



Allwell from Superior HealthPlan

Provider Orientation

Agenda



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Plan Overview

Medicare 101



Medicare is a federal health insurance program for people ages 65 (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 15 – 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.

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



Overview: Allwell Plans



- Allwell from Superior HealthPlan provides complete continuity of care to low income members. This includes:
 - Integrated coordination of care.
 - Care management.
 - Co-location of behavioral health expertise.
 - Integration of pharmaceutical services with the Pharmacy Benefit Manager (PBM).
 - Additional services specific to the member's needs.
- Superior's approach to care management facilitates the integration of community resources, health education and disease management.
- It promotes access to care as the beneficiaries are served through a multidisciplinary team including Registered Nurses (RN), 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.
 - Superior offers the Allwell Medicare (HMO) program in the following counties:

Bexar	Cameron	Collin	Dallas	Smith	Wilson	Denton
Guadalupe	Hidalgo	Nueces	Rockwall	Tarrant	Fort Bend	El Paso
Comal*	Aransas*	Jim Wells*	Montgomery*	Starr*		

*New County for 2020

- 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: <https://Allwell.SuperiorHealthPlan.com/prescription-drugs-formulary/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.
- Superior offers the Allwell Dual Medicare (HMO SNP) program in the following counties:

Bexar	Cameron	Collin	Dallas	Smith	Wilson	Guadalupe
Hidalgo	Nueces	Rockwall	Tarrant	Fort Bend	El Paso	Aransas*
Comal*	Denton*	Jim Wells*	Lubbock*	Montgomery*	Starr*	

*New County for 2020

- 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 Health 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






Allwell Medicare (HMO) Card



		MEDICARE (HMO) CMS#: <H0062-XXX> Effective: <MM/DD/YYYY>	
MEMBER INFORMATION Name: <First MI Last> Member ID#: <XXXXXXXX-XX> Issuer ID: <(80840)> <9151014609>		PHARMACY INFORMATION  Rx Claims Processor: <CVS Caremark®> RXBIN: <004336> RXPCN: <MEDDADV> RXGRP: <RX8905>	
PROVIDER INFORMATION PCP Name: <> PCP Phone: <>		FOR MEMBERS Member Services: <1-844-796-6811 (TTY: 711)> ***Extra Benefits: 24-hr Nurse Advice/Dental/ Vision <1-844-796-6811 (TTY: 711)> < https://allwell.superiorhealthplan.com > FOR PROVIDERS  For Medical/Dental/Vision eligibility and prior auth/referrals: <1-844-796-6811>  Pharmacy prior auth: <1-800-867-6564> For help: (PHARMACY USE ONLY) <1-888-865-6567> ***please refer to your EOC for your extra covered benefits	
		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 419069> <Rancho Cordova, CA> <95741-9069> MEDICAL CLAIMS EDI Payor <Allwell from Superior HealthPlan> ID: <68069> <Attn: Claims> <P.O. Box 3060, Farmington, MO 63640-3822>	

Allwell Dual Medicare (HMO SNP) Card



 <small>FROM</small>  superior healthplan.		<Dual Medicare> <(Plan Name)> CMS#: <H5294-XXX> Effective: <MM/DD/YYYY>	
MEMBER INFORMATION Name: <First MI Last> Member ID#: <XXXXXXXX-XX> Issuer ID: <(80840)> <9151014609>		PHARMACY INFORMATION  Rx Claims Processor: <CVS Caremark> RXBIN: <004336> RXPCN: <MEDDADV> RXGRP: <RX8124>	
PROVIDER INFORMATION PCP Name: <> PCP Phone: <>		FOR MEMBERS Member Services: <1-877-935-8023 (TTY: 711)> ***Extra Benefits: 24-hr Nurse Advice/Dental/ Vision <1-877-935-8023 (TTY: 711)> <https://allwell.superiorhealthplan.com>	
		FOR PROVIDERS  For Medical/Dental/Vision eligibility and prior auth/referrals: <1-877-935-8023>  Pharmacy prior auth: <1-800-867-6564> For help: (PHARMACY USE ONLY) <1-888-865-6567> ***please refer to your EOC for your extra covered benefits	
		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 419069> <Rancho Cordova, CA> <95741-9069>	
		MEDICAL CLAIMS EDI Payor ID: <68069> Allwell from Superior HealthPlan Attn: Claims P.O. Box 3060, Farmington, MO 63640-3822>	



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 – available at network retail pharmacies or mail order (deductibles may apply).
- Additional benefits and services such as wellness programs, over-the-counter items and mental health services. For a summary of plan benefits, visit:
 - <https://Allwell.SuperiorHealthPlan.com/reference-documents.html>

Pharmacy Formulary



- The Allwell formulary is available at:
 - <https://Allwell.SuperiorHealthPlan.com/prescription-drugs-formulary/formulary.html>
 - Please refer to the formulary for specific types of exceptions.
- When requesting a formulary exception, a Drug Coverage Determination form must be submitted:
 - www.SuperiorHealthPlan.com/providers/resources/forms.html (located under “Helpful Medicare Links”)
 - 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.
 - \$750 to \$1,500 in comprehensive dental benefits per year (dollar coverage dependent upon service area).

Additional Benefits



- Vision Services
 - 1 routine eye exam every year.
 - 1 pair of glasses or contacts lenses every year.
 - \$550 limit for eyewear each year (dollar coverage dependent upon service area).
- Over-The-Counter Items
 - Commonly used over-the-counter items – listing available at <https://Allwell.SuperiorHealthPlan.com/content/dam/centene/Medicare%20Blueprint%20Documents/2020-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 up to \$100 per calendar quarter (MAPD) and \$325 (DSNP).

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

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



PCP Visit	\$0
Specialist	\$35
Transportation	10 one way trips
OTC	\$60 per quarter
Dental	Preventative
Comprehensive	\$1000 max, 20-30% coinsurance
Vision	\$150
Hearing Aids	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 two (2) hearing aids total (1 per ear/ calendar year)

HMO Benefits at a Glance

Collin, Dallas, Denton, Rockwall, Tarrant



PCP Visit	\$0
Specialist	\$30
OTC	\$100 per quarter
PERS	Personal Emergency Response System
Dental	Preventative
Comprehensive	\$1000 max, 20-30% coinsurance
Vision	\$150
Hearing Aids	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 two (2) hearing aids total (1 per ear/ calendar year)

HMO Benefits at a Glance

Cameron, Hidalgo, Starr



PCP Visit	\$0
Specialist	\$30
Transportation	30 one way trips
OTC	\$80 per quarter
Dental	Preventative
Comprehensive	\$1000 max, 0% coinsurance
Vision	\$100
Hearing Aids	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 two (2) hearing aids total (1 per ear/ calendar year)

HMO Benefits at a Glance

Fort Bend, Montgomery



PCP Visit	\$5
Specialist	\$35
Transportation	10 one way trips
OTC	\$65 per quarter
Dental	Preventative
Vision	\$100
Hearing Aids	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 two (2) hearing aids total (1 per ear/ 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 our 24-Hour Nurse Advice Line.



HMO SNP Benefit Overview

HMO SNP Benefits at a Glance

Cameron, Hidalgo, Starr



Transportation	Unlimited
OTC	\$325 per quarter
Dental	Preventative
Comprehensive	\$3000 max
Vision	\$550
Podiatry	Unlimited
Meal Benefit	14 days/42 meals post inpatient discharge
PERS	Personal Emergency Response System
Hearing Aids	Benefit includes a limited selection of devices for up to 2 hearing aids total (1 hearing aid per ear per calendar year).

HMO SNP Benefits at a Glance

Collin, Dallas, Denton, Rockwall, Tarrant



Transportation	30 one way trips
OTC	\$250 per quarter
Dental	Preventative
Comprehensive	\$1500 max
Vision	\$100
Meal Benefit	14 days/28 meals post inpatient discharge
Hearing Aids	Benefit includes a limited selection of devices for up to 2 hearing aids total (1 hearing aid per ear per calendar year).

HMO SNP Benefits at a Glance

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



Transportation	Unlimited
OTC	\$325 per quarter
Dental	Preventative
Comprehensive	\$3000 max
Vision	\$550
Podiatry	Unlimited
Meal Benefit	14 days/42 meals post inpatient discharge
PERS	Personal Emergency Response System
Hearing Aids	Benefit includes a limited selection of devices for up to 2 hearing aids total (1 hearing aid per ear per calendar year).

HMO SNP Benefits at a Glance

Fort Bend, Montgomery



Transportation	30 one way trips
OTC	\$250 per quarter
Dental	Preventative
Comprehensive	\$1000 max
Vision	\$150
Hearing Aids	Benefit includes a limited selection of devices for up to 2 hearing aids total (1 hearing aid per ear per calendar year).

HMO SNP Benefits at Glance

Lubbock



Transportation	20 one way trips
OTC	\$100 per quarter
Dental	Preventative
Comprehensive	\$1500 max
Vision	\$250
Podiatry	Unlimited
Chiropractor	30 visits
PERS	Personal Emergency Response System
Hearing Aids	Benefit 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 our 24-Hour Nurse Advice Line



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 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) (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



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healthplan.™

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Health Services
Administration

INPATIENT MEDICARE AUTHORIZATION FORM

Expedited requests: **Call 1-800-218-7508**
Standard Requests: **Fax 1-877-806-2368**

For Standard (Elective Admission) requests, complete this form and FAX to 1-877-806-2368. 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 1-877-258-0960. (All inpatient stays including patients already admitted, ER patients with admission 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 *

____/____/____

REQUESTING PROVIDER INFORMATION

Requesting NPI *

Requesting TIN *

Requesting Provider Contact Name

Requesting Provider Name

Phone

____-____-____

Fax *

____-____-____

SERVICING PROVIDER / FACILITY INFORMATION

Same as Requesting Provider ☐

Servicing NPI *

Servicing TIN *

Servicing Provider Contact Name

Servicing Provider/Facility Name

Phone

____-____-____

Fax

____-____-____

AUTHORIZATION REQUEST

Primary Procedure Code

____/____/____ (ICD-9-CM)

Additional Procedure Code

____/____/____ (ICD-9-CM)

Start Date OR Admission Date *

____/____/____

Diagnosis Code *

____/____/____ (ICD-9-CM)

Additional Procedure Code

____/____/____ (ICD-9-CM)

Additional Procedure Code

____/____/____ (ICD-9-CM)

Discharge Date (if applicable) otherwise Length of Stay will be based on Medical Necessity

____/____/____ (MM/DD/YYYY)

Additional Diagnosis Code

____/____/____ (ICD-9-CM)

INPATIENT SERVICE TYPE *

(Enter the Service type number in the boxes) _____

779 C-Section Delivery	400 Skilled Nursing Facility
121 Long Term Acute Care	499 Sub-Acute
900 Medical	411 Surgical
414 Premature/Fetal Labor	509 Transplant Surgery
427 Rebirth	720 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: This authorization is not a guarantee of payment. Requestor should register all claim services as requested. Services must be a necessary result of the benefit and necessary according with prior authorization as per Plan policy and provisions.

Confidentiality: The information contained on this transmittal is confidential and may be protected under the Health Information Privacy and Accountability Act of 1996. If you are not the intended recipient, you are notified that disclosing or copying is strictly prohibited. If you have received this transmittal in error, please notify us immediately by electronic document.

SNP 00044326

Rev. 03/2007
NY-PAR-0000

Prior Authorizations



- Forms are accessible on our website by visiting:
 - 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's 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.*



- Patient List – Located on [Provider.SuperiorHealthPlan.com](https://www.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.

Patient List as of 10/08/2014					 Download	 Filter	 Cost Reports
ELIGIBLE	MEMBER NAME	MEMBER #	DATE OF BIRTH	PHONE NUMBER			
	MEMBER 1	MEMBER 1234567	01/01/1980				
	MEMBER 2	MEMBER 2345678	02/02/1981				
	MEMBER 3	MEMBER 3456789	03/03/1982				
	MEMBER 4	MEMBER 4567890	04/04/1983	(772) 307-1234			
	MEMBER 5	MEMBER 5678901	05/05/1984	(772) 307-2345			
	MEMBER 6	MEMBER 6789012	06/06/1985	(772) 307-3456			
	MEMBER 7	MEMBER 7890123	07/07/1986	(772) 307-4567			
	MEMBER 8	MEMBER 8901234	08/08/1987	(772) 307-5678			
	MEMBER 9	MEMBER 9012345	09/09/1988	(888) 765-4321			
	MEMBER 10	MEMBER 0123456	10/10/1989				
	MEMBER 11	MEMBER 1234567	11/11/1990				

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



- Pharmacy Benefit Manager: Envolve Pharmacy Solutions
 - Phone: 1-866-399-0928
 - Fax (PA requests): 1-866-399-0929
- Vision Benefits: Envolve Vision Services
 - Phone: 1-888-756-8768
 - www.EnvolveVision.com
- Non-emergent, Outpatient High Tech Imaging: National Imaging Associates (NIA)
 - Phone: 1-866-214-2569
 - www.RadMD.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.
- Effective January 1, 2020, medical eye services, provided by an ophthalmologist, will be submitted to Superior HealthPlan for processing.

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 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 will assume the management of medical eye care services delivered by ophthalmologists for all Superior members.
- Envolve Vision will continue 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 will manage 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



- Electronic Health Records/Electronic Medical Records (EHR/EMR) allows 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.
- Member's medical records must be documented to indicate whether an advance directive has been executed.
- Providers must also educate staff on issues concerning advance directives and must maintain written policies that address the rights of members to make decisions 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 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, specifically the Medicare Learning Network (MLN) Provider Compliance page. The page header includes the CMS.gov logo and navigation links like Home, About CMS, Newsroom, FAQs, Archive, Share, Help, and Print. Below the header is a search bar and a row of topic tabs: 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. It includes a "Fast Fact" section with text about medical review contractors and a "Downloads" section with links to various educational products like "Medicaid Program Integrity" and "Medicare Parts C and D Fraud, Waste, and Abuse Training".



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)



- 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 online 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!