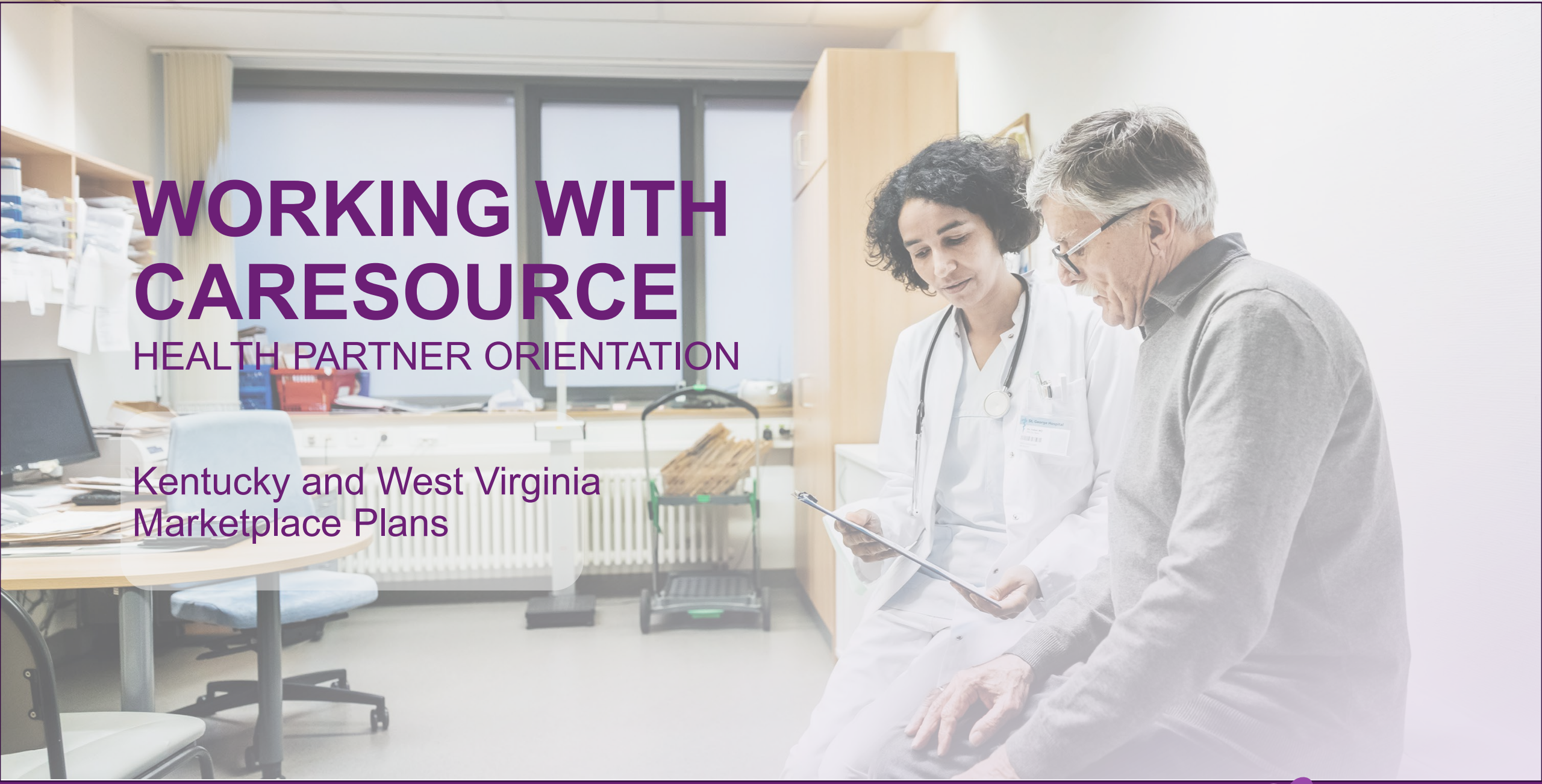


WORKING WITH CARESOURCE

HEALTH PARTNER ORIENTATION

Kentucky and West Virginia
Marketplace Plans

About 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 providers to help members make healthy choices
- Direct communication
- Timely and low-hassle medical reviews
- Accurate and efficient claims payment

Collaborative Focus

- Emphasis on quality-based improvements
- Value-based purchasing
- Creating uniform systems to ease administrative burden
- Addressing all barriers to access
- True commitment to improving the lives of our members

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 and Dual Special Needs Plans (D-SNP) programs.

Corporate Headquarters:
Dayton, Ohio

Locations:
Arkansas, Georgia, Indiana, Kentucky, Michigan, North Carolina, Ohio, West Virginia and Wisconsin

Year Established:
1989

Employees:
4,500 employees located across 47 states

Your ***Expectations***

- Provide 24/7 availability to your CareSource patients by telephone [Primary Care Providers (PCPs) only]
- Notify CareSource of any demographic changes prior to the effective date of the change
  - 60 calendar days, depending on the type of change (refer to the Provider Manual)
- Provide notification to terminate the contract 60 days advance written notice
- Do not balance bill CareSource members
- Comply with access and availability standards (refer to later slide)
- Provide medical records upon request
- Submit claims or corrected claims within the appropriate time frames below:
  - Kentucky: 90 days of date of service or date of discharge
  - West Virginia: 180 days of date of service or date of discharge
- Treat CareSource members with respect
- Coordinate member care with other referred providers

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

Our ***Responsibilities***

- Ensure an effective member/provider appeal and grievance process
- Complete credentialing process within 120 calendar days
- Provide support for every provider through the Provider Services call center
- Comply with all state and federal regulations
- Pay 100% of clean claims within 30-40 calendar days of receipt (30 calendar days for EDI, 40 calendar days for paper)
- Coordinate benefits for members with other primary insurance

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

Operations Performance

Key Performance Indicator (KPI)	Claims First Pass Accuracy	Financial Accuracy	Claim Average Days to Pay	Prompt Pay Timeliness	Encounters Submitted in 14 Days	Encounter Completeness and Accuracy
Current Rate	**99%>**	**99.96%**	**10 Days**	**100%**	**99.9%**	**99.9%**

Working with CareSource

CareSource®

Updating the ***Provider Directory***

All providers are required to attest to their provider directory information every 90 days.

Send updates to CareSource when your demographic and/or practice information changes.

Submit updates via the Provider Portal or send an email to: ProviderMaintenance@CareSource.com.

Always include in your email the HIE Form & W-9

Refer to the **Provider Manual** for additional information.

Provider Network & *Eligibility*

When referring patients, ensure other providers are in-network to ensure coverage. Use our Find-A-Doctor tool to help you 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 his or her 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.

We have partnered with Quest Analytics to streamline your verification process through their **BetterDoctor solution**.

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.

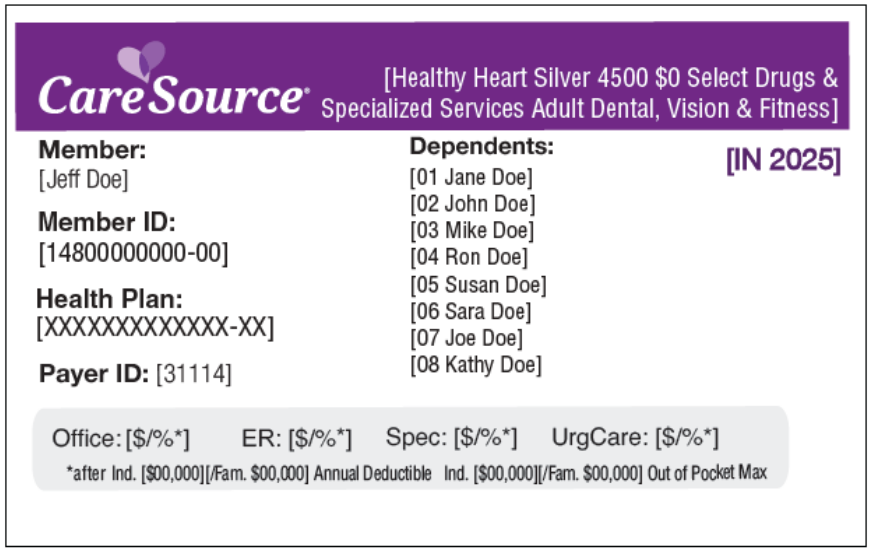
QUEST ANALYTICS BetterDoctor

Completing the Attestation Process:

1. You should receive an email or fax from BetterDoctor
2. Go to: betterdoctor.com/validate.
3. Locate the access token on the fax or email you received from BetterDoctor (it is an 8-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



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)

Digital insurance ID cards are available via the CareSource MyLife mobile app.

Submitting Claims

CareSource®

Claim ***Submissions***

SUBMISSION PROCESS

Providers can submit claims through our secure, online Provider Portal at **CareSource.com** > Provider Log-In. Here, providers can submit claims along with any documentation, track payments and more.

ELECTRONIC CLAIM SUBMISSIONS

CareSource encourages electronic claim submission as the primary submission method. We partner with ECHO Health for electronic funds transfer (EFT). You must 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.

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: https://www.availity.com/ediclearinghouse.

Claims Payments | *Electronic Funds Transfer*

ELECTRONIC FUNDS TRANSFER (EFT)

ECHO Health offers three payment options:

1. Electronic fund transfer (EFT) – preferred
2. Virtual Card Payment (QuicRemit) – Standard bank and card issuer fees apply*
3. Paper Checks

*Payment processing fees are what you pay your bank and credit card processor for use of a payment terminal to process payments via credit card.

Visit our Claims webpage at **CareSource.com** > Providers > Provider Resources > Claims, for additional information about getting paid electronically and enrolling in EFT.

Visit Enroll to complete your enrollment online. ECHO Health will work directly with you to complete your enrollment in EFT.

Providers who elect to receive EFT payment can also choose to receive an EDI 835 (Electronic Remittance Advice) through a designated clearinghouse. Providers can download the PDF version of the Explanation of Provider Payment (EPP) from the CareSource Provider Portal.

Notice: Email notifications are not sent when a deposit/payment is made. Deposits/payments are made twice weekly.

Claim Appeals *and Disputes*

ALL CLAIMS APPEALS MUST BE:

- Submitted within 30 calendar days from the date of the claim denial unless it is a COB denial, then it is 30 days from the date of the COB denial (the retro-authorization policy must still be followed).
- Submitted via one of these methods
    - CareSource Provider Portal
    - Mail: CareSource
      Attn: Provider Appeals
      P.O. Box 2008
      Dayton, OH 45401

CLAIM DISPUTES

CareSource also offers a claim payment dispute process. Additional information pertaining to claim appeals and claim payment disputes can be found in the Provider Manual or on **CareSource.com**.

***Note: An appeal or dispute is not a retro-authorization request**

- As a CareSource provider, you may submit a dispute or appeal for a member or on your own behalf.
- The Provider Portal is the most efficient method of submission to ensure timely receipt and resolution of the appeal.
- Providers must obtain a member's written consent to appeal an Adverse Benefit Determination on their behalf.
- As a CareSource provider, we may contact you to obtain documentation when a member has filed a request for one of these reviews. CareSource does not retaliate or discriminate against any member or provider for utilizing the grievance and appeals process.
- For additional information, contact Provider Services at **1-833-230-2101.**

Access and Availability

CareSource®

Access and ***Availability***

As a CareSource provider, you must ensure your practice complies with the following minimum access standards:

- Provide 24 hours of availability to your CareSource patients by telephone, answering service or message instructing them what to do to reach their PCP or backup provider.
    - Whether through an answering machine or a taped message after hours, patients should have the means to contact their PCP or back-up provider to be triaged for care.
    - 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 ensure that the services are accessible to members, as needed, 24 hours a day, 365 days a year.

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/crisis needs	Immediately upon presentation
Urgent care*	Not to exceed 48 hours*
Regular and routine care	15 business days

*For PCPs only: Provide 24-hour availability to your CareSource patients by telephone. Whether through an answering machine or a taped message used after hours, patients should be given the means to contact their PCP or back-up provider to be triaged for care. It is not acceptable to use a phone message that does not provide access to you or your back-up provider, and only recommends emergency room use for after hours.

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*
Specialist and routine care	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 on condition

*For the best interest of our members, and to promote their positive health care outcomes, CareSource supports and encourages continuity of care and coordination of care between medical care providers, as well as between physical health care providers and behavioral health providers.

Member ***Communications***

HELP YOUR CARESOURCE PATIENTS UNDERSTAND THEIR COVERAGE.

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

- MyLife.CareSource.com
- Searchable online formulary and prescription cost calculator
- Find-a-Doc tool
- Care Management
- Evidence of Coverage & Schedule of Benefits
- Member Handbook
- Total Cost Navigator
- Forms and more

For more information, visit: **CareSource.com/members.**

Communicating with *Us*

	Marketplace
Provider Services	**1-833-230-2101**
Hours	Monday to Friday from 8 a.m. to 6 p.m. Eastern Time (ET)
Member Services	**1-833-230-2099**
Hours	Monday to Friday from 7 a.m. to 7 p.m. ET

Provider Portal

CareSource®

CareSource ***Provider Portal***

SAVE TIME AND MONEY

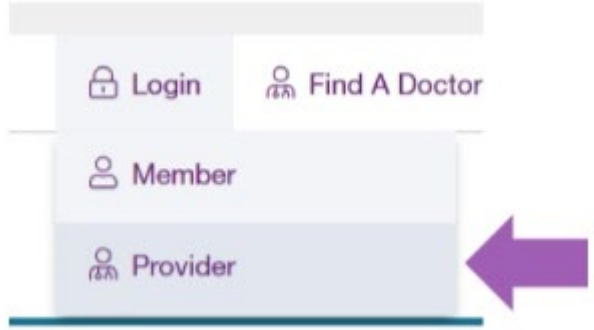
With our secure online Provider Portal, you can:

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

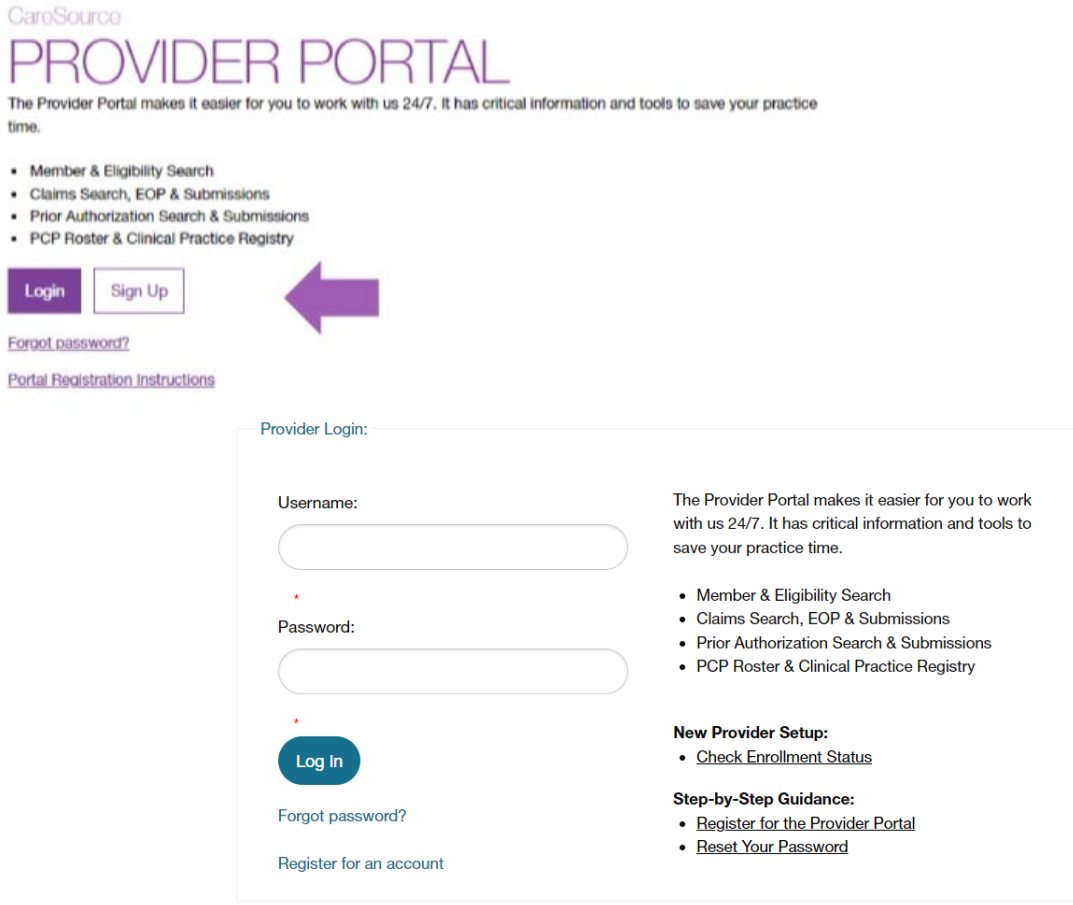
**In West Virginia, providers must submit service requests via the Provider Portal.*

Access the Provider Portal 24 hours a day, seven days a week at **CareSource.com** > Provider > Log-In.

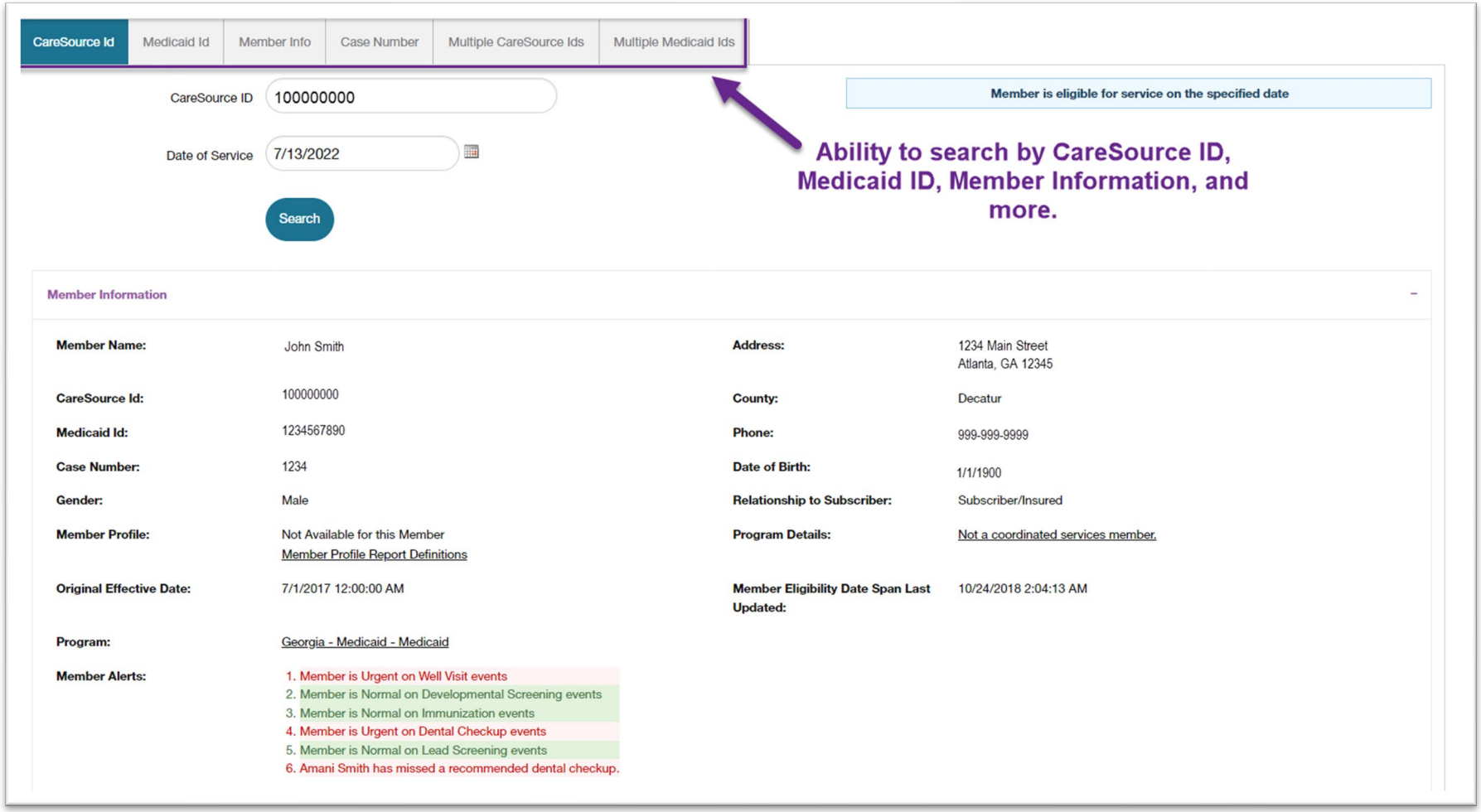
Register for the ***Provider Portal***



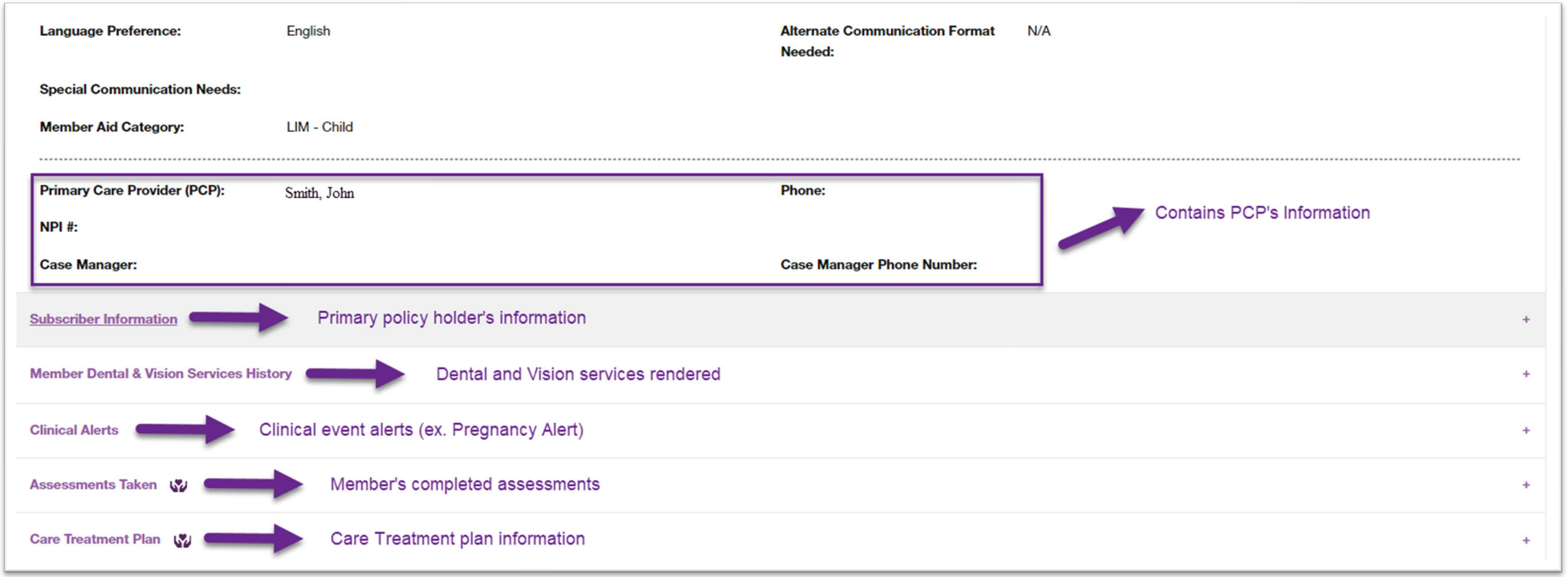
Go to **CareSource.com.**
Click Provider from the Log-in drop-down.
Select the state.
Register for the Provider Portal.
Enter your information, including your CareSource Provider Number (located in your welcome letter).
Follow remaining steps to register.



Member *Eligibility*



Member Eligibility



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 premium 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*

BENEFITS OVERVIEW

- PCP and specialist office visits
- Emergency services
- Preventive services & screenings
- Inpatient facility services
- Outpatient diagnostic services
- Home health services
- Durable medical equipment services
- Rehabilitation therapy services
- Habilitative services
- Maternity services

ADDITIONAL BENEFITS

- CareSource24® Nurse Advice Line
- Allergy testing & treatment
- Health and wellness education
- Inhalation therapy
- Opioid treatment services
- Pain management
- Vision services (For adult members who opt in)
- ActiveFit program (For adult members who opt in)

MEMBER PROGRAMS

- Integrated Care Management
- Diabetic coaching program
- Chronic Kidney Disease (CKD) program
- Neonatal Intensive Care (NICU) team
- Moms and Baby Beginnings program (for pregnant moms)
- MyHealth®
- myStrength®

Services ***Not Covered***

Services that are not considered medically necessary
Services received from a non-network provider
Experimental or investigational services
Alternative or complimentary medicine
Cosmetic procedures
Assisted reproductive therapy
Maintenance therapy treatments
Routine vision services & eyewear not provided by an EyeMed provider

For more details on each plan's covered services, visit **CareSource.com.**

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** for a full listing of benefits in this plan. Please note: these services are for members who chose to add the supplemental health care plan.

Marketplace Plan ***Supplemental Benefits***

Benefit Category	Eligible Members	Services	Benefit Overview	Member Contact
Routine Hearing (TruHearing)	✓ All Marketplace members	▪ Member Services ▪ Provider network ▪ Claims adjudication	Routine hearing exams and hearing aid discounts	**1-866-202-2561**
Routine Vision (EyeMed)	✓ All pediatric members (19 years of age for WV and 21 years of age for KY) ✓ Adults 19 years of age (WV) and 21 years of age (KY) on vision plans	▪ Member Services ▪ Provider network ▪ Claims adjudication ▪ EOBs	Routine eye exam, glasses, contacts, and other value-added services	**1-833-337-3129**
Active&Fit	✓ Adults 18+ years of age on vision plans	▪ Member Services ▪ Provider network	No cost share fitness center access, home health kits, internet tools and education	**1-877-771-2746**

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 > Plans > Marketplace > Benefits & Services

Behavioral Health ***Services***

CARESOURCE ENSURES THAT ALL MEMBERS HAVE ACCESS TO BEHAVIORAL HEALTH RESOURCES AND THAT BEHAVIORAL HEALTH IS INTEGRATED ACROSS ALL INTERVENTIONS.

- Members may **self-refer** to a participating provider for behavioral health services without referral from their PCP.
- PCPs and specialists must have screening and evaluation procedures for detection and treatment of, or referral for, any known or suspected behavioral health problems and disorders – or may provide clinically appropriate behavioral health services within their scope of practice.
- Behavioral health providers are expected to assist members in accessing emergent, urgent and routine behavioral services as required by the member's condition.
- CareSource members have access to specialty behavioral health Care Managers for assistance in obtaining both routine and higher complexity health care services.
- We can assist members and PCPs with locating appropriate participating providers and with making appointments for members in need of services.

Preventive *Care*

Preventive care is recommended for the whole family. CareSource advises members to see their PCP on a routine basis.

PREVENTIVE CARE INCLUDES BUT IS NOT LIMITED TO:

- Yearly well-care exams including BMI assessment (also counseling for nutrition and physical activity for children)
- Mammograms and cervical cancer screenings for women
- Prostate cancer screenings for men
- Colorectal cancer screenings for adults
- Routine dental and medical exams
- Recommended immunizations
- Family planning
- Annual medication review

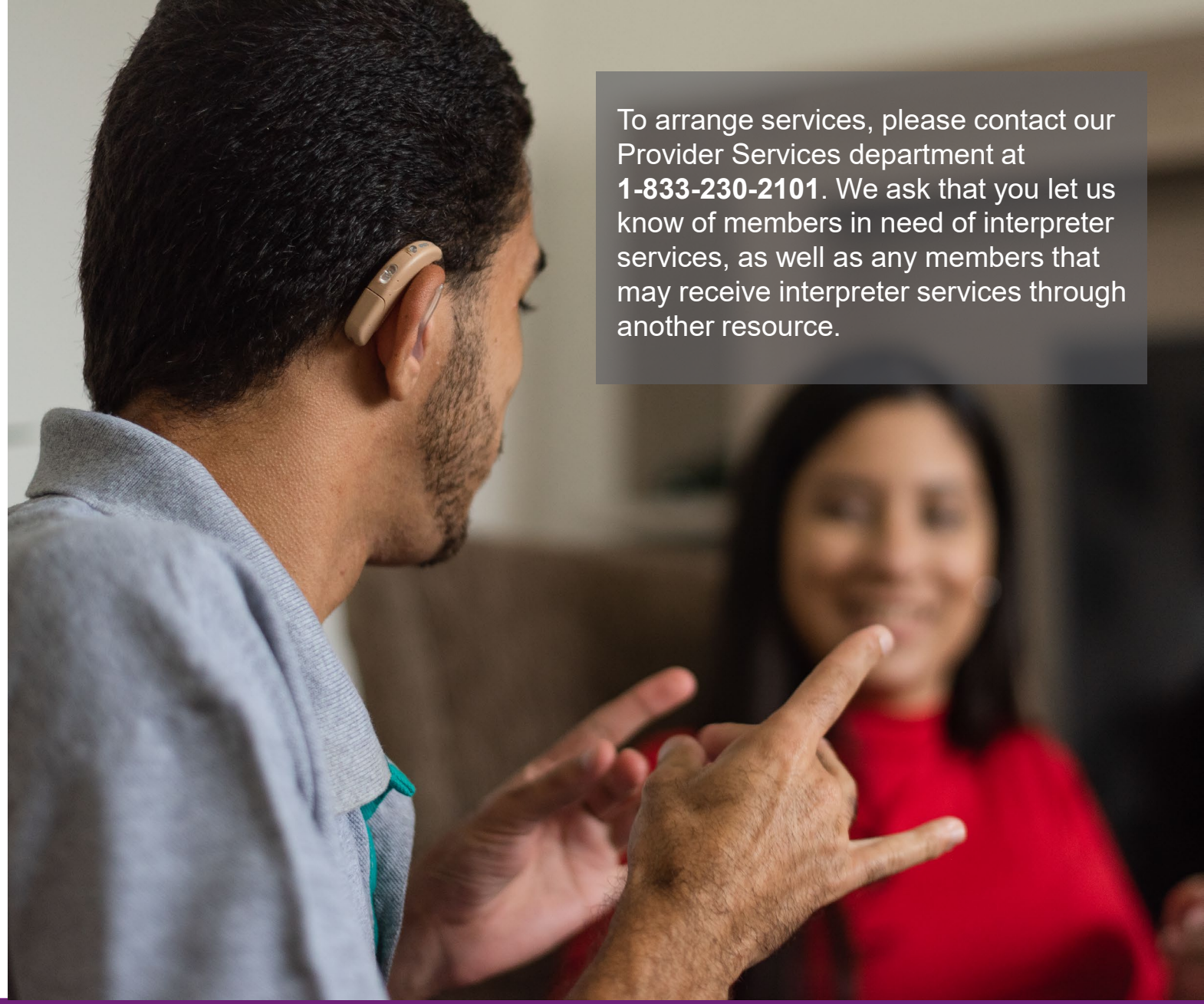
CareSource Member Incentives

- Adult members (18+) are automatically enrolled and remain eligible as long as they maintain active coverage with CareSource.
- After claims are processed for the rewardable activity, members can login to their CareSource MyLife account to redeem for their choice of gift cards to a variety of retailers.

Activity	Who's Eligible	Reward Amount
Colorectal Cancer Screening	Adults 45-75	$25
Breast Cancer Screening	Females age 50-74	$25
Chlamydia Screening	Females age 18-24	$25
Diabetes Care: A1c Test	All adults—Diagnosis of Diabetes required	$25
Diabetes Care: Eye Exam		$25
Diabetes Care: Kidney Health Evaluation		$25

Translation ***Services***

- Language and sign interpretation
- CareSource offers onsite sign and language interpreters, as well as over-the phone interpreting (OPI) and video remote interpreting (VRI) services for members who are hearing impaired, do not speak English or have limited English-speaking proficiency
- Available at no cost to the member or provider
- As a provider, you are required to identify the need for interpreter services for your CareSource patients and assist appropriately



To arrange services, please contact our Provider Services department at **1-833-230-2101**. We ask that you let us know of members in need of interpreter services, as well as any members that may receive interpreter services through another resource.

Prior Authorizations

CareSource®

WV Senate Bill 267 Prior Authorization ***Requirements***

Providers must submit **MEDICAL** prior authorizations electronically via the Provider Portal.

CareSource will only accept one medical prior authorization per episode of care.

CareSource will determine prior authorization requests within the following turnaround times:

1. Urgent: two business days
2. Standard: five business days
3. If information is incomplete, CareSource will return the prior authorization within two business days. The provider shall provide the required information within three business days. CareSource shall then render a decision within two business days of receiving the complete information. If the provider does not submit the required additional information, the prior authorization will be considered denied and a new request shall be submitted

Providers *must sign in through the CareSource Provider Portal* to access SureScripts, CoverMyMeds, NantHealth Eviti for Oncology requests, cardiac and musculoskeletal surgical procedures

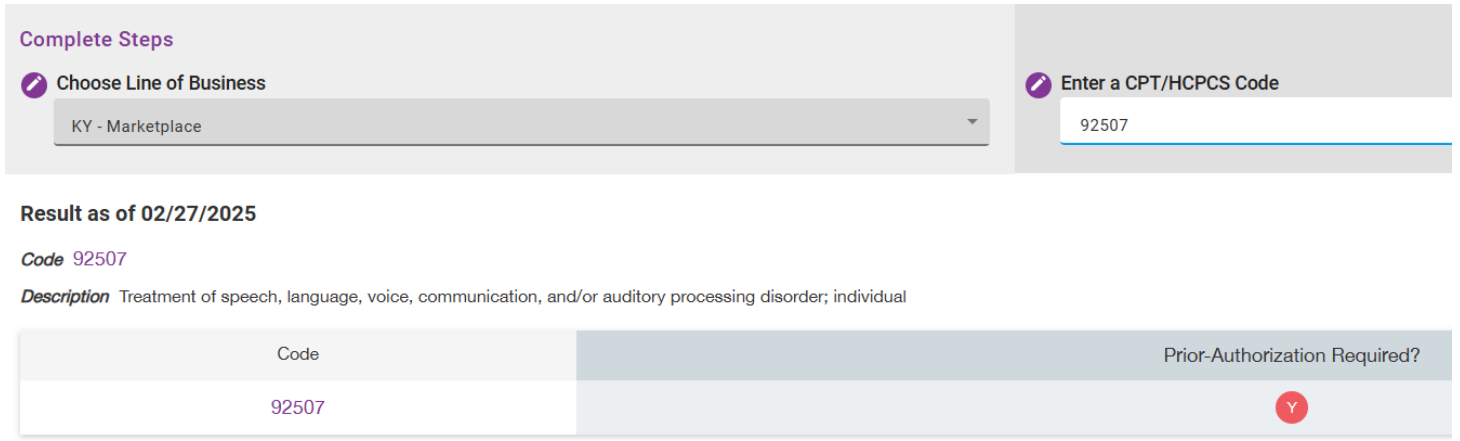
Prior Authorization *Services*

Some services require prior authorization.

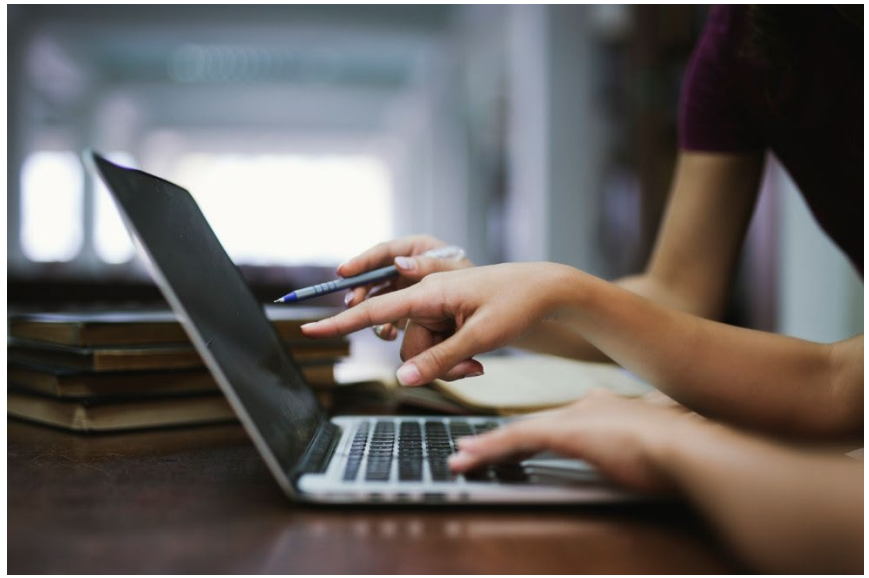
Log in to the Provider Portal at **CareSource.com** > Provider > Log-In to access the Procedure Code Look-Up Tool and search for services requiring prior authorizations.

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

Per WV Senate Bill 267, effective July 1, 2024, all providers are required to submit prior authorization requests electronically. Please note that faxed requests and phone requests will NOT be accepted.



Prior Authorization ***Services***



All retrospective authorization requests must be submitted within 30 calendar days of the date of service or date of discharge or as specified in a provider contract. The only exception is a COB denial, then there is 90 days from the other insurance notification.

PRIOR AUTHORIZATION SUBMISSION REQUIREMENTS

- Member name and CareSource member ID number
- Provider name and National Provider Identifier (NPI)
- 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: We do not require in-network providers to obtain a prior authorization for an office visit.

Prior Authorization ***Submissions***

*In West Virginia, providers **must** submit requests through the Provider Portal.*

	Marketplace
Portal	At **CareSource.com** through the Provider Portal This is the only acceptable way to request an authorization for West Virginia providers.
Online	mmHIX-Just4Me@CareSource.com
Phone	**1-833-230-2101**
Fax	844-676-0372
Mail	CareSource Attn: Utilization Management P.O. Box 1307 Dayton, OH 45401-1307

CareSource ***Vendor List***

Vendor	Service Description
Avalon	Lab Benefits/Services
Evolent	Prior Authorization/Utilization Management (UM) Review Radiology and Cardiac
TurningPoint	UM Review of Musculoskeletal and Cardiac Surgical Procedures
Eye Med	Routine Vision Benefit
Teladoc®	Telehealth – includes primary care, behavioral health and other specialty care

View CareSource plan benefits at

Benefits and Services | West Virginia – Marketplace | CareSource

Benefits and Services | Kentucky – Marketplace | CareSource

Prior Authorization *Evolent*

CareSource utilizes Evolent to implement a radiology benefit management program for outpatient advanced imaging services.

Procedures Requiring Prior Authorization through Evolent	Services Not Requiring Prior Authorization through Evolent	Evolent Authorization Phone Number
• CT/CTA • MRI/MRA • PET Scan	• Inpatient advanced imaging services • Observation setting advanced imaging services • Emergency room imaging services	Marketplace: **1-800-424-1746**
Evolent Customer Service: 1-410-953-1078 | ajsidwa@magellanhealth.com		

Expedited authorizations are accepted. Register at: RadMD.com

More resources on Evolent imaging may be found at **CareSource.com/Providers**

Prior Authorizations *TurningPoint Healthcare Solutions*

CareSource utilizes TurningPoint to implement cardiac and musculoskeletal surgical procedures.

Turning Point Authorization	Turnaround Times	Required Information
Marketplace: Phone: 1-304-603-4673 1-855-578-7350 Fax Intake Form: 304-553-7061 844-472-0481 TurningPoint Portal	• Standard non-urgent = 5 calendar days • Expedited Requests = 72 hours • Retrospective requests = 30 calendar days from the date on which the vendor received the authorization request	• Provider information • Facility information • Anticipated surgery date • Health plan information • Member demographics • Requested procedures/diagnosis • Clinical Information
Turning Point Customer Service Phone: 1-866-422-0800 email: ProviderSupport@tpshealth.com		

Please contact CareSource directly for appeals and claims

***WV Providers must use the Provider Portal**

Prior Authorization ***Avalon Healthcare Solutions***

CareSource utilizes Avalon to implement a labs benefit manager

Avalon develops and maintains policies; CareSource adapts, adopts and approves of enforcement

Avalon Policy Department	CareSource Policy Adoption
• Avalon's full time science team reviews scientific publications, professional society guidelines, public health concerns and Medicare NCDs, LCDs • Avalon policy team authors new and revised policies • Independent Clinical Advisory Board conducts quarterly review of existing and proposed policies • 100% of policies reviewed and updated at least annually	• CareSource reviews, modifies and approves all policies. • CareSource publishes link to lab policies per state regulations • Quarterly reviews • Communication to lab partners of policy changes ongoing

Laboratory | Kentucky – Marketplace | CareSource
Laboratory | West Virginia – Marketplace | CareSource

Examples of Avalon Policy Enforcement Application

Rules correspond to the criteria as defined in CareSource policy

Rule	Definition
Diagnosis Constraints and Allowances	Procedure and Diagnosis required or prohibited combinations
Demographics	Limitations based on patient age or gender
Procedure Units	Within and across claim for a Date of Service
Units/Period of Time	Maximum allowable units within a defined period of time
Time Between Procedures	Minimum time required before a second procedure is clinically appropriate

Care Management & Quality

CareSource®

Care Management *Program*

OUR CARE MANAGEMENT PROGRAM

- All members may choose to engage with Care Management.
- All members are given a complete Health Risk Assessment (HRA) to determine their care management needs.
- Care Managers work with members to create plans of care to support their needs.
- Care Managers also receive alerts of Emergency Department visits and inpatient stays.

USE OUR PROVIDER PORTAL TO:

- Refer a patient for Care Management
- Identify the Care Manager assigned to a patient
- Find contact information for Care Manager
- Interact with coordination options

Care Management

Disease Management

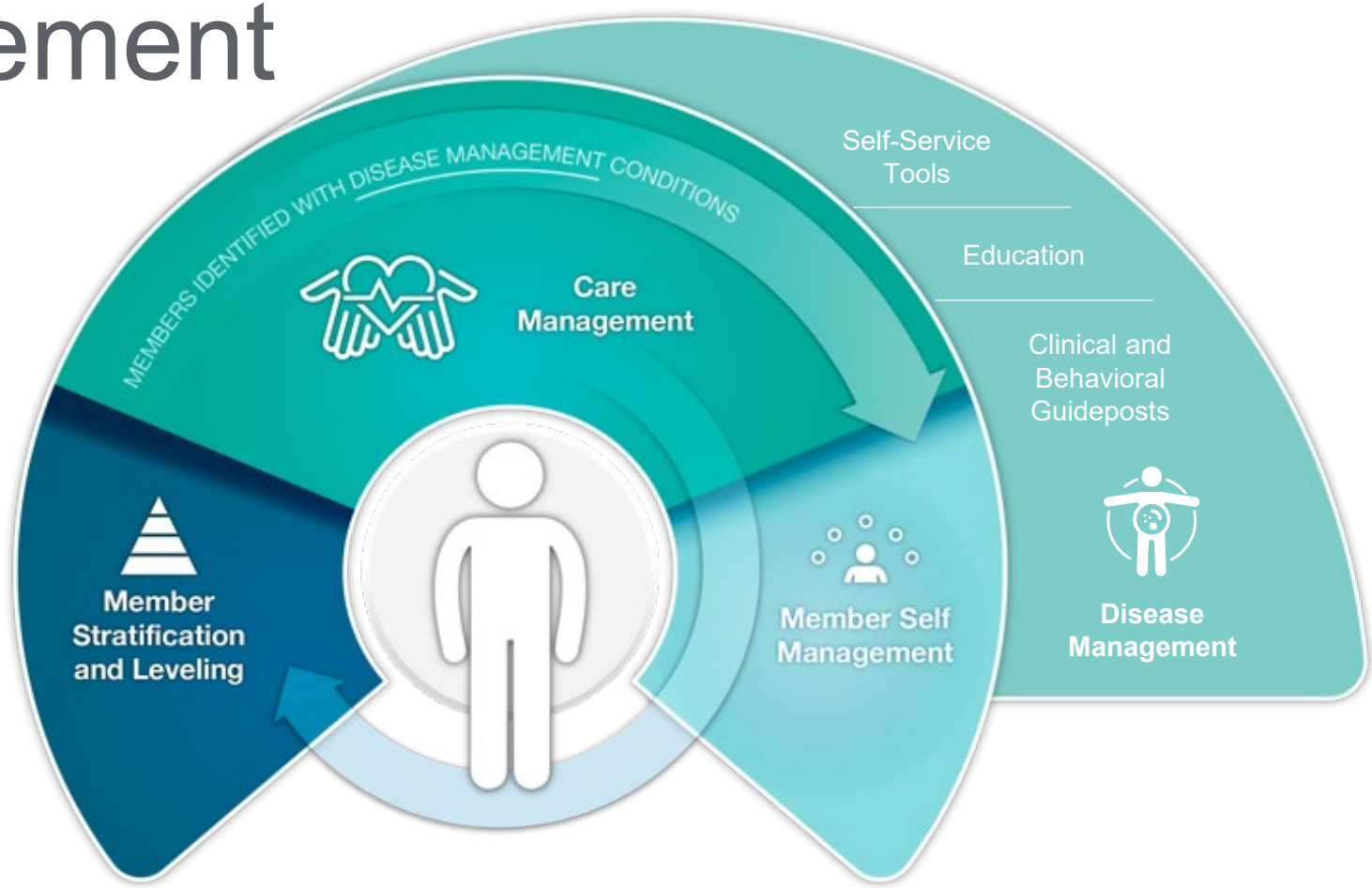
Specialized Coaching Programs

Our team partners with members and their caregivers to achieve health and wellness goals. We have developed several programs which focus on management of specific diseases including:

- CKD
- ESRD
- Diabetes
- Asthma
- Hypertension

Program content is tailored to targeted conditions and includes:

- Condition monitoring
- Adherence to treatment plans
- Health behaviors
- Psychosocial issues
- Encouraging patients to communicate with their practitioners about their health conditions and treatment



Care Management Specialty Program

NICU Neonatal Intensive Care Unit

Our NICU Integrated Care Program focuses on coordinating clinical management with our facilities and providers in a collaborative way to reduce length of stay (LOS) and readmission rates and ensure general excellence in inpatient and post-discharge care management.

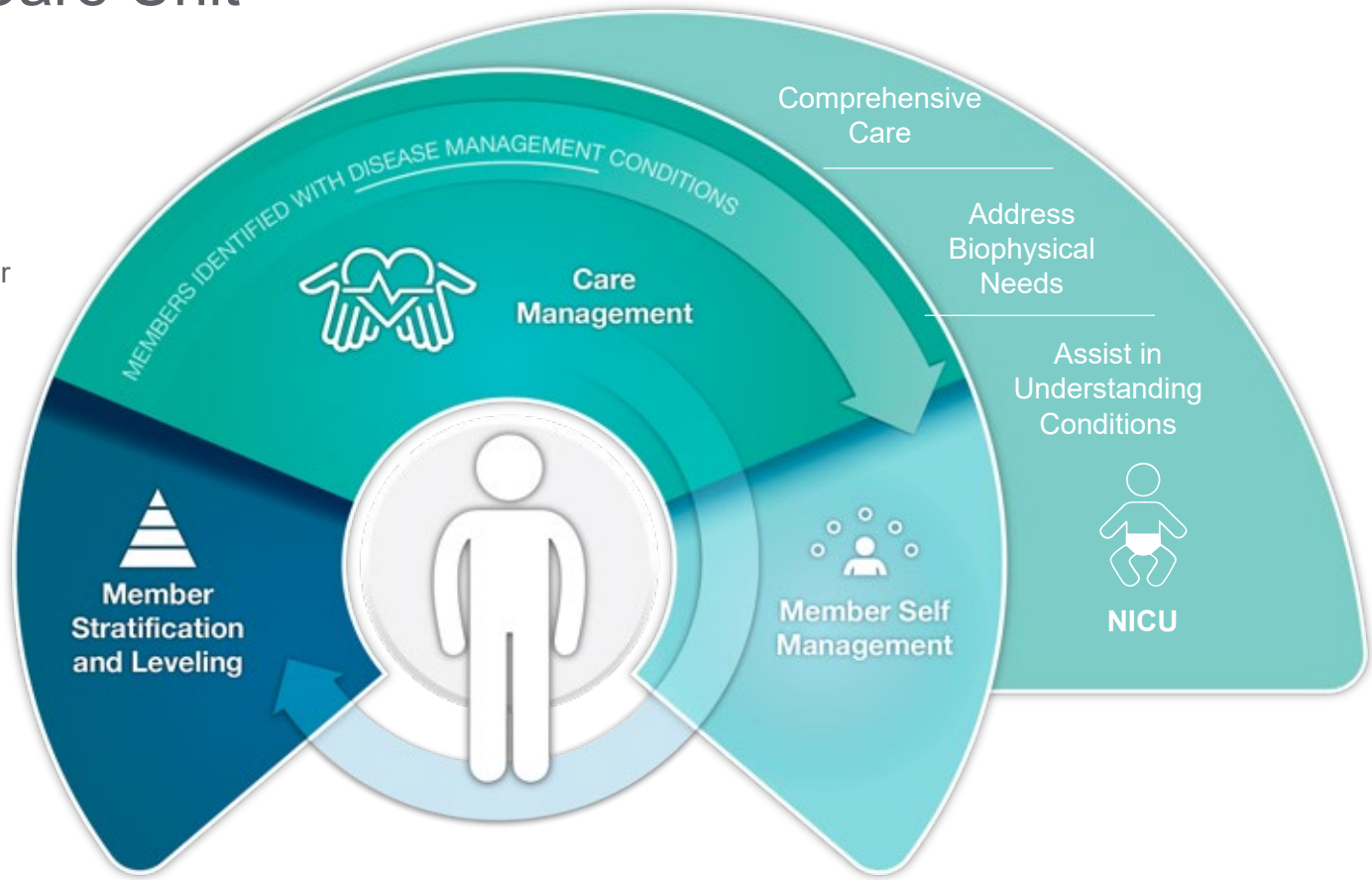
- Current data shows ALOS 11.2 days (goal < 20); Readmit rate < 3% for our Marketplace members

The team is guided by team of nurses and doctors who specialize in this population, including:

- Neonatologist
- Neonatal Nurse Practitioner
- Perinatal Loss Program

The CareSource NICU program supports our youngest and most fragile members and their families through:

- Providing comprehensive and supportive care while inpatient
- Collaboration with facility's discharge planner to promote a safe and timely discharge
- Providing Care Management to postpartum mothers, including members with a Serious Mental Illness (SMI) or Substance Use Disorder (SUD).



To refer members to NICU team, call 1-833-230-2037 or via email at NICU@CareSource.com.

Care Management Specialty Program

Mom & Baby Beginnings

The CareSource Mom & Baby Beginnings program is designed to improve the health status of our mother's and decrease clinical complications in our youngest and most fragile members and their families.

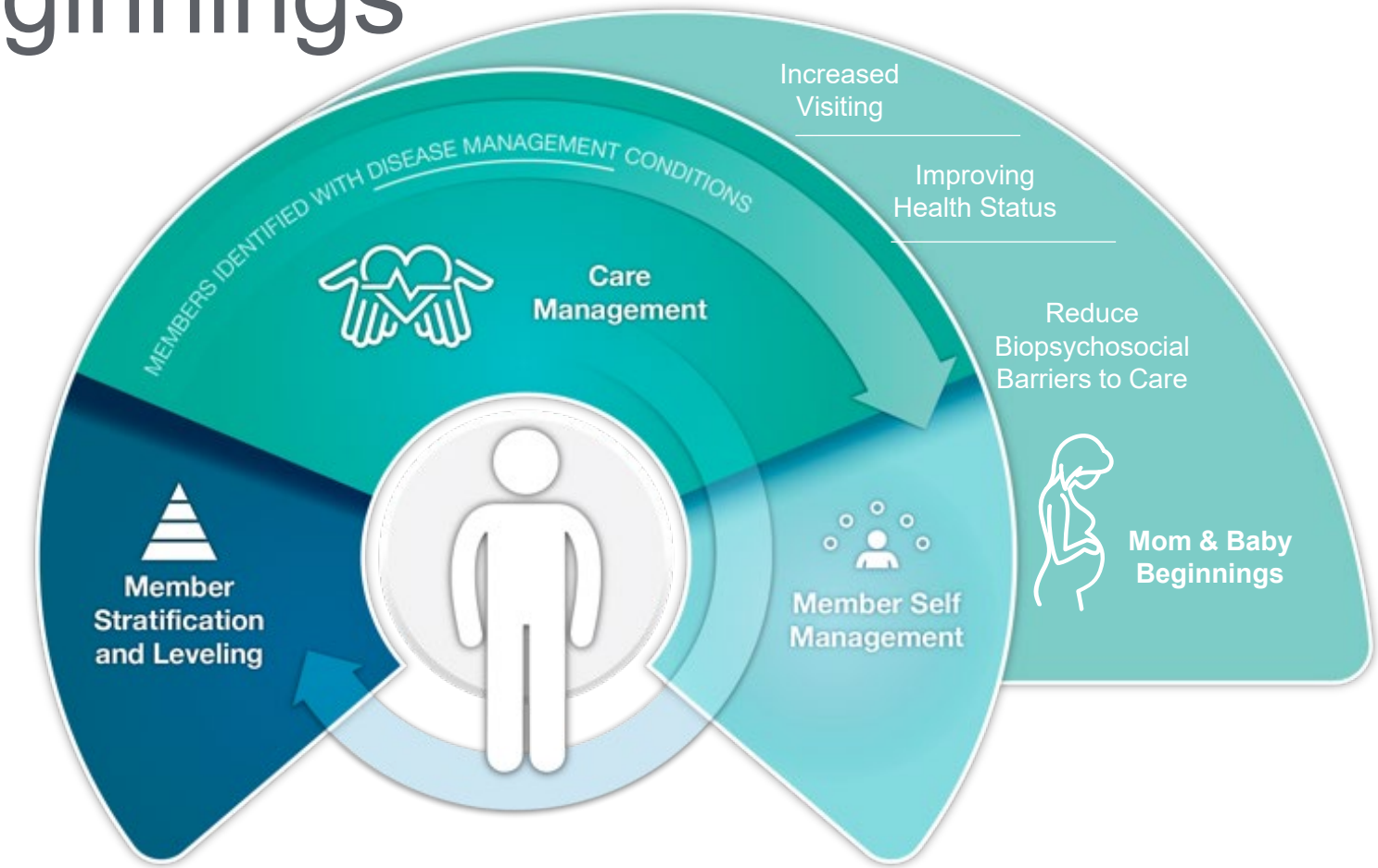
The team boast specialty staff and programs including:

- Nurse Practitioners for post-partum visits
- Certified Lactation Consultant
- Pregnancy Centering Program
- Remote Patient Monitoring

Through the early and targeted support offered by our Mom & Baby program, CareSource remains focused on:

- Increasing prenatal care and post-partum visit attendance
- Reducing neonatal admission
- Improving the health status of our mothers
- Reduce biopsychosocial barriers to care

To make referrals to the Mom & Baby team, call 1-833-230-2034.



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 are recognized as significant contributors to member 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**. The national Culturally and Linguistically Appropriate Services (CLAS) provides 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, as well as making a positive impact in the lives of our members by:

- Eliminating health disparities
- Supporting our organization's health equity initiatives
- Partnering with community stakeholders

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 vaccinations
- Immunizations for adolescents
- Breast cancer and cervical cancer screenings
- Colorectal cancer screening

Cardiovascular Conditions

- Controlling high blood pressure
- Comprehensive diabetes care
- Statin therapy for patients with cardiovascular disease or diabetes

Behavioral Health

- Follow-up after hospitalization for mental illness
- Depression screening and follow-up

Access to Care

- Children and adolescents' access to primary care providers
- Prenatal and postpartum care

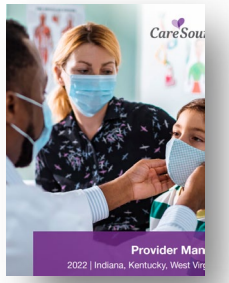
Quality ***Resources***

Quality Onboarding Training

Clinical Practice Registry Training

Clinical Practice Registry Quick Tips

Quick Reference Guides



Quality Patient Experience Guide

HEDIS Coding Guides

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 evaluation
- 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 enhance 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.

Note: Providers are required to attest to completing the training after viewing.

CALL: Provider Services at **1-855-230-2101**

FAX: 1-800-418-0248

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 works collectively with Express Scripts, our delegated pharmacy benefit manager (PBM), to manage our prescription drug costs, as well as develop and implement plan-specific formulary or formularies.

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 records (EMR), electronic health records (EHR), or e-prescribing vendor.

RESOURCES

- Find authorization requirements for prescriptions at **CareSource.com** > Pharmacy. Select your plan from the dropdown menu for specific requirements.
- The Formulary search tool and prior authorization lists are available on **CareSource.com.**
- 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
No member cost share. This tier contains preventive medications.	Contains low-cost drugs, like generics.	Higher coinsurance or copayment than those in Tier 1. This tier contains higher cost drugs like higher cost generics or preferred brand-name drugs.	Higher coinsurance or copayment than those in Tier 2. This tier contains higher cost drugs like very expensive generics or non-preferred brand-name drugs.	Higher coinsurance or copayment than those in Tier 3. This tier contains highest cost drugs including those usually classified as specialty drugs.

Visit **CareSource.com** > Pharmacy if you wish to access our full formulary list.

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/

Strategic Visit Design

- Individualized meetings
- Review your provider roster
- Review any new CareSource updates
- Your CareSource membership
- Claims scorecard for your practice
- Denial dashboard
- Quality initiatives specific to your office
- Closing care gaps
- Discuss any concerns or issues you may have with CareSource

CareSource ***Contacts***

	Marketplace	
Dr. Griffin Chief Medical Officer	1-502-377-0607	
Provider Services	1-833-230-2101	
Member Services	1-833-230-2099	
Utilization Management Fax	844-676-0372	
Email	mmHIX-Just4Me@CareSource.com	
Electronic Funds Transfer	ECHO Health: 1-888-485-6233	
Electronic Claims Submission	***Kentucky:*** KYCS1 | ***West Virginia:*** WVCS1	
Claim Address	***Kentucky*** CareSource Attn: Claims Department P.O. Box 824 Dayton, OH 45401-824	***West Virginia*** CareSource Attn: Claims Department P.O. Box 8041 Dayton, OH 45401-8041
Timely Filing	***Kentucky***: 90 days from date of service or discharge ***West Virginia***: 180 calendar days from date of service or discharge	
CareSource24® Nurse Line	***Kentucky***: 1-866-206-7879 ***West Virginia***: 1-866-206-0701	

Webinar Registration

Risk Adjustment Overview and Documentation Best Practices

Get a fast-track overview of Risk Adjustment and Documentation Best Practices in a short 15 min webinar with our CareSource Provider Educators

Topics:

- ✓ Government Oversight
- ✓ Overview of Risk Adjustment
- ✓ Documentation Best Practices
- ✓ Common Documentation Errors
- ✓ Open Floor Q & A

Scan the QR code or click on the link to register!

https://forms.office.com/r/Y7X5uKAAtc

Are you contracted with all our plans?

Join us on our journey to healthy outcomes.

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

CareSource®

PARTNER with *Purpose*

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