

WORKING WITH CARESOURCE

HEALTH PARTNER ORIENTATION

*GEORGIA MARKETPLACE AND
DUAL-ELIGIBLE SPECIAL NEEDS PLAN
(D-SNP)*


CareSource[®]





About CareSource


CareSource[®]

Our Mission

MISSION

To make a lasting difference in our members' lives by improving their health and well-being

PLEDGE

- Make it easier for you to work with us
- Partner with you to help members make healthy choices
- Provide direct communication
- Timely and low-hassle medical reviews
- Accurate and efficient claims payment



Health Care with Heart

MISSION-FOCUSED

Comprehensive, member-centric health and life services

EXPERIENCED

With over 30 years of service, CareSource is a leading non-profit health insurance company

DEDICATED

We serve over 2.1 million members through our Medicaid, Marketplace, MyCare, Dual-Eligible Special Needs Plans (D-SNP) and Arkansas PASSE programs



Our Plans

MEDICAID

Children, Pregnant Women & Low-Income Working Families

Risk-based managed care; Aged, Blind & Disabled (ABD) populations; Healthy Start & Healthy Families population

MYCARE OHIO

Medicaid & Medicare-Eligible

Coordination of physical, behavioral & long-term care services

MARKETPLACE

Commercial Health Plan

Reduced premiums or cost-sharing; Pediatric Vision; Optional Adult Vision and Fitness

DUAL ADVANTAGE

Dual-Eligible Special Needs (D-SNP) Plan

Medicare only benefits with the member population being dual-eligible



CareSource Expectations of Providers

- Primary Care Providers (PCPs) - provide 24-hour availability to your CareSource patients by telephone
- Notify CareSource of any changes prior to the effective date of the change
 - 10 to 60 days depending on the type of change (refer to the Provider Manual)
- Provide notice to terminate the contract 90 days in advance of desired termination
- Do not balance bill CareSource members
- Comply with access and availability standards
- Provide medical records upon request
- Submit claims or corrected claims within 180 days of date of service or date of discharge
- Treat CareSource members with respect
- Complete model of care training (D-SNP providers)

Please refer to your contract and the Provider Manual for more information on provider expectations and responsibilities.





Working with CareSource


CareSource[®]

Provider Network & Eligibility

CareSource members choose or are assigned a primary care provider (PCP) upon enrollment. When referring patients, ensure other providers are in-network. Use our Find-a-Doc tool at [CareSource.com](https://www.caresource.com) to help locate a participating CareSource provider by plan.

OUT OF NETWORK SERVICES

Out-of-network services are NOT covered unless they are emergency services, services covered by the No Surprises Act, or services prior authorized by CareSource.

MEMBER ELIGIBILITY

Be sure to ask to see each patient's CareSource member ID card to ensure you take their plan. Be sure to confirm which CareSource plan the member is asking that you accept.



Provider Directory Attestation



Accurate provider directory information ensures we can connect the right patients to the right provider.



Centers for Medicare & Medicaid Services (CMS) requires health plans to verify the accuracy of provider directory information **every 90 days.**



We have partnered with Quest Analytics to streamline your verification process.




Completing the Attestation Process:

1. BetterDoctor will send you an email or fax.
2. Go to: betterdoctor.com/validate.
3. Locate the access token on the fax or email you received from BetterDoctor (it is an eight-character alphanumeric code (for example ABC123D4), and it is not case sensitive).
4. Enter the access token.
5. Click 'Submit.'
6. Verify and update your information using the online tool via the BetterDoctor portal.
7. Larger practices can submit rosters directly to Quest Analytics.

Issues? Contact support@betterdoctor.com



ID Cards: Marketplace Members

		Low Premium Silver 6000 \$3 Generic Drugs Adult Vision & Fitness	
Member: Jeff Doe	Effective: XX/XX/XXXX	Dependents:	GA 2025
Member ID: 14800000000-00		01 Jane Doe 02 John Doe 03 Mike Doe 04 Ron Doe 05 Susan Doe 06 Sara Doe 07 Joe Doe 08 Sam Doe	
Health Plan: XXXXXXXXXXXXXXX-XX			
Payer ID: CSGA1			
Office: \$35 ER: \$500 Spec: \$75 UrgCare: \$70 <small>*after Ind. \$6,000/Fam. \$12,000 Annual Deductible Ind. \$9,000/Fam. \$18,000 Out of Pocket Max</small>			

CareSource.com/marketplace
 This card does not guarantee coverage. To verify benefits, view claims, or find a provider, visit the website or call Member Services.

MEMBER NUMBERS	Member Services:	1-833-230-2099
	CareSource24[®] Nurse Advice Line:	1-833-687-7342
	TTY Service for Hearing Impaired:	1-800-255-0056
	Vision Ped Only EyeMed	1-833-337-3129
PROVIDER INFO	Hearing	1-866-202-2582
	Fitness Active&Fit	1-877-771-2746
	Provider Services:	1-833-230-2101 ESI: 1-800-420-3560
	RxBin: 003858 RxPCN: A4 RxGrp: RXINN04 Medical Claims: P.O. Box 8730, Dayton, OH 45401-8730	

Note: Make sure the state matches your contracted region.

Marketplace dependents are indicated by the member ID + dependent suffix (portion after the “-”)

- Example: 14800000000-01 (Jane Doe)



ID Cards: D-SNP Members



Member Name:

<John Doe>

Member ID#: <12345678900>

Medicaid ID#: <12345678900>

Health Plan: 80840 **Payer ID:** <XXXXXX>

Primary Care Provider/Clinic Name:

<Good, I Am A.>

Provider/Clinic Phone: <XXX- XXX-XXXX>

PROVIDERS: DO NOT BILL MEMBER.

Copays:

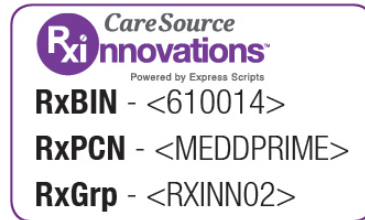
Office: <\$XX.XX> ER: <\$XX.XX>

Spec: <\$XX.XX> UrgCare: <\$XX.XX>

Effective Date:

<01/01/2024>

<GA>



CMS: <XXXXXX-XXX>

CareSource.com/Medicare

This card does not guarantee coverage. To verify benefits, view claims, or find a provider, visit the website or call:

MEMBERS: 1-833-230-2020 TTY: 1-833-711-4711 or 711

24/7 Nurse Advice Line:

<X-XXX-XXX-XXXX>

Vision Benefits:

EyeMed 1-866-299-1425

Hearing Benefits:

TruHearing 1-833-759-6826

Medical Claims:

CareSource
P.O. Box 8730
Dayton, OH 45401-8730

Providers:

1-833-230-2176

Dental Network:

DentaQuest <X-XXX-XXX-XXXX>

Pharmacy:

<1-XXX-XXX-XXXX>

Pharmacy Claims:

Express Scripts
ATTN: Medicare Part D
P.O. Box 14718
Lexington, KY 40512-4718

PROVIDERS: DO NOT BILL MEMBER. Please submit Medicare claims to the plan. Please bill Medicaid for any remaining charges.



Claim Submissions

ELECTRONIC CLAIM SUBMISSIONS

CareSource encourages electronic claim submission as the primary submission method. We partner with ECHO Health for electronic funds transfer (EFT). Enroll with ECHO Health to participate. Find the enrollment form for ECHO Health online at: www.echohealthinc.com. For questions, call ECHO Support at: 1-888-485-6233.

ALTERNATE SUBMISSION PROCESS

Providers can submit claims through our secure, online Provider Portal at **CareSource.com** > [Provider Log-In](#).

CLEARINGHOUSES

For electronic data interchange (EDI) transactions, CareSource accepts electronic claims through our clearinghouse, Availity. Providers can find a list of EDI vendors online at: www.availity.com/ediclearinghouse.



Access and Availability

As a CareSource provider, please ensure your practice meets the following minimum access standards:

- Provide **24-hour availability** to your CareSource patients by telephone.
 - Whether through an answering machine or a taped message after hours, patients need a way to contact their PCP or back-up provider to be triaged for care.
 - Return urgent care calls within 20 minutes and all other calls within one hour.
 - It is not acceptable to use a phone message that doesn't provide access to you or your back-up provider and only recommends an emergency room after hours.

Please refer to our Provider Manual at **CareSource.com** > Providers > Tools & Resources > [Provider Manual](#) for a complete listing of Access and Availability Standards.



Access and Availability

Primary Care Providers (PCPs)

Marketplace Members

Type of Visit	Should be seen...
Emergency needs	Immediately upon presentation
Urgent care*	Not to exceed 48 hours
Regular and routine care	Not to exceed 15 business days

*Providers should see members as expeditiously as their condition and severity of symptoms warrant. It is expected that if a provider is unable to see the member within the designated time frame, CareSource will facilitate an appointment with another participating provider, or a non-participating provider, when necessary.



Access and Availability

Non-PCP Specialists	Marketplace Members
Type of Visit	Should be seen...
Emergency needs	Immediately upon presentation
Urgent care*	Not to exceed 48 hours
Regular and routine care	Not to exceed 30 business days

*Providers should see members as expeditiously as their condition and severity of symptoms warrant. It is expected that if a provider is unable to see the member within the designated time frame, CareSource will facilitate an appointment with another participating provider, or a non-participating provider, when necessary.



Access and Availability

Behavioral Health Providers

Marketplace Members

Type of Visit	Should be seen...
Emergency needs	Immediately upon presentation
Non-life-threatening emergency*	Not to exceed 6 hours
Urgent care*	Not to exceed 48 hours
Initial visit for routine care	Not to exceed 10 business days
Follow-up routine care	Not to exceed 30 calendar days based off the condition

*Providers should see members as expeditiously as their condition and severity of symptoms warrant. It is expected that if a provider is unable to see the member within the designated time frame, CareSource will facilitate an appointment with another participating provider, or a non-participating provider, when necessary.



Member Communications

HELP YOUR CARESOURCE PATIENTS UNDERSTAND THEIR COVERAGE.

Encourage your patients to visit **CareSource.com**, where they can access:

- MyCareSource.com member portal
- Searchable online formulary and prescription cost calculator
- Find-a-Doc tool
- Evidence of Coverage & Schedule of Benefits
- Member Handbook (*Marketplace only*)
- Evidence of Coverage (*D-SNP only*)
- Engagement Cost Estimator (*Marketplace only*)
- Forms and more

For more information, visit: [CareSource.com/Members](https://www.caresource.com/members).



Communicating with Us

	Marketplace	D-SNP
Provider Services	1-833-230-2101	1-833-230-2176
Hours	Monday – Friday 8 a.m. – 6 p.m. Eastern Time (ET)	
Member Services	1-833-230-2030	1-833-230-2020
Hours	Monday – Friday, 7 a.m. – 7 p.m. ET	Monday – Friday, 8 a.m. – 8 p.m. ET from Oct. 1 – March 31, we are open the same hours, 7 days a week





Provider Portal


CareSource[®]

CareSource Provider Portal

SAVE TIME AND MONEY

With CareSource's secure online provider portal, you can:

- ✓ Check member eligibility and benefit limits
- ✓ Find prior authorization requirements
- ✓ Submit prior authorization request and check status
- ✓ Submit claims and verify claim status
- ✓ Verify or update Coordination of Benefits
- ✓ And more!

Access the provider portal 24 hours a day, seven days a week at **CareSource.com** > Provider > [Login](#).



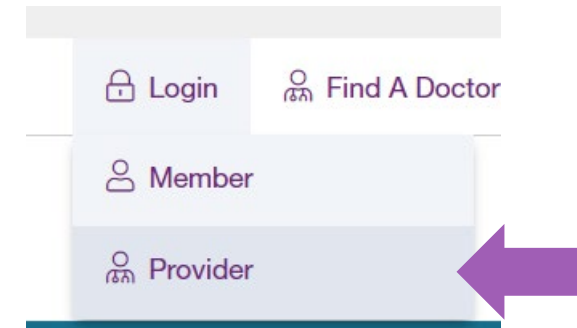
Register for the Provider Portal

1. Go to “**Sign Up**” to establish your account by creating your username and password.

2. For added security, set up the multifactor authentication.

3. To connect your account, you will need your Provider Name, Tax ID, CareSource Provider ID and your Zip Code.

4. Review and accept the Agreement.



CareSource

PROVIDER PORTAL

The Provider Portal makes it easier for you to work with us 24/7. It has critical information and tools to save your practice time.

- Member & Eligibility Search
- Claims Search, EOP & Submissions
- Prior Authorization Search & Submissions
- PCP Roster & Clinical Practice Registry

Login Sign Up

[Forgot password?](#)

[Portal Registration Instructions](#)



Member Eligibility

CareSource Id	Medicaid Id	Member Info	Case Number	Multiple CareSource Ids	Multiple Medicaid Ids
CareSource ID	<input type="text"/>	Member is eligible for service on the specified date			
Date of Service	<input type="text" value="11/28/2022"/>				
<input type="button" value="Search"/>					
Member Information					
Member Name:	<input type="text"/>	Address:	<input type="text"/>		
CareSource Id:	<input type="text"/>	County of Residence:	<input type="text"/>		
Medicaid Id:	<input type="text"/>	County of Eligibility:	<input type="text"/>		
Case Number:	<input type="text"/>	Phone:	<input type="text"/>		
Gender:	Male	Date of Birth:	<input type="text"/>		
Member Profile:	Click To View	Relationship to Subscriber:	Subscriber/Insured		
	Member Profile Report Definitions	Program Details:	Not a coordinated services member.		
Original Effective Date:	9/1/2007 12:00:00 AM	Member Eligibility Date	1/24/2020 2:07:29 PM		
		Spec Last Updated:			



Member Eligibility

Program:	[REDACTED]		
Member Alerts:	1. No ambulatory or preventive care visits recorded. 2. 1-2 ER visits in 15 mos		
Language Preference:	English	Alternate Communication Format Needed:	N/A
Special Communication Needs:			
Member Aid Category:	Healthy Families		

Primary Care Provider (PCP):	[REDACTED]	Phone:	[REDACTED]
NPI #:	[REDACTED]		
Case Manager:		Case Manager Phone Number:	
<hr/>			
Subscriber Information			+
Member Covered Benefits Summary			+
Member Dental & Vision Services History			+
EPSDT Alerts			+
Upload Consent Form			+



Marketplace Member *Financial Responsibility*

ANNUAL DEDUCTIBLE, COPAYMENTS & COINSURANCE

These costs are applicable for most covered services. It is up to the provider to collect these amounts at the time of service.

BALANCE BILLING

Network providers **may not** balance bill CareSource members for covered services.

Out-of-network providers may not balance bill CareSource members for covered services protected under the No Surprise Act.

Balance billing is when a provider bills the patient for the difference between the provider's charge and the allowed amount. **For example, if the provider's typical fee is \$100, and the allowed billable amount is \$70, the provider may not bill the patient for the remaining \$30.**



Marketplace Member *Financial Responsibility*

GRACE PERIOD

Members have a federally mandated 90-day grace period if they are receiving Advance Premium Tax Credit (APTC), or a 31-day grace period if they are not receiving APTC in which to make their payment.

- Not applicable for their initial payment
- For APTC-receiving members, 30 days after their due date CareSource will: flag the member in the eligibility file and on the Provider Portal, suspend pharmacy benefits and pend claims rendered
- For non-APTC members, the day after their due date, CareSource will: flag the member in the eligibility file and on the Provider Portal, suspend pharmacy benefits and pend any claims rendered

If members bring their account into good standing before the expiration of the grace period, pharmacy benefits will start again and pended claims will be processed.

TERMINATION

After the grace period has expired, the member is terminated for non-payment of premium.

- CareSource will retroactively terminate the member to either the last day of the first month of the grace period (APTC) or the last paid date (non-APTC).
- CareSource will then deny any claims that are pended during the grace period and reserves the right to recover any amounts paid in this period.





Covered Benefits & Services


CareSource[®]

Covered Services

MEMBER PROGRAMS

Care Management

MyHealth[®]

MyStrength

BENEFITS OVERVIEW

PCP and specialist office visits

Allergy testing and treatment

Inhalation therapy

Pain management

Emergency services

Preventive services & screenings

Inpatient facility services

Outpatient facility services

Outpatient diagnostic services

Home health services

Hospice services (*Marketplace only*)

Durable medical equipment services

Pediatric vision services (*Marketplace only*)



Covered Services

ENHANCED BENEFITS

CareSource 24 Nurse Advice Line

Disease management education through Care Management (CM)

Health and Wellness education

Meal delivery (*Medicare only*)

Silver & Fit (*Medicare only*)

Active & Fit (*Adult Vision and Fitness for Marketplace only**)

**The Adult Dental, Vision and Fitness rider allows consumers to add in coverage for some adult services under Marketplace.*

Rehabilitation therapy services

Habilitative services (*Marketplace only*)

Family planning services

Maternity services

Adult dental services (*Medicare only*)

Adult vision services

Pharmacy benefits



Services Not Covered

Medically unnecessary services

Services received from a non-network providers, with specific exceptions

Experimental or investigational services

Alternative or complimentary medicine

Cosmetic procedures

Assisted reproductive therapy

Maintenance therapy treatments

Routine dental services not provided by a DentaQuest provider

Routine vision services & eyewear not provided by an EyeMed provider

Routine hearing services & eyewear not provided by an Truhearing provider

For more details on each plan's covered services, visit [CareSource.com](https://www.caresource.com).



D-SNP Transportation *Services*

Provider Scheduling Line	833-247-RIDE, Option 1 - 7 a.m. to 7 p.m. from Monday - Friday
Standard Scheduling Timeline	Trips must be scheduled 48 hours (two business days) up to 30 days in advance
Same Day/Sick Visit Instructions	Same-day/sick visit trips available by calling scheduling line above; provider may need to confirm urgency
Unlimited One-Way Trips	Offered for doctor, pharmacy, gym, grocery or redetermination appointment transportation needs



Supplemental Benefits Overview

ABOUT OUR BENEFIT MANAGERS

CareSource partners with select vendors to provide expanded benefits and services, including expertise in the services and broadened networks.

These are exclusive relationships for the services considered – meaning our member must use a provider within the benefit manager’s network in order for CareSource to contribute.

See [CareSource.com](https://www.caresource.com) for a full listing of benefits in this plan.



Marketplace Plan *Supplemental Benefits*

Benefit Category	Eligible Members	Services	Benefit Overview	Member Contact
Routine Hearing (TruHearing)	✓ All Marketplace members	<ul style="list-style-type: none"> Member Services Provider network Claims adjudication 	Routine hearing exams & hearing aid discounts	1-866-202-2674
Routine Vision (EyeMed)	<ul style="list-style-type: none"> ✓ All pediatric members (<19 years of age) ✓ Adults 19+ years of age on dental & vision plans 	<ul style="list-style-type: none"> Member Services Provider network Claims adjudication EOBs 	Routine eye exam, glasses, contacts, and other value-added services	1-833-337-3129
Fitness (American Specialty Health)	✓ Adults 18+ years of age on vision & fitness plans	<ul style="list-style-type: none"> Member Services Provider network 	No cost share fitness center access, home health kits, internet tools & education	1-877-771-2746

Note: You may refer your CareSource patients to these vendors using the numbers provided above.



Dual Advantage Plan *Supplemental Benefits*

Benefit Category	Eligible Members	Services	Benefit Overview	Member Contact
Routine Dental (DentaQuest)	✓ All Dual Advantage members	<ul style="list-style-type: none"> Member Services Provider network Claims adjudication EOBs 	Preventive, diagnostic, restorative, comprehensive care with annual limits of \$4,000	1-855-453-5284
Routine Hearing (TruHearing)	✓ All Dual Advantage members	<ul style="list-style-type: none"> Member Services Provider network Claims adjudication 	Routine hearing exams & hearing aid fittings with two TruHearing Advanced hearing aids every three years	1-866-759-6826
Routine Vision (EyeMed)	✓ All Dual Advantage members	<ul style="list-style-type: none"> Member Services Provider network Claims adjudication EOBs 	Routine eye exam, glasses, contacts (with \$500 allowance) and other value-added services	1-866-299-1425
Fitness (American Specialty Health)	✓ All Dual Advantage members	<ul style="list-style-type: none"> Member Services Facility network 	No cost share fitness center access, one home fitness kit, internet tools & education	1-877-427-4788
Healthy Benefits+ card	✓ All Dual Advantage members	<ul style="list-style-type: none"> Member Services 	\$255 monthly allowance	1-833-230-2020

Note: You may refer your CareSource patients to these vendors using the numbers provided above.



CareSource Benefit Information

VISIT CARESOURCE.COM FOR MORE DETAILS ON:

Marketplace Plan Benefits

CareSource.com > Marketplace > [Benefits & Services](#)

Dual-Eligible Plan Benefits

CareSource.com > Dual Advantage > Benefits & Services > [Medical Benefits](#)





Prior Authorizations


CareSource[®]

Prior Authorization Services

Some services require prior authorization.

To use our Prior Authorization tool:

- Visit **CareSource.com** > Providers > [Prior Authorization](#)
- Select the proper state and plan
- Click the link to the CPT/HCPCS Prior Authorization Look-up Tool
- Select your state from the tool's drop-down
- Enter a CPT/HCPCS code into the tool

For fast authorization processing, CareSource offers **Cite AutoAuth**, an automated evidence-based system. It's quicker than phone or fax! It can be accessed on the Provider Portal.



Prior Authorization Submissions

	Marketplace	D-SNP
Online	<u>Provider Portal</u>	
Phone	1-833-230-2101	1-833-230-2176
Fax	844-676-0372	844-417-6157
Mail	CareSource Attn: Utilization Management P.O. Box 1307 Dayton, OH 45401-1307	



Prior Authorization Information Checklist

PRIOR AUTHORIZATION SUBMISSION REQUIREMENTS

- Member/patient name, date of birth and CareSource member ID number
- Provider name, National Provider Identifier (NPI) and Tax ID
- Anticipated date(s) of service
- Diagnosis code and narrative
- Procedure, treatment, or service(s) requested
- Number of visits requested, if applicable
- Reason for referring to an out-of-plan provider if applicable
- Clinical information to support the medical necessity of a service
- Inpatient services need to include whether the service is elective, urgent, or emergency, admitting diagnosis, symptoms & plan of treatment

Note: CareSource does not require PCP referrals to see a Specialist.

You can find more information on prior authorizations in our Provider Manual, located at **CareSource.com** > Providers > Tools & Resources > [Provider Manual](#).



Prior Authorization Evolent

CareSource utilizes Evolent to manage prior authorization of some outpatient radiology services.

Procedures Requiring Prior Authorization through Evolent	Services Not Requiring Prior Authorization through Evolent
<ul style="list-style-type: none">• CT/CTA• MRI/MRA• PET Scan	<ul style="list-style-type: none">• Inpatient advanced imaging services• Observation setting advanced imaging services• Emergency room imaging services

Expedited authorizations are accepted. Register at [RadMD.com](https://www.RadMD.com).

More resources on Evolent imaging may be found at [CareSource.com/Providers](https://www.CareSource.com/Providers).





Care Management & Quality


CareSource[®]

Care & Disease Management

MEMBER EDUCATION

- MyHealth online self-management tool
- Disease-specific newsletters
- Coordination with outreach teams who provide topic-specific information
- One-to-one care management



Cultural Competency

Providers are expected to provide services in a culturally competent manner, including:

- Removing all language barriers to service
- Accommodating unique cultural, ethnic and social needs of members
- Understanding the social determinants of health that contribute to a member's health outcomes and quality of life
- Meeting the requirements of all applicable state and federal law, including contractual requirements

RESOURCES

We provide cultural competency training resources in the Provider Manual and online at [CareSource.com](https://www.caresource.com). The National Culturally and Linguistically Appropriate Services (CLAS) Standards provide specific guidelines to assist you in developing a culturally competent practice.



CareSource Health Equity Commitment

At CareSource, we are dedicated to the communities in which we serve and in making a positive impact in the lives of our members. We work to eliminate health disparities, support our organization's health equity initiatives, and partner with community stakeholders to carry out this much needed work.

LIFE SERVICES

Our Life Services Department is dedicated to serving marginalized communities and to making a positive impact in the lives of diverse member populations to eliminate health disparities.

Life Services is taking an integrated approach to health equity and embedding it across CareSource. As a result, we have developed our objectives based on Pillars of Life Services:

- **Workforce Development:** promote long-term employment opportunities, financial literacy, connection to job training and increasing assets such as home ownership.
- **Housing:** increase the quality of safe and affordable housing, enhanced financial tools to develop and preserve housing units and improved affordability of housing.
- **Food & Nutrition:** regular and consistent access to healthy foods, education on nutrition and overall health impacts, addressing food deserts and inequalities.
- **Health Equity:** pursuit of health equality for black, indigenous and people of color (BIPOC), LGBTQIA, and complex populations; elimination of health disparities, partnerships with outside organizations, drive policy and advocate for change.



Multi-Language *Insert*

FOR D-SNP ONLY:

The Centers for Medicare & Medicaid Services (CMS) requires that all health plan enrollees receive the multi-language insert (MLI) document to inform beneficiaries that free interpreter services are available for the top 15 languages spoken in the United States, plus all additional languages that meet a five percent service area threshold. The MLI may be included as part of required materials or as a standalone document that includes the CareSource® brand logo.

To meet this requirement, the MLI will be included with the following materials:

- An Important Message from Medicare About Your Rights (IM)
- Detailed Notice of Discharge Form (DND)
- Medicare Outpatient Observation Notice (MOON)

Achieving Health Equity requires that our members receive health information in the language they understand. Review this document at [CMS.gov/Medicare/Managed Care Marketing Documents](https://www.cms.gov/Medicare/Managed%20Care/Marketing/Managed%20Care%20Marketing%20Documents).

For questions, please contact Provider Services at **1-833-230-2176**.



Quality Measures

HEDIS® MEASURES

CareSource monitors member quality of care, health outcomes, and satisfaction through the collection, analysis and the annual review of the Healthcare Effectiveness Data and Information Set (HEDIS).

HEDIS includes a multitude of measures that look at different domains of care:

- Effectiveness of Care
- Access/Availability of Care
- Experience of Care
- Utilization and Risk Adjusted Utilization
- Relative Resource Use
- Health Plan Descriptive Information
- Measures Collected Using Electronic Data Systems

Wellness & Prevention

- Childhood immunizations
- Immunizations for adolescents
- Adult immunization status
- Breast cancer and cervical cancer screenings
- Colorectal cancer screening

Chronic Conditions

- Controlling high blood pressure
- Recommended diabetes tests and screenings
- Statin therapy for patients with cardiovascular disease or diabetes

Behavioral Health

- Follow up after hospitalization for mental illness
- Antidepressant Medication Management

Access to Care

- Well-child visits
- Annual dental visit
- Prenatal and postpartum care



Quality Resources



Quality Onboarding Training



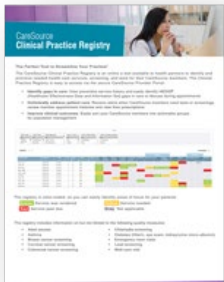
Quality Patient Experience Guide



Clinical Practice Registry Training



HEDIS Coding Guides



Clinical Practice Registry Quick Tips



Clinical Practice Guideline Information



Clinical Practice Registry

The CareSource Clinical Practice Registry is an online tool available to providers to identify and prioritize needed health care services, screening, and tests for their CareSource members. It is easy to access via the secure CareSource provider portal.

The registry includes information on, but not limited to the following measures:

- Adult access
- Asthma
- Breast cancer screening
- Cervical cancer screening
- Colorectal cancer screening
- Diabetes (HbA1c, eye exam, kidney/urine tests)
- Emergency room visits
- Well-care visits

Identify Gaps in Care

View preventive service history and easily identify HEDIS gaps in care to discuss during appointments

Holistically Address Patient Care

Receive alerts when CareSource members need tests or screenings, review member appointment histories and view their prescriptions

Improve Clinical Outcomes

Easily sort your CareSource members into actionable groups for population management

CareSource provides performance reports for these metrics to assist providers in enhancing practice procedures. Reports can be exported to PDF or Excel file for enhanced use.



Fraud, Waste & Abuse

Help CareSource stop fraud.

Contact us to report any suspected fraudulent activities.

CALL NAVEX Hotline at **1-844-415-1272**

FAX 800-418-0248

EMAIL Fraud@CareSource.com

MAIL CareSource

Attn: Program Integrity

P.O. Box 1940

Dayton, OH 45401-1940





Pharmacy


CareSource[®]

Pharmacy Overview

PARTNERSHIP WITH EXPRESS SCRIPTS

CareSource contracts Express Scripts, Inc., a pharmacy benefit management (PBM) company, who administers our prescription drug benefit program.

SPECIALTY DRUGS

Accredo can provide specialty medications directly to the member or the prescribing physician and coordinate nursing care, if required.

E-PRESCRIBING

CareSource formulary files are available through your electronic medical record (EMR), electronic health record (EHR), or e-prescribing vendor.

RESOURCES

- Find prior authorization criteria and the formulary search tool at **CareSource.com** > Providers > [Tools & Resources](#). Select your plan's dropdown for specific requirements.
- Medication Therapy Management (MTM) allows pharmacists to work collaboratively with physicians to prevent or address medication-related problems, decrease member costs and improve prescription drug adherence.



Marketplace Plan *Pharmacy Benefits*

FORMULARY STRUCTURE

The higher the tier, the higher the cost of the drug

Tier 0	Tier 1	Tier 2	Tier 3	Tier 4
<p>No member cost share.</p> <p>This tier contains preventive medications.</p>	<p>Contains low-cost generic drugs.</p>	<p>Higher coinsurance or copayment than those in Tier 1.</p> <p>This tier contains preferred medications that may be generic drugs or single- or multi-source brand-name drugs.</p>	<p>Higher coinsurance or copayment than those in Tier 2.</p> <p>This tier contains non-preferred medications. Includes medications considered single- or multisource brand name drugs.</p>	<p>Higher coinsurance or copayment than those in Tier 3.</p> <p>Medications generally classified as specialty medications fall into this category.</p>

Visit [CareSource.com](https://www.caresource.com) > [Pharmacy](#) if you wish to access our full formulary list.



Dual Advantage Plan *Pharmacy Benefits*

If members receive “Extra Help” from Medicare to pay for their prescription drugs, all covered Part D drugs are \$0.

Members have flexibility to choose...

- A pharmacy within our national network that’s right for them
- A 30-day supply, 60-day supply, or even a 102-day supply
- Retail or mail order





Provider Resources


CareSource[®]

Provider Resources

Visit CareSource.com to access:

- Downloadable [Provider Manual](#)
- Downloadable [Provider Orientation](#)
- [Newsletters](#) & [Network Notifications](#)
- [Formularies](#)
- Covered benefits
- [Quick reference guides](#)
- and more!

CARESOURCE PROVIDER PORTAL

<https://providerportal.caresource.com/GA/User/Login.aspx>



Provider Directory Information Attestation

State and federal regulations require health plans to validate, and update published information regarding their contracted provider network every 90 days. This validation ensures we have the most accurate information for claims payment and provider directories. This information is critical to process your claims. In addition, it ensures our Provider Directories are up-to-date and reduces unnecessary calls to your practice. This information is also reportable to Medicaid and Medicare. **Providers are required to attest to directory information every 90 days.**

What happens if I do not attest to my information?

CMS requires health plans to verify the accuracy of provider directory information every 90 days. Not attesting to your information and/or providing updated information when applicable can result in claims payment issues and inaccurate provider data in our online and printed directories. With the No Surprises Act – in effect as of January 1, 2022 – providers who do NOT attest quarterly, risk being suppressed in impacted provider directories.

Accurate provider directory information ensures we can connect the **right patients to the right provider.**



CareSource Contacts

	Marketplace	D-SNP
Provider Services	1-833-230-2101	1-833-230-2176
Utilization Management Fax	844-676-0372	844-417-6157
Provider Portal	https://providerportal.caresource.com/GA/User/Login.aspx?ReturnUrl=%2fGA	https://providerportal.caresource.com/GA/User/Login.aspx?ReturnUrl=%2fGA
Electronic Funds Transfer	ECHO Health: 1-888-485-6233	
Electronic Claims Submission	GACS1	GACS1
Claim Address	CareSource, Attn: Claims Department, P.O. Box 803, Dayton, OH, 45401-0803	
Timely Filing	180 calendar days from date of service or discharge	





Are you contracted with all our plans?

*Join us on our journey to healthy
outcomes.*

Visit **CareSource.com** to start the
contracting process.


CareSource[®]



PARTNER with *Purpose*