

# Member Enrollment and Eligibility



## Medicaid — Member Enrollment

A Michigan county case worker determines a person's eligibility for Medicaid. Those who are eligible for specific categories of Medicaid assistance are eligible to join CareSource. The Michigan Department of Community Health (MDCH) provides eligibility information to CareSource on a monthly basis. New members are effective on the first of the month, including newborns who are made effective retroactive to the beginning of their birth month. This is reflected on the member ID card.

*New members are effective on the first of the month, including newborns who are made effective retroactive to the beginning of their birth month.*

## Member ID Cards

Once eligibility is confirmed, all new CareSource members receive a membership ID card which replaces the state Medicaid card. CareSource ID cards are issued when a member joins CareSource. A new card is issued only when the information on the card changes, if a member loses a card, or if a member requests an additional card.

Members are asked to present an ID card each time services are accessed. If you are not familiar with the person seeking care, and cannot verify the person as a member of our health plan, please ask to see photo identification. If you suspect fraud, please contact our Special Investigations Unit immediately by calling **1-800-390-7102** and follow the appropriate menu options to report fraud.

The member ID card contains the following information:

### Member's Name

**Member's ID Number**  
This number should be used on claims.

**Primary Care Provider's Name**  
Members choose a participating provider to be their Primary Care Provider (PCP). If a choice is not made, a PCP is assigned.

<b>Member Name</b> Jane J. Doe	<b>Date of Birth</b> 01-01-1989	
<b>External ID</b> 0012345678	<b>Enrollment Date</b> 01-23-2006	<b>Group #</b> C
<b>Primary Care Provider Name</b> Joseph B. Well	<b>Primary Care Provider Phone</b> (989) 555-5555	
<b>Member Services: 1-800-390-7102</b> (TTY: 1-800-649-3777 or 711) <b>CareSource 24</b> , 24-hour nurse advice line: <b>1-866-206-0488</b>		
<a href="http://www.caresource.com">www.caresource.com</a>		

### Member's Date of Birth

**Member's Effective Date**  
This is the date the patient became an eligible CareSource member. This date does not guarantee that the member is currently eligible.

### PCP's Phone Number

The member ID card is used to identify a CareSource member, but it does not prove eligibility for benefits or guarantee coverage since members may disenroll from CareSource and retain an old card. Therefore, it is important to **verify member eligibility before providing services**. Patients must be eligible CareSource members at the time of service in order for services to be covered.

*It is important to **verify member eligibility before providing services**. Patients must be eligible CareSource members at the time of service in order for services to be covered.*

Please note: CareSource may be notified by MDCH that a member has lost eligibility retroactively. This occurs occasionally. In those situations, CareSource will take back payments made for dates when a member lost eligibility. The take-back code will appear on the next Explanation of Payment (EOP) for any affected claims.

## Member Eligibility Verification

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**Provider Portal:** <https://providerportal.caresource.com/MI/> — After a one-time registration, you can log into our secure Provider Portal where you have 24-hour access to member eligibility.

Health care providers should always verify member eligibility before rendering services except in an emergency. It is important to verify that CareSource members are eligible for care on the date of service. This helps prevent unpaid claims.

## Newborn Enrollment

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Newborns whose mothers are CareSource members on their date of birth are covered from their date of birth. In many cases, the newborn's name will appear on the PCP's member eligibility list for the month following the birth.

## Member Disenrollment

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Members may disenroll from CareSource for a number of reasons. Disenrollments may be initiated by the member, the provider, CareSource or MDCH. Some reasons we may disenroll a member include:

- Unauthorized use of a member ID card
- Use of fraud or forgery to obtain medical services
- Disruptive or uncooperative behavior to the extent that it seriously impairs the ability to provide services to the member or others

Please notify CareSource if any of the situations listed above occurs, so we can begin to either counsel the member or, in severe cases, initiate a request for disenrollment. MDCH will review all cases and determine whether or not the member should be disenrolled from CareSource, but members have the right to appeal the cancellation of coverage.

If members lose Medicaid eligibility, they are also ineligible for CareSource.

## Procedures for Dismissing Non-Compliant Members

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Participating health care providers can request that a CareSource member be involuntarily dismissed from their practice if a member does not respond to recommended patterns of treatment or behavior.

Examples include noncompliance with medication schedules, no-show office policies, or behavior modification. Any time a physician's office is concerned about a CareSource member, please remember to contact our Care Management Department. We can assist the member and facilitate an improved relationship with the physician's office, and ideally avoid patient disenrollment from your practice.

*Any time a physician's office is concerned about a CareSource member, please remember to contact our Care Management Department.*

It is strongly recommended that there be at least three attempts to educate the member regarding noncompliant behavior, documented in the patient's record, as well as documentation about notification to our Care Management Department for assistance. After all attempts to correct the situation have failed, providers may initiate a dismissal by:

- The provider office must notify the member of the dismissal and the reason for dismissal by certified letter.
- A copy of the letter must be sent to CareSource at the following address:

**CareSource**  
**Attention: Member Services Manager**  
**P.O. Box 1947**  
**Dayton, OH 45401-1947**

You can also fax the dismissal letter to:

**CareSource**  
**1-937-396-3095**

**For PCPs only:** The letter must contain specific language stating that:

- The member must contact CareSource's Member Services to choose another PCP
- The PCP will provide 30 days of emergency coverage to the patient

Providers are required to continue to see members for 30 days after the date of the dismissal letter. Please call Provider Services if you have questions about disenrollment reasons or procedures.

## Automatic Renewal of Membership

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If CareSource members lose Medicaid eligibility, but become eligible again within 60 days, they are automatically re-enrolled in CareSource and, if possible, assigned to the same Primary Care Provider (PCP).

## **Enrollment Methods by County**

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MDCH has established voluntary, mandatory and preferred-option enrollment programs. Each county uses one of these enrollment methods.

**Mandatory Program County** — In a mandatory county, eligible Medicaid consumers must choose to receive their health care services through an MDCH-contracting managed care plan. If a choice is not made, MDCH will assign the consumer to a managed care plan in the county.

**Preferred Option Program County** — In a preferred-option county, eligible Medicaid consumers can choose to receive their health care services through an MDCH-contracting managed care plan or through the traditional fee-for-service program. If a choice is not made, MDCH will assign the consumer to the preferred-option health plan in the county.

## **Member Enrollment and Provider Marketing**

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It is common for health care providers to inform their patients about their contracted managed care plans. However, advocating enrollment in a specific health plan is unacceptable according to rules defined by MDCH. Because CareSource is a contracted Michigan Medicaid health plan, we are governed by MDCH rules and are responsible for upholding them.

Please remember that any materials that CareSource may give to you for distribution in your office or facility are pre-approved by MDCH.

### ***Medicare — Member Enrollment***

#### **CareSource Advantage**

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CareSource Advantage is a special needs health care plan committed to helping members get the care they need. CareSource Advantage is a Health plan with a Medicare contract available to those who are eligible for Medicare Part A and enrolled in Medicare Part B, as well as full Medicaid.

## Medicare Member Enrollment and Eligibility

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The Centers for Medicare and Medicaid Services (CMS) determines eligibility for Medicare. CareSource verifies a member's eligibility for Medicaid and Medicare Part A, and enrollment in Medicare Part B, before the applicant can be enrolled in CareSource Advantage. New members are effective on the first day of the month.

*New members are effective on the first day of the month.*

To be eligible to receive services through CareSource, a person must:

- Be entitled to Medicare Part A and enrolled in Medicare Part B
- Have full Medicaid benefits
- Not have end-stage renal disease (ESRD)
- Live in our CareSource Advantage service area (visit [www.caresource.com](http://www.caresource.com) to see which counties in Michigan offer this plan)
- Choose CareSource Advantage during a valid election period
- Agree to the rules of the CareSource Advantage plan
- Continue to pay Medicare Part B premiums if not paid by Medicaid or another third party

## Member ID Cards

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Each new CareSource Advantage member receives a member ID card. As a person dually eligible under Medicare and Medicaid, a member should present a CareSource Advantage ID card *and* a Medicaid Fee-For-Service (FFS) ID card when receiving all health care services.

**The member should still carry his or her Medicaid FFS card.** An ID card for CareSource Advantage is issued when a member joins CareSource. Members can continuously use the same CareSource Advantage ID card as long as they maintain eligibility. CareSource will issue a new ID card only when the information on the card changes, if a member loses a card, or if a member requests additional cards. Because ID cards do not guarantee eligibility, providers must verify member's eligibility on each date of service.

Members should not present their red, white and blue card for Original Medicare. If a CareSource Advantage member uses their red, white and blue Medicare card instead of their CareSource card and you bill the Medicare program instead of CareSource, the Medicare program will not pay for these services.

Please bill CareSource for the Medicare portion of services. CareSource is the primary payer for CareSource Advantage members, and Medicaid FFS is the secondary payer. After you receive payment from CareSource, if the service is eligible for any additional payment through Medicaid, you must bill Medicaid FFS for the unpaid balance.

*CareSource is the primary payer for CareSource Advantage members, and Medicaid FFS is the secondary payer.*

**Members are asked to present a CareSource ID card each time services are accessed.** If you are not familiar with the person seeking care and cannot verify the person as a member of our health plan, please ask to see photo identification. If you suspect fraud, please contact our Special Investigations Unit immediately by calling **1-800-390-7102** and follow the appropriate menu options to report fraud.

The CareSource Advantage member ID card is **light blue** and contains the following information:

**Member's Name**  
Indicates CareSource Advantage member

**Member ID Number**  
This CareSource ID number should be used on claims.

**Policy #**  
This is **not** the member's ID number or a billing number.

**CMS Contract #**  
The CMS number for the Ohio CareSource Advantage plan.

**Plan Identifier**  
Indicates CareSource Advantage member

**CVS Caremark**  
Pharmacy Benefit Manager

**Primary Care Provider's Name and Phone Number**  
Members choose a participating provider to be their primary care physician (PCP). If a choice is not made, a PCP is assigned.

**Card Fields:**  
 CareSource CareSource Advantage (HMO)  
 Member Name: Mary X. Doe      RxBin: 012189  
 Member ID: xxxxxx      RxPCN: 5044  
 Policy #: xxxx  
 Plan Type: Managed Care  
 Primary Care Physician/Clinic: Dr. xxx  
 Physician/Clinic Phone: xxxx  
 CMS Contract # H0141  
 Issuer (80840)  
 MedicareRx Prescription Drug Coverage

The back of the CareSource Advantage member ID card contains the following information:

**Provider Services**  
The toll-free phone number for providers who have questions or wish to verify eligibility over the phone.

**Information about our Pharmacy Program**  
Send Paper Claims To

**MEMBER CONTACT INFORMATION:**  
 Member Services: **1-877-725-4581** (TTY: 1-800-649-3777 or 711)  
 24-hour toll-free nurse advice line: **1-866-206-0437** (TTY: 1-800-649-3777 or 711)  
 In case of an emergency, call 911 or go to the nearest emergency room.

**PROVIDER CONTACT INFORMATION:**  
 Provider Services: **1-800-390-7102**  
 Eligibility verification: [www.caresource.com](http://www.caresource.com)  
 Providers must verify eligibility for date of service.  
 Authorization is required for inpatient admission.  
 Pharmacy questions: **1-877-725-4534**

**MAIL MEDICAL CLAIMS TO:** CareSource  
 P.O. Box 1307  
 Dayton, OH 45401-1307

**MAIL PHARMACY CLAIMS TO:** RxAmerica  
 P.O. Box 22690  
 Salt Lake City, Utah 84122-0690

**Nurse Advice Line**  
Our Website contains information about CareSource Advantage as well as special functionality: verify eligibility, check claims and prior authorization status, submit a prior authorization, check other insurance information and more.

The Pharmacy Benefit Manager for CareSource Advantage is CVS Caremark.

CVS Caremark  
 P.O. Box 53993  
 Phoenix, AZ 85072-3993

*The Pharmacy Benefit Manager for CareSource Advantage is CVS Caremark.*

Please refer to [www.caresource.com](http://www.caresource.com) for the most current information.

The member ID card is used to identify CareSource Advantage members. Because member ID cards do not guarantee eligibility, providers must verify member's eligibility on each date of service. We encourage providers to use the Provider section of [www.caresource.com](http://www.caresource.com), which includes up-to-date member eligibility information. Members must be eligible with CareSource Advantage on the date of service in order for services to be covered.

## Member Eligibility Verification

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To verify member eligibility, please use the following method:

- Log on to our secure Provider Portal. Go to [www.caresource.com](http://www.caresource.com) and access the Provider Portal section in the menu. You can check CareSource member eligibility up to 12 months after the date of service on a secured area of our website. You can search by date of service plus any one of the following: member name and date of birth, Medicare number or CareSource member ID number.

PCPs can view a list of **eligible members who have chosen them or are assigned to** them as of the first day of that month. This list does not prove eligibility for benefits or guarantee coverage. Please use the above method to verify member eligibility. Log onto our website to view or print your list.

All health care providers should always verify member eligibility before rendering services except in an emergency. This helps prevent unpaid claims.

## Member Disenrollment

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A member may request disenrollment at any time, for any reason, by notifying CareSource. Refer members to CareSource Member Services at **1-877-725-4581** if they need information on disenrollment. The member's termination of enrollment will take effect on the first of the month following the receipt of this written request by CareSource. Members are advised to continue to use their CareSource Advantage ID card and to coordinate all services through their PCP until their disenrollment becomes effective.

If you learn that a member plans to disenroll, you may avoid payment delays by reminding the member to notify CareSource, and validating eligibility with CareSource Advantage on the date of each visit.

### CareSource Involuntary Termination

Each member's enrollment is generally in effect as long as the member retains eligibility and chooses to stay with CareSource Advantage. The Plan cannot and will not terminate a member because of the amount or cost of services. Nonetheless, CareSource can terminate members with CMS's approval for the following:

- If the member loses entitlement to Medicare Part B coverage
- If the member loses entitlement to Medicare Part A coverage
- If the member loses entitlement to Medicaid coverage
- If the member permanently moves or resides outside the service area for more than six consecutive months
- If the member has committed fraud
- If the member has abused the CareSource Plan Beneficiary ID card and/or benefits
- If the member has or demonstrated disruptive behavior that interfered with care for the member or others

*If you learn that a member plans to disenroll, you may avoid payment delays by reminding the member to notify CareSource, and validating eligibility with CareSource Advantage on the date of each visit.*

Please notify CareSource if any of the situations listed above occurs, so we can discuss the disenrollment request with the member and if necessary, initiate a request to CMS for member disenrollment. CMS will review all cases and determine whether or not the member should be disenrolled from CareSource Advantage, but members have the right to appeal the cancellation of coverage.

## **Procedures for Dismissing Non-Compliant Members**

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### **Procedures for Dismissing Members for Disruptive Behavior or Fraud and Abuse**

Participating health care providers can request that a CareSource Advantage member be involuntarily dismissed from their practice if a member does not respond to recommended patterns of treatment or behavior. Examples include non-compliance with medication schedules, no-show office policies, or failure to modify behavior as requested. Any time a member misses three or more consecutive appointments, providers are expected to notify our Care Management Department for assistance.

*Any time a member misses three or more consecutive appointments, providers are expected to notify our Care Management Department for assistance.*

We strongly recommend that your office make at least three attempts to educate the member about non-compliant behavior and document them in the patient's record. Please remember that CareSource's outreach staff can assist you in educating the member. After three attempts, providers may initiate the dismissal by following the guidelines below:

- The provider office must notify the member of the dismissal by certified letter
- A copy of the letter must be sent to CareSource at the following address:

**CareSource**  
**Attention: Member Services Manager**  
**P.O. Box 1947**  
**Dayton, OH 45401-1947**

**For PCPs only**, the letter must contain specific language stating that:

- The member must contact CareSource's Member Services to choose another PCP
- The dismissing PCP will provide 30 days of emergency coverage to the patient from the date of dismissal

Please call Provider Services at **1-800-390-7102** if you have questions about disenrollment reasons or procedures.

### **Loss of Medicaid Membership**

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If CareSource Advantage members lose Medicaid eligibility, but retain their Medicare eligibility, CareSource will continue to cover their Medicare benefits for up to 90 days.

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## Member Enrollment and Provider Marketing

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It is common for health care providers to inform their patients about their contracted managed care plans. Advocating enrollment in a specific health plan, however, is unacceptable according to the CMS Medicare Marketing Guidelines. CMS allows providers to discuss participation under specified circumstances.

### Provider Marketing

Providers should remain neutral parties in assisting plan sponsors with marketing to beneficiaries or assisting with enrollment decisions. Providers may not be fully aware of plan benefits and costs, and it's important that beneficiaries receive the right information needed to make an informed decision about their health care options.

Therefore, it is inappropriate for providers to be involved in any of the following actions:

- Offering sales/appointment forms
- Accepting enrollment applications for MA/MA-PD or PDPs
- Directing, urging or attempting to persuade beneficiaries to enroll in a specific plan based on financial or any other interests
- Mailing marketing materials on behalf of plan sponsors
- Offering anything of value to induce plan enrollees to select them as their provider
- Offering inducements to persuade beneficiaries to enroll in a particular plan or organization
- Health screening when distributing information to patients, as health screening is a prohibited marketing activity
- Accepting compensation directly or indirectly from the plan for beneficiary enrollment activities

### Providers contracted with plan sponsors (and their contractors) are permitted to do the following:

- Provide the names of plan sponsors with which they contract and/or participate
- Provide information and assistance in applying for the low income subsidy
- Provide objective information on ALL plan sponsors' specific plan formularies, based on a particular patient's medications and health care needs
- Provide objective information regarding ALL plan sponsors' specific plans being offered, such as covered benefits, cost sharing, and utilization management tools
- Distribute all PDPs marketing materials with whom the provider contracts, including enrollment application forms
- Make available and/or distribute plan marketing materials for all plans with which the provider participates (including PDP enrollment applications, but not MA or MA-PD enrollment applications)
- Refer their patients to other sources of information, such as the Special Health Insurance Plans, plan marketing representatives, their State Medicaid Office, local Social Security Office, CMS's website at [www.medicare.gov](http://www.medicare.gov) or call **1-800-MEDICARE**, and print out and share information with patients from CMS's website.

The “Medicare and You” Handbook or “Medicare Options Compare” (from [www.medicare.gov](http://www.medicare.gov)), may be distributed by providers without additional approvals. There may be other documents that provide comparative and descriptive material about plans, of a broad nature, that are written by CMS or have been previously approved by CMS. These materials may be distributed by plan sponsors and providers without further CMS approval. This includes CMS Plan Finder information via a computer terminal for access by beneficiaries. Plan sponsors should advise contracted providers of the provisions of these rules.

***NOTE:*** *A provider should not attempt to switch or steer plan enrollees or potential plan enrollees to a specific plan or group of plans to further the financial or other interests of the provider.*