

2021

Provider Manual

Senior Whole Health Massachusetts



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Section 1 – Introduction

1.1 Purpose

Welcome to Senior Whole Health (SWH).

The purpose of the Provider Manual is to give our providers and their administrative and billing staff ready access to the information they need to efficiently and effectively care for our members and to conduct business with SWH.

1.2 Overview of the SWH program

Senior Whole Health offers a Medicare Advantage Special Needs Plan (SNP), a Senior Whole Health Nursing Home Certifiable Plan (HMO SNP) and a Senior Care Options Plan (SCO). All plans are designed to meet the needs of our members who are 65 or older.

The Medicare Advantage SNP and Nursing Home Certifiable HMO SNP plan members qualify for and receive Medicare and Medicaid benefits. The SCO plan members qualify for Medicaid but receive both Medicare and Medicaid benefits supported by the state of Massachusetts. SWH coordinates the member's Medicare, Medicaid and Medicare Part D Prescription Drug benefits as a single integrated benefit for ALL members. Despite the type of Plan, SWH members receive the same comprehensive benefits. All Senior Whole Health members are assigned a Nurse Care Manager who works with the member's PCP to manage all of the benefits, including medical, behavioral health, prescription drug, vision and dental. Additionally, SWH coordinates a wide range of social and non-medical community-based services in order to enhance a Member's health and ability to live independently.

Enrollment in SWH is available to individuals who meet the enrollment criteria and live in Bristol, Essex, Hampden, Middlesex, Norfolk, Plymouth, Suffolk or Worcester counties.

1.3 Our mission statement

Our mission is to maximize the quality of life, health, security and independence of our members.

1.4 When this manual and your contract differ

The Provider Manual is a supplemental document to your contract with Senior Whole Health. It provides detailed information to answer many day-to-day operational questions about SWH, our products and members, and your relationship with us. In cases where your Contract and this document differ, your contract takes precedence.

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Section 1 – Introduction

1.5 Organization of this manual

Each section is organized to answer the most commonly asked questions first. All forms and work aids can be found in the Appendices. Within each section, we've provided hyperlinks to the referenced forms and aids.

The manual is organized for ease of use. We recommend you take a few minutes to familiarize yourself with the table of contents. Doing so will help when you need an answer quickly.

Each section of the manual and each form and aid is updated independently. The date of update, if any, is noted. Each manual section, form and aid is reviewed at least annually. For the most current version of any section, we recommend you visit our website.

Section 2 – Compliance

2.1 Our commitment

Senior Whole Health (SWH) is committed to conducting our business operations honestly and ethically with members, providers, suppliers, governmental agencies, and First Tier, Downstream and Related Entities (FDR) and in a way that is in keeping with applicable federal and state statutes, ethical standards and rules and regulations including, but not limited to those pertaining to the Centers for Medicare and Medicaid Services (CMS) Part C and D programs; the Massachusetts Executive Office of Health and Human Services (EOHHS), Mass Health and the Office of the Inspector General (OIG).

SWH's Corporate Compliance Program is a comprehensive program designed to educate all employees to the ethical standards and code of conduct that guides our operations and promotes reporting of inappropriate behavior and unlawful activity. The compliance program applies to all lines of business.

The structure of SWH's Compliance Program contains the following elements:

- Oversight of Code of Conduct
- Compliance Officer and Compliance Committee oversight
- Development and implementation of Code of Conduct and Policies and Procedures
- Creating awareness through training and publicized disciplinary standards and enforcement
- Assessing compliance through monitoring and auditing
- Maintaining compliance through monitoring and auditing
- Maintaining an effective reporting mechanism and prompt response to allegations of misconduct and potential fraud, waste and abuse

2.2 Fraud, Waste & Abuse Responsibilities

SWH does not tolerate fraud, waste or abuse, by providers, members or staff. Accordingly, we have instituted extensive fraud, waste and abuse programs to combat these problems. SWH is committed to preventing, identifying, investigating and acting on resolutions of suspected fraud, waste and abuse. Our Fraud, Waste & Abuse (FWA) Program is an integral part of our Compliance Program.

SWH and anyone conducting business with SWH agrees to comply with all applicable federal and state statutes, regulations, sub-regulatory guidance and contractual commitments related to the delivery of covered services which include, but are not limited to Federal and State False Claims Acts, Anti-Kickback statutes, prohibitions on inducements to beneficiaries, Health Insurance Portability and Accountability Act (HIPAA), applicable whistleblower protection laws, the Deficit Reduction Act of 2005, the American

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Recovery and Reinvestment Act of 2009, the Patient Protection and Affordable Care Act of 2010 and applicable state and federal billing requirements for state and federally funded programs.

SWH's expects that providers to fully cooperate and participate with its fraud, waste and abuse programs.

The provider's responsibility is to:

- Comply with all laws and SWH's requirements
- Comply with all federal and state laws regarding fraud, waste and abuse
- Provide and bill only for medically necessary services that are delivered to members in accordance with SWH's policies and procedures and applicable regulations
- Ensure that all claims submissions are accurate
- Notify SWH immediately of any suspension, revocation, condition, limitation, qualification or other restriction on the provider's license, or upon initiation of any investigation or action that could reasonably lead to a restriction on the provider's license, or the loss of any certification or permit by any federal authority, or by any state in which the provider is authorized to provide healthcare services
- Cooperate with SWH audits and reviews. SWH's expectation is that each provider will fully cooperate and participate with its fraud, waste and abuse programs. This includes, but is not limited to, permitting SWH access to member treatment records and allowing SWH to conduct on-site audits or reviews. SWH may also interview members as part of an audit or review, without notifying providers.

As a contracted provider with Senior Whole Health, federal law requires you and all your organization's employees take FWA training at the time of hire and on an annual basis. Many providers already meet this requirement through their enrollment in the Medicare program.

If you are not a Medicare-participating provider or you still need to take FWA training for this calendar year, [visit the standardized web-based training module developed by CMS](#). Download two training courses: Combating Medicare Parts C and D Fraud, Waste & Abuse Training and Medicare Parts C and D General Compliance Training. Please ensure your employees, including contractors, part time and temporary workers, also follow this requirement. Keep a record of completion for all employees. CMS regulation requires that you keep these records for at least 10 years.

CMS requires that all providers abide to CMS guidelines to sign an annual attestation by December 31 of each year.

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Definitions of Fraud Waste and Abuse

1. **Fraud** means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to him/her or some other person. It includes any act that constitutes fraud under applicable federal or state law.
2. **Abuse** means provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to government-sponsored programs, and other healthcare programs/plans, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for healthcare. It also includes recipient practices that result in unnecessary costs to federally and/ or state-funded healthcare programs, and other payers.
3. **Waste** means over-utilization of services or other practices that result in unnecessary costs.

Examples of Potential Fraud, Waste and Abuse (including, but not limited to):

1. Billing for services or procedures that have not been performed or have been performed by others;
2. Submitting false or misleading information about services performed;
3. Misrepresenting the services performed (e.g., up-coding to increase reimbursement);
4. Retaining and failing to refund and report overpayments (e.g., if the provider's claim was overpaid, the provider is required to report and refund the overpayment, and unpaid overpayments also are grounds for program exclusion);
5. A claim that includes items or services resulting from a violation of the Anti-Kickback Statute now constitutes a false or fraudulent claim under the False Claims Act;
6. Providing or ordering medically unnecessary services and tests based on financial gain;
7. An individual provider billing multiple codes on the same day where the procedure being billed is a component of another code billed on the same day;
8. An individual provider billing multiple codes on the same day where the procedure is mutually exclusive of another code billed on the same day;
9. Providing services over the telephone or internet and billing using face-to-face codes;
10. Providing services in a method that conflicts with regulatory requirements;
11. Treating all patients weekly regardless of medical necessity;
12. Routinely maxing out of members' benefits or authorizations regardless of whether or not the services are medically necessary;
13. Inserting a diagnosis code not obtained from a physician or other authorized individual;
14. Violating another law (e.g., a claim is submitted appropriately but the service was the result of an illegal relationship between a physician and the hospital such as a physician receiving kickbacks for referrals);

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15. Submitting claims for services ordered by a provider that has been excluded from participating in federally and/or state-funded healthcare programs; and/or
16. Lying about credentials, such as degree and licensure information.

Reporting Suspected Fraud, Waste or Abuse

SWH expects providers and their staff and agents to report any suspected cases of fraud, waste or abuse. SWH does not retaliate against providers or individuals who report suspected cases of fraud, waste or abuse. SWH has the responsibility to assess the merits of and report any allegation of fraud, waste, or abuse. SWH coordinates and fully cooperates with any state or federal agency in identifying, investigating, sanctioning or prosecuting suspected fraud, abuse or waste. Reports of provider fraud, abuse or waste should be reported to SWH through one of the following methods.

Contacting the AlertLine:

- By phone at 1-866-606-3889
- Online at <https://molinahealthcare.alertline.com>

Our anonymous toll-free AlertLine is available 24 hours a day, 7 days a week. All calls are investigated and remain confidential.

2.3 Regulatory compliance information for all contract providers

Because SWH is a Medicare Advantage Special Needs Plan (MA SNP), our contracted providers are required to adhere to the following federal, state and Medicare Advantage provisions which are incorporated into the *SWH and Contracted Provider Agreement*.

Anti-discrimination federal funds

Contracted providers agree not to discriminate against a member based on color, race, creed, age, gender, sexual orientation, disability, place of origin, source of payment, or type of illness or condition.

Contracted providers are obligated to comply with all laws applicable to individuals and entities receiving federal funds, including without limitation (i) the Civil Right Act of 1964, (ii) the Age Discrimination Act of 1975 and (iii) the Americans with Disabilities Act.

HIPAA

SWH and its contracted providers agree to comply with applicable provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the Health Information Technology for Economic and Clinical Health Act (HITECH) and the implementing

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regulations under HIPAA and HITECH, as modified from time to time. Furthermore, SWH reserves the right to audit the contracted provider's written information security program, no less than once every three (3) years, to determine whether the program meets the requirements of the security regulations issued under HIPAA and/or HITECH.

Some of the ways SWH protects access to protected health information (PHI) include:

- Utilizing strict guidelines for how member information may be used and disclosed;
- Requiring all employees to understand and adhere to the processes for responding to any unauthorized uses or disclosures of confidential member information;
- Requiring employees and visitors to sign statements concerning confidentiality of information, release of information, and communication requirements;
- Making sure that the Authorization to Use or Disclose Protected Health Information form we use complies with applicable state and federal laws;
- Monitoring provider adherence to privacy policies and procedures through site visits, quality reviews and routine contact;
- Monitoring member feedback through the complaint process, member satisfaction survey results, and internal quality audits;
- Complying with applicable state and federal laws and accrediting organization standards;
- Establishing and maintaining procedures for timely and appropriate responses to member rights issues, including but not limited to requests for confidential communications, access to protected health information, amendments to protected health information, and accounting of disclosures;
- Implementing technical barriers and protections to systems by requiring authorizations and passwords to access systems containing confidential information; and
- Requiring employees to use the minimum necessary information for routine uses and disclosures of health information.

As a SWH provider, the provider's responsibility is to:

- Comply with applicable state and federal laws and regulations that pertain to member privacy and confidentiality of PHI;
- Use only HIPAA-compliant authorization forms and consent for treatment forms that comply with applicable state and federal laws;
- Use only secure email and secure messaging when requesting member PHI;
- Establish office procedures regarding communication with members (e.g., telephone and cellphone use, and written, fax and internet communication);

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- Establish a process that allows members to access their records in a confidential manner;
- Establish systems that safeguard member PHI at the provider location and anywhere PHI may be stored;
- Maintain the confidentiality of a minor’s consultation, examination, and treatment for a sexually transmissible disease, in accordance with Arizona laws and regulations;
- Participate in and comply with SWH’s quality review, site visit process and contract obligations.

SWH responsibility is to:

- Collaborate with providers to protect member privacy and confidentiality;
- Request the minimum necessary PHI to perform needed healthcare operations and payment activities;
- Only respond to electronic (internet) requests for PHI through secure email channels; and
- Only provide PHI upon receipt of a valid authorization of use and disclosure form.

Certification regarding lobbying

Contracted providers agree that no federally appropriated funds have been paid or will be paid to any person by, or on behalf of, the contracted provider for the purpose of influencing, or attempting to influence, an officer or employee of any agency, a Member of Congress or an employee of a Member of Congress in connection with the award of any federal contract, the making of any federal grant, the making of any federal loan, the entering into of any cooperative agreement, or the extension, continuation, renewal, amendment, or modification of any federal contract, grant, loan or cooperative agreement. Contract provider agree to complete and submit, if required, a “Certification Regarding Lobbying” if payments to the contracted provider by SWH under this Agreement exceed \$100,000.

If any funds other than federally appropriated funds have been paid or will be paid to any person for the purpose of influencing, or attempting to influence, an officer or employee of any agency, a Member of Congress, an officer or employee of Congress or an employee of a Member of Congress in connection with the award of any federal contract, the making of any federal grant, the making of any federal loan, the entering into of any cooperative agreement, or the extension, continuation, renewal, amendment, or modification of any federal contract, grant, loan or cooperative agreement and payment to the contractor by SWH under the agreement exceed \$100,000, the contracted provider shall complete and submit Standard Form-LLL “Disclosure Form to Report Lobbying,” if required, in accordance with its instructions.

Contracted providers shall include in their subcontracts that exceed \$100,000 a provision substantially similar to this section, including the requirement that a subcontractor shall certify and disclose as required.

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Fraud and Abuse Prevention Policy; Whistle blower protection

In accordance with Section 6032 of the Deficit Reduction Act of 2005 (DRA), contracted providers shall comply with SWH's Fraud and Abuse Prevention policy, as revised from time to time by SWH. Contracted providers shall make available to all employees and agents, and to the extent required by DRA his or her contractors, a copy of the SWH Fraud and Abuse Prevention Policy, including specific discussion of the provisions of the SWH Fraud and Abuse Prevention Policy in an employee handbook, if such agent or contractor has an employee handbook.

False Claims Act and related state laws

The federal False Claims Act (FCA) sets forth liability for any person who knowingly submits a false claim for payment to the government. As a recipient of federal funding from the Medicare program, SWH and all our employees and agents are bound by the FCA. SWH also receives funding from state Medicaid programs and is therefore subject to similar FCA laws at the state level in both Massachusetts.

Collectively, these FCA laws extend liability to anyone who knowingly makes a false assertion to get a false claim paid by the government or who causes another person to submit a false claim to the government. FCA laws also cover improper acts designed to get money from the government, but to avoid having to pay money to the government, and for those who conspire to violate the law.

SWH encourages you to report fraud or suspected fraud by calling our anonymous AlertLine, available 24 hours a day, at 1-866-606-3889 or SWH's Compliance Officer at 617-551-4128.

Non-discrimination

Contracted providers shall provide services to members on the same basis as it provides services for all patients; and providers may only deny, limit or condition the provision of services to a member on the same grounds as it denies, limits or conditions the provision of such services to others, subject to any applicable SWH policies or terms of the agreement. Contracted providers shall provide covered services to members in a culturally competent manner, including members with limited English proficiency, limited reading skill and diverse cultural and ethnic backgrounds.

Providers shall ensure that Senior Whole Health members have access to the same hours of operation as patients covered under commercial plans. Senior Whole Health's expectation is that all hours of operation should be the same for all lines of business.

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Medicare Advantage provisions

Contracted providers agree to comply with all state and federal laws, rules and regulations governing the Medicare Advantage program and CMS instruction which, if applicable, are expressly incorporated into the agreement and are binding upon the parties to the agreement.

Copay, coinsurance and deductibles

SWH may impose copays, coinsurance or deductibles (collectively known as member expenses) for covered Medicare Part A and B services, which may also be amended from time to time. For members eligible for both Medicare and MassHealth (dual eligible members), the amount collected for Member Expenses may not exceed the amount that could be collected had the member otherwise been enrolled in original Medicare and MassHealth. Dual eligible members will not be responsible or billed for any member expenses for Medicare Part A and B services when the MassHealth program or SWH is responsible for paying those amounts. Contracted providers may accept SWH payment as payment in full or bill MassHealth in accordance with 42 CFR § 422.504(g) (1) (iii), effective January 1, 2010.

Federally Required Disclosures

Contracted providers agree to comply with state and federal law and disclose information as to business ownership and control, business transactions and criminal convictions.

In the event of any inconsistency between the Provider Manual Section 2.3 and the SWH and Contracted Provider Agreement, both parties agree that the then-current state or federal laws, rules and regulations governing the Medicare Advantage program and CMS instructions, whichever are applicable, shall govern in order to ensure contracted providers' full compliance with all such current laws, rules, regulations and requirements.

2.4 Provider Promotional, Marketing and Outreach Activities

All promotional, marketing and outreach activities must be conducted in a responsible manner so that potential members receive the most accurate and complete information possible to allow the member to make an informed decision.

Provider promotional, marketing and outreach activities must comply with all relevant federal and state laws. This includes, when applicable, the anti-kickback statute, and civil monetary penalty prohibiting inducements to members [42 CFR §438.104].

Provider promotional, marketing and outreach activities targeting prospective members may not:

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- Engage in any informational or marketing activities which could mislead, confuse, or defraud prospective members or misrepresent the Department (42 CFR§438.104).
- Directly or indirectly, conducting door-to-door, telephonic, or other “cold call” marketing of enrollment at residences and provider sites (42 CFR § 438.104).
- Participate in any mailings on behalf of a health plan without being processed through the AHCCCS.
- Conduct unsolicited personal/individual appointments to influence enrollment in a health plan.
- Offer financial incentive, reward, gift, or opportunity to prospective members as an inducement to enroll in a health plan.
- Conduct continuous, periodic activities to the same prospective member, e.g., monthly or quarterly giveaways, as an inducement to enroll in a health plan.
- Assert that prospective members must enroll with a health plan to keep from losing benefits.

2.5 Presence on Federal and State Exclusion List

SWH is required to screen for OIG Exclusion prior to entering into a contract with a provider and on a monthly basis thereafter. An OIG exclusion is an administrative action taken against an individual or entity (such as a provider or vendor) by the Dept. of Health and Human Services (HHS), Office of Inspector General (OIG). The HHS OIG is in charge of enforcing exclusions against individuals or entities.

The OIG mandates that healthcare organizations do not hire or do business with “excluded or *sanctioned*” individuals or entities. If an individual or entity is excluded, he/she/it is prohibited from participating in reimbursements for or from federally funded healthcare programs (CMS.gov – Centers for Medicare & Medicaid Services).

Providers identified as being excluded will be denied participation or terminated from participation in SWH’s network and will not be considered for participation or reinstatement until the exclusion is lifted and reinstatement is verified. Reinstatement is not automatic. A new application must be submitted, and the credentialing process begun again.

Excluded providers may not receive any payments from federal or state healthcare programs. SWH will immediately stop all payments to providers upon confirmation of provider’s sanction or exclusion and will withhold payment until such time that an investigation is complete and SWH is allowed by state and federal regulators to release payment.

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Providers must ensure that no management staff, individuals with ownership interest in the provider's practice or other persons who have been excluded by Medicaid, Medicare or other federal or state health care programs are employed or subcontracted by the provider. Providers must immediately notify SWH of any imposed sanction or adverse action taken against the provider, any individual with ownership interest in the practice, any member of their staff or subcontractor.

Required Disclosures

Providers must disclose to SWH whether they, a staff practitioner or subcontractor have any prior violation, fine, suspension, termination or other administrative action as a result of violation of any of the following:

- Medicare or Medicaid laws,
- The rules or regulations of any state where the provider practices,
- The federal government, and/or
- Any public insurer

Section 3 – Quick Reference Guide

The SWH Quick Reference Guide is available in job-aid format to answer most commonly-asked-questions. It lists important telephone numbers, fax numbers and web URLs for most needed resources. Additional information on quick reference topics is provided in the appropriate section of this manual. A link to the Quick Reference Guide is found in the Appendix.

3.1 How to contact Senior Whole Health

The Provider Relations Department is your main contact for Senior Whole Health. If a representative can't help you directly, he or she will connect you with the department best able to handle your question or concern. Please remember to check out the provider portal, which is available 24 hours per day, where you may more immediately get answers to your questions regarding member eligibility, claims status and your panel.

Contact	Info
Provider Portal Registration	Online Registration Manual
Provider Relations	1-855-838-7999 Monday-Friday, 8 a.m.-5.p.m. (checked hourly for messages; calls returned within 1 business day)
Provider Relations email	providerrelations@seniorwholehealth.com
Provider Relations fax	617-551-4185 (Attn: Provider Relations)
Member Care Coordination	1-888-794-7268 8 a.m. to 8 p.m., 7 days a week
Clinical Services	1-888-794-7268 8 a.m. to 8 p.m., 7 days a week
Secure email	If you wish to email Protected Health Information (PHI) and do not have a secure email service, call Provider Relations and ask that a secure email be sent to you to establish a link

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Contact	Info
US Mail	Senior Whole Health Attn: Provider Relations 1075 Main Street, Suite 400 Waltham, Massachusetts 02451
Member Services	1-888-794-7268 8 a.m. to 8 p.m., 7 days a week Available after hours for member-specific urgent matters

3.2 How to contact SWH sub-contracted vendors

We use several vendors to administer certain benefits:

- Behavioral Health** Magellan Behavioral Health: 1-800-424-4536 or via email at SWHProvider@Magellanhealth.com
Dental DentaQuest 1-844-234-9829
Vision Vision Services Plan (VSP): 1-800-615-1883

Section 4 – Referrals & Authorizations

4.1 Referrals and authorizations

Senior Whole Health does not require referrals for participating providers. Please refer to the SWH Provider Directory. Authorizations are required for non-participating specialty physicians and for some service types. Refer to the Authorization Grid in the Appendix to determine if a particular service requires an authorization.

4.2 Non-participating physician authorizations

Members who choose non-participating specialty providers may not receive services without an authorization from Senior Whole Health. The SWH Physician Directory is available on our website.

To request services from a non-participating specialist, complete and fax the SWH Standard Prior Authorization form found on our website to the confidential clinical fax line at 617-494-5543. A link to the form can be found in the Appendix. An organization determination letter will be faxed within 14 calendar days unless more time is needed to make a decision. The provider will be notified if SWH needs additional time.

4.3 Durable Medical Equipment (DME) authorizations

All requests for DME must be sent to the vendor, not to SWH. The vendor will supply SWH with all required DME codes.

All vendor requests must be faxed to SWH.

4.4 Home Health authorizations

All Home Health services require an authorization. To request authorization, complete and fax the Universal Home Health Authorization form to the confidential clinical fax line at 617-494-5554 or 508-823-6375. A copy of the form can be found in the appendix. The completed authorization letter will be completed within 14 calendar days unless additional information is required to complete the request.

4.5 Other services requiring authorization

Refer to the Authorization Grid in the Appendix to determine if a particular service requires an authorization. To request authorization for other services, complete and fax the Standard Prior Authorization form found on the SWH website to the confidential clinical fax line at 617-494-5554 or 508-823-6375. The completed authorization letter will be completed within 14 calendar days unless additional information is required to complete the request.

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4.6 Retroactive authorizations

To request a retroactive authorization for any service requiring authorization, complete and fax the SWH Standard Prior Authorization form to the confidential clinical fax line at 617-494-5554 or 508-823-6375 and provide a detailed explanation regarding why the authorization is needed on a retroactive basis. For services provided more than fourteen days prior to the request, the claim may be submitted, denied by SWH and then appealed.

4.7 Inpatient authorizations

Authorization numbers require clinical information. Authorization will not be given, and denial will be issued if clinical information is not received from the provider. Clinical information is required within one day for urgent and non-urgent pre-service inpatient admissions, medical admissions and urgent pre-service outpatient services. Information can be called in to 617-252-6357. When leaving a recorded message, please include your name and phone number, the member's name and SWH ID number, and the date of admission so an SWH clinical staff member can return your call.

4.8 Pharmacy authorizations

A small number of drugs require prior authorization. Other exceptions to the standard formulary require specific documentation. Refer to Section 7 (Pharmacy: Requesting an exception) for instructions specific to the situation.

Section 5 – Claims

5.1 Billing procedures

The information provided here enables providers to comply with the policies and procedures governing Senior Whole Health.

SWH pays clean claims submitted for covered services provided to eligible members. In most cases, Senior Whole Health pays clean claims within 30 days.

A remittance advice is provided for all claim payments. The remittance advice addresses paid and denied, but not pended, claims. SWH accepts both electronic and paper claims.

All claims received must comply with the Health Information Portability and Accountability Act (HIPAA). Industry-standard diagnosis codes and procedure codes are required.

A clean claim must be submitted within 90 days of the date of service or discharge and/or within your specific contract terms. When a member's care is ongoing, a claim must be submitted within 90 days after the last day of the month. We request that providers bill every 30 days. The final bill must be received within 90 days of the last date of service.

Interim billing may be used for inpatient hospital admissions, skilled nursing facility admissions, hospice admissions and other types of ongoing care.

Claims should be billed in accordance with CMS's Correct Coding Initiative (CCI) guidelines. SWH processes claims utilizing CCI-based claims editing software and may deny services that do not conform to CCI guidelines. Because SWH coverage include MassHealth as well as Medicare services, overrides allow some services typically denied by Medicare to be paid by SWH.

When modifiers are utilized in billing and effect pricing, it is important to place those pricing modifiers in the 1st and 2nd modifier positions on the claims (paper and EDI transactions). All other modifiers can follow thereafter. When reporting service units for HCPCS codes where the procedure is not defined by a specific timeframe (untimed CPT/HCPCS), the provider enters '1' in the field labeled units.

For untimed codes, units are reported based on the number of times the procedure is performed, as described in the CPT/HCPCS code definition (often once per day).

Example: A beneficiary received a speech-language pathology evaluation represented by HCPCS - untimely code 92506.

Regardless of the number of minutes spend providing this service, only one unit of service is appropriately billed on the same day.

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Several CPT codes used for therapy modalities, procedures, and tests and measurements specify that the direct (one-on-one) time spent in patient contact is 15 minutes. Providers report procedure codes for services delivered on any single calendar day using CPT codes and the appropriate number of 15-minute units of service.

Example: A beneficiary received occupational therapy (HCPCS - timely code 97530 which is defined in 15-minute units).

5.2 Clean claims

Unless otherwise stated in the providers' contract, all providers must submit clean claims, both initial and corrected, to SWH. The start date for determining the timely filing period is as follows:

- CMS-1500/837P claims: measured by the 'from' date of service
- UB-04/837I claims: measured by the 'thru' date of service

Unless prohibited by federal law or CMS, Senior Whole Health may deny payment of any claims that fail to meet the submission requirement for a clean claim or failure to submit timely.

SWH defines a clean claim as a claim that has no defect, impropriety or lack of substantiating documentation, complies with standard CMS coding guidelines and/or other government program requirements where applicable, and requires no further documentation, information or alteration in order to be processed and paid timely.

To be considered a clean claim by SWH all claims must be submitted on the appropriate claim form, either in electronic format or CMS-1500/UB-04 (or alternative), and have the required fields completed. Electronically submitted claims must comport with all HIPAA Administrative Simplification Act requirements for electronic transactions.

The following information is required for all claims.

Member information:

- Member name
- Member date of birth
- Member SWH member identification number

Provider information:

- Servicing provider name
- Servicing provider address

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- Servicing provider NPI number
- Billing provider group name and address, if applicable
- Billing provider NPI number
- Billing provider federal tax identification number (TIN)
 - TIN/NPI number combination must match the W-9 information on file with SWH

Service level information:

- Date of service (from and to)
- Valid diagnosis codes (ICD-9 or ICD-10 as of 10/1/15)
- Place of service/bill type
- Procedure code (CPT-4, HCPCS or successors) and/or revenue code
- Modifier, as required
- Units, properly measured (per visit, per minute, etc.)
- Total billed charge

5.3 Non-clean claims

A non-clean claim is a claim that requires corrected data, additional information or further investigation in order for it to be processed.

The following are considered non-clean claims:

- Claims to be investigated for coordination of benefits, subrogation or worker's compensation
- Claims that require medical records for processing
- Claims that include billing for non-covered services
- Claims that include billing for unlisted procedures
- Claims lacking any of the required element of a clean claim

5.4 Electronic Data Interchange (EDI) claims

Independence Care Systems accepts electronic claims through EDI as its preferred method of claim submission. All files submitted to Senior Whole Health must be in the ANSI ASC X12N format, version 5010A or its successor version.

Claims submitted via EDI must comply with HIPAA transaction requirements. EDI claims are to be sent via clearing house. Senior Whole Health works with Change Healthcare and Ability Network.

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For claims to be routed to Independence Care Systems, please be sure to include our payer ID number — 83035. This pin is the identifier at the clearinghouse to route claims directly to Claims Operations Department.

Type	Format	Submit to:
EDI – Institutional claims	HIPAA compliant 837-i format	EDI Payer ID 83035
EDI – Professional claims	HIPAA compliant 837-p format	EDI Payer ID 83035
Paper and correct claims	CMS-1500 or UB-04	Senior Whole Health Claims Department P.O. Box 956 Elk Grove Village, IL 60009-0956
Appeals	Claims appeal form and any additional documentation	Senior Whole Health Claims Department 1075 Main Street, Suite 400 Waltham, Massachusetts 02451
EDI Support: If you are currently submitting via Change Healthcare, you should have a login for ON 24/7 website. ON 24/7 web-based system that allows customers to submit service requests and check on the state of those requests 24 hours a day, 7 days a week. Please contact Change Healthcare directly at 1-888-363-3361 or visit the ON 24/7 site at http://clientsupport.emdeon.com/login.aspx .		

The bill frequency in CLMO5-3 indicates the claim is an original, replacement or a void. For example, a value of ‘7’ represents a replacement claim and a value of ‘8’ represents a void claim.

1	Indicates the claim is an original claim
7	Indicates the new claim is a replacement or corrected claim. The information present on this claim represents a complete replacement of the previously issued claim.
8	Indicates the claim is a voided/canceled claim.

For a replacement or a void, the payer assigned claim number for the last known claim being replaced is sent in Loop 2300, REF02 where REF01 is equal to F8.

5.5 Paper claims submissions

Senior Whole Health accepts submissions of properly coded claims from providers by Electronic Data Interchange (EDI) or standard paper claims. The provider acknowledges and agrees that each claim submitted for reimbursement reflects the performance of a covered service that is fully and accurately documented in the member’s medical record prior to the initial submission of any claims. No reimbursement or compensation is due should there be a failure in such documentation.

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We encourage all providers to submit electronic claims whenever possible. We recognize, however, that some providers may choose to submit for reimbursement using industry-standard paper claim forms. If the provider does submit paper claim forms, both CMS 1500 and UB 04 are acceptable.

All paper claims must be submitted on original claim forms (red ink on white paper). Any missing, illegible, incomplete or invalid information in any field will cause the claim to be rejected or processed incorrectly.

All information must be aligned with the data fields and must:

- Be typed (do not print, hand-write or stamp any extraneous data on the form):
 - In black ink
 - In a large dark font such as Pica or Arial size 10, 11 or 12 point
 - In capital letters
- Have all required fields populated in order to be considered a clean claim
- Have all fields completed entirely and accurately
- Submitted in a 9" x 12" or larger envelope
- Include the correct NPI
- Include the correct member ID number

The typed information must not have:

- Broken characters
- Incorrect NPI
- Incorrect member ID number

5.6 Replacement submission

Replacement and void claims should be submitted electronically using industry-standard claim frequency codes. Providers may submit corrected claims via EDI to correct both paid and denied claims that were previously submitted and processed.

Corrected claims must include:

- The original or last paid claim number
- An indication of these item(s) needing correction
- Submission within 30 days of the original claims Remittance Advice (RA) date

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Corrected claims must not include:

- Handwritten changes
- Correction fluid

A replacement is sent when an element of data on the claim was either not previously sent or needs correction. Examples include incorrect dates of service or units.

To qualify for a replacement, certain identifying information must remain the same. If these values change, the prior claim must be voided, and a new claim sent with the appropriate frequency.

- Provider (2010AA Loop)
- Patient (either 2010BA or 2010CA Loop)
- Payer (2010BB Loop)
- Subscriber (2010BB Loop)
- Institutional statement period (2300, DTP Segment)

*Enter claim frequency type code (billing code) in the 2300 loop in the CLM*05 03.*

*Enter the original or last paid claim number in the 2300 loop in the REF*F8*.*

5.7 Void submission

When identifying elements change, a void submission is required to eliminate the previously submitted claim. The entire claim must match the original with the exception of the claim frequency code, condition code and payer assigned claim number.

Example:

Incorrect provider, patient, payer, insured and statement period on an institutional claim or patient did not want insurer to be billed for services.

There is no need to send negative values on a void claim. The claim frequency code indicates that the values are negated. If a new original is required after the void, you should verify the void is finalized prior to sending a new one to avoid duplication.

5.8 Correcting/void — paper HCFA 1500 claim

For profession claims, the provider must include the original or last paid claim number and bill frequency code per industry standards. When submitting a corrected or voided claim, enter the appropriate bill frequency code left justified.

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Claim form: CMS 1500

Box number: 22 (list original or last paid claim number)

Title: Medicaid Resubmission and/or Original Reference Number

Instructions: When resubmitting a claim, enter the appropriate claim frequency code left justified in the left-hand side of the field

7- Replacement of prior claim

8- Void/cancellation of prior claim

Example:

22. MEDICAID RESUBMISSION	
CODE	ORIGINAL REF. NO.
7 OR 8	1234567890A33456

5.9 Correcting/void — paper UB04 claim

For institutional claims, the provider must include the original or last paid claim number and bill frequency code per industry standards.

Example:

Box 4 – Type of Bill: the third character represents the "Frequency Code"

Box 64 – Place the Claim number of the Prior Claim in Box 64

3a PAT. CNTL. #			4 TYPE OF BILL		
b. MED. REC. #			117	298370064	
5 FED. TAX NO.	6 STATEMENT COVERS PERIOD FROM	7 THROUGH			

5.10 Claims appeals

A claim appeal is a provider's written notice to SWH challenging, contesting, appealing or requesting reconsideration of a claim or a bundled group of substantially similar claims that are individually numbered and have been denied or adjusted. Claims appeals must be submitted in writing to the SWH claims department. Appeals must be submitted on the Provider Payment Dispute and Adjustment form found on the SWH website.

The appeal must include:

- Provider's tax ID number
- Provider's contact information (an individual person's name and phone number)

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- Claim number(s)
- SWH member's ID number
- Date of service
- CPT or HCPCS codes
- Authorization number (if authorization was required)
- A clear explanation of basis upon which the provider believes the payment amount (denial or adjustment), the request for additional information, the request for reimbursement for the underpayment of the claim or other SWH action is incorrect.

When submitting multiple batches of claim appeals:

- Sort appeals by similar issue or by individual member name
- Provide a Provider Payment Dispute and Adjustment form for each batch that gives a summary description of all the batches
- Number each Provider Payment Dispute and Adjustment form

Mail via US Mail to:

Claims Operations Department
Senior Whole Health
1075 Main Street, Suite 400
Waltham, Massachusetts 02451

5.11 Incomplete provider appeals

Provider appeals that do not include all required information as listed above will be returned to the submitter for completion. Appeals will be closed if complete information, as requested, is not received within 30 days of the request for additional information.

Payment disputes:

- Seeking resolution of billing determination (adjusted, denied, paid incorrectly or overpaid)
- Disputing a request for recovery of overpayments
- Seeking resolution of a contractual issue

If you believe SWH is paying an amount different than was contractually agreed upon, please direct your dispute to the Provider Relations Department at 1-855-838-7999.

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Member appeals:

- Appeals made by a provider on behalf of a specific member

Please direct member appeals to the SWH Claims Department at 1-866-233-4773. See Section 7 — Membership and eligibility for more information on filing member appeals.

Incomplete or incorrect claims:

If a claim is found to be incomplete or incorrect, the claim will be denied, and an appropriate reason code will appear on the remittance advice. For example, an NPI number and provider name may not match or a quantity may not have been specified when one was required. The claim may be resubmitted with the requested information.

Senior Whole Health does not discriminate or retaliate against providers due to appeals.

6.1 Eligibility inquiry

Senior Whole Health strongly recommends that providers confirm member eligibility prior to every scheduled service. For emergency services, please verify eligibility as soon as possible following provision of the service. We provide a number of tools for checking eligibility but prefer that providers use online tools.

SWH Provider Portal:

- Access portal via <https://swhiweb.seniorwholehealth.com/providerportal> to check member eligibility. (See the Appendix for instructions on how to register.)

NEHEN (New England Healthcare EDI Network):

- Log in and select Medicaid as the payer. Scroll to the Additional/Alternate Payer section; SWH is listed in the Managed Care Coordinator subsection.
- Available at no cost to NEHEN members.
- For NEHEN membership and other information, visit www.NEHEN.org or call 781-290-1290.

New MMIS:

- Log in to the Provider Online Service Center, click Manage Members/Eligibility and look up patient by SSN or member name and DOB.
- Scroll to the section titled List of Managed Care Data (for MCO).

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- Free registration for MassHealth providers
- New MMIS also has an Interactive Voice Response (IVR) option for up to three patient inquiries per call at 1-800-841-2900.

6.2 Filing an appeal or grievance on behalf of a member

A physician may, when acting on behalf of a member, file an appeal or grievance. You must have the member's written consent to do so. To be appointed as a member's representative, both the member making the appointment and the representative accepting the appointment must sign, date and complete an Appointment of Representation form. A non-clinical representative may also complete and sign the form with the member's consent. Call Member Services at 1-888-794-7268 to request a form.

To file an appeal or grievance on behalf of a member, call or write to us at:

Member Services
Senior Whole Health
1075 Main Street, Suite 400
Waltham, Massachusetts 02451
Phone: 1-888-794-7268
Fax: 1-855-838-7998

Appeals

Senior Whole Health members have the right to appeal a service decision made by us that terminates, suspends or reduces a previously authorized service; denies a requested service or delays providing or arranging for a service.

Appeals procedure:

Appeals will be answered in writing within 30 days of the date of receipt. If a delay is in the interest of the member, we may request a fourteen (14) calendar-day extension.

If information from the physician or other sources indicate that waiting the 30 days could jeopardize the member's life, health or ability to regain maximum function, the appeal will be expedited. Expedited appeals must be resolved within 72 hours.

Grievances

A grievance is any member complaint or dispute expressing dissatisfaction with any aspect of the operations, activities or behavior of a plan sponsor, regardless of whether remedial action is requested. Grievances also include complaints regarding the timeliness, appropriateness of, access to and/or setting of a provided services, procedure or item.

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A provider, when assigned by the member, may file a grievance on behalf of a member within 60 days of the event precipitating the grievance. Grievances regarding quality of care may be filed beyond the 60-day time frame, but no longer than 180 days.

Grievance procedure:

Typically, SWH Member Services handles routine matters and attempts to resolve problems immediately. If the grievance can't be immediately resolved or is more complicated, we may ask you to submit additional information. You must do so within fourteen (14) days of the request.

Grievances regarding quality of care will be investigated by the quality department. SWH will notify the member and/or the member's designated representative of our finding in writing within 30 days of filing the grievance or 44 days if an extension was granted.

We will send a Notice of Plan's Decision Regarding a Grievance for all quality of care grievances and for all types of grievances whenever a written response is specifically requested.

6.3 Referring a prospective member (patient)

SWH offers many options to providers to help them inform patients of the opportunity to join our plan. If you wish to refer prospective members, please note SWH will not reach out to prospective members without a direct request from that patient or the patient's designated representative. We operate a telephone line dedicated to taking prospective member inquiries. The line is staffed by trained and licensed representative. Patients should call 1-888-566-3526.

Business replay cards

We also offer informational brochures and office displays that are available in several languages. These brochures contain a business reply card. A patient may request a call from an SWH outreach representative for more information or to schedule an appointment by completing the requested information on the card and send it to Senior Whole Health. Please contact your Provider Relations Account Manager or call the Provider Relations line at 1-855-838-7999 for details.

We can also work with you to facilitate and develop a mailing to potential members. Providers may send a CMS approved letter to patients to inform them of the opportunity to join our plan. Please call Provider Relations for information.

On-site outreach

Your practice may arrange to have an SWH Account Manager on-site for informational sessions for potential members. Please call Provider Relations to schedule.

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6.4 Who is eligible to become a Senior Whole Health member?

You can become an SWH member if you:

- Are 65 years old or older
- Live in Bristol, Essex, Middlesex, Norfolk, Plymouth, Suffolk, Worcester or Hampden county
- Have both Medicare Part A and B and MassHealth Standard
- Do not have ESRD

Please note: If you have MassHealth Standard but not Medicare Part A and/or Part B, you may be eligible to enroll in our MassHealth Senior Care Options program.

Exclusions:

- Those diagnosed with end stage renal disease
- Residents of an intermediate care facility for the developmentally disabled
- Individuals who are inpatient in a chronic or rehabilitation hospital

An SWH outreach representative will further assess eligibility and assist the applicant with enrollment

6.5 Members who want to change PCPs

SWH members may change their PCP at any time for any reason. If you become aware of a member's desire to change their PCP, please advise them to call Member Services at 1-888-794-7268.

6.6 Member benefits

SWH members receive all the benefits of Medicare, MassHealth and the Medicare Part D Prescription Drug Program. We also offer other medically necessary benefits not typically available through Medicare and/or MassHealth when identified by the member's Personal Care Team as being important to maintaining independence at home.

A full description of SWH benefits is available in the annual Summary of Benefits and the annual Evidence of Coverage. [link to http://www.seniorwholehealth.com/mass/members/summary_of_benefits.htm and http://www.seniorwholehealth.com/mass/members/evidence_of_coverage.htm] To request paper copies, call Provider Services at 1-855-838-7999.

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6.7 Copays, coinsurance and deductibles

SWH members receive covered services paid in full:

- No copays (include no copays for drugs unless required by regulation)
- No deductibles
- No coinsurance

6.8 Additional benefits

SWH members receive additional health and wellness benefits not covered by traditional Medicare and/or MassHealth. You may encourage your patients to take advantage of these:

6.8.1 OTC drug coverage -- We cover OTC medications (listed on the Over-the-Counter formulary) when prescribed by a physician. See Section 7 —Pharmacy for more information on this benefit.

6.8.2 Health club membership/fitness classes -- We cover fitness club memberships up to an allotted dollar amount. Members should call Member Services for additional information.

6.8.3 Preventive health and disease management programs -- We offer programs for the following programs designed to help members and their caregivers better understand chronic conditions or prevent falls. These programs use population-based interventions to help members develop self-management skills that may improve health outcomes, or to assist caregivers in improving outcomes for the member. Programs include:

- Cardiovascular disease (CVD)
- Diabetes
- Fall prevention
- Congestive heart failure (CHF)

Health and disease management program components can include:

- Educational materials that can assist your patients with nutrition, fitness, medication compliance, fall prevention or disease facts
- In-person educational interventions by a visiting SWH Nurse Care Manager
- Telephonic coaching by a Nurse Care Manager or telephonic education through SWH's Client Services
- Appointment reminder and access to PCPs if needed

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- Coordination of home health and DME
- Coordination with Aging Service Access Points (ASAP)
- Coordination with SWH's complex care management programs
- Healthy Living Center of Excellence Program classes

Eligible members have been diagnosed with CVD, diabetes or CHF, or have been identified as being at risk for falls. Members are identified through algorithms based on:

- ICD-10 codes from HEDIS® or
- Pharmacy codes from HEDIS®

Physicians may refer members or members may self-refer. Caregivers may also refer members. Members are automatically opted into a management program if referred or assigned based on diagnosis; however, members may opt out at any time.

We may inform you about gaps in care related to these programs.

6.8.4 Transitions of care – SWH promotes continuity of care between care settings to assist member transitions and to reduce the potential for hospital/facility readmission during periods of high vulnerability. Our Nurse Care Managers actively engage in transition planning and follow-up including facilitating physician communication and follow-up visits, as well as medication management. Services are provided for all members; no requests are necessary. For more information on transitions of care, see Section 12 — SWH Care Model, Transitions of Care.

6.8.5 Non-emergency transportation

SWH's medical transportation benefit is handled directly between SWH and the member, with no paperwork required from the provider (no PT-1 forms). Members may call Member Services directly at 1-888-794-7268 to request transportation to/from medical appointments. Providers who believe a member may need transportation to keep medical appointments may call Senior Whole Health.

As MassHealth recipients, SWH members cannot be held liable for payments. Providers may not bill or collect payment from members for a covered service for any reason. If you have questions, please contact Provider Services at 617-494-5353.

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6.9 Enrollment & Disenrollment

Enrollment

New SWH members are enrolled effective on the first day of the month. Upon enrollment, new members are screened by a geriatric social worker from the local elder services agency (ASAP) to identify needs for community long-term care and social support services. Those who are deemed at risk or nursing home certifiable are screened further by a Nurse Care Manager in their homes. For more information on these procedures, see the Care Management section.

All new members receive a welcome call from Member Services in their own language.

Disenrollment – voluntary

SWH members may voluntarily disenroll at any time, for any reason. All disenrollments are effective on the last day of the month in which SWH was notified of the intent to disenroll.

A provider who becomes aware of a member's wish to disenroll should advise the member or the members representative to contact SWH at 1-888-794-7268. Members with Medicare Part D Prescription coverage will need assistance with the transition.

SWH will ensure the member understands when coverage will discontinue. We advise members about the transition back to Medicare, Mass Health and Medicare Part D or another health plan.

Disenrollment – involuntary

SWH may disenroll a member involuntarily for a number of reasons. The most common reason for involuntary disenrollment is loss of MassHealth eligibility. SWH regularly monitors members' MassHealth eligibility. If a member needs to complete a redetermination application for MassHealth, SWH will attempt to assist the member in order to meet the deadline and avoid disruption of service.

Disenrollments are effective on the last day of the month in which the member loses eligibility.

Examples of voluntary disenrollment	Examples of involuntary disenrollment
<ul style="list-style-type: none">▪ Member wishes to change plans▪ Member wishes to return to fee-for-service Medicare or MassHealth coverage▪ Member wishes to see an out-of-network PCP	<ul style="list-style-type: none">▪ Member loses MassHealth eligibility▪ Member stayed outside the SWH service area for more than 6 consecutive months▪ Member permanently relocated outside the service area

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Examples of voluntary disenrollment	Examples of involuntary disenrollment
	<ul style="list-style-type: none">▪ Fraud or abuse

Disenrollment – retroactive

A small percent of SWH members are retroactively disenrolled from the plan. The typical reason for retroactive disenrollment is a determination by MassHealth that the member lost eligibility. MassHealth makes these determinations.

Please refer to the Section 5 – Claims for information on the financial implications of retroactive disenrollment.

6.10 Senior Whole Health member ID card

SWH member ID cards list the member’s name and date of birth, the plan ID number, the plan membership effective date, the PCP name and contact information, copay information and SWH contact information. (See the Appendix for a sample ID card.)

6.11 Member rights and responsibilities

Member rights

SWH is dedicated to providing quality health care services for our members and to treating each member with dignity and respect. Member rights include the right to:

- Obtain a second opinion from a qualified health professional within the Provider Network prior to surgery at no cost to the member.
- Receive information about SWH services, practitioners and providers, enrollment, informational or instructional materials, grievance and appeal rights, and the member’s rights and responsibilities annually in a manner appropriate to their condition and ability to understand;
- Receive reasonable accommodations if required;
- Be treated with respect and recognition of their dignity and their right to privacy;
- Participate with practitioners in making decisions about their health care, including the right to refuse treatment;
- Have a candid discussion of appropriate or medically necessary treatment options for their conditions, regardless of cost or benefit coverage;
- Voice complaints or appeals about SWH or the care provided;
- Make recommendations regarding SWH’s member rights and responsibilities policy;
- Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation;
- Request and receive a copy of their medical records and request that the record be amended or corrected;

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- Not to be balanced billed by a provider for any service;
- Receive updates and/or changes to the rights and responsibilities at least annually;
- Receive access to the Evidence of Coverage annually; and
- Exercise their member rights without negative consequences.

Member Responsibilities

SWH defines basic member responsibilities to include the following:

- Provide, to the extent possible, information SWH and its practitioners and providers need in order to care for a member;
- Follow the agreed upon plans and instructions for care;
- Be familiar with covered services and the rules the member must follow to obtain the covered services;
- Inform SWH if there is any other health insurance coverage or prescription drug coverage in addition to the SWH plan;
- Tell their doctors and other health care providers they are enrolled in a SWH plan;
- Help doctors and other providers help the member by giving the doctors and providers information, asking questions and following through on the care plan;
- Be considerate by respecting the rights of other patients and acting in a way that is respectful of a health care practitioner or provider and staff;
- Pay any health care bills owed;
- Tell SWH if there is a change of residence; and
- Call Member Services for help when there are questions or concerns.

6.12 Member complaints about office settings

SWH will conduct a site visit if we receive three (3) or more member complaints in a 12 month period about an office site (including cleanliness or access); or if a practice-specific survey detects a deficiency; or if an unfavorable report is received as a result of a provider relations site visit.

- SWH Provider Relations will schedule an on-site office review within 60 days of receipt of the third member complaint or detection of a deficiency.
- SWH will provide a confidentiality statement to the practice prior to reviewing sample patient records as part of the standard on-site review (if patient record reviews are necessary). If requested by the practice, the SWH representative will sign an appropriate confidentiality agreement provided by the practice.

Section 6 – Membership & Eligibility

- Site reviews shall be conducted during normal business hours at a time acceptable to the practice and in a manner so as not to unreasonably interfere with practice operations.
- A trained SWH Provider Relations staff person will conduct the site review using the SWH Office Site Visit Checklist — Office Evaluation Survey Tool. A member of the office practice staff may accompany the SWH reviewer during the entire site review.
- Results of the office visit evaluation will be provided to the practitioner with any corrective action plan required.
- If deficiencies are noted, the site must develop and submit a corrective action plan for improvement within 30 days of notification of the office visit results.
- Once an action plan has been submitted and approved by SWH, a SWH site representative shall evaluate the site at least every six (6) months and shall reassess each area where a deficiency is noted until the performance standard for that area has been met.

Section 7 – Pharmacy

7.1 Contact information

SWH pharmacy technicians and clinical pharmacists are available via phone to review Medicare Part D medication coverage requests, discuss coverage denials, review complex medication regimens or answer any pharmaceutical questions you may have. Please use the contact information below to make any request.

Phone: 617-252-6366
Toll free: 1-855-818-4876
Hours: Monday – Friday, 8 a.m. to 8 p.m.
After hours: 1-855-818-4876
(A pharmacist is on call from 8 a.m. to 8 p.m. on weekends and holidays)
Fax: 1-844-810-2659
Email: pharmacy.seniorwholehealth.com

Pharmacy prior authorization and coverage determination requests fax number: 1-888-251-7823

7.2 Resources

The following resource materials are located on our website at <https://www.seniorwholehealthma.com/for-providers-2/provider-materials/>

Comprehensive Formulary

- Over-the-counter (OTC) & Additional Coverage Drug List
- Prior authorization criteria
- Prior authorization form
- Step therapy algorithms
- Information about quantity level limits

The most up-to-date documents are posted on our website the same day changes take effect. We will also remind you of recent formulary changes in your quarterly Provider Newsletter.

7.3 Senior Whole Health pharmacy benefits

Section 7 – Pharmacy

SWH pharmacy benefits include medications in three benefit categories:

1. **Medicare Part D-eligible formulary:** SWH reviews and updates an extensive formulary on an ongoing basis
2. **Medicaid covered OTC and additional drugs:** This list includes many OTC drugs and some prescription medicines not covered under the Part D benefit but covered under Medicaid. A prescription is required.
3. **Medicare Part B drugs provided at the pharmacy:** Some oral, injectable or inhaled prescription drugs may be eligible for payment under either Part B or Part D. When the claim is submitted by a pharmacy, SWH pharmacy will determine the correct benefit and pay the claim. The SWH pharmacy does not review or determine Part B claims submitted by a prescriber or provider (only a pharmacy). See Section 5 for physician billing instructions.

SWH members have no out-of-pocket expense for drugs on the formulary or approved by SWH.

Vaccines:

- Senior Whole Health provides coverage for Part B and Part D covered vaccines for our members.
- Vaccines can be administered and billed by a provider or a pharmacy.
- Pharmacists are considered to be Part D providers by Medicare.
- Physicians that purchase and administer vaccines for our Medicaid SCO members should bill SWH directly for the vaccine and its administration.
- Claims processors and plan sponsors must provide a method for physicians and pharmacists to be able to bill for vaccines and the administration of vaccines regardless of whether the vaccine is covered under Medicare Part B or Part D.
- Physicians that purchase and administer Part D covered vaccines in their office must bill for the vaccine and administration through an intermediary such as TransactRX.
 - To enroll in Transact Vaccine Manager, visit https://www.mytransactrx.com/ws_enroll/enrollinstructions.jsp
 - Please contact TransactRX direct at 1-866-522-EDVM (386) to submit Part D-covered vaccine claims or visit https://www.mytransactrx.com/ws_enroll/login.jsp?profile=TRANSACTRX
- When billing Vaccine Manager for Part D vaccines, you must also submit the administration code.
- Do not bill the member for administration of Part D vaccines. Vaccine Manager will reimburse you directly for both the vaccine and its administration costs. Part D-covered vaccines must be submitted within 30 days of administration.

When you are administering a vaccine that has been provided by the member or their pharmacy, you may submit the administration code directly to SWH, regardless of whether the vaccine is a Part B or a Part D vaccine. Never charge a SWH member for the cost of administering a vaccine.

Section 7 – Pharmacy

The chart below provides a list of common Part B and Part D vaccines.

Part B	Part D	
<p><u>INFLUENZA:</u> AFLURIA EZFLU FLUARIX FLUBLOK FLUCELVAX FLULAVAL FLUMIST FLUVIRIN FLUZONE PHYSICIANS EZ USE FLU</p> <p><u>PNEUMOCOCC AL:</u> PNEUMOVAX PREVNAR 13 SINGLE USE EZ FLU</p> <p><u>HEPAITIS B SINGLE:</u> ENERGIX-B*</p>	<p>ACTHIB ADACEL BCG VACCINE BEXSERO BOOSTRIX CERVARIX COMVAX DAPTACEL DTAP DIPHTHERIA-TETANUS ENGERIX-B* GARDASIL HAVRIX HIBERIX IMOVAX RABIES INFANRIX DTAP IPOL IXIARO KINRIX M-M-R II MENACTRA MENHIBRIX</p>	<p>MENOMUNE-A-C-Y-W-135 MENVEO A-C-Y-W-135-DIP MUMPSVAX PEDIARIX PEDVAXHIB PENTACEL PROQUAD QUADRACEL DTAP-IPV RABAVERT RECOMBIVAX-HB Shingrix TENIVAC TETANUS-DIPH TETANUS-TOXOID TRUMENBA TWINRIX TYPHIM VI VAQTA VARIVAX YF-VAX ZOSTAVAX</p>

Drugs excluded from the benefit

Certain drugs not covered by Medicare or MassHealth may not be covered by SWH. For example, drugs prescribed for erectile dysfunction are not covered. There may be technical or regulatory reasons that a drug is not covered.

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7.4 Drugs with special requirements or restrictions

Drugs requiring an exception: Certain drugs and certain situations require a pharmacist review for coverage. All drugs requiring review are noted in the formulary as having a restriction (e.g. prior authorization) or are not listed in the formulary.

Our formulary is updated monthly. For the most up-to-date formulary, visit our website at www.seniorwholehealth.com

Process for a formulary exception

Providers may request coverage from the SWH pharmacy prior authorization team by:

- Using our website at www.seniorwholehealth.com/request-for-medicare-part-d-prescription-drug-coverage.html
- Sending an email to pharmacy@seniorwholehealth.com
- Faxing us at 1-888-251-7823
- Calling 1-855-818-4876

If you need clarification regarding special requirements or restrictions, please call us at 1-855-818-4876. For immediate resolution, please call us.

SWH sends all approval and denial notifications to the requesting provider's office via fax. If fax is unavailable, SWH will provide either verbal or written (mailed) notification with required timeframes. All exception request decisions are made within 72 hours of receipt of a complete supporting statement. A prescriber can request an expedited exception decision, which will be made within 24 hours of receipt of the complete supporting statement. Most decisions, both standard and expedited, are made much sooner than the required turnaround time. Prior authorization expedited decisions are made within 24 hours of receipt of the request.

Prior authorization (PA): Drugs requiring prior authorization often require clinical information from your office. Use the PA form available on the SWH website and through www.covermymeds.com. The form is available in the Appendix.

Step therapy (ST): Certain drugs require that a member try one drug or group of drugs before going to the next drug or group of drugs. If the member has tried the pre-required drugs within the specified timeframe, the next step will be processed without office intervention. If step therapy is not appropriate for the patient, call the SWH prior authorization team for an exception. Algorithms are available on our website.

Section 7 – Pharmacy

Quantity limits (QLL): For certain drugs, SWH limits the quantity that can be prescribed per time period. Quantity limits are specified for clinical and/or cost reasons. SWH does not require table splitting; however, dosage consolidation is required. A pharmacy or the SWH Pharmacy Department may call to suggest alternative quantities of the same drug. Exceptions are granted when titrating a drug dosage up or down. A list is available on the SWH website.

Medicare Part B vs. Medicare Part D: Certain medications may be covered by a different part of Medicare depending on the diagnosis. For example, anti-emetics when used in conjunction with chemotherapy are covered under part B; whereas, they are typically covered under Medicare part D. Both Part B and Part D drugs are covered by SWH. A diagnosis is needed in order to categorize medications for specific members. Include the diagnosis when writing prescriptions.

7.5 Quantity supply per prescription

30- or 90-day supplies: Pharmacies are contracted to provide either a 30-day or 90-day supply of medications per prescription. Prescribers are encouraged to write 90-day prescriptions as appropriate as many SWH network pharmacies will provide a 90-day supply of medications. Members may also order 90-day supplies from Express Scripts Mail Order Pharmacy. Physicians may advise members to all SWH Member Services to find the most convenient 90-day pharmacy.

Vacation supplies: 90-day supplies mitigate the need for special vacation prescriptions. SWH grants vacation overrides as needed (refills ahead of schedule and/or larger-than-usual quantities). Supplies of greater than 90 days require special authorization by SWH.

Lost medications: There is no need for authorization for your office unless a pattern is detected. A member, physician or pharmacist may call for an override if a medication was lost or left behind.

7.6 Special compliance packaging

If a SWH member needs assistance in managing their medications, specialized packaging may be appropriate and helpful. Please contact the Pharmacy Department if you would like to set this up for a patient.

7.7 Medication Therapy Management (MTM)

Managing medications appropriately keeps our members out of hospitals and nursing homes. MTM is available to all SWH members. SWH contracts with a vendor that uses both retail and consultant pharmacists to meet with and counsel patients about the medication use. Providers can make special requests for these services. Call the SWH Pharmacy Department at 1-855-818-4876 to refer a patient.

Section 7 – Pharmacy

7.8 Medication recall notifications

Senior Whole Health pharmacists monitor FDA notifications for drug recalls. Our pharmacy will notify you of any Class II recall by fax or by mail within 30 calendar days. We will notify you of any Class I recall by fax or mail within 72 hours. SWH will contact members who have paid claims for recalled medications, but you should also contact members to discuss what action needs to be taken.

FDA definitions

Class I recall: A situation in which there is a reasonable probability that the use of or exposure to a violative product will cause serious adverse health consequences or death.

Class II recall: A situation in which use or or exposure to a violative product may cause temporary or medically reversible adverse health consequences or where the probability of serious adverse health consequences is remote.

Class II recall: A situation in which use of or exposure to a violative product is not likely to cause adverse health consequences.

Please contact our SWH Pharmacy Department at 1-855-818-4876 with any questions about drug recalls.

Section 8 – Primary Care Providers

8.1 Primary care team (PCT) and responsibilities

SWH forms a primary care team (PCT) for certain members. The PCT is designed to assist providers with management of members with complex care needs by offering SWH resources to coordinate non-medical resources, such as transportation, personal care, homemaking and medication management.

The PCT is comprised of the member's PCP or clinical designee at the practice, the SWH Nurse Care Manager and, if the member is a community resident, a Geriatric Support Services Coordinator. The PCP or practice designee provides clinical direction and oversight. If needed, other professionals and support disciplines may be invited to participate in evaluation and planning services.

SWH reimburses the PCP for participation in the PCT.

PCT meetings range from a brief telephonic discussion to a face-to-face meetings. The purpose is to review complex care members and identify those members who need SWH nurse care manager assessment.

8.2 Monthly PCP reports

PCP practices receive a monthly panel report via mail identifying the SWH members in their panel and the current month activity. Panel reports include:

- Member disenrollments which are retroactive and reflect those from the prior month.
- Member effective dates.
- A header message – usually clinical in nature.

If you see a member on your panel who is not your patient, please contact Provider Relations at 1-855-838-7999.

Practices with professional email addresses may receive panel reports via secure email. Email accounts may not be internet-based, i.e. Yahoo, Gmail, Hotmail, Mail.com, etc. or belong to an individual employee of the practice.

PCP practice billing groups/entities also receive a monthly roster showing current active members.

NOTE: PCPs of long term care residents who become SWH members do not need to complete an initial assessment or subsequent assessments. The nursing home must complete an MDS 2.0 and return it to SWH within the requested number of days.

8.3 Member initial assessment

Initial assessments are critical in that they allow the member's SWH Nurse Care Manager to understand the key issues facing the member.

Section 8 – Primary Care Providers

SWH combines information from the PCP completing the assessment with the information gathered during the home-based assessment to more easily and quickly identify a new member's health and functional status.

This tool is critical to improving outcomes; therefore, we pay PCPs upon receipt of completed forms.

The initial assessment form

Provider may download the form from our website.

Providers with an EMR (Electronic Medical Record) may pull the required data from the EMR and send to SWH in lieu of our form. Chart summaries from the EMR with an e-signature are acceptable. Please note: assessments must include the member's:

- Clinical and non-clinical assessment
- Current diagnoses
- Medications
- Allergies
- Advance directives
- Health care proxy
- Any other pertinent information
- PCP signature (may be electronic)

Notes pertaining to a specific visit or notes limited to a prescription change are not adequate.

When should assessment forms be completed?

1. Whenever a new member joins; this is critical to implementing timely treatment and other interventions.
2. When significant health changes occur, including when a member enters a nursing facility, has a new diagnosis or there is a change in his or her ability to complete an ADL.
3. Annually, even if no significant health changes occur.

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Send completed forms to:

Clinical Services

Attn: PCP Assessments

Senior Whole Health

1075 Main Street, Suite 400

Waltham, Massachusetts 02451

Fax: 617-494-5554

8.4 Opening and closing a member panel

SWH defines the following panel statuses:

- New: PCP will accept SWH members as new patients
- Existing: PCP will only accept those patients currently in their practice who choose to join SWH
- Nursing home only: PCP will only accept new SWH members who reside in long-term care facilities

All panel status changes require written notice to SWH at:

Senior Whole Health

Attn: Provider Relations

1075 Main Street, Suite 400

Waltham, Massachusetts 02451

8.5 Removing members from provider practices

SWH views decisions to terminate a physician-patient relationship very seriously. We are available to assist providers with difficult patient situations. You may seek assistance from Member Services by contacting 1-888-794-7268. You must send the member a written notification clearly stating the reason(s) for the termination and the effective date with a reference to the PCP's internal policy by certified mail, return receipt. You must also forward the same correspondence to SWH at the following address:

Senior Whole Health, LLC

Attn: Member Services Director

1075 Main Street, Suite 400

Waltham, Massachusetts 02451

Section 8 – Primary Care Providers

You must continue to provide care to the member for at least 30 days after the termination date. SWH will assist the member in selecting another PCP and will notify you if the transition occurs in less than 30 days.

8.6 Visit and access requirements

All urgent care and symptomatic office visits must be available to members within 48 hours. A symptomatic office visit is an encounter associated with the presentation of medical symptoms or signs, but not requiring immediate attention.

All non-symptomatic office visits must be available to members within 30 calendar days of the member's request. Examples of non-symptomatic visits include well and preventive-care visits for covered services, such as annual physical examinations and immunizations.

PCPs must ensure 24/7 access to physician consultation (at least by telephone). PCPs must also have arrangements with covering health care providers to provide for the provisions of medically necessary services when the PCP is not available.

8.7 Medical Records

Each primary care office is responsible for maintaining adequate (paper or electronic) medical records of patient care. Records should be maintained in accordance with applicable federal and state privacy laws. SWH has the right to review your records for claims authorization and service authorization. All medical records should be maintained in a manner consistent with professional practices and prevailing community standards.

You are required to maintain records for seven (7) years after termination of your agreement with Senior Whole Health and for the period of time required by federal and state law and membership contracts, including the period required by CMS and NCQA.

Access to and copies of records

Our Client Services and/or Compliance Department staff may request records from your office for one of our covered members for several reason, including:

- Quality of care measures (HEDIS)
- HCC risk adjustment
- Authorization requests
- Claims payment issues
- Assistance with case coordination
- Determination of requests to term member from provider panel status

Section 8 – Primary Care Providers

- Follow up to a member complaint

Confidentiality of information

Providers are responsible for ensuring and maintaining the confidentiality of information about members and their medical records in accordance with applicable federal and state laws. The names of any member receiving public social services must be kept confidential and protected from unauthorized disclosure. This includes all information, records and data collected and maintained for the operation of the agreement. Providers may not use any such information for any purpose other than carrying out the terms of the agreement. In compliance with The Health Insurance Portability and Accountability Act (HIPAA), members are entitled to an accounting of any disclosure of information.

8.8 Nurse Practitioners (NPs) as PCPs

SWH allows NPs to practice as PCPs and hold their own panels. In order to qualify for this status, the following conditions must be met:

- The NP must be delivering care in a practice contracted with SWH for primary care services
- The NP must be delivering care under a supervising MD, who must be credentialed with SWH
- The NP must have arrangements for admitting at an SWH contracted hospital
- NPs not yet credentialed with SWH must follow guidelines for becoming a credentialed provider (see Section 12 — Credentialing).
- NPs must notify SWH of the desire to act as a PCP by contacting SWH Provider Relations at 1-855-838-7999.
- An NP can begin building a member panel following receipt of a “Change in Status” letter for currently credentialed NPs or a “Welcome Letter” for newly credentialed NPs.

When the status is changed to PCP-NP, the NP’s name will appear in our Provider and Pharmacy Directory as a PCP-NP; and the practice can inform current patients of the opportunity to select the NP as a PCP.

(NB: Providers on older contracts may require a simple contract amendment. Call Provider Relations with questions.)

Billing for NPs as PCPs:

All nurse practitioners, both PCP and non-PCP, should bill using their own NPI number. Do not bill “incident to.”

Section 9 – Specialty Care Providers

9.1 Referrals

Specialists who are participating with SWH do not need to obtain an authorization for professional services rendered in an office or outpatient setting.

Elective hospital admission do require authorization.

Referrals to non-participating specialists must come from the member's PCP and be authorized by SWH. See Appendix for a copy of the Authorization Request Form.

If a specialist feels that additional treatment is required and he or she cannot provide these services, the specialist is responsible for contacting the member's PCP and suggesting the PCP provide the member with an additional referral.

Section 10 – Quality Improvement Program

10.1 Introduction

The SWH Quality Improvement Program (QIP) is an ongoing, systematic, interdisciplinary program designed to measure, assess and improve the quality of care and services provided by SWH to its members, and to support the mission of SWH to “maximize the quality of life, health, security and independence of members.” The QIP includes medical and behavioral health aspects of care as well as issues related to patient safety. The program description includes the scope of the program and the processes and information resources used to assist in identifying opportunities for improvement in care and services. Annually, Senior Whole Health selects specific quality improvement initiatives to focus on in our Quality Work Plan. When the year is over, we conduct a full program evaluation. The QIP Summary Description is available in the Appendix. A complete copy of the QIP Description can be obtained by contacting Provider Relations at 1-855-838-7999.

10.2 Participating providers

As part of their commitment to the Quality Improvement Program, SWH’s contracted providers are expected to:

- Abide by the policies and procedures set forth by SWH
- Actively take part in SWH’s care management process, serving as vital participants of the member’s Primary Care Team and working to ensure optimal delivery of care and services
- Participate in relevant quality improvement initiatives
- Cooperate with medical chart review activities and audits
- Provide member information in support of state and federal regulations and accreditation standards.

10.3 Quality model

The purpose of the QIP is to assess the quality and appropriateness of care and services members receive. The program assists Senior Whole Health’s Board of Directors in developing strategies to maintain and improve quality within the organization as a whole. The board has ultimate authority and responsibility for quality of care and services provided to SWH members. The board delegates its quality improvement responsibilities to the Quality Improvement Committee (QIC) and Chief Medical Officer. The Medical Advisory Committee, a subcommittee of the QIC chaired by the Chief Medical officer or a Medical Director, provides advice and consultation on clinical quality of care issues.

Quality improvement activities focus on member satisfaction, complaints and appeals, contract services and credentialing, clinical services, utilization management and clinical program initiatives, outreach activities, education and reporting compliance.

Section 10 – Quality Improvement Program

The QIP's major function is assessment of the quality of care provided to members as well as the overall efficacy of SWH health care initiatives.

Section 11 – Senior Whole Health Care Model

11.1 Program and philosophy

Senior Whole Health's Care Model reflects its mission to maximize members' quality of life, health, security and independence. With its unique capacity to integrate all Medicare Part A and B, Medicare Part D and MassHealth benefits, the care model mitigates fragmented care, promotes extended community care tailored to individual needs and supports members and providers through care coordination to avoid acute care episodes and unnecessary long-term placement.

The SWH Care Model is grounded in the philosophy that:

- Care should remain local and aligned with the providers and community with whom the elder is familiar.
- Member choice in care setting, planning and services is fundamental
- Coordination and advocacy across time, change in health and functional status and care setting is the optimal way to provide care.
- Care is holistic, including psychosocial, behavioral and spiritual needs as well as physical.
- Cultural and linguistic competency is critical to access and quality of care.

The core elements of a patient-centered medical home are fundamental to the SWH Care Model. The member is at the nucleus of a care system and the PCP is the "medical home" providing medical oversight in care planning and delivery. SWH supports the PCP through the use of Nurse Care Managers who focus on care coordination. Assessment and screening for both medical and psychosocial needs, risk identification, care planning, and ongoing monitoring and reassessment are supported by the SWH Nurse Care Manager and other care team participants. SWH offers preventive services and other benefits to promote the health and well-being of the member and caregiver, all of which are incorporated into the care planning process.

The wide array of community support services available to SWH members promotes independence and options for elders to remain in the community while also recognizing and supporting the need for institutional care as the right choice for some members.

11.2 Interdisciplinary Care Team and responsibilities

The SWH Care Model is supported by SWH staff that actively assist with care planning, advocacy and care coordination along with the PCP. Care plans tailored to individual needs and services are evidenced-based and quality driven. To ensure a comprehensive, holistic approach to meeting members' needs, a Primary Care Team of professionals and paraprofessionals is used for assessment, coordination and monitoring. The interactions may be telephonic, written or in-person. The PCP may invite other professional and persons critical to meeting the care needs of the member to participate in evaluating and planning services. The member and his or her designated representative are active participants in care plan decisions.

Section 11 – Senior Whole Health Care Model

Primary Care Team (PCT) participants include:

- Member and caregiver(s)
- Primary care provider (PCP)
- SWH Nurse Care Manager
- Aging Services Access Point (ASAP) Geriatric Support Services Coordinator (GSSC)
- SWH pharmacy consultant
- Customer Care Associates (CCA)
- Community service coordinators (CSC)
- Behavioral health consultants
- Others as needed.

11.3 Primacy care provider (PCP)

Each SWH member is required to select a network PCP at the time of enrollment. Generally, this is the PCP with whom the member has an established relationship. The PCP is the team leader and provides overall clinical direction to the PCT and serves as the “medical home” for the member. The PCP:

- Provides medical oversight
- Provides primary care services
- Assesses the member initially and ongoing as needed
- Collaborates in Individual Care Plan development and reinforces care plan compliance
- Works with SWH to identify changes in member status

11.4 Role of the nurse care manager (NCM)

SWH Nurse Care Managers are RNs; they do not provide direct care. SWH has three (3) types of Nurse Care Managers with expertise in specific care settings.

NCM Type	Responsibilities
Community Nurse Care Managers	Manage members with complex care needs residing in the community who require intensive care management of multiple services

Section 11 – Senior Whole Health Care Model

NCM Type	Responsibilities
Skilled Nursing Facility (SNF) Nurse Care Managers	Manage long-term custodial members and coordinate discharge planning with Community NCMs for members with short-term SNF stays
UM Nurse Care Managers	Authorizes hospital, SNF and other facility stays, assists with discharge planning transitions and coordinates with the NCM assigned to the member.

Community Nurse Care Managers

All Members are assigned a SWH Nurse Care Manager (NCM). The NCM's primary responsibilities are to conduct care planning and coordinate services for community-based members with complex care needs. The NCM is the single point of contact for providers and their role is to foster clear and consistent communication among the PCP, member and other providers.

Ongoing communication and collaboration between the PCP and NCM is essential for care plan development and implementation. Interaction with the PCP may be telephonic, written or in person. A SWH NCM is available telephonically 24 hours a day, 7 days a week.

The Community NCM:

- Assesses members in their homes and meets directly with family/caregivers
- Develops Individual Care Plans and communicates with the member, PCP and other providers to implement and manage the care plan
- Arranges and coordinates services identified in the care plan and coordinates care across care settings
- Reviews and monitors care plan with the PCP, ICT and Member

SNF Nurse Care Managers

A SNF NCM is assigned to each contracted nursing facility and is on site at least weekly. Like their community counterparts, SNF NCMs coordinate among providers and facilitate care plan development and implementation. In addition to managing custodial members, the SNF NCM oversees members receiving short-term care and collaborates with the Community NCM for transition of care upon admission and discharge.

Section 11 – Senior Whole Health Care Model

11.5 Aging Services Access Points (ASAPs) and Geriatric Support Services Coordinators (GSSCs)

ASAPs are local elder agencies responsible for state home- and community-based services such as homemaking, personal care, meal preparation, etc. These agencies are essential in helping keep members at home and preventing hospitalization or nursing home placement. SWH contracts with ASAPs for care management services by a GSSC and for other home-based services. Every community-residing SWH member, regardless of health status, is assessed upon enrollment and at scheduled intervals by a GSSC for functional status and psychosocial needs. The GSSC collaborates with the SWH NCM in care planning and service implementation as well as performing reassessments.

11.6 Senior Whole Health Pharmacy Department

SWH's Pharmacy Department works closely with SWH NCMs and providers to assist in the management of care for SWH members. Goals of Pharmacy Care Management are safety, assess, compliance, education and optimization of therapy. As a provider, you can request a medication review for your patients. In addition, the Pharmacy Department is actively engaged in programs related to medication management and medication reconciliation.

11.7 Role of SWH Member Support Representatives (MSR) and Community Services Coordinators (CSC)

SWH serves a linguistically and culturally diverse elder population making the delivery of health care more challenging. To address this issue, SWH has incorporated Customer Care Associates into the clinical arena with multi-lingual staff representing major language groups. Customer Care Associates have a role that goes beyond traditional Member Services by providing personal, high-touch telephonic communication. MSRs are available to respond quickly to questions and concerns. They educate members upon enrollment and have a roster of members they contact on a regular basis to identify changing needs or confirm health status.

Community Service Coordinators (CSC) are also linguistically and culturally diverse. They communicate routinely with the GSSC to review long-term care assessments. CSCs work with GSSCs and members to coordinate with local agencies and providers and the SWH NCM to ensure clinical and community-based resources are effectively linked.

11.8 Care management process

SWH is committed to empowering our members and their families to participate in short- and long-term planning to support community living as long and as safely as possible. The health status and care needs of individuals are fluid. SWH incorporates systems to ensure ongoing re-evaluation and restructuring of care services to respond to changing needs.

Section 11 – Senior Whole Health Care Model

11.8.1 Assessment and risk categories

SWH conducts multidimensional assessments of our members in order to:

- Have baseline information about the member’s health status, services and unmet needs
- Stratify for risk in order to ensure adequate care management oversight
- Ensure continuity of existing services upon enrollment in Senior Whole Health
- Develop appropriate individual care plans
- Enable ongoing monitoring and rapid identification of status changes.

Assessments include appraisals of:

- Diagnostic conditions
- Functional status Activities of Daily Living (ADL) and Instrumental Activities of Daily Living (IADL)
- Psychosocial status
- Informal and formal support systems

Risk categories

Based on assessment, members are stratified into risk categories aligned with the intensity of care management needs.

Category	Risk	Definition	Care Manager
Community Other	Low risk	No ADL or IADL deficits, high functioning; limited or no chronic diseases.	CSC and GSSC
Complex Care Needs	High risk	Members with conditions or situations requiring expert coordination of multiple services	SWH NCM w/PCP and GSSC
	Nursing Home Certifiable (NHC)	A member residing in the community meeting MassHealth eligibility criteria for nursing facility care based on a state assessment tool conducted by SWH NCM. ADL and IADL deficits.	SWH NCM w/ PCP and GSSC

Section 11 – Senior Whole Health Care Model

Category	Risk	Definition	Care Manager
	Alzheimer's/Dementia/ Chronic Mental Illness (AD/CMI)	A member residing in the community meeting MassHealth eligibility criteria for medical illness, psychiatric illness or cognitive impairment that requires skilled nursing to manage essential unskilled services and care. Based on state assessment tool conducted by SWH NCM.	SWH NCM w/ PCP and GSSC
Nursing Home	Long-term Custodial Care (NH)	Long-term resident of a nursing facility	SWH NCM w/ PCP

These categories are identified on monthly PCP Panel Reports with members' names.

11.9 Features of the SWH care model

To promote health and prevent unnecessary illness, all facets of an individual's life must be addressed. Preventing acute episodes of illness and supporting elders in the home when necessary, leads to a healthier, more independent individual.

This holistic approach incorporates the following steps:

- Intake and initial assessment
- Individualized care plans (ICP)
- Coordinated, integrated care delivery
- Monitoring and continuous reassessment

11.9.1 Intake and initial assessment

Information gathering about the new member's health status and existing services begins as soon as possible after CMS acceptance of an enrollment application in order to ensure:

- Existing services continue without disruption
- Continuity of care with existing providers and appointments
- Transition of existing medications
- Early identification of risk factors to ensure rapid implementation of needed services and stabilization of the member.

Section 11 – Senior Whole Health Care Model

An initial assessment is a comprehensive assessment that serves as the basis for the Individual Care Plan and includes an evaluation of clinical status, functional status, nutritional status and physical well-being; the medical history, including relevant family members and illnesses; screenings for mental-health status and tobacco, alcohol and drug use; and an assessment of need for long-term care services including the availability of informal support.

Initial assessments for SWH members include:

Phone triage	SWH uses a phone triaging process to identify high risk triggers indicating whether or not an in-home assessment should be conducted by a SWH NCM as close to the first day of enrollment as possible.
In-home assessment for at-risk populations	If the triage NCM determines a new member is at risk, a SWH NCM is assigned to meet with the member at home. A standardized state assessment tool is used that identifies: diagnoses, medications, ADL status, IADL status, support systems, mental health status and nutritional status.
Welcome calls	MSRs conduct welcome calls to all new members within the first month of enrollment. During that call, MSRs may obtain information about needs of the member. The MSR will forward this information to the SWH NCM for follow up.
GSSC In-Home Assessment	GSSCs have extensive experience in assessing elders for home-based services. The GSSC completes an assessment in the member's home to assess environmental, supportive and social needs. Every new member, regardless of health status, receives this assessment to ensure the availability of baseline information. This facilitates early identification of status changes, ensures that needed services are in place and identifies psychosocial issues that need to be addressed immediately.
PCP Assessment	PCPs are requested to submit an annual assessment either on a SWH PCP Assessment form or using the Summary of the providers EMR to help SWH NCMs identify diagnoses, medications, preventive services, special needs and the PCPs priorities for the member.

Section 11 – Senior Whole Health Care Model

11.9.2 Individual care plan (ICP)

Each member gets an individual care plan based on:

The PCP, NCM and GSSC's assessments and service recommendations

- The member's functional, physical, behavioral and psychosocial needs
- The member's wishes (to the extent possible)
- What is feasible given the availability of a support network and caregivers
- Health promotion and preventive services

Members with complex care needs (at risk community-based members including NHC and AD/CMI) receive in-depth care plans drafted by the SWH NCM and based on assessments and meetings with members and their families. Recommendations of the PCP and GSSC are incorporated. SWH NCMs confer with PCPs to determine whether further evaluation and care planning is needed, arrange referrals if necessary and authorize services. Member concurrence with the ICP is a necessary component of care planning. CSCs work with GSSCs to arrange and implement home-based services. Nursing home residents have ICPs based on the recommendations of PCPs, facility staff and the member.

11.9.3 Coordinated, integrated care delivery

The SWH NCM oversees implementation of ICP services and ongoing care needs through communication with the PCP, utilization management, the member and his or her caregivers, the GSSC who monitors home-based services and others involved in the member's care. Contractual relationships with providers across care settings including home, hospital, outpatient, rehabilitation, DME, SNFs (both long and short-term) and behavioral health allow NCMs to coordinate care in a meaningful way that fosters a "medical home" for the member. This ensures timely and effective delivery of services without fragmentation and disruption. If a member has unique needs, NCMs will consult the PCP to determine whether a new approach or exception to benefit is needed. PCPs should contact the NCM at 1-888-794-7268 or Provider Relations at 1-855-838-7999.

11.9.4 Monitoring and ongoing assessments

The SWH NCM, GSSC and MSR all have a role in monitoring the member and his or her services to assure services are delivered according to quality standards and the member is satisfied. NCMs and GSSCs conduct in-home reassessments at scheduled intervals based on risk category as well as any timer there is a suspected change in status, or an issue identified. CSCs maintain close telephonic contact with members to determine needs and issues. PCPs are involved when changes and potential problems surface.

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Reassessments are as follows:

Category	Risk	Definition	Care Manager
Community other	Low risk	No ADL or IADL deficits; high functioning; limited or no chronic conditions	CSC and GSSC
Complex care needs	High risk	Members with conditions or situations requiring expert coordination of multiple services	

11.10 Centralized enrollee record (CER)

SWH uses an electronic member record to communicate information about the member among internal staff, including MSRs, CSCs, NCMs, and with GSSCs. This is not an Electronic Health Record (HER), but a repository of information collected through assessments, claims (medical and pharmacy), case management notes, telephonic communication with providers and members, ICPs, referrals and authorizations, demographic information, etc. The information is real time and web-based allowing NCMs access to up-to-date information 24 hours a day, 7 days a week. This is a tool to facilitate care planning and communication.

11.11 Transitions of care

SWH promotes continuity of care between care settings to assist member transitions of care and reduce the potential for hospital/facility readmission. NCMs actively engage in transition planning and follow up including facilitation of physician communication and follow-up visits as well as medication management.

The SWH NCM:

- Works with the member, his or her caregivers and the ICT to plan, review and agree on the care plan and transfer arrangements
- Collaborates with the GSSC to arrange services prescribed in the care plan, including transportation, home care, nursing, physical therapy, personal care, etc. and ensures services are in place and staff is notified as appropriate
- Phones staff in the new care setting to determine status of member and services
- Schedules reassessments for ICT review of member care plan following the transfer for up to 3 weeks and then quarterly thereafter, unless there is change in status.

The following table describes the transitions of care responsibilities for different care settings.

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Transition of Care	Tasks/Responsibilities
Hospital to SNF/LTAC/Rehab	<p>SWH NCM-UM:</p> <ul style="list-style-type: none"> • Identifies participating nursing home providers, directs hospital discharge planner to participating facility • Notifies SWH NCM-SNF of impending transition • Notifies SWH NCM-Community and FSSC of transition • Establishes admission level of care and services with facility • Enters authorization into the authorization application
SNF/LTAC/Rehab to Hospital	<p>SNF Staff:</p> <ul style="list-style-type: none"> • Contacts PCP when member condition changes • Transfers member in an emergency situation to nearest facility as appropriate • Contacts SWH NCM-SNF to report transfer <p>SWH NCM-SNF:</p> <ul style="list-style-type: none"> • Monitors inpatient admission • Arranges for SNF bed hold • Coordinates discharge planning with hospital and nursing facility staff • Enters authorization into authorization application

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Transition of Care	Tasks/Responsibilities
Hospital to Home	<p>SWH NCM-UM:</p> <ul style="list-style-type: none"> • Ascertains member’s condition and status • Coordinates post discharge care plan with hospital discharge planner • Authorizes needed services • Enters authorization into authorization application • Communicates with appropriate SWH NCM-Community to alert NCM of need for post-hospital follow up <p>SWH NCM-Community:</p> <ul style="list-style-type: none"> • Conducts post discharge phone call or home visit to member to manage transition • Schedules assessments, drafts care plan and coordinates an ICT review when change in status has occurred • Provides PCP with update on hospital stay
Home to Hospital (non-elective)	<p>SWH NCM-UM:</p> <ul style="list-style-type: none"> • Reviews preadmission status and care plan with NCM-Community and shares with hospital care manager (review may include factors which affect hospital course and optimal discharge) • Contacts admitting facility to perform medical necessity review of admission • Enters authorization into the authorization application • Monitors progress of inpatient stay • Coordinates discharge plan with hospital staff with a focus on alignment of post-acute needs (i.e. advocacy for SNF placement, proximity to member’s community, CLAS) • Communicates transition with SWH NCM-Community, GSSC

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Transition of Care	Tasks/Responsibilities
Home to Hospital (elective)	<p>Facility, member/caregiver, home care nurse or PCP contacts SWH NCM-UM/-Community SWH NCM-UM/NCM-Community:</p> <ul style="list-style-type: none"> • Discusses admission with PCP • Contacts admitting physician to perform medical necessity review of admission and procedure • Arranges, as appropriate: <ul style="list-style-type: none"> ○ Pre-procedure conditioning programs ○ Nursing facility site visits ○ Home evaluation for DME ○ Skilled service needs in the home ○ Support in home post discharge ○ Community-based services in place prior to admission • Enters authorization into authorization application • Monitors progress of inpatient stay • Coordinates discharge plan with hospital staff
Home to SNF	<p>SWH NCM:</p> <ul style="list-style-type: none"> • Coordinates nursing facility admission with PCP, facility, member and ICT • Obtains orders from PCP and makes sure they're sent to receiving facility • Establishes level of care and services required with nursing home staff • Reviews care needs and health status, and arranges transportation and admission • Enters authorization into authorization application • Notifies NCM-SNF of admission and care plan

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Transition of Care	Tasks/Responsibilities
SNF to Home	<p>SWH NCM-SNF:</p> <ul style="list-style-type: none"> • Ascertains member’s condition and status • Arranges for discharge planning meeting at facility, including participants of the ICT (member and/or caregiver, NCM-Community and the GSSC) • Develops care and service plans • Arranges for both skilled and non-skilled services, including home- and community-based services • Verifies authorized services are in place • Requests medication reconciliation from Pharmacy Team and review at discharge • Confirms member/caregiver has filled prescriptions and understand medication changes • Confirms member has made a follow-up appointment with the appropriate physician • Completes a nursing home checklist to be used for post-discharge calls
Home to Adult Day Health (ADH)	<p>SWH NCM-Community:</p> <ul style="list-style-type: none"> • Ensures PCP has assessed member • Drafts care plan and coordinates ICT • ICT finalizes care plan • Reviews care plan and obtains signature from member/designated representative • Contacts ADH staff, reviews care needs and health status • Alerts CSC and GSSC that member authorized for ADH • Enters authorization into the authorization application

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Transition of Care	Tasks/Responsibilities
ADH to Home	<p>SWH NCM-Community:</p> <ul style="list-style-type: none">• Contacts ADH staff, reviews care needs and health status• Reviews status with GSSC and PCP• Drafts care plan and coordinates ICT• Assures PCT finalizes care plan• Reviews care plan and obtains signature from member/designated representative• Enters authorization into the authorization application

11.12 Utilization management (UM)

SWH adopts evidence-based clinical practice guidelines to assist practitioners in making decisions about appropriate care for specific clinical issues.

The clinical practice guidelines address preventive medical services, acute or chronic medical services and behavioral health services. Specific clinical practice guidelines form the clinical basis for SWH disease management programs. The guidelines are reviewed at least every two years. When guidelines are updated, practitioners are notified by SWH. All clinical practice guidelines can be found on SWH's website at www.seniorwholehealth.com under Disease Resources Library

SWH applies objective and evidence-based criteria, taking into account individual circumstances and the local delivery system, when determining medical appropriateness of health care services during the utilization management process. Criteria used by SWH are stated in notices of denial of medical coverage. Criteria can be obtained upon request by contacting Utilization Management staff within Clinical Services at 1-888-794-7268.

SWH clinical staff who make UM decisions annual affirm that:

- The UM decisions made are based only on appropriateness of care and services and existence of coverage
- Individuals are not rewarded for issuing denials of coverage
- Financial incentives do not encourage decisions that result in underutilization

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UM staff within Clinical Services is available from 8 a.m. to 8 p.m., 7 days a week. You can obtain information about the UM process and the authorization of care by calling toll free 1-888-794-7268. After hours, send a fax to 617-494-5554 and we'll respond the following day.

12.1 Credentialing a new MD (physician) provider

Credentialing a new provider is a simple process. Providers may only become credentialed if they are directly contracted with SWH or part of a larger entity that is contracted with SWH.

SWH requires that new providers submit:

- Completed SWH Provider Data form or an HCAS form
- Federally required disclosure form
- W-9
- Sample claim (with PHI removed)
- Joinder (if your contract requires a joinder, you will be notified)
- PCP attestation form (credentialing will send to primary practice)

For providers enrolled in CAQH, SWH requests that you enable SWH to access your records through CAQH.

For providers not enrolled in CAQH, we require that additional fields be completed on the Provider Data form. These include but are not limited to UPIN, social security and license. The Provider Data form is available on our website at www.seniorwholehealth.com or may be requested. Call Provider Relations at 1-855-838-7999 or send an email to providerrelations@seniorwholehealth.com

SWH may follow up with providers to gather more complete or up-to-date information than what is available in CAQH. This includes office hours, languages spoken and more. Providers undergoing full credentialing will be effective the first of the month following the month in which they are approved by SWH's Credentialing Committee. We will notify providers in writing once you have been approved. For large group providers, we also offer a convenient group submittal form upon request.

12.2 Credentialing a new non-MD provider

In addition to physicians, SWH also credentials licensed health professionals such as NPs; physical, occupational and speech therapists; dietitians; podiatrists and chiropractors. NPs must meet standard credentialing criteria.

For NPs interested in participating as PCPs, addition criteria must be met including:

- You must be delivering care in a practice contracted with SWH for primary care services

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- You must be delivering care under a supervising MD who must be SWH credentialed or meet credentialing criteria
- You must have arrangements for admitting to a hospital contracted with SWH
- You must notify us of your desire to act as a PCP by completing a special enrollment form available from Provider Relations.

Please contact Provider Relations at 1-855-838-7999 if you have questions about credentialing.

12.3 Delegated credentialing

SWH may delegate credentialing to practitioner groups, ancillary facilities, NCQA-certified credentialing vendors or NCQA-accredited managed behavioral health care organizations. Delegates must follow the individual state law for recredentialing time frames.

12.4 Facility credentialing

SWH initially credentials and recredentials ancillary facilities. An ancillary facility is an institution or organization that provides services, such as a hospital, residential treatment center, home health agency or rehabilitation facility.

Medical ancillary facilities include hospitals, home health agencies, skilled nursing facilities and free-standing surgical centers.

12.5 Behavioral health ancillary facilities

The credentialing of behavioral health ancillary facilities is handled by Magellan Behavioral Health. Behavioral health ancillary facilities include inpatient, residential and ambulatory facilities.

The Centers for Medicare and Medicaid (CMS) requires that specific ancillary facilities are accredited and in good standing.

12.6 Recredentialing providers

SWH recredentials providers in accordance with Massachusetts regulations. We make an effort to begin the process two (2) months in advance of the recredentialing due date and notify providers at least twice in writing if information is missing or needs updating. Timely provider assistance with this process helps avoid potential patient care disruptions.

12.7 Provider demographic changes

Change	Action	Notice Period
Providers new to a practice	Submit provider data form & federally required disclosure form	60 days prior to joining practice

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Change	Action	Notice Period
Providers leaving a practice	Written notice	60 days prior to last day
Change of address, phone, panel status, etc.	Written notice	30 days prior to effective date
New Tax ID number	New W-9 form	30 days prior to effective date

Written notifications should be mailed to:

Senior Whole Health
Attn: Provider Relations
1075 Main Street, Suite 400
Waltham, Massachusetts 02451

You may also send via email to providerrelations@seniorwholehealth.com or fax to 617-551-4185.

Please call Provider Relations at 1-855-838-7999 with questions.

12.8 Notice requirements for providers terminating from groups

Provider groups shall provide SWH written notice when a credentialed PCP or SCP terminates their group affiliation at least sixty 60 days prior to termination. In the event the PCP or SCP's termination is effective in a time period less than sixty 60 days, the group shall provide SWH written notice immediately. When we receive notice less than 45 days prior to termination, we will enter a provider termination date into the system that is 45 days in advance of the term date. This will allow us at least 30 days to notify members.

12.9 Ongoing monitoring and appeal process

SWH monitors, on an on-going basis, Medicare and Medicaid sanctions and sanctions or limitation on licensure. We also review complaints and adverse events that involve providers. If we receive information about a sanction, limitation or specific reportable incident that involves a SWH provider, we will report it to the appropriate authority when required. This include the National

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Practitioner Database, Medicare or MassHealth. If we suspend or terminate a provider for quality reasons, we will also report it to the appropriate authority.

If we suspend or terminate a practitioner from our network, they may appeal the suspension or termination. We will provide written notice along with an explanation of the action we've taken. We will also include information on appeal rights and the appeal process.

12.10 Provider rights

SWH does not make credentialing or recredentialing decisions based on practitioner's race, ethnicity, national identity, gender, age, sexual orientation or the types of procedures or types of patients treated.

Provider rights in the credentialing and recredentialing process include:

- The right to correct erroneous information
- The right to review information submitted to support their credentialing application (except National Practitioner Data Bank (NPDB) reports, as required by law)
- The right to be informed of the status of their credentialing or recredentialing application upon request
- The right to confidentiality

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13.2 SWH Provider Directory

SWH publishes a printed provider directory for members and will provide copies of these directories to any participating provider upon request. We include contracted providers in directories on the same basis as other similar participating providers.

13.3 Directory on demand

We maintain an online provider directory that can be accessed via the web at <https://www.seniorwholehealthma.com/for-members/member-materials-and-forms-2021/>

13.4 Updates and corrections

If any information regarding a provider listing is incorrect or needs to be modified, please contact the Provider Relations department at Senior Whole Health. Refer to the Notice Provisions in the Provider Credentialing and Provider Changes section of the manual.

Section 14 – Appendix

To access these materials, click on the links below or visit our website at www.seniorwholehealth.com/Provider-Massachusetts

14.1 Quick References

- [Referral and Authorization Grid](#)
- [Quick Reference Guide](#)
- [SNF Quick Reference Guide](#)
- [Model of Care Training Presentation](#)
- [Standard Prior Authorization Form](#)
- [Provider Portal Online Registration Manual](#)

14.2 Claims

- [Provider Payment Dispute & Adjustment Request](#)
- [Submitting Claims](#)

14.3 Membership & Eligibility

- [How Do Members Enroll?](#)
- [Enrollment Verification Checklist](#)

14.4 Pharmacy

- [Part D Formulary](#)
- [SCO Formulary](#)
- [Part D Formulary Change Chart](#)
- [Prior Authorization Form](#)
- [Step Therapy Algorithms](#)

14.5 Primary Care Physicians

- [SWH PCP Assessment Form](#)
- [Enrollment Form – Nurse Practitioner as PCP](#)

14.6 Specialty Care Physicians

- [Standard Prior Authorization Form](#)

14.7 Provider Credentialing & Changes

- [Provider Data Form](#)
- [Federally Required Disclosure Form](#)

14.8 Quality Improvement Program

- [SWH Quality Improvement Program](#)

SWH Quality Program Summary

Our mission is to maximize the quality of life, health, security and independence of our members. It is critical to that mission that we provide members with top quality care and service. The company has established a Quality Improvement Team, structure and contributing resources to deliver on this goal. The Quality Improvement Team monitors nationally established indicators of business performance and compares them to benchmarks to identify opportunities for improvement.

As opportunities are identified, projects are proposed, prioritized, implemented and managed to attain the desired improvements. As the programs take effect, the quality metrics continue to be monitored to make sure the desired performance is achieved. Over time, current projects are sustained, and new opportunities are identified and prioritized.

By using this approach, SWH is continually working to improve the care and services we provide to our members. As we achieve these improvements, members' health and quality of life will improve, too.

Clinical Quality Improvement examples

Disease management

Our disease management programs help members with diabetes and cardiovascular disease better self-manage their conditions.

Members in these programs received mailed materials, telephonic coaching and, in some cases, home visits. The goal of these programs is to improve member self-management and help members be as healthy as possible.

Examples of measures include medication compliance, blood pressure levels and eye screenings for people with diabetes.

If you know a member who may qualify for these programs, call Member Services.

Care Transitions

At times, members need the specialized care only found in the inpatient or skilled nursing setting. As members experience these transitions into and out of different settings, there are quality and safety risks associated with the handoffs that occur.

The goal of this project is to help facilitate these transitions by working with the member to understand their care needs and working with their doctors to provide that care. If successful, members have a good recoveries and better outcomes.

Success of the program is measured by whether members stay safely in the homes after they are discharged.

Complex Case Management

Many SWH members have multiple, complicated medical conditions that require special care and attention. Such members are enrolled into the Complex Case Management program, where their needs are assessed, and specialized care plans are developed.

Depending on the needs identified in the care plan, a member may be eligible for special care and services arranged by the plan. As these services are provided, the member's health and ability to live independently improve.

The program is assessed by an evaluation of the services provided and whether those services help improve the member's health.

Service Quality Improvement examples

SWH Quality Program Summary

Transportation

It's very important that members seeking care have access to transportation necessary to keep their appointments. This project is working to improve the transportation network serving our members.

The goal is for members to be able to access dependable transportation with no difficulty.

Member Services improvements

SWH has many interactions with our members. These include calls and home visits. We are always working to monitor these interactions and to identify ways to improve them. Our goal is to have highly satisfied members.

What you can do to help improve health care quality

Providers

- Spend enough time with your patients to make sure you understand their needs and the care you're providing is appropriate.
- Follow up on gap opportunities provided to you by Senior Whole Health.
- Work with us to make sure the care provided to members is coordinated.

Members

- See your doctor when you need care
- Understand all your health needs and treatments provided
- Ask questions of the doctors and nurses that care for you
- Be as healthy as possible by eating well, taking your medicines as prescribed, getting immunized and staying active

For more information about the quality program, including a complete description and the latest evaluation, contact the Quality Department at 617-551-5009.