



Allwell from Superior HealthPlan

Provider Orientation

Agenda



- Plan Overview
- Membership
- Benefits and Additional Services
- HMO Benefit Overview
- HMO SNP Benefit Overview
- Providers and Authorizations
- Preventive Care and Screenings
- Medicare Star Ratings
- Web-Based Tools
- Network Partners
- Billing Overview
- Electronic Funds Transfer and Electronic Remittance Advice
- Meaningful Use - Electronic Medical Records
- Advance Directives
- Regulatory Matters
- Fraud, Waste and Abuse
- CMS Mandatory Trainings
- Model of Care
- Questions and Answers







Plan Overview

Medicare 101



Medicare is a federal health insurance program for people 65 years of age and older (under 65 with qualifying disabilities). It is made up of the following parts:

Part A	Hospital Insurance 	This portion pays for hospital stays, skilled nursing facilities and hospice stays.	Part C	Medicare Insurance 	Medicare Advantage plans such as HMO's and PPO's. MA plans cover the same services as traditional Medicare and may offer prescription drug coverage (Part D), dental, vision and hearing care.
Part B	Medical Insurance 	This pays for doctors' services – both inpatient and outpatient – as well as lab services, medical equipment and supplies.	Part D	Rx Coverage 	This pays for prescription drugs for home use.

Medicare 101 – Election Period



Annual Election Period (AEP)

October 1 – December 7

Add, drop, or change Medicare Advantage and/or Prescription Drug Plan (PDP) coverage.

Plan changes are effective January 1 of the following year.

3 months before
your birth month

Special Election Periods (SEP)

Dates vary;
Rules are based on the specific SEP

Add or change a Medicare Advantage plan or PDP (strictly controlled)

Examples:

- Special Needs Plan (SNP) eligibility
- Medicaid or Extra Help eligibility
- A move out of a plan's service area
- Loss of group insurance

3 months after
your birth month

**Initial
Enrollment**

65th birthday month

Overview: Allwell Plans



- Allwell is a Medicare Advantage plan.
- We provide quality health care you would expect from a big company, but delivered on a local level.
- Superior's members benefit from strategic care coordination and programs through the strong and collaborative relationships we build with health-care providers and community organizations.
- Allwell is designed to give members:
 - Affordable health-care coverage.
 - Benefits they need to take good care of themselves.
 - Access to doctors, nurses and specialists who work together to help them feel their best.
 - Coverage for prescription drugs.
 - Extra benefits that are not covered by Medicare Part A or Part B (Original Medicare).

Overview: Allwell Plans



- Allwell provides complete continuity of care to Medicare members.
- This includes:
 - Integrated coordination care.
 - Care management.
 - Co-location of behavioral health expertise.
 - Integration of pharmaceutical services with the Pharmacy Benefits Manager (PBM).
 - Additional services specific to the beneficiary needs.
- Superior's approach to care management facilitates the integration of community resources, health education and disease management.
- Allwell promotes members' access to care through a multidisciplinary team, including registered nurses, social workers, pharmacy technicians and behavioral health case managers, all co-located in a single, locally based unit.

Allwell Medicare (HMO)



- Superior offers non-dual HMO plans. These HMO plans cover all Medicare-required services, along with a prescription drug benefit. HMO plans (unlike HMO SNP and MMP) do not require Medicaid to enroll.
 - Most Medicare plans (sometimes referred to as "Part C") include the Part D prescription drug benefit plan. This is Superior's Allwell Medicare (HMO) plan.
 - HMO plans cover the most commonly prescribed drugs. However, each specific Part D plan may determine which drugs are covered. The covered drugs are included in the plan's formulary, or list of drugs:
Allwell.SuperiorHealthPlan.com/drug-pharmacy/formulary.html

Allwell Dual Medicare (HMO SNP)



- Allwell Dual Medicare (HMO SNP) is a plan for individuals with specific conditions or financial needs who are eligible for both Medicare and medical assistance from Texas Medicaid.
- For HMO SNP members, Medicare is always the primary payor and Medicaid is secondary payor.
- HMO SNP members may have both Superior Medicare and Superior Medicaid but not always, so it is important to verify coverage prior to servicing the member.

Please note: You may see members with Superior Medicare where their Medicaid is under another health plan or traditional Fee-For-Service (FFS) Medicaid or vice versa.



Membership

Membership



- Medicare beneficiaries have the option to stay in the original Fee-For-Service Medicare plan or choose a Medicare Advantage Plan, such as Allwell from Superior HealthPlan.
- Allwell members may change Primary Care Providers (PCPs) at any time. Changes take effect on the first day of the month.
- Providers should verify eligibility before every visit by using one of the options below:
 - Secure Provider Portal: Provider.SuperiorHealthPlan.com
 - 24/7 Interactive Voice Response Line: 1-800-218-7453
 - Provider Services: HMO and HMO SNP – 1-877-391-5921

Member ID Card



SAMPLE CARD FRONT

Plan Name

Product Name

Plan Contract Number

Member Effective Date

MEMBER INFORMATION

NAME: Name A. Sample

MEMBER ID#: 000000000-00

ISSUER ID: (00000) 0000000000

PROVIDER INFORMATION

PCP Name: Name Sample, MD

PCP Phone: 000-000-0000

HMO

CMS#: H0000-000

Effective: 00/00/0000

PHARMACY INFORMATION

MedicareRx

RxClaims Processor:

Rx Processor Name*

RXBIN: 000000

RXPCN: XXXXXXXX

RXGRP: RX0000

Member Information

Provider Information

Pharmacy Claims Filing Information

SAMPLE CARD BACK

Eligibility Confirmation

Part D Drug Claims Address

FOR MEMBERS

Member Services: 1-000-000-0000 (TTY: 711)

24-hr Nurse Advice: 1-000-000-0000

<https://allwell.stateplan.com>

FOR PROVIDERS

For eligibility: 1-000-000-0000

Prior authorization or case management referrals: 1-000-000-0000

Pharmacy prior auth: 1-000-000-0000

For help: (PHARMACY USE ONLY) 1-000-000-0000

MEDICAL CLAIMS

EDI Payor ID: 00000

Allwell-Attn: Claims

P.O. Box 0000 Anytown, ST 00000-0000

FOR EMERGENCIES

Dial 911 or go to the nearest Emergency Room (ER).

Submit Part D Drug Claims to:

Allwell-Attn: Pharmacy Claims

P.O. Box 000000

Anytown, ST 00000-0000

Prior Authorization or Case Management

Pharmacy Prior Authorization

Medical Claims Address



Benefits and Additional Services

Plan Coverage



Allwell covers:

- All Part A and Part B benefits by Medicare.
- Part B drugs – such as chemotherapy drugs.
- Part D drugs – no deductible at network retail pharmacies or mail order*
- Additional benefits and services such as:
 - Dental
 - Vision
 - No Cost/Low Cost PCP copay*
 - \$0 generic prescription drugs
- For a summary of plan benefits, visit: Allwell.SuperiorHealthPlan.com/plan-benefit-materials.html

**Dependent on plan*

Pharmacy Formulary



- The Allwell formulary is available at Allwell.SuperiorHealthPlan.com/drug-pharmacy/formulary.html.
 - Please refer to the formulary for specific types of exceptions.
- When requesting a formulary exception, a Drug Coverage Redetermination form must be submitted. These forms can be found under the 'Redeterminations' section of the Coverage Determinations and Redeterminations for Drugs webpage:
 - Allwell.SuperiorHealthPlan.com/drug-pharmacy/coverage-determinations-redeterminations.html
 - The completed form can be faxed to Envolve Pharmacy Solutions at 1-866-226-1093.

Covered Services



- Covered Services include, but are not limited to:
 - Ambulance
 - Behavioral Health
 - Dental
 - Hearing
 - Hospital Inpatient/Outpatient
 - Lab and X-Ray
 - Medical Equipment and Supplies
 - Physician
 - Podiatry
 - Prescribed Medicines
 - Therapy
 - Transportation*
 - Vision
 - Wellness Programs

**Specific counties only.*

Additional Benefits



- Hearing Services
 - \$0 co-pay for 1 routine hearing test every year.
 - \$0 co-pay for 1 hearing aid fitting evaluation.
 - \$500 to \$1,000 coverage limit per year for hearing aids (dollar coverage dependent upon service area); 1 hearing aid every year.
- Dental Services
 - 2 Oral exams per year with no co-pay.
 - 2 Cleanings per year with no co-pay.
 - 1 Dental X-Ray per year with no co-pays.
 - \$2,000 to 4,000 in comprehensive dental benefits per year (dollar coverage dependent upon plan/service area).

Additional Benefits



- Vision Services
 - 1 routine eye exam every year.
 - 1 pair of glasses or contacts lenses every year.
 - Coverage for eyewear each year (dollar coverage dependent upon service area).
- Over-The-Counter Items
 - Commonly used over-the-counter items:
Allwell.SuperiorHealthPlan.com/content/dam/centene/Medicare%20Blueprint%20Documents/2021-OTC-ALLWELL-RETAIL.pdf
 - Conveniently shipped to member's home within 5 – 12 business days.
 - Call Member Services at 1-866-528-4679 to order items.

Additional Benefits



- 24-Hour Nurse Advice Line
 - Free health information line staffed with registered nurses 24/7 to answer health questions.
- Certified fitness program at specified gyms at no extra cost

Additional Services



- Multi-language Interpreter Services
 - Interpreter services are available at no cost to Allwell members and providers without unreasonable delay at all medical points of contact. To get an interpreter, call member services at:
 - HMO: 1-844-796-6811 (TTY: 711)
 - HMO SNP: 1-877-935-8023 (TTY: 711)
- Non-Emergency Transportation
 - Covered for a specified number (dependent upon the member's service area) of one-way trips per year, to approved locations.
 - Schedule trips 48 hours in advance using the plan's contracted providers.
 - Contact us at 1-877-718-4201 to schedule non-emergency transportation.

Network



- HCA/Methodist
- Texas Tech
- University Hospital –Bexar, El Paso
- El Paso Medical Network
- Christus Santa Rosa Health
- Doctors Hospital at Renaissance (DHR)
- Mission Health
- Baptist health System
- Southwest General Hospital
- Texas Health Resources (THR)



HMO Benefit Overview

HMO Benefits at a Glance – H0062_001



- Aransas
- Bexar
- Comal
- El Paso
- Guadalupe
- Jim Wells
- Nueces
- Wilson

PCP Visit	\$0 copay
Specialist	\$35 copay
Transportation	10 one-way trips
OTC	\$50 every 3 months
Dental	\$0 Preventive Dental: 2 exams, 2 cleanings, 1 bitewing x-ray / year. \$35 Comprehensive Dental with 20-50% coinsurance, max allowance \$1,000 per year.
Max Out-of Pocket	\$7,550
Vision	\$0-\$35 routine eye exam (1 per year) \$150 every year (combined for all eyewear)
Hearing	Level I \$0 copay / hearing aid Level II \$475 copay / hearing aid Level III \$595 copay / hearing aid Level IV \$800 copay / hearing aid Level V \$1350 copay / hearing aid Up to 2 hearing aids total (1 per ear / calendar year)

HMO Benefits at a Glance – H0062_002



- Collin
- Dallas
- Denton
- Rockwall
- Tarrant

PCP Visit	\$0
Specialist	\$30 copay
OTC	\$85 every 3 months
Dental	\$0 Preventive Dental: Two 2 exams, 2 cleanings, 1 bitewing x-ray / year. \$30 Comprehensive Dental with 20-50% coinsurance, max allowance \$1,000 per year.
Max Out-of-Pocket	\$7,550
Vision	\$0 routine eye exam (1 per year) \$150 every year (combined for all eyewear)
Hearing	Level I \$0 copay / hearing aid Level II \$700 copay / hearing aid Level III \$1125 copay / hearing aid Level IV \$1580 copay / hearing aid Up to 2 hearing aids total (1 per ear / calendar year)

HMO Benefits at a Glance – H0062_003



- Cameron
- Hidalgo
- Starr

PCP Visit	\$0 copay
Specialist	\$30 copay
Transportation	30 one-way trips
OTC	\$70 every 3 months
Max Out-of-Pocket	\$7,550
Dental	\$0 Preventive Dental: 2 exams, 2 cleanings, 1 bitewing x-ray / year. Max allowance \$1,000 per year.
Vision	\$0-\$30 routine eye exam (1 per year) \$100 every year (combined for all eyewear)
Hearing	Level I \$0 copay / hearing aid Level II \$475 copay / hearing aid Level III \$595 copay / hearing aid Level IV \$800 copay / hearing aid Level V \$1350 copay / hearing aid Up to 2 hearing aids total (1 per ear/ calendar year)

HMO Benefits at a Glance – H5294_011



- Aransas
- Bee
- Brooks
- Cameron
- Goliad
- Hidalgo
- Jim Hogg
- Jim Wells
- Kenedy
- Kleberg
- Nueces
- Refugio
- Starr
- Willacy
- Zapata

PCP Visit	\$0 copay
Specialist	\$25 copay
Transportation	50 one-way trips
OTC	\$90 every 3 months
Max Out-of-Pocket	\$3,450
Dental	\$0 Preventive Dental: 2 exams, 2 cleanings, 1 bitewing x-ray / year. Comprehensive Dental with max allowance \$2,000 per year.
Vision	\$0-\$25 copay routine eye exam (1 per year) \$250 every year (combined for all eyewear)
Hearing	Level I \$0 copay / hearing aid Level II \$475 copay / hearing aid Level III \$595 copay / hearing aid Level IV \$800 copay / hearing aid Level V \$1350 copay / hearing aid Up to 2 hearing aids total (1 per ear / calendar year)

HMO Benefits at a Glance – H5294_012



- Aransas
- Bee
- Brooks
- Cameron
- Goliad
- Hidalgo
- Jim Hogg
- Jim Wells
- Kenedy
- Kleberg
- Nueces
- Refugio
- Starr
- Willacy

PCP	\$5 copay
Specialist	\$50 copay
OTC	\$20 every 3 months
Max Out-of-Pocket	\$7,550
Dental	\$0 Preventive Dental: 2 exams, 2 cleanings, 1 bitewing x-ray / year. \$50 Comprehensive Dental with max allowance \$1,000 per year.
Vision	\$0-\$50 copay routine eye exam (1 per year) \$150 every year (combined for all eyewear)
PERS	Personal Emergency Response System
Hearing	\$50 routine hearing exam (1 per year), Level I \$0 copay per hearing aid Level II \$700 copay per hearing aid Level III \$1,125 copay per hearing aid Level IV \$1,580 copay per hearing aid up to 2 hearing aids total (1 per year, per calendar year)

HMO Benefits at a Glance – H5294_013



- Aransas
- Bee
- Brooks
- Cameron
- Goliad
- Hidalgo
- Jim Hogg
- Jim Wells
- Kenedy
- Kleberg
- Nueces
- Refugio
- Starr
- Willacy
- Zapata

PCP	\$0 copay
Specialist	\$20 copay
Transportation	50 one-way medical trips every year
Max Out-of-Pocket	\$3,450
OTC	\$100 every 3 months
Dental	\$0 Preventive Dental: 2 exams, 2 cleanings, 1 bitewing x-ray / year. \$20 Comprehensive Dental with max allowance \$2,000 per year.
Vision	\$0-\$20 copay routine eye exam (1 per year) \$300 every year (combined for all eyewear)
Hearing	\$20 routine hearing exam (1 per year), \$0 hearing aid fitting/ evaluation (1 per year) Level I \$0 copay per hearing aid Level II \$475 copay per hearing aid Level III \$595 copay per hearing aid Level IV \$800 copay per hearing aid Level V \$1,350 copay per hearing aid up to two (2) hearing aids total (1 per year, per calendar year)

HMO Benefits at Glance – H5294_014



Aransas, Armstrong, Atascosa, Bailey, Bandera, Bastrop, Bee, Bexar, Blanco, Borden, Bosque, Briscoe, Brooks, Burnet, Caldwell. Calhoun, Cameron, Castro, Cochran, Coke, Collin, Colorado, Comal, Crosby, Dallas, Denton, DeWitt, Dickens, Dimmit, Donley, Duval, El Paso, Erath, Fayette, Fisher, Floyd, Garza, Gillespie, Glasscock, Goliad, Gonzales, Grimes, Guadalupe, Hale, Hamilton, Hays, Hidalgo, Hill, Hockley, Hunt, Irion, Jack, Jim Hogg, Jim Wells, Karnes, Kendall, Kenedy, Kent, Kimble, Kleberg, La Salle, Lamb, Lee, Leon, Limestone, Lubbock, Lynn, Martin, Mason, Maverick, McCulloch, McMullen, Medina, Milam, Mills, Mitchell, Navarro, Nolan, Nueces, Palo Pinto, Real, Refugio, Rockwall, San Saba, Shackelford, Somervell, Starr, Sterling, Swisher, Tarrant, Terry, Throckmorton, Uvalde, Willacy, Williamson, Wilson, Zapata, Zavala

PCP	\$0 copay
Specialist	\$25 copay
Transportation	30 one-way medical trips every year
OTC	\$100 every 3 months
Max Out-of-Pocket	\$3,450
Dental	\$0 Preventive Dental: Two (2) exams, two (2) cleanings, one (1) bitewing x-ray/ year.
Vision	\$0-\$25 copay routine eye exam (1 per year) \$350 every year (combined for all eyewear)
Hearing	\$25 routine hearing exam (1 per year), \$0 hearing aid fitting/ evaluation (1 per year) Level I \$0 copay per hearing aid Level II \$475 copay per hearing aid Level III \$595 copay per hearing aid Level IV \$800 copay per hearing aid Level V \$1,350 copay per hearing aid up to two (2) hearing aids total (1 per year, per calendar year)

HMO Benefits at a Glance – H5294_016



Armstrong, Atascosa, Bailey, Bandera, Bastrop, Bexar, Blanco, Borden, Bosque, Briscoe, Burnet, Caldwell, Calhoun, Castro, Cochran, Coke, Collin, Colorado, Comal, Crosby, Dallas, Denton, DeWitt, Dickens, Dimmit, Donley, Duval, El Paso, Erath, Fayette, Fisher, Floyd, Garza, Gillespie, Glasscock, Gonzales, Grimes, Guadalupe, Hale, Hamilton, Hays, Hockley, Hill, Hunt, Irion, Jack, Karnes, Kendall, Kent, Kimble, La Salle, Lamb, Lee, Leon, Limestone, Lubbock, Lynn, Martin, Mason, Maverick, McCulloch, McMullen, Medina, Milam, Mills, Mitchell, Navarro, Nolan, Palo Pinto, Real, Rockwall, San Saba, Shackelford, Somervell, Sterling, Swisher, Tarrant, Terry, Throckmorton, Uvalde, Williamson, Wilson, Zavala

PCP	\$0 copay
Specialist	\$30 copay
OTC	\$100 every 3 months
Transportation	30 one-way medical trips every year
Max Out-of-Pocket	\$3,450
Dental	\$0 Preventive Dental: 2 exams, 2 cleanings, 1 bitewing x-ray / year. \$30 Comprehensive Dental with max allowance \$2,000 per year.
Vision	\$0-\$30 copay routine eye exam (1 per year) \$250 every year (combined for all eyewear)
Hearing	\$30 routine hearing exam (1 per year), \$0 hearing aid fitting / evaluation (1 per year) Level I \$0 copay per hearing aid Level II \$475 copay per hearing aid Level III \$595 copay per hearing aid Level IV \$800 copay per hearing aid Level V \$1,350 copay per hearing aid up to 2 hearing aids total (1 per year, per calendar year)

HMO Benefits at a Glance – H5294_017



- Atascosa
- Bandera
- Bexar
- Comal
- Guadalupe
- Karnes
- Kendall
- Medina
- Wilson

PCP	\$0 copay
Specialist	\$30 copay
Transportation	30 one-way medical trips every year
OTC	\$80 ever 3 months
Max Out-of-Pocket	\$4,300
Dental	\$0 Preventive Dental: 2 exams, 2 cleanings, 1 bitewing x-ray / year. \$30 Comprehensive Dental, max allowance \$2,000 per year.
Vision	\$0-\$30 copay routine eye exam (1 per year) \$300 every year (combined for all eyewear)
Hearing	\$30 routine hearing exam (1 per year), \$0 hearing aid fitting / evaluation (1 per year) Level I \$0 copay per hearing aid Level II \$475 copay per hearing aid Level III \$595 copay per hearing aid Level IV \$800 copay per hearing aid Level V \$1,350 copay per hearing aid up to 2 hearing aids total (1 per year, per calendar year)

HMO Benefits at a Glance – H5294_018



- Lubbock

PCP	\$0 copay
Specialist	\$35 copay
Transportation	20 one-way medical trips every year
OTC	\$80 every 3 months
Max Out-of-Pocket	\$4,100
Dental	\$0 Preventive Dental: 2 exams, 2 cleanings, 1 bitewing x-ray / year. \$35 Comprehensive Dental, max allowance \$2,000 per year.
Vision	\$0-\$35 copay routine eye exam (1 per year) \$250 every year (combined for all eyewear)
Hearing	\$35 routine hearing exam (1 per year), \$0 hearing aid fitting/evaluation (1 per year) Level I \$0 copay per hearing aid Level II \$475 copay per hearing aid Level III \$595 copay per hearing aid Level IV \$800 copay per hearing aid Level V \$1,350 copay per hearing aid up to 2 hearing aids total (1 per year, per calendar year)

HMO Additional Benefits



- Member rewards include:

Member Rewards	
Colorectal Exam	\$50 gift card will be mailed after colorectal exam has been completed.
Breast Cancer Screening	\$20 gift card will be mailed after the breast cancer screening has been completed.
Flu Vaccine	\$20 gift card will be mailed after vaccine has been administered.
Wellness Visit	\$20 gift card will be mailed after wellness visit has been completed.
HbA1C	\$20 gift card will be mailed after HbA1c screening has been completed.

- Members also receive access to Superior's 24-Hour Nurse Advice Line.



HMO SNP Benefit Overview

HMO DSNP Benefits at a Glance – H5294_010



Aransas, Armstrong, Atascosa, Bailey, Bandera, Bee, Bexar, Borden, Bosque, Briscoe, Brooks, Calhoun, Cameron, Castro, Cochran, Coke, Collin, Colorado, Comal, Crosby, Dallas, Denton, DeWitt, Dickens, Dimmit, Donley, Duval, El Paso, Erath, Fayette, Fisher, Floyd, Garza, Gillespie, Glasscock, Goliad, Gonzales, Grimes, Guadalupe, Hale, Hamilton, Hidalgo, Hill, Hockley, Hunt, Irion, Jack, Jim Hogg, Jim Wells, Karnes, Kendall, Kenedy, Kent, Kimble, Kleberg, La Salle, Lamb, Leon, Limestone, Lubbock, Lynn, Martin, Mason, Maverick, McCulloch, McMullen, Medina, Mills, Mitchell, Navarro, Nolan, Nueces, Palo Pinto, Real, Refugio, Rockwall, San Saba, Shackelford, Somervell, Starr, Sterling, Swisher, Tarrant, Terry, Throckmorton, Uvalde, Willacy, Wilson, Zapata, Zavala

PCP	\$0
Specialist	\$0
Transportation	Unlimited one-way medical trips every year and 20 one-way non-medical trips per year
OTC	\$335 every 3 months
Max Out-of Pocket	\$3,450
Dental	\$0 Preventive Dental: 2 exams, 2 cleanings, 1 bitewing x-ray / year. Comprehensive Dental with max allowance \$4,000 per year.
Vision	\$0 copay routine eye exam (1 per year) \$550 every year (combined for all eyewear)
Meal Benefit	Home delivered meals following discharge. Three (3) meals per day for 14 days, max 42 meals per occurrence, unlimited number of occurrences per year
Hearing Aids	\$0 routine hearing exam (1 per year), \$0 hearing aid fitting/ evaluation (1 per year) Includes a limited selection of devices for up to 2 hearing aids total (1 hearing aid per ear per calendar year)

HMO DSNP Benefits at a Glance – H5294_015



Aransas, Armstrong, Atascosa, Bailey, Bandera, Bastrop, Bee, Bexar, Blanco, Borden, Bosque, Briscoe, Brooks, Burnet, Caldwell, Calhoun, Cameron, Castro, Cochran, Coke, Collin, Colorado, Comal, Crosby, Dallas, Denton, DeWitt, Dickens, Dimmit, Donley, Duval, El Paso, Erath, Fayette, Fisher, Floyd, Garza, Gillespie, Glasscock, Goliad, Gonzales, Grimes, Guadalupe, Hale, Hamilton, Hays, Hidalgo, Hill, Hockley, Hunt, Irion, Jack, Jim Hogg, Jim Wells, Karnes, Kendall, Kenedy, Kent, Kimble, Kleberg, La Salle, Lamb, Lee, Leon, Limestone, Lubbock, Lynn, Martin, Mason, Maverick, McCulloch, McMullen, Medina, Milam, Mills, Mitchell, Navarro, Nolan, Nueces, Palo Pinto, Real, Refugio, Rockwall, San Saba, Shackelford, Somervell, Starr, Sterling, Swisher, Tarrant, Terry, Throckmorton, Uvalde, Willacy, Williamson, Wilson, Zapata, Zavala

PCP	\$0 copay
Specialist	\$0 copay
Transportation	Unlimited medical trips every year and 20 one-way non-medical trips per year
OTC	\$325 every 3 months
Dental	\$0 Preventive Dental: 2 exams, 2 cleanings, 1 bitewing x-ray / year. \$0 Comprehensive Dental with max allowance \$3,000 per year.
Vision	\$0 copay routine eye exam (1 per year) \$450 every year (combined for all eyewear)
Meal Benefit	Home delivered meals following discharge. 3 meals per day for 14 days, max 42 meals per occurrence, unlimited number of occurrences per year
Hearing Aids	\$0 routine hearing exam (1 per year), \$0 hearing aid fitting / evaluation (1 per year) Includes a limited selection of devices for up to 2 hearing aids total (1 hearing aid per ear per calendar year)

HMO SNP Additional Benefits



- Member rewards include:

Member Rewards	
Colorectal Exam	\$50 gift card will be mailed after colorectal exam has been completed.
Breast Cancer Screening	\$20 gift card will be mailed after the breast cancer screening has been completed.
Flu Vaccine	\$20 gift card will be mailed after vaccine has been administered.
Wellness Visit	\$20 gift card will be mailed after wellness visit has been completed.
HbA1C	\$20 gift card will be mailed after HbA1c screening has been completed.
Retinal (Eye) Screening	\$20 gift card will be mailed after retinal screening has been completed.

- Members also receive access to Superior's 24-Hour Nurse Advice Line and the SILVER&FIT Healthy Aging and Exercise Program.



Providers and Authorization

Primary Care Providers (PCPs)



- PCPs serve as a medical home and provide the following:
 - Sufficient facilities and personnel.
 - Covered services as needed.
 - 24-hours a day, 365 days a year.
 - Coordination of medical services and specialist referrals.
 - After-hours accessibility using one of the following methods:
 - Answering service.
 - Call center system connecting to a live person.
 - Recording directing member to a covering practitioner.
 - Live individual who will contact a PCP.

Interdisciplinary Care Team



- The purpose of the Interdisciplinary Care Team (ICT) is to collaborate with the member, their providers/specialists and other health-care professionals to ensure appropriate services are in place, and to identify alternative solutions to barriers identified in a member's care plan.
- Superior's program is member-centric with the PCP being the primary ICT point of contact. Superior staff works with all members of the ICT in coordinating the plan of care for the member.

Interdisciplinary Care Team



- As part of the ICT process, providers are responsible for:
 - Accepting invitations to attend member's ICT.
 - Maintaining copies of the Individualized Care Plan (ICP), ICT worksheets and transition of care notifications in the member's medical record.
 - Collaborating and actively communicating with care managers the ICT, members and caregivers.
- Superior Care Managers (CMs) work with the member to encourage self-management of their condition, as well as communicate the member's progress toward these goals to the other members of the ICT.

Interdisciplinary Care Team



- The ICT will be led by a Care Coordinator, and at a minimum is comprised of the following core members:
 - Member and/or authorized representative.
 - PCP.
 - Family and/or caregiver, if approved by the member.
 - Care coordinator(s) (Service Coordinator [SC], Behavioral Health CM).
 - Specialist if serving as member's PCP.



Responsibility of the Interdisciplinary Care Team



- Analyze and incorporate the results of the initial and annual health risk assessment into the individualized care plan.
- Coordinate the medical, cognitive, psychosocial and functional needs of members.
- The development and implementation of ICP with the member's participation, as feasible.
- Conduct ICT meetings according to the member's condition; these meetings may be held face to face, via conference call, or web- based interface.

Utilization Management



- Authorization must be obtained prior to the delivery of certain elective and scheduled services. The preferred method for submitting authorization requests is through the Secure Provider Portal at Provider.SuperiorHealthPlan.com.

Service Type	Time Frame
Elective/scheduled admissions	Required five business days prior to the scheduled admit date
Emergent inpatient admissions	Notification required within one business day
Emergency room and post stabilization	Notification requested within one business day

Prior Authorizations



- Prior authorization is required for:
 - Inpatient admissions, including observation
 - Home health services
 - Ancillary services
 - Radiology (MRI, MRA, PET, CT)
 - Pain management programs
 - Outpatient therapy and rehab (OT, PT, ST)
 - Transplants
 - Surgeries
 - Durable Medical Equipment (DME)
 - Part B drugs

INPATIENT MEDICARE AUTHORIZATION FORM

Expedited requests: Call 1-800-218-7508
Standard Requests: Fax 1-877-808-9368

For Standard (Elective Admission) requests, complete this form and FAX to 1-877-808-9368. Determination made as expeditiously as the enrollee's health condition requires, but no later than 14 calendar days after the receipt of request.
For Expedited requests, please CALL 1-800-218-7508. Expedited requests are made when the enrollee or his/her physician believes that waiting for a decision under the standard timeframe could place the enrollee's life, health, or ability to regain maximum function in serious jeopardy.
For Concurrent requests, complete this form and FAX to 1-877-851-6966. (All inpatient stays including patients already admitted, ER patients with admit orders and direct admits). Determination within 24 hours of receipt of all necessary information.

*** Indicates Required Field**

MEMBER INFORMATION

Member ID * Last Name, First Date of Birth *
(999999999) (999999) (MM/DD/YYYY)

REQUESTING PROVIDER INFORMATION

Requesting NP * Requesting TIN * Requesting Provider Contact Name
(999999999) (999999) (9999999999999999)

Requesting Provider Name Phone Fax
(9999999999999999) (9999999999) (9999999999)

SERVICING PROVIDER / FACILITY INFORMATION

Same as Requesting Provider

Servicing NP * Servicing TIN * Servicing Provider Contact Name
(999999999) (999999) (9999999999999999)

Servicing Provider/Facility Name Phone Fax
(9999999999999999) (9999999999) (9999999999)

AUTHORIZATION REQUEST

Primary Procedure Code Additional Procedure Code Start Date OR Admission Date * Diagnosis Code *
(99999999) (99999999) (MM/DD/YYYY) (99999)

Additional Procedure Code Additional Procedure Code Discharge Date (if applicable) otherwise Length of Stay will be based on Medical Necessity Additional Diagnosis Code
(99999999) (99999999) (MM/DD/YYYY) (99999)

INPATIENT SERVICE TYPE * (Enter the Service type number in the boxes)

709 C-Section Delivery	400 Skilled Nursing Facility
101 Long Term Acute Care	490 Sub-Acute
300 Medical	411 Surgical
414 Premature/Vaginal Labor	309 Transplant Surgery
427 Rehab	700 Vaginal Delivery

ALL REQUIRED FIELDS MUST BE FILLED IN AS INCOMPLETE FORMS WILL BE REJECTED.
COPIES OF ALL SUPPORTING CLINICAL INFORMATION ARE REQUIRED. LACK OF CLINICAL INFORMATION MAY RESULT IN DELAYED DETERMINATION.

Disclaimer: An authorization is not a guarantee of payment. Member must be eligible at the time services are rendered. Services must be a covered Health Plan benefit and medically necessary with prior authorization as per Plan policy and procedures.
Confidentiality: The information contained in this transaction is confidential and may be protected under the Health Insurance Portability and Accountability Act of 1996. If you are not the intended recipient any use, distribution, or copying is strictly prohibited. If you have received this document in error, please notify us immediately and destroy the document.
Rev. 10/18/2017
W1-PAP-076
DWP_20184138

Prior Authorizations



- Forms are accessible on the Superior website:
 - www.SuperiorHealthPlan.com/providers/resources/forms.html (located under Medicare Acute Care Services)
- There are three ways to submit requests:
 - Fax: 1-877-808-9368
 - Phone: 1-800-218-7508
 - Secure Web Portal: Provider.SuperiorHealthPlan.com

Out-of-Network Coverage



- Plan authorization is required for out-of-network services, except:
 - Emergency care.
 - Urgently needed care when the network provider is not available (usually due to out-of-area).
 - Kidney dialysis at Medicare-certified dialysis center when temporarily out of the service area.

Medical Necessity Determination



- When medical necessity cannot be established, a peer-to-peer review is offered.
- Denial letters will be sent to the member and provider.
- The clinical basis for the denial will be indicated.
- Member appeal rights will be fully explained.



Preventive Care and Screenings

Preventive Care



- No copay for all preventive services covered under original Medicare at zero cost-sharing.
- Initial Preventive Physical Exam – Welcome to Medicare:
 - Measurement of height, weight, body mass index, blood pressure, visual acuity screen and other routine measurements. Also includes an electrocardiogram, education and counseling. Does not include lab tests. Limited to one per lifetime.
- Annual Wellness Visit
 - Available to members after the member has the one-time initial preventive physical exam (Welcome to Medicare Physical).

Preventive Care



- Abdominal Aortic Aneurysm Screening
- Alcohol Misuse Counseling
- Blood Pressure Screening
- BMI, Functional Status
- Bone Mass Measurement
- Breast Cancer Screening (mammogram)
- Cardiovascular Disease (behavioral therapy)
- Cardiovascular Screenings
- Cervical and Vaginal Cancer Screenings
- Colonoscopy
- Colorectal Cancer Screenings
- Depression Screening
- Diabetes Screenings
- Fecal Occult Blood Test
- Flexible Sigmoidoscopy
- HIV Screening
- Medical Nutrition Therapy Services
- Medication Review
- Obesity Screening and Counseling
- Pain Assessment
- Prostate Cancer Screenings (PSA)
- Sexually Transmitted Infections Screening and Counseling
- Tobacco Use Cessation Counseling (counseling for people with no sign of tobacco-related disease)
- Vaccines, Including Flu Shots, Hepatitis B Shots, Pneumococcal Shots



Medicare Star Ratings

Medicare Star Ratings



- What are Centers for Medicare and Medicaid Services (CMS) Star Ratings?
 - CMS uses a five-star quality rating system to measure Medicare beneficiaries' experience with their health plans and the health-care system. This rating system applies to Allwell plans that cover both health services and prescription drugs (Allwell Medicare [HMO] and Allwell Dual Medicare [HMO SNP]).
 - The ratings are posted on the CMS consumer website, www.Medicare.gov, to give beneficiaries help in choosing a plan offered in their area. The Star Rating System is designed to promote improvement in quality and recognize primary care providers for demonstrating an increase in performance measures over a defined period of time.

Medicare Star Ratings



- CMS' Star Rating Program is based on measures in 9 different areas:

Part C:

1. Staying healthy: screenings, tests and vaccines.
2. Managing chronic (long-term) conditions.
3. Member experience with the health plan.
4. Member complaints, problems. getting services and improvement in the health plan's performance
5. Health plan customer service.

Part D:

1. Drug plan customer service.
2. Member complaints and changes in the drug plan's performance.
3. Member experience with the drug plan.
4. Drug safety and accuracy of drug pricing.

How Can Providers Improve Star Ratings?



- Continue to encourage patients to obtain preventive screenings annually or when recommended.
- Manage chronic conditions, such as hypertension and diabetes, including medication adherence.
- Continue to talk to patients and document interventions regarding topics such as fall prevention, bladder control and the importance of physical activity and emotional health and wellbeing (HOS).
- Create office practices to identify noncompliant patients at the time of their appointment.
- Identify opportunities to have an impact on patient health and wellbeing.

How Can Providers Improve Star Ratings?



- Submit complete and correct encounters/claims with appropriate codes and properly document medical charts for all members, including availability of medical records for chart abstractions.
- Review the gap in care files that list members with open gaps. These are available on Superior's Secure Provider Portal.
- Review medication and follow up with members within 14 days post hospitalization.
- Make appointments available to patients and reduce wait times (CAHPS).
- Follow up with patients regarding their test results (CAHPS).



Web-Based Tools

SuperiorHealthPlan.com

Superior Website



- Through www.SuperiorHealthPlan.com, providers can access:
 - Billing Manuals
 - Forms
 - HEDIS Quick Reference Guide
 - Provider News
 - Pre-Auth Needed Tool
 - Provider Resources

Superior Secure Provider Portal



- On Superior's Secure Provider Portal (Provider.SuperiorHealthPlan.com), providers can access:
 - Authorizations
 - Claims
 - Download Payment History
 - Processing Status
 - Submission / Adjustments
 - Clean Claim Connection – Claim Auditing Software
 - Health Records
 - Care Gaps*
 - Patient Listings* and Member Eligibility

**Available for PCPs only.*

Primary Care Provider Reports



- Patient List – Located on Provider.SuperiorHealthPlan.com.
 - Includes member's name, ID number, date of birth and telephone number. The Patient List is available to download to Excel or PDF formats and includes additional information such as member's effective date, termination date, product, gender and address.

The screenshot shows a web interface for a 'Patient List' as of 10/08/2014. It includes a 'Download' button, a 'Filter' search box, and a 'Cost Reports' menu icon. The table below lists member details:

ELIGIBLE	MEMBER NAME	MEMBER #	DATE OF BIRTH	PHONE NUMBER
👍	ABRAHAM, ABRAHAM	000000001	01/22/1980	
👍	ABRAHAM, ABRAHAM	000000001	00/11/1980	
👍	ABRAHAM, ABRAHAM	000000001	00/00/1970	
👍	ABRAHAM, ABRAHAM	000000001	11/11/1980	(770) 807-0000
👍	ABRAHAM, ABRAHAM	000000001	00/00/1980	(770) 807-0000
👍	ABRAHAM, ABRAHAM	000000001	01/01/1980	(770) 807-0000
👍	ABRAHAM, ABRAHAM	000000001	00/00/1980	(770) 807-0000
👍	ABRAHAM, ABRAHAM	000000001	01/01/1980	(800) 700-0000
👍	ABRAHAM, ABRAHAM	000000001	00/11/1980	
👍	ABRAHAM, ABRAHAM	000000001	01/01/1980	

Updating Your Data



- Providers can improve member access to care by ensuring that their data is current in our provider directory.
- To update your provider data:
 1. Log in to the Secure Provider Portal
 2. From the main tool bar, select “Account Details”
 3. Select the provider whose data you want to update
 4. Choose the appropriate service location
 5. Make appropriate edits and save

PCP Cost Reports



- **Members with Frequent ER visits:** This report includes members who frequently visit the ER on a monthly basis. The report is available in Excel and PDF formats, and provides member information, paid (ER) provider information, claim number, procedure information, diagnosis and cost.
- **High Cost Claims:** This report includes members with high-cost claims. The report is available in Excel and PDF formats, and provides detailed member information, provider information, claim number, procedure information, diagnosis and cost.
- **Rx Claims Report:** This report includes members with pharmacy claims on a monthly basis. The report is available in Excel and PDF formats, provides detailed member information, provider information, detailed prescription information (such as pharmacy, units, days refill, etc.) and cost.



Network Partners

Partners and Vendors



Service	Specialty Company/Vendor	Contact Information
High Tech Imaging Services	National Imaging Associates	1-866-214-2569 www.radmd.com
Interventional Pain Management	National Imaging Associates	1-866-214-2569 www.radmd.com
Vision Services	Involve Vision Benefits	1-800-334-3937 www.involvevision.com
Dental Services	Dental Health and Wellness	www.dentalhw.com
Pharmacy Services	Involve Pharmacy solutions	1-866-399-0928 (Phone) 1-866-399-0929 (Fax)
Hearing Aids	Hearing Care Solutions	1-303-407-6813 www.hearingcaresolutions.com

TurningPoint HealthCare Solutions



- Effective November 15, 2019, Superior HealthPlan started working with TurningPoint Healthcare Solutions, LLC to launch a new Surgical Quality and Safety Management Program.
- TurningPoint is responsible for processing prior authorizations requests for medical necessity and appropriate length of stay for Musculoskeletal Surgical procedures.
- This process applies to: STAR, STAR+PLUS, STAR Health, STAR Kids, CHIP, Allwell (HMO and HMO SNP) and Ambetter.
- Physicians started submitting requests to TurningPoint for prior authorization beginning on November 1, 2019 for dates of service on or after November 15, 2019.
- TurningPoint's Procedure Coding and Medical Policy Information can be located under Billing Resources at www.SuperiorHealthPlan.com/providers/resources.html.

TurningPoint HealthCare Solutions



- Prior authorization will be required for the following Musculoskeletal surgical procedures in both inpatient and outpatient settings*:

Orthopedic Surgical Procedures	Spinal Surgical Procedures
Knee Arthroplasty and Arthroscopy	Spinal Fusion Surgeries
Uni/Bi-compartmental Knee Replacement	Cervical
Hip Arthroplasty and Arthroscopy	Lumbar
Acromioplasty and Rotator Cuff Repair	Thoracic
Ankle Fusion and Arthroplasty	Disc Replacement
Femoroacetabular Arthroscopy	Implantable Pain Pumps
Osteochondral Defect Repair	Laminectomy/Discectomy

*This is not an all-inclusive list. For a detailed list of impacted CPT codes, visit TurningPoint's Web Portal or www.SuperiorHealthPlan.com/providers/preauth-check.html.

TurningPoint Healthcare Solutions



- Emergency related procedures do not require authorization.
- It is the responsibility of the ordering physician to obtain authorization.
- Providers rendering the above services should verify that the necessary authorization has been obtained. Failure to do so may result in non-payment of claims.
- Authorization requirements for facility and radiology may also be applicable.
- For questions, utilization management or precertification, and to submit prior authorization requests, please contact TurningPoint at:
 - Web Portal Intake: <http://www.myturningpoint-healthcare.com>
 - Telephonic Intake: 469-310-3104 | 855-336-4391
 - Facsimile Intake: 214-306-9323

Lab and DME Partners



Lab Partners
Bio Reference
Sequenome Center
MD Labs
Lab Corp
Quest

DME Partners
American Home Patient
Apria
Breg
CCS Medical
Critical Signal Technologies
DJO
EBI
Edge Park
J&B Medical
KCI
Lincare
Hanger Prosthetics and Orthotics
National Seating & Mobility
Numotion
Nextra Health

AcariaHealth - Specialty Pharmacy



- AcariaHealth is a national, comprehensive specialty pharmacy providing services in all specialty disease states including:
 - Cystic Fibrosis
 - Hemophilia
 - Hepatitis C
 - Multiple Sclerosis
 - Oncology
 - Rheumatoid Arthritis
- Most biopharmaceuticals and injectables require prior authorization at:
 - CustomerCare@acariahealth.com



Billing Overview

Electronic Claims Transmission and Support



- 6 clearinghouses for Electronic Data Interchange (EDI) submission:
 - Payer ID: 68069
 - Faster processing turn around time than paper submission.
- Companion guides for EDI billing requirements and loop segments can be found at www.SuperiorHealthPlan.com.
- For more information, email EDIBA@centene.com.

Claims Filing Timelines



- Allwell claims should be mailed to the following billing address:
 - Allwell from Superior HealthPlan
Attn: Claims
P.O. Box 3060
Farmington, MO 63640-3822
- Participating providers have 95 days from the date of service to submit a timely claim.
- All requests for reconsideration or claim disputes must be received within 120 days from last timely processed claim.

Claims Payment



- A clean claim is received in a nationally accepted format in compliance with standard coding guidelines, and requires no further information, adjustment or alteration for payment.
- A claim will be paid or denied with an Explanation of Payment (EOP) mailed to the provider who submitted the original claim.
- Providers may not bill members for services when the provider fails to obtain authorization and the claim is denied.
- Dual-eligible members are protected by law from balance billing for Medicare Parts A and B services. This includes deductibles, co-insurance and copayments.
- Providers may not balance bill members for any differential.

Coding Auditing and Editing



- Allwell uses code editing software based on edits from:
 - American Medical Association (AMA).
 - Specialty society guidance.
 - Clinical consultants.
 - Centers for Medicare and Medicaid Services (CMS).
 - National Correct Coding Initiative (NCCI).
- Software audits for coding inaccuracies, including:
 - Unbundling.
 - Upcoding.
 - Invalid codes.

Corrected Claims and Requests for Reconsideration



- A corrected claim is submitted when information requires a change from the original claim submission.
- A request for reconsideration is submitted when there is a disagreement with the manner in which a claim was processed. Reconsideration request may require medical records if related to code audit, code edit or auth denial.
- Submit corrected claims or reconsiderations to:
 - Allwell from Superior HealthPlan
Attn: Corrections/Reconsiderations
PO Box 3060
Farmington, MO 63640-3822

Claim Reconsiderations and Disputes



- A claim dispute is to be used only when a provider has received an unsatisfactory response to a request for reconsideration.
- Submit claim disputes to:
 - Allwell from Superior HealthPlan
Attn: Claim Dispute
PO Box 3060
Farmington, MO 63640-3822

Ophthalmology for Medical Eye Care Services



- Effective for service dates beginning January 1, 2020, Superior HealthPlan assumed the management of medical eye care services delivered by ophthalmologists for all Superior members.
- Envolve Vision continues to manage routine eye care services and full-scope of licensure optometric services for Superior HealthPlan.

Ophthalmology for Medical Eye Care Services



- Beginning January 1, 2020, Superior began managing all functions for ophthalmologists providing medical eye care services, including but not limited to:
 - Claim Processing and Appeals.
 - Contracting/Credentialing.
 - Prior Authorization.
 - Retrospective Utilization Review.
 - Medical Necessity Appeals.
 - Provider Complaints related to medical eye care services.
 - Provider Relations/Account Management.
 - Provider Services.
 - Secure Provider Portal.
- For code-specific details of services requiring prior authorization, refer to Superior's Prior Authorization tool:
www.SuperiorHealthPlan.com/providers/preauth-check.html



Electronic Funds Transfer (EFT) and Electronic Remittance Advice (ERA)

EFT/ERA



- Electronic payment benefits include:
 - Obtaining faster payments, leading to improvements in cash flow.
 - Eliminating re-keying of remittance data.
 - Matching payments to statements promptly.
 - Connecting quickly with any payers that are using Payspan to settle claims.
 - Accessing payment services for free: www.PayspanHealth.com.



Meaningful Use – Electronic Medical Records

Electronic Medical Records



- The exchange of patient data between health-care providers, insurers and members is critical to advancing member care, data security and the health-care industry as a whole.
- Electronic Health Records/Electronic Medical Records (EHR/EMR) allow health-care professionals to provide patient information electronically instead of using paper records.
- EHR/EMR can provide many benefits, including:
 - Complete and accurate information.
 - Better access to information.
 - Patient empowerment.

Please note: Incentive programs may be available.



Advance Directives

Advance Directives



- An advance directive will help the PCP understand the member's wishes about their health care in the event they become unable to make decisions on their own behalf. Examples include:
 - Living Will
 - Health Care Power of Attorney
 - “Do Not Resuscitate” Orders
- Execution of an advance directive must be documented in the member's medical records.
- Providers must educate staff on issues concerning advance directives and must maintain written policies that address a member's right to make decisions their own about medical care.



Regulatory Matters

Medicare Outpatient Observation Notice (MOON)



- Contracted hospitals and critical access hospitals must deliver the Medicare Outpatient Observation Notice (MOON) to any member who receives observation services as an outpatient for more than 24 hours.
- The MOON is a standardized notice to a member informing that the member is an outpatient receiving observation services and not an inpatient of the hospital or critical access hospital and the implications of such status.
- The MOON must be delivered no later than 36 hours after observation services are initiated, or if sooner upon release.
- The Office of Management and Budget (OMB) approved MOON and accompanying form instructions can be found at www.cms.gov/Medicare/Medicare-General-Information/BNI/index.html.



Fraud, Waste and Abuse

Fraud, Waste and Abuse



- Allwell follows the 4 parallel strategies of the Medicare and Medicaid programs to prevent, detect, report and correct fraud, waste and abuse:
 1. Preventing fraud through effective enrollment and education of physicians, providers, suppliers and beneficiaries.
 2. Detection through data analytics and medical records review.
 3. Reporting any identified or investigated violations to the appropriate partners, including contractors, the NBI-MEDIC and federal and state law enforcement agencies, such as the Office of Inspector General (OIG), Federal Bureau of Investigation (FBI), Department of Justice (DOJ) and Medicaid Fraud Control Unit (MFCU).
 4. Correcting fraud, waste or abuse by applying fair and firm enforcement policies, such as pre-payment review, retrospective review and corrective action plan.

Fraud, Waste and Abuse



- Allwell performs front and back-end audits to ensure compliance with billing regulations. Most common errors include:
 - Use of incorrect billing code
 - Not following the service authorization
 - Procedure code not being consistent with provided service
 - Excessive use of units not authorized by the care manager.
 - Lending of insurance card
- Benefits of stopping Fraud, Waste and Abuse:
 - Improves patient care
 - Helps save dollars and identify recoupments
 - Decreases wasteful medical expenses

Fraud, Waste and Abuse



- Allwell expects all providers, contractors and subcontractors to comply with applicable laws and regulations including, but not limited to, the following:
 - Federal and State False Claims Act.
 - Qui Tam Provision (Whistleblower).
 - Anti-Kickback Statute.
 - Physician Self-Referral Law (Stark Law).
 - Health Insurance Portability and Accountability Act (HIPAA).
 - Social Security Act (SSI).
 - US Criminal Codes.

Fraud, Waste and Abuse



- First-Tier, Downstream and Related Entities (FDR), as well as delegated entities, will be required to complete training via the Medicare Learning Network (MLN) website.
- The trainings must be completed by each individual provider/practitioner within the group rather than one person representing the group collectively.
- The updated regulation requires all applicable entities (providers, practitioners, administrators) to complete the training within 90 days of contracting or becoming a delegated entity and annually thereafter.
- Once training is complete, each applicable entity will need to complete the certificate(s) of completion or attestation through the CMS MLN and provide a copy to the health plan upon request.

Medicare Reporting



- Potential fraud, waste or abuse reports may be called in to our anonymous and confidential hotline at 1-866-685-8664 or by contacting the Compliance Officer at 1-866-796-0530.
- To report suspected fraud, waste or abuse in the Medicare program, please use one of the following avenues:
 - Office of Inspector General (OIG):
1-800-HHS-TIPS (1-800-447-8477)
 - Medicare: 1-800-Medicare (1-800-633-4227)



CMS Mandatory Trainings

CMS Mandatory Trainings



- All contracted providers, contractors, and subcontractors are required to complete three required trainings:
 - Model of Care (MOC): Within 30 days of joining Allwell and annually thereafter (DSNP and MMP only).
 - General Compliance (Compliance): Within 90 days of joining Allwell and annually thereafter.
 - Fraud, Waste, and Abuse (FWA): Within 90 days of joining Allwell and annually thereafter.

General Compliance and Medicare Fraud, Waste and Abuse Training



- Providers are required to complete training via the Medicare Learning Network (MLN) website.
- Must be completed by each individual provider/practitioner within the group rather than one person representing the group collectively.
- Training must be completed within 90 days of contracting and annually thereafter.
- Complete the certificate(s) of completion or attestation through the CMS MLN and provide a copy to Allwell.

A screenshot of the CMS.gov website showing the Medicare Learning Network (MLN) Provider Compliance page. The page header includes navigation links for Home, About CMS, Newsroom, FAQs, Archive, Share, Help, and Print. Below the header is a search bar and a navigation menu with categories like Medicare, Medicaid/CHIP, Medicare-Medicaid Coordination, Private Insurance, Innovation Center, Regulations & Guidance, Research, Statistics, Data & Systems, and Outreach & Education. The main content area is titled "MLN Provider Compliance" and features the Medicare Learning Network logo. A "Fast Fact" section discusses medical review contractors and signature requirements. Below this, there is a "Downloads" section with links to PDF documents such as "Medicaid Program Integrity, Safeguarding Your Medical Identity, Educational Products [PDF, 193KB]" and "Medicare Parts C and D Fraud, Waste, and Abuse Training and Medicare Parts C and D General Compliance Training [PDF, 131KB]".



Model of Care

Allwell Dual Medicare (HMO SNP) Only

Model of Care (HMO SNP Only)



- The Model of Care is Allwell's plan for delivering integrated care management programs to members with special needs. The goals of Model of Care are:
 - Improve access to medical, mental health and social services.
 - Improve access to affordable care.
 - Improve coordination of care through an identified point of contact.
 - Improve transitions of care across health-care settings and providers.
 - Improve access to preventive health services.
 - Assure appropriate utilization of services.
 - Assure cost-effective service delivery.
 - Improve beneficiary health outcomes.

Model of Care (HMO SNP Only)



- Model of Care elements:
 - Description of the HMO SNP population.
 - Care coordination and care transitions protocol
 - Provider network.
 - Quality measurements and performance improvement.

Model of Care Process (HMO SNP Only)



- Every dual member is evaluated with a comprehensive Health Risk Assessment (HRA) within 90 days of enrollment and, at a minimum, annually, or more frequently with any significant change in condition or transition of care.
- The HRA collects information about the member's medical, psychosocial, cognitive and functional needs, and medical and behavioral health history.
- Members are then triaged to the appropriate Allwell Case Management Program for follow up.

Model of Care Process (HMO SNP Only)



- Superior values its partnership with network physicians and providers.
- The Model of Care requires that Superior and providers collaborate to benefit members by:
 - Enhancing communication between members, physicians, providers and Allwell.
 - Taking an interdisciplinary approach with regard to the member's special needs.
 - Providing comprehensive coordination with all care partners.
 - Supporting the member's preferences in the Model of Care.
 - Reinforcing the member's connection with their medical home.

Model of Care Information (HMO SNP Only)



- Model of Care information is available at www.SuperiorHealthPlan.com/providers/training-manuals/model-of-care-form.html.
- Model of Care training is a CMS requirement for newly contracted Medicare providers within 30 days of execution of their contract.
- The Model of Care Training must be completed by each participating provider annually, during each calendar year.

Model of Care Training

Superior HealthPlan network providers who serve Superior HealthPlan Medicare Advantage (HMO SNP) and Superior HealthPlan STAR+PLUS Medicare-Medicaid Plan (MMP) members are required to complete an annual Model of Care training.

Click on either of the links below to review the Model of Care training. Then, submit the form to verify the training was completed.

- [Provider Model of Care Training \(presentation\)](#)
- [Provider Model of Care Training \(attestation included\)](#)

Provider Group *

Provider TIN(s) *



Questions and Answers

Thank you for attending!
