standard appeal in writing by submitting a signed request.**
  - If you have someone appealing our decision for you other than your doctor, your appeal must include an Appointment of Representative form authorizing this person to represent you. (To get the form, call Member Services and ask for the “Appointment of Representative” form. It is also available on Medicare’s website at <http://www.cms.hhs.gov/cmsforms/downloads/cms1696.pdf> or on our website at [www.bchpohio.com](http://www.bchpohio.com)). While we can accept an appeal request without the form, we cannot complete our review until we receive it. If we do not receive the form within 44 days after receiving your appeal request (our

deadline for making a decision on your appeal), your appeal request will be sent to the Independent Review Organization for dismissal.

- **If you are asking for a fast appeal, make your appeal in writing or call us** at the phone number shown in Chapter 2, Section 1 (How to contact us when you are making an appeal about your medical care).
- **You must make your appeal request within 60 calendar days** from the date on the written notice we sent to tell you our answer to your request for a coverage decision. If you miss this deadline and have a good reason for missing it, we may give you more time to make your appeal. Examples of good cause for missing the deadline may include if you had a serious illness that prevented you from contacting us or if we provided you with incorrect or incomplete information about the deadline for requesting an appeal.
- **You can ask for a copy of the information regarding your medical decision and add more information to support your appeal.**
  - You have the right to ask us for a copy of the information regarding your appeal.
  - If you wish, you and your doctor may give us additional information to support your appeal.

If your health requires it, ask for a “fast appeal” (you can make a request by calling us)

<b>Legal Terms</b>	A “fast appeal” is also called an “ <b>expedited reconsideration.</b> ”
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- If you are appealing a decision we made about coverage for care you have not yet received, you and/or your doctor will need to decide if you need a “fast appeal.”
- The requirements and procedures for getting a “fast appeal” are the same as those for getting a “fast decision.” To ask for a fast appeal, follow the instructions for asking for a fast decision. (These instructions are given earlier in this section.)
- If your doctor tells us that your health requires a “fast appeal,” we will give you a fast appeal.

### **Step 2: We consider your appeal and we give you our answer.**

- When we are reviewing your appeal, we take another careful look at all of the information about your request for coverage of medical care. We check to see if we were following all the rules when we said no to your request.
- We will gather more information if we need it. We may contact you or your doctor to get more information.

### **Deadlines for a “fast” appeal**

- When we are using the fast deadlines, we must give you our answer **within 72 hours after we receive your appeal**. We will give you our answer sooner if your health requires us to do so.
  - However, if you ask for more time, or if we need to gather more information that may benefit you, we **can take up to 14 more calendar days**. If we decide to take extra days to make the decision, we will tell you in writing.
  - If we do not give you an answer within 72 hours (or by the end of the extended time period if we took extra days), we are required to automatically send your request on to Level 2 of the appeals process, where it will be reviewed by an independent organization. Later in this section, we tell you about this organization and explain what happens at Level 2 of the appeals process.
- **If our answer is yes to part or all of what you requested**, we must authorize or provide the coverage we have agreed to provide within 72 hours after we receive your appeal.
- **If our answer is no to part or all of what you requested**, we will send you a written denial notice informing you that we have automatically sent your appeal to the Independent Review Organization for a Level 2 Appeal.

#### Deadlines for a “**standard**” appeal

- If we are using the standard deadlines, we must give you our answer **within 30 calendar days** after we receive your appeal if your appeal is about coverage for services you have not yet received. We will give you our decision sooner if your health condition requires us to.
  - However, if you ask for more time, or if we need to gather more information that may benefit you, **we can take up to 14 more calendar days**.
  - If you believe we should not take extra days, you can file a “fast complaint” about our decision to take extra days. When you file a fast complaint, we will give you an answer to your complaint within 24 hours. (For more information about the process for making complaints, including fast complaints, see Section 11 of this chapter.)
  - If we do not give you an answer by the deadline above (or by the end of the extended time period if we took extra days), we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent outside organization. Later in this section, we tell about this review organization and explain what happens at Level 2 of the appeals process.
- **If our answer is yes to part or all of what you requested**, we must authorize or provide the coverage we have agreed to provide within 30 days after we receive your appeal.
- **If our answer is no to part or all of what you requested**, we will send you a written denial notice informing you that we have automatically sent your appeal to the Independent Review Organization for a Level 2 Appeal.

**Step 3: If our plan says no to part or all of your appeal, your case will automatically be sent on to the next level of the appeals process.**

- To make sure we were following all the rules when we said no to your appeal, **we are required to send your appeal to the “Independent Review Organization.”** When we do this, it means that your appeal is going on to the next level of the appeals process, which is Level 2.

**Section 6.4 Step-by-step: How to make a Level 2 Appeal**

If we say no to your Level 1 Appeal, your case will automatically be sent on to the next level of the appeals process. During the Level 2 Appeal, the **Independent Review Organization** reviews the decision we made when we said no to your first appeal. This organization decides whether the decision we made should be changed.

<b>Legal Terms</b>	The formal name for the “Independent Review Organization” is the “ <b>Independent Review Entity.</b> ” It is sometimes called the “ <b>IRE.</b> ”
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**Step 1: The Independent Review Organization reviews your appeal.**

- **The Independent Review Organization is an independent organization that is hired by Medicare.** This organization is not connected with us and it is not a government agency. This organization is a company chosen by Medicare to handle the job of being the Independent Review Organization. Medicare oversees its work.
- We will send the information about your appeal to this organization. This information is called your “case file.” **You have the right to ask us for a copy of your case file.**
- You have a right to give the Independent Review Organization additional information to support your appeal.
- Reviewers at the Independent Review Organization will take a careful look at all of the information related to your appeal.

If you had a “fast” appeal at Level 1, you will also have a “**fast**” appeal at Level 2

- If you had a fast appeal to our plan at Level 1, you will automatically receive a fast appeal at Level 2. The review organization must give you an answer to your Level 2 Appeal **within 72 hours** of when it receives your appeal.
- However, if the Independent Review Organization needs to gather more information that may benefit you, **it can take up to 14 more calendar days.**

If you had a “standard” appeal at Level 1, you will also have a “**standard**” appeal at Level 2

- If you had a standard appeal to our plan at Level 1, you will automatically receive a standard appeal at Level 2. The review organization must give you an answer to your Level 2 Appeal **within 30 calendar days** of when it receives your appeal.

- However, if the Independent Review Organization needs to gather more information that may benefit you, **it can take up to 14 more calendar days.**

### **Step 2: The Independent Review Organization gives you their answer.**

The Independent Review Organization will tell you its decision in writing and explain the reasons for it.

- **If the review organization says yes to part or all of what you requested,** we must authorize the medical care coverage within 72 hours or provide the service within 14 calendar days after we receive the decision from the review organization.
- **If this organization says no to part or all of your appeal,** it means they agree with our plan that your request (or part of your request) for coverage for medical care should not be approved. (This is called “upholding the decision.” It is also called “turning down your appeal.”)
  - The notice you get from the Independent Review Organization will tell you in writing if your case meets the requirements for continuing with the appeals process. For example, to continue and make another appeal at Level 3, the dollar value of the medical care coverage you are requesting must meet a certain minimum. If the dollar value of the coverage you are requesting is too low, you cannot make another appeal, which means that the decision at Level 2 is final.

### **Step 3: If your case meets the requirements, you choose whether you want to take your appeal further.**

- There are three additional levels in the appeals process after Level 2 (for a total of five levels of appeal).
- If your Level 2 Appeal is turned down and you meet the requirements to continue with the appeals process, you must decide whether you want to go on to Level 3 and make a third appeal. The details on how to do this are in the written notice you got after your Level 2 Appeal.
- The Level 3 Appeal is handled by an administrative law judge. Section 10 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

<b>Section 6.5</b>	<b>What if you are asking us to pay you back for our share of a bill you have received for medical care?</b>
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If you want to ask us for payment for medical care, start by reading Chapter 7 of this booklet: Asking us to pay our share of a bill you have received for covered medical services or drugs. Chapter 7 describes the situations in which you may need to ask for reimbursement or to pay a bill you have received from a provider. It also tells how to send us the paperwork that asks us for payment.

## **Asking for reimbursement is asking for a coverage decision from us**

If you send us the paperwork that asks for reimbursement, you are asking us to make a coverage decision (for more information about coverage decisions, see Section 5.1 of this chapter). To make this coverage decision, we will check to see if the medical care you paid for is a covered service (see Chapter 4: Benefits Chart (what is covered and what you pay)). We will also check to see if you followed all the rules for using your coverage for medical care (these rules are given in Chapter 3 of this booklet: Using the plan's coverage for your medical services).

### **We will say yes or no to your request**

- If the medical care you paid for is covered and you followed all the rules, we will send you the payment for our share of the cost of your medical care within 60 calendar days after we receive your request. Or, if you haven't paid for the services, we will send the payment directly to the provider. When we send the payment, it's the same as saying yes to your request for a coverage decision.)
- If the medical care is not covered, or you did not follow all the rules, we will not send payment. Instead, we will send you a letter that says we will not pay for the services and the reasons why. (When we turn down your request for payment, it's the same as saying no to your request for a coverage decision.)

### **What if you ask for payment and we say that we will not pay?**

If you do not agree with our decision to turn you down, **you can make an appeal**. If you make an appeal, it means you are asking us to change the coverage decision we made when we turned down your request for payment.

**To make this appeal, follow the process for appeals that we describe in part 5.3 of this section.** Go to this part for step-by-step instructions. When you are following these instructions, please note:

- If you make an appeal for reimbursement, we must give you our answer within 60 calendar days after we receive your appeal. (If you are asking us to pay you back for medical care you have already received and paid for yourself, you are not allowed to ask for a fast appeal.)
- If the Independent Review Organization reverses our decision to deny payment, we must send the payment you have requested to you or to the provider within 30 calendar days. If the answer to your appeal is yes at any stage of the appeals process after Level 2, we must send the payment you requested to you or to the provider within 60 calendar days.

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## SECTION 7 Your Part D prescription drugs: How to ask for a coverage decision or make an appeal

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Have you read Section 5 of this chapter (A guide to “the basics” of coverage decisions and appeals)? If not, you may want to read it before you start this section.

<b>Section 7.1</b>	<b>This section tells you what to do if you have problems getting a Part D drug or you want us to pay you back for a Part D drug</b>
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Your benefits as a member of our plan include coverage for many outpatient prescription drugs. Medicare calls these outpatient prescription drugs “Part D drugs.” You can get these drugs as long as they are included in our plan’s List of Covered Drugs (Formulary) and the use of the drug is a medically accepted indication. (A “medically accepted indication” is a use of the drug that is either approved by the Food and Drug Administration or supported by certain reference books. See Chapter 5, Section 4 for more information about a medically accepted indication.)

- **This section is about your Part D drugs only.** To keep things simple, we generally say “drug” in the rest of this section, instead of repeating “covered outpatient prescription drug” or “Part D drug” every time.
- For details about what we mean by Part D drugs, the List of Covered Drugs (Formulary), rules and restrictions on coverage, and cost information, see Chapter 5 (Using our plan’s coverage for your Part D prescription drugs) and Chapter 6 (What you pay for your Part D prescription drugs).

### Part D coverage decisions and appeals

As discussed in Section 5 of this chapter, a coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your drugs.

<b>Legal Terms</b>	An initial coverage decision about your Part D drugs is called a “ <b>coverage determination.</b> ”
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Here are examples of coverage decisions you ask us to make about your Part D drugs:

- You ask us to make an exception, including:
  - Asking us to cover a Part D drug that is not on the plan’s List of Covered Drugs (Formulary)
  - Asking us to waive a restriction on the plan’s coverage for a drug (such as limits on the amount of the drug you can get)
  - Asking to pay a lower cost-sharing amount for a covered non-preferred drug

- You ask us whether a drug is covered for you and whether you meet the requirements for coverage. (For example, when your drug is on the plan’s List of Covered Drugs (Formulary) but we require you to get approval from us before we will cover it for you.)
  - Please note: If your pharmacy tells you that your prescription cannot be filled as written, you will get a written notice explaining how to contact us to ask for a coverage decision.
- You ask us to pay for a prescription drug you already bought. This is a request for a coverage decision about payment.

If you disagree with a coverage decision we have made, you can appeal our decision.

This section tells you both how to ask for coverage decisions and how to request an appeal. Use the chart below to help you determine which part has information for your situation:

<b>Which of these situations are you in?</b>			
<p>Do you need a drug that isn’t on our Drug List or need us to waive a rule or restriction on a drug we cover?</p> <p>You can ask us to make an exception. (This is a type of coverage decision.)</p> <p>Start with <b>Section 7.2</b> of this chapter.</p>	<p>Do you want us to cover a drug on our Drug List and you believe you meet any plan rules or restrictions (such as getting approval in advance) for the drug you need?</p> <p>You can ask us for a coverage decision.</p> <p>Skip ahead to <b>Section 7.4</b> of this chapter.</p>	<p>Do you want to ask us to pay you back for a drug you have already received and paid for?</p> <p>You can ask us to pay you back. (This is a type of coverage decision.)</p> <p>Skip ahead to <b>Section 7.4</b> of this chapter.</p>	<p>Have we already told you that we will not cover or pay for a drug in the way that you want it to be covered or paid for?</p> <p>You can make an appeal. (This means you are asking us to reconsider.)</p> <p>Skip ahead to <b>Section 7.5</b> of this chapter.</p>

## **Section 7.2      What is an exception?**

If a drug is not covered in the way you would like it to be covered, you can ask us to make an “exception.” An exception is a type of coverage decision. Similar to other types of coverage decisions, if we turn down your request for an exception, you can appeal our decision.

When you ask for an exception, your doctor or other prescriber will need to explain the medical reasons why you need the exception approved. We will then consider your request. Here are two examples of exceptions that you or your doctor or other prescriber can ask us to make:

**1. Covering a Part D drug for you that is not on our List of Covered Drugs (Formulary).**

(We call it the “Drug List” for short.)

<b>Legal Terms</b>	Asking for coverage of a drug that is not on the Drug List is sometimes called asking for a <b>“formulary exception.”</b>
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- If we agree to make an exception and cover a drug that is not on the Drug List, you will need to pay the cost-sharing amount that applies to drugs in the non-preferred brand tier. You cannot ask for an exception to the copayment or coinsurance amount we require you to pay for the drug.
- You cannot ask for coverage of any “excluded drugs” or other non-Part D drugs which Medicare does not cover. (For more information about excluded drugs, see Chapter 5.)

**2. Removing a restriction on our coverage for a covered drug.** There are extra rules or restrictions that apply to certain drugs on our List of Covered Drugs (Formulary) (for more information, go to Chapter 5 and look for Section 5).

<b>Legal Terms</b>	Asking for removal of a restriction on coverage for a drug is sometimes called asking for a <b>“formulary exception.”</b>
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- The extra rules and restrictions on coverage for certain drugs include:
  - Being required to use the generic version of a drug instead of the brand name drug.
  - Getting plan approval in advance before we will agree to cover the drug for you. (This is sometimes called “prior authorization.”)
  - Quantity limits. For some drugs, there are restrictions on the amount of the drug you can have.
- If we agree to make an exception and waive a restriction for you, you can ask for an exception to the copayment or coinsurance amount we require you to pay for the drug.

<b>Section 7.3</b>	<b>Important things to know about asking for exceptions</b>
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**Your doctor must tell us the medical reasons**

Your doctor or other prescriber must give us a statement that explains the medical reasons for requesting an exception. For a faster decision, include this medical information from your doctor or other prescriber when you ask for the exception.

Typically, our Drug List includes more than one drug for treating a particular condition. These different possibilities are called “alternative” drugs. If an alternative drug would be just as effective as the drug you are requesting and would not cause more side effects or other health problems, we will generally not approve your request for an exception.

### **We can say yes or no to your request**

- If we approve your request for an exception, our approval usually is valid until the end of the plan year. This is true as long as your doctor continues to prescribe the drug for you and that drug continues to be safe and effective for treating your condition.
- If we say no to your request for an exception, you can ask for a review of our decision by making an appeal. Section 7.5 tells how to make an appeal if we say no.

The next section tells you how to ask for a coverage decision, including an exception.

<b>Section 7.4</b>	<b>Step-by-step: How to ask for a coverage decision, including an exception</b>
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**Step 1: You ask us to make a coverage decision about the drug(s) or payment you need.** If your health requires a quick response, you must ask us to make a “fast decision.” **You cannot ask for a fast decision if you are asking us to pay you back for a drug you already bought.**

What to do

- **Request the type of coverage decision you want.** Start by calling, writing, or faxing us to make your request. You, your representative, or your doctor (or other prescriber) can do this. For the details, go to Chapter 2, Section 1 and look for the section called, How to contact us when you are asking for a coverage decision about your Part D prescription drugs. Or if you are asking us to pay you back for a drug, go to the section called, Where to send a request that asks us to pay for our share of the cost for medical care or a drug you have received.
- **You or your doctor or someone else who is acting on your behalf** can ask for a coverage decision. Section 5 of this chapter tells how you can give written permission to someone else to act as your representative. You can also have a lawyer act on your behalf.
- **If you want to ask us to pay you back for a drug,** start by reading Chapter 7 of this booklet: Asking us to pay our share of a bill you have received for covered medical services or drugs. Chapter 7 describes the situations in which you may need to ask for reimbursement. It also tells how to send us the paperwork that asks us to pay you back for our share of the cost of a drug you have paid for.
- **If you are requesting an exception, provide the “doctor’s statement.”** Your doctor or other prescriber must give us the medical reasons for the drug exception you are requesting. (We call this the “doctor’s statement.”) Your doctor or other prescriber can fax or mail the statement to us. Or your doctor or other prescriber

can tell us on the phone and follow up by faxing or mailing a written statement if necessary. See Sections 6.2 and 6.3 for more information about exception requests.

If your health requires it, ask us to give you a “fast decision”

<b>Legal Terms</b>	A “fast decision” is called an “ <b>expedited coverage determination.</b> ”
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- When we give you our decision, we will use the “standard” deadlines unless we have agreed to use the “fast” deadlines. A standard decision means we will give you an answer within 72 hours after we receive your doctor’s statement. A fast decision means we will answer within 24 hours.
- **To get a fast decision, you must meet two requirements:**
  - You can get a fast decision only if you are asking for a drug you have not yet received. (You cannot get a fast decision if you are asking us to pay you back for a drug you are already bought.)
  - You can get a fast decision only if using the standard deadlines could cause serious harm to your health or hurt your ability to function.
- **If your doctor or other prescriber tells us that your health requires a “fast decision,” we will automatically agree to give you a fast decision.**
- If you ask for a fast decision on your own (without your doctor’s or other prescriber’s support), we will decide whether your health requires that we give you a fast decision.
  - If we decide that your medical condition does not meet the requirements for a fast decision, we will send you a letter that says so (and we will use the standard deadlines instead).
  - This letter will tell you that if your doctor or other prescriber asks for the fast decision, we will automatically give a fast decision.
  - The letter will also tell how you can file a complaint about our decision to give you a standard decision instead of the fast decision you requested. It tells how to file a “fast” complaint, which means you would get our answer to your complaint within 24 hours. (The process for making a complaint is different from the process for coverage decisions and appeals. For more information about the process for making complaints, see Section 11 of this chapter.)

## **Step 2: We consider your request and we give you our answer.**

Deadlines for a “**fast**” coverage decision

- If we are using the fast deadlines, we must give you our answer **within 24 hours.**
  - Generally, this means within 24 hours after we receive your request. If you are requesting an exception, we will give you our answer within 24 hours after we receive your doctor’s statement supporting your request. We will give you our answer sooner if your health requires us to.

- If we do not meet this deadline, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent outside organization. Later in this section, we tell about this review organization and explain what happens at Appeal Level 2.
- **If our answer is yes to part or all of what you requested**, we must provide the coverage we have agreed to provide within 24 hours after we receive your request or doctor's statement supporting your request.
- **If our answer is no to part or all of what you requested**, we will send you a written statement that explains why we said no.

#### Deadlines for a “**standard**” coverage decision about a drug you have not yet received

- If we are using the standard deadlines, we must give you our answer **within 72 hours**.
  - Generally, this means within 72 hours after we receive your request. If you are requesting an exception, we will give you our answer within 72 hours after we receive your doctor's statement supporting your request. We will give you our answer sooner if your health requires us to.
  - If we do not meet this deadline, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent organization. Later in this section, we tell about this review organization and explain what happens at Appeal Level 2.
- **If our answer is yes to part or all of what you requested –**
  - If we approve your request for coverage, we must **provide the coverage** we have agreed to provide **within 72 hours** after we receive your request or doctor's statement supporting your request.
- **If our answer is no to part or all of what you requested**, we will send you a written statement that explains why we said no.

#### Deadlines for a “**standard**” coverage decision about payment for a drug you have already bought

- We must give you our answer **within 14 calendar days** after we receive your request.
  - If we do not meet this deadline, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent organization. Later in this section, we tell about this review organization and explain what happens at Appeal Level 2.
- **If our answer is yes to part or all of what you requested**, we are also required to make payment to you within 30 calendar days after we receive your request.
- **If our answer is no to part or all of what you requested**, we will send you a written statement that explains why we said no.

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**Step 3: If we say no to your coverage request, you decide if you want to make an appeal.**

- If we say no, you have the right to request an appeal. Requesting an appeal means asking us to reconsider – and possibly change – the decision we made.

<b>Section 7.5</b>	<b>Step-by-step: How to make a Level 1 Appeal (how to ask for a review of a coverage decision made by our plan)</b>
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<b>Legal Terms</b>	An appeal to the plan about a Part D drug coverage decision is called a plan “ <b>redetermination.</b> ”
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**Step 1: You contact us and make your Level 1 Appeal.** If your health requires a quick response, you must ask for a “**fast appeal.**”

What to do

- **To start your appeal, you (or your representative or your doctor or other prescriber) must contact us.**
  - For details on how to reach us by phone, fax, or mail for any purpose related to your appeal, go to Chapter 2, Section 1, and look for the section called, “How to contact our plan when you are making an appeal about your Part D prescription drugs.”
- **If you are asking for an appeal, you may make your appeal in writing or you may call us at the phone number shown in Chapter 2, Section 1** (“How to contact our plan when you are making an appeal about your part D prescription drugs”).
- **You must make your appeal request within 60 calendar days** from the date on the written notice we sent to tell you our answer to your request for a coverage decision. If you miss this deadline and have a good reason for missing it, we may give you more time to make your appeal. Examples of good cause for missing the deadline may include if you had a serious illness that prevented you from contacting us or if we provided you with incorrect or incomplete information about the deadline for requesting an appeal.
- **You can ask for a copy of the information in your appeal and add more information.**
  - You have the right to ask us for a copy of the information regarding your appeal.
  - If you wish, you and your doctor or other prescriber may give us additional information to support your appeal.

If your health requires it, ask for a “fast appeal”

<b>Legal Terms</b>	A “fast appeal” is also called an “ <b>expedited redetermination.</b> ”
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- If you are appealing a decision our plan made about a drug you have not yet received, you and your doctor or other prescriber will need to decide if you need a “fast appeal.”
- The requirements for getting a “fast appeal” are the same as those for getting a “fast decision” in Section 7.4 of this chapter.

### **Step 2: Our plan considers your appeal and we give you our answer.**

- When our plan is reviewing your appeal, we take another careful look at all of the information about your coverage request. We check to see if we were following all the rules when we said no to your request. We may contact you or your doctor or other prescriber to get more information.

#### **Deadlines for a “fast” appeal**

- If we are using the fast deadlines, we must give you our answer **within 72 hours after we receive your appeal**. We will give you our answer sooner if your health requires it.
  - If we do not give you an answer within 72 hours, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an Independent Review Organization. Later in this section, we tell about this review organization and explain what happens at Level 2 of the appeals process.
- **If our answer is yes to part or all of what you requested**, we must provide the coverage we have agreed to provide within 72 hours after we receive your appeal.
- **If our answer is no to part or all of what you requested**, we will send you a written statement that explains why we said no and how to appeal our decision.

#### **Deadlines for a “standard” appeal**

- If we are using the standard deadlines, we must give you our answer **within 7 calendar days** after we receive your appeal. We will give you our decision sooner if you have not received the drug yet and your health condition requires us to do so. If you believe your health requires it, you should ask for “fast” appeal.
  - If we do not give you a decision within 7 calendar days, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an Independent Review Organization. Later in this section, we tell about this review organization and explain what happens at Level 2 of the appeals process.
- **If our answer is yes to part or all of what you requested –**
  - If we approve a request for coverage, we must **provide the coverage** we have agreed to provide as quickly as your health requires, but **no later than 7 calendar days** after we receive your appeal.

- If we approve a request to pay you back for a drug you already bought, we are required to **send payment to you within 30 calendar days** after we receive your appeal request.
- **If our answer is no to part or all of what you requested**, we will send you a written statement that explains why we said no and how to appeal our decision.

**Step 3: If we say no to your appeal, you decide if you want to continue with the appeals process and make another appeal.**

- If we say no to your appeal, you then choose whether to accept this decision or continue by making another appeal.
- If you decide to make another appeal, it means your appeal is going on to Level 2 of the appeals process (see below).

<b>Section 7.6</b>	<b>Step-by-step: How to make a Level 2 Appeal</b>
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If we say no to your appeal, you then choose whether to accept this decision or continue by making another appeal. If you decide to go on to a Level 2 Appeal, the **Independent Review Organization** reviews the decision we made when we said no to your first appeal. This organization decides whether the decision we made should be changed.

<b>Legal Terms</b>	The formal name for the “Independent Review Organization” is the “ <b>Independent Review Entity.</b> ” It is sometimes called the “ <b>IRE.</b> ”
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**Step 1: To make a Level 2 Appeal, you must contact the Independent Review Organization and ask for a review of your case.**

- If we say no to your Level 1 Appeal, the written notice we send you will include **instructions on how to make a Level 2 Appeal** with the Independent Review Organization. These instructions will tell who can make this Level 2 Appeal, what deadlines you must follow, and how to reach the review organization.
- When you make an appeal to the Independent Review Organization, we will send the information we have about your appeal to this organization. This information is called your “case file.” **You have the right to ask us for a copy of your case file.**
- You have a right to give the Independent Review Organization additional information to support your appeal.

**Step 2: The Independent Review Organization does a review of your appeal and gives you an answer.**

- **The Independent Review Organization is an independent organization that is hired by Medicare.** This organization is not connected with us and it is not a government agency. This organization is a company chosen by Medicare to review our decisions about your Part D benefits with us.

- Reviewers at the Independent Review Organization will take a careful look at all of the information related to your appeal. The organization will tell you its decision in writing and explain the reasons for it.

#### Deadlines for “**fast**” appeal at Level 2

- If your health requires it, ask the Independent Review Organization for a “fast appeal.”
- If the review organization agrees to give you a “fast appeal,” the review organization must give you an answer to your Level 2 Appeal **within 72 hours** after it receives your appeal request.
- **If the Independent Review Organization says yes to part or all of what you requested**, we must provide the drug coverage that was approved by the review organization **within 24 hours** after we receive the decision from the review organization.

#### Deadlines for “**standard**” appeal at Level 2

- If you have a standard appeal at Level 2, the review organization must give you an answer to your Level 2 Appeal **within 7 calendar days** after it receives your appeal.
- **If the Independent Review Organization says yes to part or all of what you requested** –
  - If the Independent Review Organization approves a request for coverage, we must **provide the drug coverage** that was approved by the review organization **within 72 hours** after we receive the decision from the review organization.
  - If the Independent Review Organization approves a request to pay you back for a drug you already bought, we are required to **send payment to you within 30 calendar days** after we receive the decision from the review organization.

### **What if the review organization says no to your appeal?**

If this organization says no to your appeal, it means the organization agrees with our decision not to approve your request. (This is called “upholding the decision.” It is also called “turning down your appeal.”)

To continue and make another appeal at Level 3, the dollar value of the drug coverage you are requesting must meet a minimum amount. If the dollar value of the coverage you are requesting is too low, you cannot make another appeal and the decision at Level 2 is final. The notice you get from the Independent Review Organization will tell you the dollar value that must be in dispute to continue with the appeals process.

### **Step 3: If the dollar value of the coverage you are requesting meets the requirement, you choose whether you want to take your appeal further.**

- There are three additional levels in the appeals process after Level 2 (for a total of five levels of appeal).

**Step 3: If we say no to your coverage request, you decide if you want to make an appeal.**

- If we say no, you have the right to request an appeal. Requesting an appeal means asking us to reconsider – and possibly change – the decision we made.

<b>Section 7.5</b>	<b>Step-by-step: How to make a Level 1 Appeal (how to ask for a review of a coverage decision made by our plan)</b>
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<b>Legal Terms</b>	An appeal to the plan about a Part D drug coverage decision is called a plan “ <b>redetermination.</b> ”
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**Step 1: You contact us and make your Level 1 Appeal.** If your health requires a quick response, you must ask for a “**fast appeal.**”

What to do

- **To start your appeal, you (or your representative or your doctor or other prescriber) must contact us.**
  - For details on how to reach us by phone, fax, or mail for any purpose related to your appeal, go to Chapter 2, Section 1, and look for the section called, “How to contact our plan when you are making an appeal about your Part D prescription drugs.”
- **If you are asking for an appeal, you may make your appeal in writing or you may call us at the phone number shown in Chapter 2, Section 1** (“How to contact our plan when you are making an appeal about your part D prescription drugs”).
- **You must make your appeal request within 60 calendar days** from the date on the written notice we sent to tell you our answer to your request for a coverage decision. If you miss this deadline and have a good reason for missing it, we may give you more time to make your appeal. Examples of good cause for missing the deadline may include if you had a serious illness that prevented you from contacting us or if we provided you with incorrect or incomplete information about the deadline for requesting an appeal.
- **You can ask for a copy of the information in your appeal and add more information.**
  - You have the right to ask us for a copy of the information regarding your appeal.
  - If you wish, you and your doctor or other prescriber may give us additional information to support your appeal.

If your health requires it, ask for a “fast appeal”

<b>Legal Terms</b>	A “fast appeal” is also called an “ <b>expedited redetermination.</b> ”
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- If you are appealing a decision our plan made about a drug you have not yet received, you and your doctor or other prescriber will need to decide if you need a “fast appeal.”
- The requirements for getting a “fast appeal” are the same as those for getting a “fast decision” in Section 7.4 of this chapter.

### **Step 2: Our plan considers your appeal and we give you our answer.**

- When our plan is reviewing your appeal, we take another careful look at all of the information about your coverage request. We check to see if we were following all the rules when we said no to your request. We may contact you or your doctor or other prescriber to get more information.

#### **Deadlines for a “fast” appeal**

- If we are using the fast deadlines, we must give you our answer **within 72 hours after we receive your appeal**. We will give you our answer sooner if your health requires it.
  - If we do not give you an answer within 72 hours, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an Independent Review Organization. Later in this section, we tell about this review organization and explain what happens at Level 2 of the appeals process.
- **If our answer is yes to part or all of what you requested**, we must provide the coverage we have agreed to provide within 72 hours after we receive your appeal.
- **If our answer is no to part or all of what you requested**, we will send you a written statement that explains why we said no and how to appeal our decision.

#### **Deadlines for a “standard” appeal**

- If we are using the standard deadlines, we must give you our answer **within 7 calendar days** after we receive your appeal. We will give you our decision sooner if you have not received the drug yet and your health condition requires us to do so. If you believe your health requires it, you should ask for “fast” appeal.
  - If we do not give you a decision within 7 calendar days, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an Independent Review Organization. Later in this section, we tell about this review organization and explain what happens at Level 2 of the appeals process.
- **If our answer is yes to part or all of what you requested –**
  - If we approve a request for coverage, we must **provide the coverage** we have agreed to provide as quickly as your health requires, but **no later than 7 calendar days** after we receive your appeal.

- If we approve a request to pay you back for a drug you already bought, we are required to **send payment to you within 30 calendar days** after we receive your appeal request.
- **If our answer is no to part or all of what you requested**, we will send you a written statement that explains why we said no and how to appeal our decision.

**Step 3: If we say no to your appeal, you decide if you want to continue with the appeals process and make another appeal.**

- If we say no to your appeal, you then choose whether to accept this decision or continue by making another appeal.
- If you decide to make another appeal, it means your appeal is going on to Level 2 of the appeals process (see below).

<b>Section 7.6</b>	<b>Step-by-step: How to make a Level 2 Appeal</b>
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If we say no to your appeal, you then choose whether to accept this decision or continue by making another appeal. If you decide to go on to a Level 2 Appeal, the **Independent Review Organization** reviews the decision we made when we said no to your first appeal. This organization decides whether the decision we made should be changed.

<b>Legal Terms</b>	The formal name for the “Independent Review Organization” is the “ <b>Independent Review Entity.</b> ” It is sometimes called the “ <b>IRE.</b> ”
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**Step 1: To make a Level 2 Appeal, you must contact the Independent Review Organization and ask for a review of your case.**

- If we say no to your Level 1 Appeal, the written notice we send you will include **instructions on how to make a Level 2 Appeal** with the Independent Review Organization. These instructions will tell who can make this Level 2 Appeal, what deadlines you must follow, and how to reach the review organization.
- When you make an appeal to the Independent Review Organization, we will send the information we have about your appeal to this organization. This information is called your “case file.” **You have the right to ask us for a copy of your case file.**
- You have a right to give the Independent Review Organization additional information to support your appeal.

**Step 2: The Independent Review Organization does a review of your appeal and gives you an answer.**

- **The Independent Review Organization is an independent organization that is hired by Medicare.** This organization is not connected with us and it is not a government agency. This organization is a company chosen by Medicare to review our decisions about your Part D benefits with us.

- Reviewers at the Independent Review Organization will take a careful look at all of the information related to your appeal. The organization will tell you its decision in writing and explain the reasons for it.

#### Deadlines for “fast” appeal at Level 2

- If your health requires it, ask the Independent Review Organization for a “fast appeal.”
- If the review organization agrees to give you a “fast appeal,” the review organization must give you an answer to your Level 2 Appeal **within 72 hours** after it receives your appeal request.
- **If the Independent Review Organization says yes to part or all of what you requested**, we must provide the drug coverage that was approved by the review organization **within 24 hours** after we receive the decision from the review organization.

#### Deadlines for “standard” appeal at Level 2

- If you have a standard appeal at Level 2, the review organization must give you an answer to your Level 2 Appeal **within 7 calendar days** after it receives your appeal.
- **If the Independent Review Organization says yes to part or all of what you requested** –
  - If the Independent Review Organization approves a request for coverage, we must **provide the drug coverage** that was approved by the review organization **within 72 hours** after we receive the decision from the review organization.
  - If the Independent Review Organization approves a request to pay you back for a drug you already bought, we are required to **send payment to you within 30 calendar days** after we receive the decision from the review organization.

#### What if the review organization says no to your appeal?

If this organization says no to your appeal, it means the organization agrees with our decision not to approve your request. (This is called “upholding the decision.” It is also called “turning down your appeal.”)

To continue and make another appeal at Level 3, the dollar value of the drug coverage you are requesting must meet a minimum amount. If the dollar value of the coverage you are requesting is too low, you cannot make another appeal and the decision at Level 2 is final. The notice you get from the Independent Review Organization will tell you the dollar value that must be in dispute to continue with the appeals process.

**Step 3: If the dollar value of the coverage you are requesting meets the requirement, you choose whether you want to take your appeal further.**

- There are three additional levels in the appeals process after Level 2 (for a total of five levels of appeal).

- If your Level 2 Appeal is turned down and you meet the requirements to continue with the appeals process, you must decide whether you want to go on to Level 3 and make a third appeal. If you decide to make a third appeal, the details on how to do this are in the written notice you got after your second appeal.
- The Level 3 Appeal is handled by an administrative law judge. Section 10 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

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## **SECTION 8      How to ask us to cover a longer inpatient hospital stay if you think the doctor is discharging you too soon**

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When you are admitted to a hospital, you have the right to get all of your covered hospital services that are necessary to diagnose and treat your illness or injury. For more information about our coverage for your hospital care, including any limitations on this coverage, see Chapter 4 of this booklet: Benefits Chart (what is covered and what you pay).

During your hospital stay, your doctor and the hospital staff will be working with you to prepare for the day when you will leave the hospital. They will also help arrange for care you may need after you leave.

- The day you leave the hospital is called your “**discharge date.**” Our plan’s coverage of your hospital stay ends on this date.
- When your discharge date has been decided, your doctor or the hospital staff will let you know.
- If you think you are being asked to leave the hospital too soon, you can ask for a longer hospital stay and your request will be considered. This section tells you how to ask.

<b>Section 8.1      During your inpatient hospital stay, you will get a written notice from Medicare that tells about your rights</b>
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During your hospital stay, you will be given a written notice called An Important Message from Medicare about Your Rights. Everyone with Medicare gets a copy of this notice whenever they are admitted to a hospital. Someone at the hospital (for example, a caseworker or nurse) must give it to you within two days after you are admitted. If you do not get the notice, ask any hospital employee for it. If you need help, please call Member Services. You can also call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

- 1. Read this notice carefully and ask questions if you don’t understand it.** It tells you about your rights as a hospital patient, including:
  - Your right to receive Medicare-covered services during and after your hospital stay, as ordered by your doctor. This includes the right to know what these services are, who will pay for them, and where you can get them.

- Your right to be involved in any decisions about your hospital stay, and know who will pay for it.
- Where to report any concerns you have about quality of your hospital care.
- Your right to appeal your discharge decision if you think you are being discharged from the hospital too soon.

**Legal  
Terms**

The written notice from Medicare tells you how you can “**request an immediate review.**” Requesting an immediate review is a formal, legal way to ask for a delay in your discharge date so that we will cover your hospital care for a longer time. (Section 8.2 below tells you how you can request an immediate review.)

**2. You must sign the written notice to show that you received it and understand your rights.**

- You or someone who is acting on your behalf must sign the notice. (Section 5 of this chapter tells how you can give written permission to someone else to act as your representative.)
- Signing the notice shows only that you have received the information about your rights. The notice does not give your discharge date (your doctor or hospital staff will tell you your discharge date). Signing the notice **does not mean** you are agreeing on a discharge date.

**3. Keep your copy** of the signed notice so you will have the information about making an appeal (or reporting a concern about quality of care) handy if you need it.

- If you sign the notice more than 2 days before the day you leave the hospital, you will get another copy before you are scheduled to be discharged.
- To look at a copy of this notice in advance, you can call Member Services or 1-800 MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048. You can also see it online at [http://www.cms.gov/BNI/12\\_HospitalDischargeAppealNotices.asp](http://www.cms.gov/BNI/12_HospitalDischargeAppealNotices.asp).

**Section 8.2**

**Step-by-step: How to make a Level 1 Appeal to change your hospital discharge date**

If you want to ask for your hospital services to be covered by us for a longer time, you will need to use the appeals process to make this request. Before you start, understand what you need to do and what the deadlines are.

- **Follow the process.** Each step in the first two levels of the appeals process is explained below.
- **Meet the deadlines.** The deadlines are important. Be sure that you understand and follow the deadlines that apply to things you must do.

- **Ask for help if you need it.** If you have questions or need help at any time, please call Member Services (phone numbers are on the back cover of this booklet). Or call your State Health Insurance Assistance Program, a government organization that provides personalized assistance (see Section 2 of this chapter).

**During a Level 1 Appeal, the Quality Improvement Organization reviews your appeal.** It checks to see if your planned discharge date is medically appropriate for you.

**Step 1: Contact the Quality Improvement Organization in your state and ask for a “fast review” of your hospital discharge. You must act quickly.**

<b>Legal Terms</b>	A “fast review” is also called an “ <b>immediate review.</b> ”
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What is the Quality Improvement Organization?

- This organization is a group of doctors and other health care professionals who are paid by the Federal government. These experts are not part of our plan. This organization is paid by Medicare to check on and help improve the quality of care for people with Medicare. This includes reviewing hospital discharge dates for people with Medicare.

How can you contact this organization?

- The written notice you received (An Important Message from Medicare About Your Rights) tells you how to reach this organization. (Or find the name, address, and phone number of the Quality Improvement Organization for your state in Chapter 2, Section 4, of this booklet.)

Act quickly:

- To make your appeal, you must contact the Quality Improvement Organization before you leave the hospital and **no later than your planned discharge date.** (Your “planned discharge date” is the date that has been set for you to leave the hospital.)
  - If you meet this deadline, you are allowed to stay in the hospital after your discharge date without paying for it while you wait to get the decision on your appeal from the Quality Improvement Organization.
  - If you do not meet this deadline, and you decide to stay in the hospital after your planned discharge date, you may have to pay all of the costs for hospital care you receive after your planned discharge date.
- If you miss the deadline for contacting the Quality Improvement Organization about your appeal, you can make your appeal directly to our plan instead. For details about this other way to make your appeal, see Section 8.4.

Ask for a “fast review”:

- You must ask the Quality Improvement Organization for a **“fast review”** of your discharge. Asking for a “fast review” means you are asking for the organization to use the “fast” deadlines for an appeal instead of using the standard deadlines.

<b>Legal Terms</b>	A “fast review” is also called an <b>“immediate review”</b> or an <b>“expedited review.”</b>
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### **Step 2: The Quality Improvement Organization conducts an independent review of your case.**

What happens during this review?

- Health professionals at the Quality Improvement Organization (we will call them “the reviewers” for short) will ask you (or your representative) why you believe coverage for the services should continue. You don’t have to prepare anything in writing, but you may do so if you wish.
- The reviewers will also look at your medical information, talk with your doctor, and review information that the hospital and we have given to them.
- By noon of the day after the reviewers informed our plan of your appeal, you will also get a written notice that gives your planned discharge date and explains the reasons why your doctor, the hospital, and we think it is right (medically appropriate) for you to be discharged on that date.

<b>Legal Terms</b>	This written explanation is called the <b>“Detailed Notice of Discharge.”</b> You can get a sample of this notice by calling Member Services or 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. (TTY users should call 1-877-486-2048.) Or you can get see a sample notice online at <a href="http://www.cms.hhs.gov/BNI/">http://www.cms.hhs.gov/BNI/</a>
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### **Step 3: Within one full day after it has all the needed information, the Quality Improvement Organization will give you its answer to your appeal.**

What happens if the answer is yes?

- If the review organization says yes to your appeal, **we must keep providing your covered hospital services for as long as these services are medically necessary.**
- You will have to keep paying your share of the costs (such as deductibles or copayments, if these apply). In addition, there may be limitations on your covered hospital services. (See Chapter 4 of this booklet).

What happens if the answer is no?

- If the review organization says no to your appeal, they are saying that your planned discharge date is medically appropriate. If this happens, **our coverage for your hospital services will end** at noon on the day after the Quality Improvement Organization gives you its answer to your appeal.

- If the review organization says no to your appeal and you decide to stay in the hospital, then **you may have to pay the full cost** of hospital care you receive after noon on the day after the Quality Improvement Organization gives you its answer to your appeal.

**Step 4: If the answer to your Level 1 Appeal is no, you decide if you want to make another appeal.**

- If the Quality Improvement Organization has turned down your appeal, and you stay in the hospital after your planned discharge date, then you can make another appeal. Making another appeal means you are going on to “Level 2” of the appeals process.

<b>Section 8.3</b>	<b>Step-by-step: How to make a Level 2 Appeal to change your hospital discharge date</b>
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If the Quality Improvement Organization has turned down your appeal, and you stay in the hospital after your planned discharge date, then you can make a Level 2 Appeal. During a Level 2 Appeal, you ask the Quality Improvement Organization to take another look at the decision they made on your first appeal. If we turn down your Level 2 Appeal, you may have to pay the full cost for your stay after your planned discharge date.

Here are the steps for Level 2 of the appeal process:

**Step 1: You contact the Quality Improvement Organization again and ask for another review.**

- You must ask for this review **within 60 calendar days** after the day when the Quality Improvement Organization said no to your Level 1 Appeal. You can ask for this review only if you stayed in the hospital after the date that your coverage for the care ended.

**Step 2: The Quality Improvement Organization does a second review of your situation.**

- Reviewers at the Quality Improvement Organization will take another careful look at all of the information related to your appeal.

**Step 3: Within 14 calendar days, the Quality Improvement Organization reviewers will decide on your appeal and tell you their decision.**

If the review organization says yes:

- **We must reimburse you** for our share of the costs of hospital care you have received since noon on the day after the date your first appeal was turned down by the Quality Improvement Organization. **We must continue providing coverage for your hospital care for as long as it is medically necessary.**

- You must continue to pay your share of the costs and coverage limitations may apply.

If the review organization says no:

- It means they agree with the decision they made on your Level 1 Appeal and will not change it.
- The notice you get will tell you in writing what you can do if you wish to continue with the review process. It will give you the details about how to go on to the next level of appeal, which is handled by a judge.

**Step 4: If the answer is no, you will need to decide whether you want to take your appeal further by going on to Level 3.**

- There are three additional levels in the appeals process after Level 2 (for a total of five levels of appeal). If the review organization turns down your Level 2 Appeal, you can choose whether to accept that decision or whether to go on to Level 3 and make another appeal. At Level 3, your appeal is reviewed by a judge.
- Section 10 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

**Section 8.4 What if you miss the deadline for making your Level 1 Appeal?**

**You can appeal to us instead**

As explained above in Section 8.2, you must act quickly to contact the Quality Improvement Organization to start your first appeal of your hospital discharge. (“Quickly” means before you leave the hospital and no later than your planned discharge date). If you miss the deadline for contacting this organization, there is another way to make your appeal.

If you use this other way of making your appeal, the first two levels of appeal are different.

**Step-by-Step: How to make a Level 1 Alternate Appeal**

If you miss the deadline for contacting the Quality Improvement Organization, you can make an appeal to us, asking for a “fast review.” A fast review is an appeal that uses the fast deadlines instead of the standard deadlines.

<b>Legal Terms</b>	A “fast” review (or “fast appeal”) is also called an “ <b>expedited appeal</b> ”.
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**Step 1: Contact us and ask for a “fast review.”**

- For details on how to contact our plan, go to Chapter 2, Section 1 and look for the section called, How to contact our plan when you are making an appeal about your medical care.

- **Be sure to ask for a “fast review.”** This means you are asking us to give you an answer using the “fast” deadlines rather than the “standard” deadlines.

**Step 2: We do a “fast” review of your planned discharge date, checking to see if it was medically appropriate.**

- During this review, we take a look at all of the information about your hospital stay. We check to see if your planned discharge date was medically appropriate. We will check to see if the decision about when you should leave the hospital was fair and followed all the rules.
- In this situation, we will use the “fast” deadlines rather than the standard deadlines for giving you the answer to this review.

**Step 3: We give you our decision within 72 hours after you ask for a “fast review” (“fast appeal”).**

- **If we say yes to your fast appeal,** it means we have agreed with you that you still need to be in the hospital after the discharge date, and will keep providing your covered services for as long as it is medically necessary. It also means that we have agreed to reimburse you for our share of the costs of care you have received since the date when we said your coverage would end. (You must pay your share of the costs and there may be coverage limitations that apply.)
- **If we say no to your fast appeal,** we are saying that your planned discharge date was medically appropriate. Our coverage for your hospital services ends as of the day we said coverage would end.
  - If you stayed in the hospital after your planned discharge date, then **you may have to pay the full cost** of hospital care you received after the planned discharge date.

**Step 4: If we say no to your fast appeal, your case will automatically be sent on to the next level of the appeals process.**

- To make sure we were following all the rules when we said no to your fast appeal, **we are required to send your appeal to the “Independent Review Organization.”** When we do this, it means that you are automatically going on to Level 2 of the appeals process.

**Step-by-Step: How to make a Level 2 Alternate Appeal**

If we say no to your Level 1 Appeal, your case will automatically be sent on to the next level of the appeals process. During the Level 2 Appeal, the **Independent Review Organization** reviews the decision we made when we said no to your “fast appeal.” This organization decides whether the decision we made should be changed.

<b>Legal Terms</b>	The formal name for the “Independent Review Organization” is the <b>“Independent Review</b>
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**Entity.”** It is sometimes called the **“IRE.”**

**Step 1: We will automatically forward your case to the Independent Review Organization.**

- We are required to send the information for your Level 2 Appeal to the Independent Review Organization within 24 hours of when we tell you that we are saying no to your first appeal. (If you think we are not meeting this deadline or other deadlines, you can make a complaint. The complaint process is different from the appeal process. Section 11 of this chapter tells how to make a complaint.)

**Step 2: The Independent Review Organization does a “fast review” of your appeal. The reviewers give you an answer within 72 hours.**

- **The Independent Review Organization is an independent organization that is hired by Medicare.** This organization is not connected with our plan and it is not a government agency. This organization is a company chosen by Medicare to handle the job of being the Independent Review Organization. Medicare oversees its work.
- Reviewers at the Independent Review Organization will take a careful look at all of the information related to your appeal of your hospital discharge.
- **If this organization says yes to your appeal,** then we must reimburse you (pay you back) for our share of the costs of hospital care you have received since the date of your planned discharge. We must also continue the plan’s coverage of your hospital services for as long as it is medically necessary. You must continue to pay your share of the costs. If there are coverage limitations, these could limit how much we would reimburse or how long we would continue to cover your services.
- **If this organization says no to your appeal,** it means they agree with us that your planned hospital discharge date was medically appropriate.
  - The notice you get from the Independent Review Organization will tell you in writing what you can do if you wish to continue with the review process. It will give you the details about how to go on to a Level 3 Appeal, which is handled by a judge.

**Step 3: If the Independent Review Organization turns down your appeal, you choose whether you want to take your appeal further.**

- There are three additional levels in the appeals process after Level 2 (for a total of five levels of appeal). If reviewers say no to your Level 2 Appeal, you decide whether to accept their decision or go on to Level 3 and make a third appeal.
- Section 10 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

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## **SECTION 9      How to ask us to keep covering certain medical services if you think your coverage is ending too soon**

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<b>Section 9.1</b>	<b>This section is about three services <u>only</u>: Home health care, skilled nursing facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF) services</b>
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This section is about the following types of care only:

- **Home health care services** you are getting.
- **Skilled nursing care** you are getting as a patient in a skilled nursing facility. (To learn about requirements for being considered a “skilled nursing facility,” see Chapter 12, Definitions of important words.)
- **Rehabilitation care** you are getting as an outpatient at a Medicare-approved Comprehensive Outpatient Rehabilitation Facility (CORF). Usually, this means you are getting treatment for an illness or accident, or you are recovering from a major operation. (For more information about this type of facility, see Chapter 12, Definitions of important words.)

When you are getting any of these types of care, you have the right to keep getting your covered services for that type of care for as long as the care is needed to diagnose and treat your illness or injury. For more information on your covered services, including your share of the cost and any limitations to coverage that may apply, see Chapter 4 of this booklet: Benefits Chart (what is covered and what you pay).

When we decide it is time to stop covering any of the three types of care for you, we are required to tell you in advance. When your coverage for that care ends, we will stop paying our share of the cost for your care.

If you think we are ending the coverage of your care too soon, **you can appeal our decision**. This section tells you how to ask for an appeal.

<b>Section 9.2</b>	<b>We will tell you in advance when your coverage will be ending</b>
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1. **You receive a notice in writing.** At least two days before our plan is going to stop covering your care, the agency or facility that is providing your care will give you a notice.
  - The written notice tells you the date when we will stop covering the care for you.
  - The written notice also tells what you can do if you want to ask our plan to change this decision about when to end your care, and keep covering it for a longer period of time.

<b>Legal</b>	In telling you what you can do, the written notice
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<b>Terms</b>	is telling how you can request a “ <b>fast-track appeal.</b> ” Requesting a fast-track appeal is a formal, legal way to request a change to our coverage decision about when to stop your care. (Section 9.3 below tells how you can request a fast-track appeal.)
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<b>Legal Terms</b>	The written notice is called the “ <b>Notice of Medicare Non-Coverage.</b> ” To get a sample copy, call Member Services or 1-800-MEDICARE (1-800-633-4227, 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.). Or see a copy online at <a href="http://www.cms.hhs.gov/BNI/">http://www.cms.hhs.gov/BNI/</a>
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## 2. You must sign the written notice to show that you received it.

- You or someone who is acting on your behalf must sign the notice. (Section 5 tells how you can give written permission to someone else to act as your representative.)
- Signing the notice shows only that you have received the information about when your coverage will stop. **Signing it does not mean you agree** with the plan that it’s time to stop getting the care.

<b>Section 9.3</b>	<b>Step-by-step: How to make a Level 1 Appeal to have our plan cover your care for a longer time</b>
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If you want to ask us to cover your care for a longer period of time, you will need to use the appeals process to make this request. Before you start, understand what you need to do and what the deadlines are.

- **Follow the process.** Each step in the first two levels of the appeals process is explained below.
- **Meet the deadlines.** The deadlines are important. Be sure that you understand and follow the deadlines that apply to things you must do. There are also deadlines our plan must follow. (If you think we are not meeting our deadlines, you can file a complaint. Section 11 of this chapter tells you how to file a complaint.)
- **Ask for help if you need it.** If you have questions or need help at any time, please call Member Services (phone numbers are on the back cover of this booklet). Or call your State Health Insurance Assistance Program, a government organization that provides personalized assistance (see Section 2 of this chapter).

**During a Level 1 Appeal, the Quality Improvement Organization reviews your appeal and decides whether to change the decision made by our plan.**

**Step 1: Make your Level 1 Appeal: contact the Quality Improvement Organization in your state and ask for a review. You must act quickly.**

### What is the Quality Improvement Organization?

- This organization is a group of doctors and other health care experts who are paid by the Federal government. These experts are not part of our plan. They check on the quality of care received by people with Medicare and review plan decisions about when it's time to stop covering certain kinds of medical care.

### How can you contact this organization?

- The written notice you received tells you how to reach this organization. (Or find the name, address, and phone number of the Quality Improvement Organization for your state in Chapter 2, Section 4, of this booklet.)

### What should you ask for?

- Ask this organization to do an independent review of whether it is medically appropriate for us to end coverage for your medical services.

### Your deadline for contacting this organization.

- You must contact the Quality Improvement Organization to start your appeal no later than noon of the day after you receive the written notice telling you when we will stop covering your care.
- If you miss the deadline for contacting the Quality Improvement Organization about your appeal, you can make your appeal directly to us instead. For details about this other way to make your appeal, see Section 9.5.

## **Step 2: The Quality Improvement Organization conducts an independent review of your case.**

### What happens during this review?

- Health professionals at the Quality Improvement Organization (we will call them “the reviewers” for short) will ask you (or your representative) why you believe coverage for the services should continue. You don't have to prepare anything in writing, but you may do so if you wish.
- The review organization will also look at your medical information, talk with your doctor, and review information that our plan has given to them.
- By the end of the day the reviewers informed us of your appeal, and you will also get a written notice from us that gives our reasons for ending our coverage for your services.

<b>Legal Terms</b>	This notice explanation is called the “ <b>Detailed Explanation of Non-Coverage.</b> ”
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## **Step 3: Within one full day after they have all the information they need, the reviewers will tell you their decision.**

### What happens if the reviewers say yes to your appeal?

- If the reviewers say yes to your appeal, then **we must keep providing your covered services for as long as it is medically necessary.**
- You will have to keep paying your share of the costs (such as deductibles or copayments, if these apply). In addition, there may be limitations on your covered services (see Chapter 4 of this booklet).

What happens if the reviewers say no to your appeal?

- If the reviewers say no to your appeal, then **your coverage will end on the date we have told you.** We will stop paying its share of the costs of this care.
- If you decide to keep getting the home health care, or skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services after this date when your coverage ends, then **you will have to pay the full cost** of this care yourself.

**Step 4: If the answer to your Level 1 Appeal is no, you decide if you want to make another appeal.**

- This first appeal you make is “Level 1” of the appeals process. If reviewers say no to your Level 1 Appeal – and you choose to continue getting care after your coverage for the care has ended – then you can make another appeal.
- Making another appeal means you are going on to “Level 2” of the appeals process.

<b>Section 9.4</b>	<b>Step-by-step: How to make a Level 2 Appeal to have our plan cover your care for a longer time</b>
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If the Quality Improvement Organization has turned down your appeal and you choose to continue getting care after your coverage for the care has ended, then you can make a Level 2 Appeal. During a Level 2 Appeal, you ask the Quality Improvement Organization to take another look at the decision they made on your first appeal. If we turn down your Level 2 Appeal, you may have to pay the full cost for your home health care, or skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services after the date when we said your coverage would end.

Here are the steps for Level 2 of the appeal process:

**Step 1: You contact the Quality Improvement Organization again and ask for another review.**

- You must ask for this review **within 60 days** after the day when the Quality Improvement Organization said no to your Level 1 Appeal. You can ask for this review only if you continued getting care after the date that your coverage for the care ended.

**Step 2: The Quality Improvement Organization does a second review of your situation.**

- Reviewers at the Quality Improvement Organization will take another careful look at all of the information related to your appeal.

**Step 3: Within 14 days, the Quality Improvement Organization reviewers will decide on your appeal and tell you their decision.**

What happens if the review organization says yes to your appeal?

- **We must reimburse you** for our share of the costs of care you have received since the date when we said your coverage would end. **We must continue providing coverage** for the care for as long as it is medically necessary.
- You must continue to pay your share of the costs and there may be coverage limitations that apply.

What happens if the review organization says no?

- It means they agree with the decision we made to your Level 1 Appeal and will not change it.
- The notice you get will tell you in writing what you can do if you wish to continue with the review process. It will give you the details about how to go on to the next level of appeal, which is handled by a judge.

**Step 4: If the answer is no, you will need to decide whether you want to take your appeal further.**

- There are three additional levels of appeal after Level 2, for a total of five levels of appeal. If reviewers turn down your Level 2 Appeal, you can choose whether to accept that decision or to go on to Level 3 and make another appeal. At Level 3, your appeal is reviewed by a judge.
- Section 10 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

<b>Section 9.5</b>	<b>What if you miss the deadline for making your Level 1 Appeal?</b>
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### **You can appeal to us instead**

As explained above in Section 9.3, you must act quickly to contact the Quality Improvement Organization to start your first appeal (within a day or two, at the most). If you miss the deadline for contacting this organization, there is another way to make your appeal. If you use this other way of making your appeal, the first two levels of appeal are different.

### **Step-by-Step: How to make a Level 1 Alternate Appeal**

If you miss the deadline for contacting the Quality Improvement Organization, you can make an appeal to us, asking for a “fast review.” A fast review is an appeal that uses the fast deadlines instead of the standard deadlines.

Here are the steps for a Level 1 Alternate Appeal:

<b>Legal Terms</b>	A “fast” review (or “fast appeal”) is also called an “ <b>expedited appeal</b> ”.
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**Step 1: Contact us and ask for a “fast review.”**

- For details on how to contact us, go to Chapter 2, Section 1 and look for the section called, How to contact our plan when you are making an appeal about your medical care.
- **Be sure to ask for a “fast review.”** This means you are asking us to give you an answer using the “fast” deadlines rather than the “standard” deadlines.

**Step 2: We do a “fast” review of the decision we made about when to end coverage for your services.**

- During this review, we take another look at all of the information about your case. We check to see if we were following all the rules when we set the date for ending the plan’s coverage for services you were receiving.
- We will use the “fast” deadlines rather than the standard deadlines for giving you the answer to this review. (Usually, if you make an appeal to our plan and ask for a “fast review,” we are allowed to decide whether to agree to your request and give you a “fast review.” But in this situation, the rules require us to give you a fast response if you ask for it.)

**Step 3: We give you our decision within 72 hours after you ask for a “fast review” (“fast appeal”).**

- **If we say yes to your fast appeal,** it means we have agreed with you that you need services longer, and will keep providing your covered services for as long as it is medically necessary. It also means that we have agreed to reimburse you for our share of the costs of care you have received since the date when we said your coverage would end. (You must pay your share of the costs and there may be coverage limitations that apply.)
- **If we say no to your fast appeal,** then your coverage will end on the date we have told you and we will not pay after this date. We will stop paying its share of the costs of this care.
- If you continued to get home health care, or skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services after the date when we said your coverage would your coverage ends, then **you will have to pay the full cost** of this care yourself.

**Step 4: If we say no to your fast appeal, your case will automatically go on to the next level of the appeals process.**

- To make sure we were following all the rules when we said no to your fast appeal, **we are required to send your appeal to the “Independent Review Organization.”** When we do this, it means that you are automatically going on to Level 2 of the appeals process.

### Step-by-Step: How to make a Level 2 Alternate Appeal

If we say no to your Level 1 Appeal, your case will automatically be sent on to the next level of the appeals process. During the Level 2 Appeal, the **Independent Review Organization** reviews the decision we made when we said no to your “fast appeal.” This organization decides whether the decision we made should be changed.

<b>Legal Terms</b>	The formal name for the “Independent Review Organization” is the <b>“Independent Review Entity.”</b> It is sometimes called the <b>“IRE.”</b>
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#### **Step 1: We will automatically forward your case to the Independent Review Organization.**

- We are required to send the information for your Level 2 Appeal to the Independent Review Organization within 24 hours of when we tell you that we are saying no to your first appeal. (If you think we are not meeting this deadline or other deadlines, you can make a complaint. The complaint process is different from the appeal process. Section 11 of this chapter tells how to make a complaint.)

#### **Step 2: The Independent Review Organization does a “fast review” of your appeal. The reviewers give you an answer within 72 hours.**

- **The Independent Review Organization is an independent organization that is hired by Medicare.** This organization is not connected with our plan and it is not a government agency. This organization is a company chosen by Medicare to handle the job of being the Independent Review Organization. Medicare oversees its work.
- Reviewers at the Independent Review Organization will take a careful look at all of the information related to your appeal.
- **If this organization says yes to your appeal,** then we must reimburse you (pay you back) for our share of the costs of care you have received since the date when we said your coverage would end. We must also continue to cover the care for as long as it is medically necessary. You must continue to pay your share of the costs. If there are coverage limitations, these could limit how much we would reimburse or how long we would continue to cover your services.
- **If this organization says no to your appeal,** it means they agree with the decision our plan made to your first appeal and will not change it.
  - The notice you get from the Independent Review Organization will tell you in writing what you can do if you wish to continue with the review process. It will give you the details about how to go on to a Level 3 Appeal.

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**Step 3: If the Independent Review Organization turns down your appeal, you choose whether you want to take your appeal further.**

- There are three additional levels of appeal after Level 2, for a total of five levels of appeal. If reviewers say no to your Level 2 Appeal, you can choose whether to accept that decision or whether to go on to Level 3 and make another appeal. At Level 3, your appeal is reviewed by a judge.
- Section 10 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

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**SECTION 10 Taking your appeal to Level 3 and beyond**

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<b>Section 10.1 Levels of Appeal 3, 4, and 5 for Medical Service Appeals</b>
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This section may be appropriate for you if you have made a Level 1 Appeal and a Level 2 Appeal, and both of your appeals have been turned down.

If the dollar value of the item or medical service you have appealed meets certain minimum levels, you may be able to go on to additional levels of appeal. If the dollar value is less than the minimum level, you cannot appeal any further. If the dollar value is high enough, the written response you receive to your Level 2 Appeal will explain who to contact and what to do to ask for a Level 3 Appeal.

For most situations that involve appeals, the last three levels of appeal work in much the same way. Here is who handles the review of your appeal at each of these levels.

<p><b>Level 3 Appeal</b> A judge who works for the Federal government will review your appeal and give you an answer. This judge is called an “Administrative Law Judge.”</p>
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- **If the Administrative Law Judge says yes to your appeal, the appeals process may or may not be over** - We will decide whether to appeal this decision to Level 4. Unlike a decision at Level 2 (Independent Review Organization), we have the right to appeal a Level 3 decision that is favorable to you.
  - If we decide not to appeal the decision, we must authorize or provide you with the service within 60 days after receiving the judge’s decision.
  - If we decide to appeal the decision, we will send you a copy of the Level 4 Appeal request with any accompanying documents. We may wait for the Level 4 Appeal decision before authorizing or providing the service in dispute.
- **If the Administrative Law Judge says no to your appeal, the appeals process may or may not be over.**
  - If you decide to accept this decision that turns down your appeal, the appeals process is over.

- If you do not want to accept the decision, you can continue to the next level of the review process. If the administrative law judge says no to your appeal, the notice you get will tell you what to do next if you choose to continue with your appeal.

**Level 4 Appeal** The **Medicare Appeals Council** will review your appeal and give you an answer. The Medicare Appeals Council works for the Federal government.

- **If the answer is yes, or if the Medicare Appeals Council denies our request to review a favorable Level 3 Appeal decision, the appeals process may or may not be over -** We will decide whether to appeal this decision to Level 5. Unlike a decision at Level 2 (Independent Review Organization), we have the right to appeal a Level 4 decision that is favorable to you.
  - If we decide not to appeal the decision, we must authorize or provide you with the service within 60 days after receiving the Medicare Appeals Council's decision.
  - If we decide to appeal the decision, we will let you know in writing.
- **If the answer is no or if the Medicare Appeals Council denies the review request, the appeals process may or may not be over.**
  - If you decide to accept this decision that turns down your appeal, the appeals process is over.
  - If you do not want to accept the decision, you might be able to continue to the next level of the review process. If the Medicare Appeals Council says no to your appeal, the notice you get will tell you whether the rules allow you to go on to a Level 5 Appeal. If the rules allow you to go on, the written notice will also tell you who to contact and what to do next if you choose to continue with your appeal.

**Level 5 Appeal** A judge at the **Federal District Court** will review your appeal.

- This is the last step of the administrative appeals process.

## **Section 10.2 Levels of Appeal 3, 4, and 5 for Part D Drug Appeals**

This section may be appropriate for you if you have made a Level 1 Appeal and a Level 2 Appeal, and both of your appeals have been turned down.

If the dollar value of the drug you have appealed meets certain minimum levels, you may be able to go on to additional levels of appeal. If the dollar value is less than the minimum level, you cannot appeal any further. If the dollar value is high enough, the written response you receive to your Level 2 Appeal will explain who to contact and what to do to ask for a Level 3 Appeal.

For most situations that involve appeals, the last three levels of appeal work in much the same way. Here is who handles the review of your appeal at each of these levels.

**Level 3 Appeal** A judge who works for the Federal government will review your

appeal and give you an answer. This judge is called an “Administrative Law Judge.”

- **If the answer is yes, the appeals process is over.** What you asked for in the appeal has been approved. We must **authorize or provide the drug coverage** that was approved by the Administrative Law Judge **within 72 hours (24 hours for expedited appeals) or make payment no later than 30 calendar days** after we receive the decision.
- **If the answer is no, the appeals process may or may not be over.**
  - If you decide to accept this decision that turns down your appeal, the appeals process is over.
  - If you do not want to accept the decision, you can continue to the next level of the review process. If the administrative law judge says no to your appeal, the notice you get will tell you what to do next if you choose to continue with your appeal.

**Level 4 Appeal** The **Medicare Appeals Council** will review your appeal and give you an answer. The Medicare Appeals Council works for the Federal government.

- **If the answer is yes, the appeals process is over.** What you asked for in the appeal has been approved. We must **authorize or provide the drug coverage** that was approved by the Medicare Appeals Council **within 72 hours (24 hours for expedited appeals) or make payment no later than 30 calendar days** after we receive the decision.
- **If the answer is no, the appeals process may or may not be over.**
  - If you decide to accept this decision that turns down your appeal, the appeals process is over.
  - If you do not want to accept the decision, you might be able to continue to the next level of the review process. If the Medicare Appeals Council says no to your appeal, the notice you get will tell you whether the rules allow you to go on to a Level 5 Appeal. If the rules allow you to go on, the written notice will also tell you who to contact and what to do next if you choose to continue with your appeal.

**Level 5 Appeal** A judge at the **Federal District Court** will review your appeal.

- This is the last step of the appeals process.

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## SECTION 11 How to make a complaint about quality of care, waiting times, customer service, or other concerns

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If your problem is about decisions related to benefits, coverage, or payment, then this section is not for you. Instead, you need to use the process for coverage decisions and appeals. Go to Section 5 of this chapter.

**Section 11.1      What kinds of problems are handled by the complaint process?**

This section explains how to use the process for making complaints. The complaint process is used for certain types of problems only. This includes problems related to quality of care, waiting times, and the customer service you receive. Here are examples of the kinds of problems handled by the complaint process.

**If you have any of these kinds of problems, you can “make a complaint”****Quality of your medical care**

- Are you unhappy with the quality of the care you have received (including care in the hospital)?

**Respecting your privacy**

- Do you believe that someone did not respect your right to privacy or shared information about you that you feel should be confidential?

**Disrespect, poor customer service, or other negative behaviors**

- Has someone been rude or disrespectful to you?
- Are you unhappy with how our Member Services has treated you?
- Do you feel you are being encouraged to leave the plan?

**Waiting times**

- Are you having trouble getting an appointment, or waiting too long to get it?
- Have you been kept waiting too long by doctors, pharmacists, or other health professionals? Or by our Member Services or other staff at the plan?
  - Examples include waiting too long on the phone, in the waiting room, when getting a prescription, or in the exam room.

**Cleanliness**

- Are you unhappy with the cleanliness or condition of a clinic, hospital, or doctor’s office?

**Information you get from us**

- Do you believe we have not given you a notice that we are required to give?
- Do you think written information we have given you is hard to understand?

The next page has more examples of possible reasons for making a complaint

**Possible complaints**  
(continued)**These types of complaints are all related to the timeliness of our actions related to coverage decisions and appeals**

The process of asking for a coverage decision and making appeals is explained in sections 4-10 of this chapter. If you are asking for a decision or making an appeal, you use that process, not the complaint process.

However, if you have already asked us for a coverage decision or made an appeal, and you think that we are not responding quickly enough, you can also make a complaint about our slowness. Here are examples:

- If you have asked us to give you a “fast response” for a coverage decision or appeal, and we have said we will not, you can make a complaint.
- If you believe we are not meeting the deadlines for giving you a coverage decision or an answer to an appeal you have made, you can make a complaint.
- When a coverage decision we made is reviewed and we are told that we must cover or reimburse you for certain medical services or drugs, there are deadlines that apply. If you think we are not meeting these deadlines, you can make a complaint.
- When we do not give you a decision on time, we are required to forward your case to the Independent Review Organization. If we do not do that within the required deadline, you can make a complaint.

**Section 11.2      The formal name for “making a complaint” is “filing a grievance”****Legal Terms**

- What this section calls a “**complaint**” is also called a “**grievance.**”
- Another term for “**making a complaint**” is “**filing a grievance.**”

- Another way to say “**using the process for complaints**” is “**using the process for filing a grievance.**”

### Section 11.3 Step-by-step: Making a complaint

#### **Step 1: Contact us promptly – either by phone or in writing.**

- **Usually, calling Member Services is the first step.** If there is anything else you need to do, Member Services will let you know. 866-389-7690 (TTY 800-750-0750) Monday through Sunday 8:00AM to 8:00PM.
- **If you do not wish to call (or you called and were not satisfied), you can put your complaint in writing and send it to us.** If you put your complaint in writing, put your complaint in writing, we will respond to your complaint in writing.
  - Your complaint will be forwarded to the appropriate designated employee to address your concern. You need to file a complaint no later than 60 days after the event of the incident. We must address your complaint as quickly as your case requires based on your health status, but no later than 30 days after receiving your complaint. We may extend the timeframe by up to 14 days if you ask for an extension, or we justify the need for additional information and the delay is in your best interest. We will respond in writing to you.
  - If you ask for a fast initial determination or appeal and we did not agree to make a fast decision, you can file a fast grievance. In these cases, we will answer your grievance within 24 hours.
- **Whether you call or write, you should contact Member Services right away.** The complaint must be made within 60 calendar days after you had the problem you want to complain about.
- **If you are making a complaint because we denied your request for a “fast response” to a coverage decision or appeal, we will automatically give you a “fast” complaint.** If you have a “fast” complaint, it means we will give you **an answer within 24 hours.**

<b>Legal Terms</b>	What this section calls a “ <b>fast complaint</b> ” is also called an “ <b>expedited grievance.</b> ”
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#### **Step 2: We look into your complaint and give you our answer.**

- **If possible, we will answer you right away.** If you call us with a complaint, we may be able to give you an answer on the same phone call. If your health condition requires us to answer quickly, we will do that.

- **Most complaints are answered in 30 calendar days.** If we need more information and the delay is in your best interest or if you ask for more time, we can take up to 14 more calendar days (44 calendar days total) to answer your complaint.
- **If we do not agree** with some or all of your complaint or don't take responsibility for the problem you are complaining about, we will let you know. Our response will include our reasons for this answer. We must respond whether we agree with the complaint or not.

<b>Section 11.4</b>	<b>You can also make complaints about quality of care to the Quality Improvement Organization</b>
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You can make your complaint about the quality of care you received to us by using the step-by-step process outlined above.

When your complaint is about quality of care, you also have two extra options:

- **You can make your complaint to the Quality Improvement Organization.** If you prefer, you can make your complaint about the quality of care you received directly to this organization (without making the complaint to us).
  - The Quality Improvement Organization is a group of practicing doctors and other health care experts paid by the Federal government to check and improve the care given to Medicare patients.
  - To find the name, address, and phone number of the Quality Improvement Organization for your state, look in Chapter 2, Section 4, of this booklet. If you make a complaint to this organization, we will work with them to resolve your complaint.
- **Or you can make your complaint to both at the same time.** If you wish, you can make your complaint about quality of care to us and also to the Quality Improvement Organization.

## **PROBLEMS ABOUT YOUR MEDICAID BENEFITS**

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### **SECTION 12 Handling problems about your Medicaid benefits**

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**To pursue a grievance or appeal about a Medicaid-covered service, contact the Ohio Department of Job and Family Services. Contact information can be found in Section 6 of Chapter 2.**

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## **Chapter 10. Ending your membership in the plan**

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## SECTION 1 Introduction

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<b>Section 1.1</b>	<b>This chapter focuses on ending your membership in our plan</b>
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Ending your membership in Buckeye may be **voluntary** (your own choice) or **involuntary** (not your own choice):

- You might leave our plan because you have decided that you want to leave.
  - You can end your membership in the plan at any time. Section 2 tells you about the types of plans you can enroll in and when your enrollment in your new coverage will begin.
  - The process for voluntarily ending your membership varies depending on what type of new coverage you are choosing. Section 3 tells you how to end your membership in each situation.
- There are also limited situations where you do not choose to leave, but we are required to end your membership. Section 5 tells you about situations when we must end your membership.

If you are leaving our plan, you must continue to get your medical care through our plan until your membership ends.

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## SECTION 2 When can you end your membership in our plan?

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<b>Section 2.1</b>	<b>You can end your membership at any time</b>
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You can end your membership in Buckeye at any time.

- **When can you end your membership?** Most people with Medicare can end their membership only during certain times of the year. However, because you get assistance from Medicaid, **you can end your membership in Buckeye at any time.**
- **What type of plan can you switch to?** If you decide to change to a new plan, you can choose any of the following types of Medicare plans:
  - Another Medicare health plan. (You can choose a plan that covers prescription drugs or one that does not cover prescription drugs.)
  - Original Medicare with a separate Medicare prescription drug plan.

If you switch to Original Medicare and do not enroll in a separate Medicare prescription drug plan, Medicare may enroll you in a drug plan.

Contact your State Medicaid Office to learn about your Medicaid plan options (telephone numbers are in Chapter 2, Section 6 of this booklet).

- **When will your membership end?** Your membership will usually end on the first day of the month after we receive your request to change your plans. Your enrollment in your new plan will also begin on this day.

<b>Section 2.2</b>	<b>Where can you get more information about when you can end your membership?</b>
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If you have any questions or would like more information on when you can end your membership:

- You can **call Member Services** (phone numbers are on the back cover of this booklet).
- You can find the information in the **Medicare & You 2012 Handbook**.
  - Everyone with Medicare receives a copy of Medicare & You each fall. Those new to Medicare receive it within a month after first signing up.
  - You can also download a copy from the Medicare website (<http://www.medicare.gov>). Or, you can order a printed copy by calling Medicare at the number below.
- You can contact **Medicare** at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

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## **SECTION 3**      **How do you end your membership in our plan?**

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<b>Section 3.1</b>	<b>Usually, you end your membership by enrolling in another plan</b>
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Usually, to end your membership in our plan, you simply enroll in another Medicare plan. However, if you want to switch from our plan to Original Medicare but you have not selected a separate Medicare prescription drug plan, you must ask to be disenrolled from our plan. There are two ways you can ask to be disenrolled:

- You can make a request in writing to us. (Contact Member Services if you need more information on how to do this.)
- --or-- You can contact Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

The table below explains how you should end your membership in our plan.

<p><b>If you would like to switch from our plan to:</b></p>	<p><b>This is what you should do:</b></p>
<ul style="list-style-type: none"> <li>• Another Medicare health plan.</li> </ul>	<ul style="list-style-type: none"> <li>• Enroll in the new Medicare health plan.</li> </ul> <p>You will automatically be disenrolled from Buckeye when your new plan’s coverage begins.</p>
<ul style="list-style-type: none"> <li>• Original Medicare with a separate Medicare prescription drug plan.</li> </ul>	<ul style="list-style-type: none"> <li>• Enroll in the new Medicare prescription drug plan.</li> </ul> <p>You will automatically be disenrolled from Buckeye when your new plan’s coverage begins.</p>
<ul style="list-style-type: none"> <li>• Original Medicare without a separate Medicare prescription drug plan.                             <ul style="list-style-type: none"> <li>○ If you switch to Original Medicare and do not enroll in a separate Medicare prescription drug plan, Medicare may enroll you in a drug plan, unless you have opted out of automatic enrollment.</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>• <b>Send us a written request to disenroll.</b> Contact Member Services if you need more information on how to do this (phone numbers are on the back cover of this booklet).</li> <li>• You can also contact <b>Medicare</b>, at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week, and ask to be disenrolled. TTY users should call 1-877-486-2048.</li> <li>• You will be disenrolled from Buckeye when your coverage in Original Medicare begins.</li> </ul>

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## **SECTION 4      Until your membership ends, you must keep getting your medical services and drugs through our plan**

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<b>Section 4.1      Until your membership ends, you are still a member of our plan</b>
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If you leave Buckeye, it may take time before your membership ends and your new Medicare coverage goes into effect. (See Section 2 for information on when your new coverage begins.) During this time, you must continue to get your medical care and prescription drugs through our plan.

- **You should continue to use our network pharmacies to get your prescriptions filled until your membership in our plan ends.** Usually, your prescription drugs are only covered if they are filled at a network pharmacy including through our mail-order pharmacy services.
- **If you are hospitalized on the day that your membership ends, your hospital stay will usually be covered by our plan until you are discharged** (even if you are discharged after your new health coverage begins).

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## **SECTION 5      Buckeye must end your membership in the plan in certain situations**

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<b>Section 5.1      When must we end your membership in the plan?</b>
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**Buckeye must end your membership in the plan if any of the following happen:**

- If you do not stay continuously enrolled in Medicare Part A and Part B.
- If you are no longer eligible for Medicaid. As stated in Chapter 1, section 2.1, our plan is for people who are eligible for both Medicare and Medicaid.
- If you move out of our service area for more than six months.
  - If you move or take a long trip, you need to call Member Services to find out if the place you are moving or traveling to is in our plan's area.
- If you become incarcerated (go to prison).
- If you lie about or withhold information about other insurance you have that provides prescription drug coverage.
- If you intentionally give us incorrect information when you are enrolling in our plan and that information affects your eligibility for our plan.

- If you continuously behave in a way that is disruptive and makes it difficult for us to provide medical care for you and other members of our plan.
  - We cannot make you leave our plan for this reason unless we get permission from Medicare first.
- If you let someone else use your membership card to get medical care.
  - If we end your membership because of this reason, Medicare may have your case investigated by the Inspector General.
- You do not meet the plan's special eligibility requirements as stated in Chapter 1, section 2.1 If this happens, you will be given a grace period to re-establish full Medicaid. At the end of that grace period, you will be disenrolled from our plan if you do not have full Medicaid.

### Where can you get more information?

If you have questions or would like more information on when we can end your membership:

- You can call **Member Services** for more information (phone numbers are on the back cover of this booklet).

<b>Section 5.2</b>	<b>We <u>cannot</u> ask you to leave our plan for any reason related to your health</b>
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### What should you do if this happens?

If you feel that you are being asked to leave our plan because of a health-related reason, you should call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You may call 24 hours a day, 7 days a week.

<b>Section 5.3</b>	<b>You have the right to make a complaint if we end your membership in our plan</b>
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If we end your membership in our plan, we must tell you our reasons in writing for ending your membership. We must also explain how you can make a complaint about our decision to end your membership. You can also look in Chapter 9, Section 11 for information about how to make a complaint.

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**Chapter 11. Legal notices**

**SECTION 1 Notice about governing law ..... 168**

**SECTION 2 Notice about nondiscrimination ..... 168**

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## **SECTION 1      Notice about governing law**

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Many laws apply to this Evidence of Coverage and some additional provisions may apply because they are required by law. This may affect your rights and responsibilities even if the laws are not included or explained in this document. The principal law that applies to this document is Title XVIII of the Social Security Act and the regulations created under the Social Security Act by the Centers for Medicare & Medicaid Services, or CMS. In addition, other Federal laws may apply and, under certain circumstances, the laws of the state you live in.

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## **SECTION 2      Notice about nondiscrimination**

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We don't discriminate based on a person's race, disability, religion, sex, health, ethnicity, creed, age, or national origin. All organizations that provide Medicare Advantage Plans, like our plan, must obey Federal laws against discrimination, including Title VI of the Civil Rights Act of 1964, the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, the Americans with Disabilities Act, all other laws that apply to organizations that get Federal funding, and any other laws and rules that apply for any other reason.

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## **Chapter 12. Definitions of important words**

**Ambulatory Surgical Center** – An Ambulatory Surgical Center is an entity that operates exclusively for the purpose of furnishing outpatient surgical services to patients not requiring hospitalization and whose expected stay in the center does not exceed 24 hours.

**Appeal** – An appeal is something you do if you disagree with our decision to deny a request for coverage of health care services or prescription drugs or payment for services or drugs you already received. You may also make an appeal if you disagree with our decision to stop services that you are receiving. For example, you may ask for an appeal if we don't pay for a drug, item, or service you think you should be able to receive. Chapter 9 explains appeals, including the process involved in making an appeal.

**Benefit Period** – The way that both our plan and Original Medicare measures your use of hospital and skilled nursing facility (SNF) services. A benefit period begins the day you go into a hospital or skilled nursing facility. The benefit period ends when you haven't received any inpatient hospital care (or skilled care in a SNF) for 60 days in a row. If you go into a hospital or a skilled nursing facility after one benefit period has ended, a new benefit period begins. You (or Medicaid on your behalf) must pay the inpatient hospital deductible for each benefit period. There is no limit to the number of benefit periods.

**Brand Name Drug** – A prescription drug that is manufactured and sold by the pharmaceutical company that originally researched and developed the drug. Brand name drugs have the same active-ingredient formula as the generic version of the drug. However, generic drugs are manufactured and sold by other drug manufacturers and are generally not available until after the patent on the brand name drug has expired.

**Catastrophic Coverage Stage** – The stage in the Part D Drug Benefit where you pay a low copayment or coinsurance for your drugs after you or other qualified parties on your behalf have spent \$4,700 in covered drugs during the covered year.

**Centers for Medicare & Medicaid Services (CMS)** – The Federal agency that administers Medicare. Chapter 2 explains how to contact CMS.

**Coinsurance** – An amount you may be required to pay as your share of the cost for services or prescription drugs after you pay any deductibles. Coinsurance is usually a percentage (for example, 20%).

**Comprehensive Outpatient Rehabilitation Facility (CORF)** – A facility that mainly provides rehabilitation services after an illness or injury, and provides a variety of services including physical therapy, social or psychological services, respiratory therapy, occupational therapy and speech-language pathology services, and home environment evaluation services.

**Copayment** – An amount you may be required to pay as your share of the cost for a medical service or supply, like a doctor's visit, hospital outpatient visit, or a prescription drug. A

copayment is usually a set amount, rather than a percentage. For example, you might pay \$10 or \$20 for a doctor's visit or prescription drug.

**Cost Sharing** – Cost sharing refers to amounts that a member has to pay when services or drugs are received (This is in addition to the plan's monthly premium). Cost sharing includes any combination of the following three types of payments: (1) any deductible amount a plan may impose before services or drugs are covered; (2) any fixed "copayment" amount that a plan requires when a specific service or drug is received; or (3) any "coinsurance" amount, a percentage of the total amount paid for a service or drug, that a plan requires when a specific service or drug is received.

**Cost-Sharing Tier** – Every drug on the list of covered drugs is in one of four (4) cost-sharing tiers. In general, the higher the cost-sharing tier, the higher your cost for the drug.

**Coverage Determination** – A decision about whether a drug prescribed for you is covered by the plan and the amount, if any, you are required to pay for the prescription. In general, if you bring your prescription to a pharmacy and the pharmacy tells you the prescription isn't covered under your plan, that isn't a coverage determination. You need to call or write to your plan to ask for a formal decision about the coverage. Coverage determinations are called "coverage decisions" in this booklet. Chapter 9 explains how to ask us for a coverage decision.

**Covered Drugs** – The term we use to mean all of the prescription drugs covered by our plan.

**Covered Services** – The general term we use to mean all of the health care services and supplies that are covered by our plan.

**Creditable Prescription Drug Coverage** – Prescription drug coverage (for example, from an employer or union) that is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage. People who have this kind of coverage when they become eligible for Medicare can generally keep that coverage without paying a penalty, if they decide to enroll in Medicare prescription drug coverage later.

**Custodial Care** – Custodial care is personal care that can be provided by people who don't have professional skills or training, such as help with activities of daily living like bathing, dressing, eating, getting in or out of a bed or chair, moving around, and using the bathroom. It may also include the kind of health-related care that most people do themselves, like using eye drops. Medicare doesn't pay for custodial care.

**Deductible** – The amount you must pay for health care or prescriptions before our plan begins to pay.

**Disenroll or Disenrollment** – The process of ending your membership in our plan. Disenrollment may be voluntary (your own choice) or involuntary (not your own choice).

**Dispensing Fee** – A fee charged each time a covered drug is dispensed to pay for the cost of filling a prescription. The dispensing fee covers costs such as the pharmacist’s time to prepare and package the prescription.

**Dual Eligible Individual** – A person who qualifies for Medicare and Medicaid coverage.

**Durable Medical Equipment** – Certain medical equipment that is ordered by your doctor for use at home. Examples are walkers, wheelchairs, or hospital beds.

**Emergency** – A medical emergency is when you, or any other prudent layperson with an average knowledge of health and medicine, believe that you have medical symptoms that require immediate medical attention to prevent loss of life, loss of a limb, or loss of function of a limb. The medical symptoms may be an illness, injury, severe pain, or a medical condition that is quickly getting worse.

**Emergency Care** – Covered services that are: 1) rendered by a provider qualified to furnish emergency services; and 2) needed to evaluate or stabilize an emergency medical condition.

**Evidence of Coverage (EOC) and Disclosure Information** – This document, along with your enrollment form and any other attachments, riders, or other optional coverage selected, which explains your coverage, what we must do, your rights, and what you have to do as a member of our plan.

**Exception** – A type of coverage determination that, if approved, allows you to get a drug that is not on your plan sponsor’s formulary (a formulary exception), or get a non-preferred drug at the preferred cost-sharing level (a tiering exception). You may also request an exception if your plan sponsor requires you to try another drug before receiving the drug you are requesting, or the plan limits the quantity or dosage of the drug you are requesting (a formulary exception).

**Extra Help** – A Medicare program to help people with limited income and resources pay Medicare prescription drug program costs, such as premiums, deductibles, and coinsurance.

**Generic Drug** – A prescription drug that is approved by the Food and Drug Administration (FDA) as having the same active ingredient(s) as the brand name drug. Generally, a “generic” drug works the same as a brand name drug and usually costs less.

**Grievance** - A type of complaint you make about us or one of our network providers or pharmacies, including a complaint concerning the quality of your care. This type of complaint does not involve coverage or payment disputes.

**Home Health Aide** – A home health aide provides services that don’t need the skills of a licensed nurse or therapist, such as help with personal care (e.g., bathing, using the toilet, dressing, or carrying out the prescribed exercises). Home health aides do not have a nursing license or provide therapy.

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**Initial Coverage Limit** – The maximum limit of coverage under the Initial Coverage Stage.

**Initial Coverage Stage** – This is the stage before your total drug expenses have reached \$4,700, including amounts you’ve paid and what our plan has paid on your behalf.

**Initial Enrollment Period** – When you are first eligible for Medicare, the period of time when you can sign up for Medicare Part B. For example, if you’re eligible for Part B when you turn 65, your Initial Enrollment Period is the 7-month period that begins 3 months before the month you turn 65, includes the month you turn 65, and ends 3 months after the month you turn 65.

**Institutional Special Needs Plan (SNP)** – A Special Needs Plan that enrolls eligible individuals who continuously reside or are expected to continuously reside for 90 days or longer in a long-term care (LTC) facility. These LTC facilities may include a skilled nursing facility (SNF); nursing facility (NF); (SNF/NF); an intermediate care facility for the mentally retarded (ICF/MR); and/or an inpatient psychiatric facility. An institutional Special Needs Plan to serve Medicare residents of LTC facilities must have a contractual arrangement with (or own and operate) the specific LTC facility (ies).

**Institutional Equivalent Special Needs Plan (SNP)** – An institutional Special Needs Plan that enrolls eligible individuals living in the community but requiring an institutional level of care based on the State assessment. The assessment must be performed using the same respective State level of care assessment tool and administered by an entity other than the organization offering the plan. This type of Special Needs Plan may restrict enrollment to individuals that reside in a contracted assisted living facility (ALF) if necessary to ensure uniform delivery of specialized care.

**List of Covered Drugs (Formulary or “Drug List”)** – A list of prescription drugs covered by the plan. The drugs on this list are selected by the plan with the help of doctors and pharmacists. The list includes both brand name and generic drugs.

**Low Income Subsidy** – See “Extra Help.”

**Maximum Out-of-Pocket Amount** – The most that you pay out-of-pocket during the calendar year for covered Part A and Part B services. Amounts you pay for your plan premiums, Medicare Part A and Part B premiums, and prescription drugs do not count toward the maximum out-of-pocket amount. In addition to the maximum out-of-pocket amount for covered Part A and Part B medical services, we also have a maximum out-of-pocket amount for certain types of services. (Note: Because our members also get assistance from Medicaid, very few members ever reach this out-of-pocket maximum.) See Chapter 4, Section 1.2 for information about your maximum out-of-pocket amount.

**Medicaid (or Medical Assistance)** – A joint Federal and state program that helps with medical costs for some people with low incomes and limited resources. Medicaid programs vary from state to state, but most health care costs are covered if you qualify for both Medicare and Medicaid. See Chapter 2, Section 6 for information about how to contact Medicaid in your state.

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**Medically Accepted Indication** – A use of a drug that is either approved by the Food and Drug Administration or supported by certain reference books. See Chapter 5, Section 4 for more information about a medically accepted indication.

**Medically Necessary** – Services, supplies, or drugs that are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.

**Medicare** – The Federal health insurance program for people 65 years of age or older, some people under age 65 with certain disabilities, and people with End-Stage Renal Disease (generally those with permanent kidney failure who need dialysis or a kidney transplant). People with Medicare can get their Medicare health coverage through Original Medicare or a Medicare Advantage Plan.

**Medicare Advantage (MA) Plan** – Sometimes called Medicare Part C. A plan offered by a private company that contracts with Medicare to provide you with all your Medicare Part A and Part B benefits. A Medicare Advantage Plan can be an HMO, PPO, a Private Fee-for-Service (PFFS) plan, or a Medicare Medical Savings Account (MSA) plan. When you are enrolled in a Medicare Advantage Plan, Medicare services are covered through the plan, and are not paid for under Original Medicare. In most cases, Medicare Advantage Plans also offer Medicare Part D (prescription drug coverage). These plans are called **Medicare Advantage Plans with Prescription Drug Coverage**. Everyone who has Medicare Part A and Part B is eligible to join any Medicare health plan that is offered in their area, except people with End-Stage Renal Disease (unless certain exceptions apply).

**Medicare Coverage Gap Discount Program** – A program that provides discounts on most covered Part D brand name drugs to Part D enrollees who have reached the Coverage Gap Stage and who are not already receiving “Extra Help.” Discounts are based on agreements between the Federal government and certain drug manufacturers. For this reason, most, but not all, brand name drugs are discounted.

**Medicare Health Plan** – A Medicare health plan is offered by a private company that contracts with Medicare to provide Part A and Part B benefits to people with Medicare who enroll in the plan. This term includes all Medicare Advantage Plans, Medicare Cost Plans, Demonstration/Pilot Programs, and Programs of All-inclusive Care for the Elderly (PACE).

**Medicare Prescription Drug Coverage (Medicare Part D)** – Insurance to help pay for outpatient prescription drugs, vaccines, biologicals, and some supplies not covered by Medicare Part A or Part B.

**“Medigap” (Medicare Supplement Insurance) Policy** – Medicare supplement insurance sold by private insurance companies to fill “gaps” in Original Medicare. Medigap policies only work with Original Medicare. (A Medicare Advantage Plan is not a Medigap policy.)

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**Member (Member of our Plan, or “Plan Member”)** – A person with Medicare who is eligible to get covered services, who has enrolled in our plan and whose enrollment has been confirmed by the Centers for Medicare & Medicaid Services (CMS).

**Member Services** – A department within our plan responsible for answering your questions about your membership, benefits, grievances, and appeals. See Chapter 2 for information about how to contact Member Services.

**Network Pharmacy** – A network pharmacy is a pharmacy where members of our plan can get their prescription drug benefits. We call them “network pharmacies” because they contract with our plan. In most cases, your prescriptions are covered only if they are filled at one of our network pharmacies.

**Network Provider** – “Provider” is the general term we use for doctors, other health care professionals, hospitals, and other health care facilities that are licensed or certified by Medicare and by the State to provide health care services. We call them “**network providers**” when they have an agreement with our plan to accept our payment as payment in full, and in some cases to coordinate as well as provide covered services to members of our plan. Our plan pays network providers based on the agreements it has with the providers or if the providers agree to provide you with plan-covered services. Network providers may also be referred to as “plan providers.”

**Organization Determination** – The Medicare Advantage organization has made an organization determination when it, or one of its providers, makes a decision about whether services are covered or how much you have to pay for covered services. Organization determinations are called “coverage decisions” in this booklet. Chapter 9 explains how to ask us for a coverage decision.

**Original Medicare** (“Traditional Medicare” or “Fee-for-service” Medicare) – Original Medicare is offered by the government, and not a private health plan like Medicare Advantage Plans and prescription drug plans. Under Original Medicare, Medicare services are covered by paying doctors, hospitals, and other health care providers payment amounts established by Congress. You can see any doctor, hospital, or other health care provider that accepts Medicare. You must pay the deductible. Medicare pays its share of the Medicare-approved amount, and you pay your share. Original Medicare has two parts: Part A (Hospital Insurance) and Part B (Medical Insurance) and is available everywhere in the United States.

**Out-of-Network Pharmacy** – A pharmacy that doesn’t have a contract with our plan to coordinate or provide covered drugs to members of our plan. As explained in this Evidence of Coverage, most drugs you get from out-of-network pharmacies are not covered by our plan unless certain conditions apply.

**Out-of-Network Provider or Out-of-Network Facility** – A provider or facility with which we have not arranged to coordinate or provide covered services to members of our plan. Out-of-network providers are providers that are not employed, owned, or operated by our plan or are not

under contract to deliver covered services to you. Using out-of-network providers or facilities is explained in this booklet in Chapter 3.

**Out-of-Pocket Costs** – See the definition for “cost sharing” above. A member’s cost-sharing requirement to pay for a portion of services or drugs received is also referred to as the member’s “out-of-pocket” cost requirement.

**Part C** – see “**Medicare Advantage (MA) Plan.**”

**Part D** – The voluntary Medicare Prescription Drug Benefit Program. (For ease of reference, we will refer to the prescription drug benefit program as Part D.)

**Part D Drugs** – Drugs that can be covered under Part D. We may or may not offer all Part D drugs. (See your formulary for a specific list of covered drugs.) Certain categories of drugs were specifically excluded by Congress from being covered as Part D drugs.

**Preferred Provider Organization (PPO) Plan** – A Preferred Provider Organization plan is a Medicare Advantage Plan that has a network of contracted providers that have agreed to treat plan members for a specified payment amount. A PPO plan must cover all plan benefits whether they are received from network or out-of-network providers. Member cost sharing will generally be higher when plan benefits are received from out-of-network providers. PPO plans have an annual limit on your out-of-pocket costs for services received from network (preferred) providers and a higher limit on your total combined out-of-pocket costs for services from both in-network (preferred) and out-of-network (non-preferred) providers.

**Premium** – The periodic payment to Medicare, an insurance company, or a health care plan for health or prescription drug coverage.

**Primary Care Provider (PCP)** – Your primary care provider is the doctor or other provider you see first for most health problems. He or she makes sure you get the care you need to keep you healthy. He or she also may talk with other doctors and health care providers about your care and refer you to them. In many Medicare health plans, you must see your primary care provider before you see any other health care provider. See Chapter 3, Section 2.1 for information about Primary Care Provider.

**Prior Authorization** – Approval in advance to get services or certain drugs that may or may not be on our formulary. Some in-network medical services are covered only if your doctor or other network provider gets “prior authorization” from our plan. Covered services that need prior authorization are marked in the Benefits Chart in Chapter 4. Some drugs are covered only if your doctor or other network provider gets “prior authorization” from us. Covered drugs that need prior authorization are marked in the formulary.

**Quality Improvement Organization (QIO)** – A group of practicing doctors and other health care experts paid by the Federal government to check and improve the care given to Medicare patients. See Chapter 2, Section 4 for information about how to contact the QIO for your state.

**Quantity Limits** – A management tool that is designed to limit the use of selected drugs for quality, safety, or utilization reasons. Limits may be on the amount of the drug that we cover per prescription or for a defined period of time.

**Rehabilitation Services** – These services include physical therapy, speech and language therapy, and occupational therapy.

**Service Area** – A geographic area where a health plan accepts members if it limits membership based on where people live. For plans that limit which doctors and hospitals you may use, it's also generally the area where you can get routine (non-emergency) services. The plan may disenroll you if you move out of the plan's service area.

**Skilled Nursing Facility (SNF) Care** – Skilled nursing care and rehabilitation services provided on a continuous, daily basis, in a skilled nursing facility. Examples of skilled nursing facility care include physical therapy or intravenous injections that can only be given by a registered nurse or doctor.

**Special Needs Plan** – A special type of Medicare Advantage Plan that provides more focused health care for specific groups of people, such as those who have both Medicare and Medicaid, who reside in a nursing home, or who have certain chronic medical conditions.

**Step Therapy** – A utilization tool that requires you to first try another drug to treat your medical condition before we will cover the drug your physician may have initially prescribed.

**Supplemental Security Income (SSI)** – A monthly benefit paid by the Social Security Administration to people with limited income and resources who are disabled, blind, or age 65 and older. SSI benefits are not the same as Social Security benefits.

**Urgently Needed Care** – Urgently needed care is care provided to treat a non-emergency, unforeseen medical illness, injury, or condition that requires immediate medical care, but the plan's network of providers is temporarily unavailable or inaccessible.