PROVIDER MANUAL

(Provider Handbook)

Senior Whole Health by Molina Healthcare

(Senior Whole Health or Senior Whole Health)

Medicaid Managed Long Term Care Plan

2024

Capitalized words or phrases used in this Provider Manual shall have the meaning set forth in your Agreement with Senior Whole Health by Molina Healthcare. “Senior Whole Health” or “SWH” have the same meaning as “Health Plan” in your Agreement. The Provider Manual is customarily updated annually but may be updated more frequently as needed. Providers can access the most current Provider Manual at MolinaHealthcare.com.

Last Updated: 10/2024

Senior Whole Health
BY MOLINA HEALTHCARE

10/1/2024

TABLE OF CONTENTS

1. SENIOR WHOLE HEALTH BY MOLINA HEALTHCARE PRODUCTS

Senior Whole Health Products Overview

Senior Whole Health offers a Managed Long-Term Care (MLTC) Plan for individuals with New York State Medicaid. The MLTC program provides Members with services that allow them to stay in their own homes and communities.

Senior Whole Health assigns a Care Manager to Members to manage and coordinate all these benefits including medical, behavioral health, prescription drug, vision, and dental. Additionally, Senior Whole Health coordinates a wide range of social and non-medical community-based services to enhance a Member's health well-being and quality outcomes and their ability to live independently in the community.

The Senior Whole Health program in New York serves Members who reside in the following counties: Bronx, Kings, New York, Queens, and Westchester.

When this Provider Manual and Your Contract Differ

The Provider Manual is a supplemental document to, and an extension of, your contract with Senior Whole Health. It provides detailed information to answer many of the day-to-day operational questions about Senior Whole Health, our product, our Members, and your relationship with us. In cases where your contract and this document differ, the contract takes precedence.

Purpose of this Provider Manual

Senior Whole Health's Provider Handbook (Provider Manual) is an extension of the Provider participation agreement (Agreement) between Senior Whole Health and all Provider types including, but not limited to, physicians, hospitals, and ancillary health care Providers (hereinafter collectively and/or individually, as the context requires, referred to as Provider(s)).

This Provider Manual furnishes all such participating Providers and their office staff with valuable information concerning Senior Whole Health's policies and procedures, claims submission and adjudication requirements, and guidelines used to administer SWH if NY Benefit Plans.

This Provider Manual replaces and supersedes any and all other previous versions and is available at https://www.MolinaHealthcare.com/providers/ny/swh/manual/medical.aspx. A paper copy may be obtained at any time upon written request to Senior Whole Health.

2. CONTACT INFORMATION

Senior Whole Health by Molina Healthcare
2900 Extension Street, Suite 202
Bronx, NY 10463

The Provider Relations team is your contact for most communications with us. If a representative cannot help you directly, you'll be connected to the department best able to handle your question or concern.

Provider Relations Department

The Provider Relations department manages telephone and written inquiries from Providers regarding address and Tax-ID changes, contracting and training. The department has Provider Relations representatives who serve all Senior Whole Health's Provider network. Eligibility verifications can be conducted at your convenience via the Availity Essentials portal.

Availity Essentials portal:	provider.MolinaHealthcare.com
Phone:	(877) 353-9819 Staffed Monday through Friday 9 a.m. – 5 p.m.
Email:	Senior Whole Health Provider Relations at swhny-providerrel-ny@molinahealthcare.com
Secure Email:	If you would like to email protected health information (PHI) and don't have a secure email service, call Provider Relations.
Fax:	(855) 818-4873 - Attn: Provider Relations
US Mail:	Senior Whole Health of New York, Inc. Attn: Provider Relations 2900 Extension Street, Suite 202 Bronx, NY 10463

Member Services Department

The Member Services department manages all telephone and written inquiries regarding member Claims, benefits, eligibility/identification, Pharmacy inquiries, selecting or changing Primary Care Providers (PCPs), and member complaints. Member Services representatives are available 8 a.m. to 8 p.m., local time, Monday through Friday, excluding State holidays. Eligibility verifications can be conducted at your convenience via the Availity Essentials portal.

Phone: (877) 353-0185
Hearing Impaired (TTY/TDD): 711

Claims Department

Senior Whole Health strongly encourages Participating Providers to submit Claims electronically (via a clearinghouse or the Availity Essentials portal) whenever possible.

- Access the Availity Essentials portal at provider.MolinaHealthcare.com
  - EDI Payer ID Number: SWHNY

To verify the status of your Claims, please use the Availity Essentials portal. Claim questions can be submitted through the chat feature on the Availity Essentials portal or contact Provider Services.

Claims Recovery Department

The Claims Recovery department manages recovery for Overpayment and incorrect payment of Claims.

Claims Recovery Correspondence Mailing Address:

Senior Whole Health by Molina Healthcare
Claims Recovery Department
PO Box 2470
Spokane, WA 99210-2470

Phone: (866) 642-8999

Compliance/Anti-Fraud Hotline

If you suspect cases of fraud, waste, or abuse, you must report it to Senior Whole Health. You may do so by contacting the Senior Whole Health Alert Line or submit an electronic complaint using the website listed below. For more information about fraud, waste, and abuse, please see the Compliance section of this Provider Manual.

Confidential
Compliance Official
Molina Healthcare, Inc.
200 Oceangate, Suite 100
Long Beach, CA 90802

Phone: (866) 606-3889
Online: MolinaHealthcare.AlertLine.com

Credentialing Department

The Credentialing department verifies all information on the Provider Application prior to contracting and re-verifies this information every three years or sooner, depending on Senior Whole Health's Credentialing criteria. The information is then presented to the Professional Review Committee to evaluate a Provider's qualifications to participate in the Senior Whole Health network.

Nurse Advice Line

This telephone-based Nurse Advice Line is available to all Senior Whole Health Members. Members may call anytime they are experiencing symptoms or need health care information. Registered nurses are available 24 hours a day, seven days a week to assess symptoms and help make good health care decisions.

Phone: (877) 353-0185
Hearing Impaired (TTY/TDD): 711

Healthcare Services Department

The Healthcare Services (formerly Utilization Management) department conducts concurrent review on inpatient cases and some outpatient services and processes Prior Authorizations/Service Requests. A primary function of The Healthcare Services (HCS) department is Care Management. All Members are assigned a care manager and a care management team which coordinates and facilitates Member care needs and navigates between the Member, Providers, and others participating in the service planning process to achieve optimal quality care outcomes. In addition to care management benefits, the HCS also provides Disease Management programs to assist Members and Providers in better managing symptomatic chronic and acute conditions and diseases. Participating Providers are required to interact with Senior Whole Health's HCS department electronically whenever possible for information and education on the health services programs available. Prior Authorization/Service Requests and status checks can be easily managed electronically.

Managing Prior Authorizations/Service Requests electronically provides many benefits to Providers, such as:

- Easy access to 24/7 online submission and status checks.
- Ensures HIPAA compliance.
- Ability to receive real-time authorization status.
- Ability to upload medical records.
- Increased efficiencies through reduced telephonic interactions.
- Reduces cost associated with fax and telephonic interactions.

Senior Whole Health offers the following electronic Prior Authorizations/Service Requests submission options:

- Submit requests directly to Senior Whole Health via the Availity Essentials portal.
- Submit requests via 278 transactions. See the EDI transaction section of Senior Whole Health's website for guidance.

Availity Essentials portal: provider.MolinaHealthcare.com
Phone: (877) 635-3101

Health Management Department

Senior Whole Health's Health Management programs will be incorporated into the Member's treatment plan to address the Member's health care needs.

Phone: (877) 353-0185

Quality

Senior Whole Health maintains a Quality department to work with Members and Providers in administering the Senior Whole Health Quality Program.

Phone: (877) 353-9819

How to Contact Senior Whole Health Sub-contracted Vendors

- Dental
  DentaQuest: (855) 343-4272

- Vision
  Vision Service Plan (VSP): (800) 877-7195

3. PROVIDER RESPONSIBILITIES

Nondiscrimination of Health Care Service Delivery

Providers must comply with the nondiscrimination of health care service delivery requirements as outlined in the Cultural Competency and Linguistic Services section of this Provider Manual.

Additionally, Senior Whole Health requires Providers to deliver services to Senior Whole Health Members without regard to source of payment. Specifically, Providers may not refuse to serve Senior Whole Health Members because they receive assistance with cost sharing from a government-funded program.

Section 1557 Investigations

All Senior Whole Health Providers shall disclose all investigations conducted pursuant to Section 1557 of the Patient Protection and Affordable Care Act to Senior Whole Health's Civil Rights Coordinator.

Molina Healthcare, Inc.
Civil Rights Coordinator
200 Oceangate, Suite 100
Long Beach, CA 90802

Toll Free: (866) 606-3889
Hearing Impaired TTY/TDD: 711
Online: MolinaHealthcare.AlertLine.com
Email: civil.rights@MolinaHealthcare.com

Should you or a Senior Whole Health Member need more information, you can refer to the Health and Human Services website: federalregister.gov/documents/2020/06/19/2020-11758/nondiscrimination-in-health-and-health-education-programs-or-activities-delegation-of-authority.

Facilities, Equipment and Personnel

The Provider's facilities, equipment, personnel, and administrative services must be at a level and quality necessary to perform duties and responsibilities to meet all applicable legal requirements including the accessibility requirements of the Americans with Disabilities Act (ADA).

Provider Data Accuracy and Validation

It is important for Providers to ensure Senior Whole Health has accurate practice and business information. Accurate information allows us to better support and serve our Members and Provider Network.

Maintaining an accurate and current Provider Directory is a State and Federal regulatory requirement, as well as an NCQA required element. Invalid information can negatively impact member access to care, Member/PCP assignments and referrals. Additionally, current information is critical for timely and accurate Claims processing.

Providers must validate their Provider information on file with Senior Whole Health at least once every 90 days for correctness and completeness. Providers must notify Senior Whole Health of any changes as soon as possible, at minimum 30 calendar days in advance. Changes include, but are not limited to:

- Change in office location(s)/address, office hours, phone, fax, or email.
- Addition or closure of office location(s).
- Addition of a Provider (within an existing clinic/practice).
- Change in Provider or practice name, Tax ID and/or National Provider Identifier (NPI).
- Opening or closing your practice to new patients (PCPs only).
- Change in specialty.
- Any other information that may impact member access to care.

For Provider terminations (within an existing clinic/practice), Providers must notify Senior Whole Health in writing in accordance with the terms expressed in the Provider Agreement.

Please visit our Provider Online Directory at SWHProviderDirectory.com/NY to validate your information. Providers can make updates through the CAQH portal, or you may submit a full roster that includes the required information above for each health care Provider and/or health care facility in your practice.

Note: Some changes may impact credentialing. Providers are required to notify Senior Whole Health of changes to credentialing information in accordance with the requirements outlined in the Credentialing and Recredentialing section of this Provider Manual.

Senior Whole Health is required to audit and validate our Provider Network data and Provider Directories on a routine basis. As part of our validation efforts, we may reach out to our Network of Providers through various methods, such as: letters, phone campaigns, face-to-face contact, fax, and fax-back verification, etc. Senior Whole Health also may use a vendor to conduct routine outreach to validate data that impacts the Provider Directory or otherwise impacts its membership or ability to coordinate member care. Providers are required to supply timely responses to such communications.

National Plan and Provider Enumeration System (NPPES) Data Verification

In addition to the above verification requirements, CMS recommends that Providers routinely verify and attest to the accuracy of their National Plan and Provider Enumeration System (NPPES) data.

NPPES allows Providers to attest to the accuracy of their data. If the data is correct, the Provider is able to attest and NPPES will reflect the attestation date. If the information is not correct, the Provider is able to request a change to the record and attest to the changed data, resulting in an updated certification date.

Senior Whole Health supports the CMS recommendations around NPPES data verification and encourages our Provider network to verify Provider data via nppes.cms.hhs.gov. Additional information regarding the use of NPPES is available in the Frequently Asked Questions (FAQ) document published at the following link: cms.gov/Medicare/Health-Plans/ManagedCareMarketing/index.

Senior Whole Health Electronic Solutions Participation

Senior Whole Health requires Providers to utilize electronic solutions and tools whenever possible.

Senior Whole Health requires all contracted Providers to participate in and comply with Senior Whole Health's Electronic Solution Requirements, which include, but are not limited to, electronic submission of prior authorization requests, prior authorization status inquiries, health plan access to electronic medical records (EMR), electronic Claims submission, electronic fund transfers (EFT), electronic remittance advice (ERA), electronic Claims Appeal and registration for and use of the Availity Essentials portal.

Electronic Claims include Claims submitted via a clearinghouse using the EDI process and Claims submitted through the Availity Essentials portal.

Any Provider entering the network as a Contracted Provider will be required to comply with Senior Whole Health's Electronic Solution Policy by enrolling for EFT/ERA payments and registering for the Availity Essentials portal within 30 days of entering the Senior Whole Health network.

Senior Whole Health is committed to complying with all HIPAA Transactions, Code Sets, and Identifiers (TCI) standards. Providers must comply with all HIPAA requirements when using electronic solutions with Senior Whole Health. Providers must obtain a National Provider Identifier (NPI) and use their NPI in HIPAA Transactions, including Claims submitted to Senior Whole Health. Providers may obtain additional information by visiting Senior Whole Health's HIPAA Resource Center located on our website at MolinaHealthcare.com.

Electronic Solutions/Tools Available to Providers

Electronic Tools/Solutions available to Senior Whole Health Providers include:

- Electronic Claims Submission Options
- Electronic Payment: EFT with ERA
- Availity Essentials portal

Electronic Claims Submission Requirement

Senior Whole Health strongly encourages participating Providers to submit Claims electronically whenever possible. Electronic Claims submission provides significant benefits to the Provider such as:

- Promoting HIPAA compliance.
- Helping to reduce operational costs associated with paper Claims (printing, postage, etc.).
- Increasing accuracy of data and efficient information delivery.
- Reducing Claim processing delays as errors can be corrected and resubmitted electronically.
- Eliminating mailing time and enabling Claims to reach Senior Whole Health faster.

Senior Whole Health offers the following electronic Claims submission options:

- Submit Claims directly to Senior Whole Health via the Availity Essentials portal.
- Submit Claims to Senior Whole Health through your EDI clearinghouse using Payer ID SWHNY, refer to our website at MolinaHealthcare.com for additional information.

While both options are embraced by Senior Whole Health, submitting Claims via the Availity Essentials portal (available to all Providers at no cost) offers a number of additional Claims processing benefits beyond the possible cost savings achieved from the reduction of high-cost paper Claims.

Availity Essentials portal Claims submission includes the ability to:

- Add attachments to Claims
- Submit corrected Claims
- Easily and quickly void Claims
- Check Claims status
- Receive timely notification of a change in status for a particular Claim
- Ability to Save incomplete/un-submitted Claims
- Create/Manage Claim Templates

For more information on EDI Claims submission, see the Claims and Compensation section of this Provider Manual.

Electronic Payment (EFT/ERA) Requirement

Participating Providers are required to enroll in Electronic Funds Transfer (EFT) and Electronic Remittance Advice (ERA). Providers enrolled in EFT payments will automatically receive ERAs as well. EFT/ERA services give Providers the ability to reduce paperwork, utilize searchable ERAs, and receive payment and ERA access faster than the paper check and remittance advice (RA) processes. There is no cost to the Provider for EFT enrollment, and Providers are not required to be in-network to enroll. Senior Whole Health uses a vendor to facilitate the HIPAA compliant EFT payment and ERA delivery processes.

Additional instructions on how to register are available under the EDI/ERA/EFT tab on Senior Whole Health's website at MolinaHealthcare.com.

Availity Essentials portal

Providers and third-party billers can use the no cost Availity Essentials portal to perform many functions online without the need to call or fax Senior Whole Health. Registration can be performed online and once completed the easy to use tool offers the following features:

- Verify member eligibility, covered services and view HEDIS® needed services (gaps)
- Claims:
  - Submit Professional (CMS1500) and Institutional (UB04) Claims with attached files
  - Correct/Void Claims
  - Add attachments to previously submitted Claims
  - Check Claims status
  - View Electronic Remittance Advice (ERA) and Explanation of Payment (EOP)
  - Create and manage Claim Templates
  - Create and submit a Claim Appeal with attached files
- Prior Authorizations/Service Requests
  - Create and submit Prior Authorization/Service Requests
  - Check status of Authorization/Service Requests
- Download forms and documents
- Send/receive secure messages to/from Senior Whole Health

Compliance

21st Century Cures Act Requirements

The 21st Century Cures Act, is a federal law, passed by Congress in December 2016, that in part requires all state Medicaid programs to implement an Electronic Visit Verification (EVV) system for personal care services (PCS) and home health care services (HHCS). All states must implement an EVV system to avoid a reduction in federal Medicaid funding.

All providers and fiscal intermediaries (FI) that provide or support EVV-applicable Medicaid-funded PCS were required to implement EVV systems that meet the requirements of the 21st Century Cures Act by January 1, 2021. Providers and FIs that provide or support EVV-applicable Medicaid-funded HHCS will be required to select and implement compliant EVV systems by January 1, 2023.

For more information on the federal law and requirements for EVV, visit:
Medicaid.gov

Providers must comply with all State and Federal Laws and regulations related to the care and management of Senior Whole Health Members.

Balance Billing

The Provider is responsible for verifying eligibility and obtaining approval for those services that require prior authorization.

Providers agree that under no circumstance shall a member be liable to the Provider for any sums that are the legal obligation of Senior Whole Health to the Provider. Balance billing a member for Covered Services is prohibited, except for the member's applicable copayment, coinsurance, and deductible amounts.

Member Rights and Responsibilities

Providers are required to comply with the Member Rights and Responsibilities as outlined in Senior Whole Health's member materials (such as Member Handbooks).

For additional information please refer to the Member Rights and Responsibilities section of this Provider Manual.

Member Information and Marketing

Any written informational or marketing materials directed to Senior Whole Health Members must be developed and distributed in a manner compliant with all State and Federal Laws and regulations and approved by Senior Whole Health prior to use.

Please contact your Provider Services representative for information and review of proposed materials.

Member Eligibility Verification

Possession of a Senior Whole Health ID Card does not guarantee member eligibility or coverage. Providers should verify eligibility of Senior Whole Health Members prior to rendering services. Payment for services rendered is based on enrollment and benefit eligibility. The contractual agreement between Providers and Senior Whole Health places the responsibility for eligibility verification on the Provider of services.

Providers who contract with Senior Whole Health may verify a Member's eligibility by checking the following:

- Availity Essentials portal at provider.MolinaHealthcare.com
- Senior Whole Health Provider Contact Center automated IVR system at (877) 353-0185

For additional information please refer to the Eligibility and Enrollment section of this Provider Manual.

Health Care Services (Utilization Management and Care Management)

Providers are required to participate in and comply with Senior Whole Health's Utilization Management and Care Management programs, including all policies and procedures regarding Senior Whole Health's facility admission, prior authorization, and Medical Necessity review determination and Interdisciplinary Care Team (ICT) procedures. Providers will also cooperate with Senior Whole Health in audits to identify, confirm, and/or assess utilization levels of covered services.

For additional information please refer to the Health Care Services section of this Provider Manual.

Participation in Quality Programs

Providers are expected to participate in Senior Whole Health's Quality Programs and collaborate with Senior Whole Health in conducting peer review and audits of care rendered by Providers. Such participation includes, but is not limited to:

- Access to Care Standards
- Site and Medical Record-Keeping Practice Reviews as applicable
- Delivery of Patient Care Information

For additional information please refer to the Quality section of this Provider Manual.

Compliance

Providers must comply with all State and Federal Laws and regulations related to the care and management of Senior Whole Health Members.

Confidentiality of Member Health Information and HIPAA Transactions

Senior Whole Health requires that Providers respect the privacy of Senior Whole Health Members (including Senior Whole Health Members who are not patients of the Provider) and comply with all applicable Laws and regulations regarding the privacy of patient and member protected health information.

For additional information please refer to the Compliance section of this Provider Manual.

Participation in Grievance and Appeals Programs

Providers are required to participate in Senior Whole Health's Grievance Program and cooperate with Senior Whole Health in identifying, processing, and promptly resolving all member complaints, grievances, or inquiries. If a member has a complaint regarding a Provider,

the Provider will participate in the investigation of the grievance. If a member submits an appeal, the Provider will participate by providing medical records or statements if needed. This includes the maintenance and retention of member records for a period of not less than 10 years and retained further if the records are under review or audit until such time that the review or audit is complete.

For additional information please refer to the Member Grievances and Appeals section of this Provider Manual.

Participation in Credentialing

Providers are required to participate in Senior Whole Health's credentialing and re-credentialing process and will satisfy, throughout the term of their contract, all credentialing and re-credentialing criteria established by Senior Whole Health and applicable accreditation, State and Federal requirements. This includes providing prompt responses to Senior Whole Health's requests for information related to the credentialing or re-credentialing process.

Providers must notify Senior Whole Health no less than 30 days in advance when they relocate or open an additional office.

More information about Senior Whole Health's Credentialing program, including Policies and Procedures, is available in the Credentialing and Recredentialing section of this Provider Manual.

Delegation

Delegated entities must comply with the terms and conditions outlined in Senior Whole Health's Delegated Services Addendum. Please see the Delegation section of this Provider Manual for more information about Senior Whole Health's delegation requirements and delegation oversight.

4. CULTURAL COMPETENCY AND LINGUISTIC SERVICES

Background

Senior Whole Health works to ensure all Members receive culturally competent care across the service continuum to reduce health disparities and improve health outcomes. The Culturally and Linguistically Appropriate Services in Health Care (CLAS) standards published by the U.S. Department of Health and Human Services (HHS), Office of Minority Health (OMH) guide the activities to deliver culturally competent services. Senior Whole Health complies with Title VI of the Civil Rights Act, the Americans with Disabilities Act (ADA) Section 504 of the Rehabilitation Act of 1973, Section 1557 of the Affordable Care Act (ACA) and other regulatory/contract requirements. Compliance ensures the provision of linguistic access and disability-related access to all Members, including those with Limited English Proficiency (LEP) and Members who are deaf, hard of hearing, non-verbal, have a speech impairment, or have an intellectual disability. Policies and procedures address how individuals and systems within the organization will effectively provide services to people of all cultures, races, ethnic backgrounds, genders, gender identities, sexual orientations, ages, and religions as well as those with disabilities in a manner that recognizes values, affirms, and respects the worth of the individuals and protects and preserves the dignity of each.

Additional information on cultural competency and linguistic services is available at MolinaHealthcare.com, from your local Provider Services representative and by calling Senior Whole Health Provider Relations at (877) 353-9819.

Nondiscrimination in Health Care Service Delivery

Senior Whole Health complies with Section 1557 of the ACA. As a Provider participating in Senior Whole Health's Provider Network, you and your staff must also comply with the nondiscrimination provisions and guidance set forth by the Department of Health and Human Services, Office for Civil Rights (HHS-OCR); State law; and Federal program rules, including Section 1557 of the ACA.

You are required to do, at a minimum, the following:

1. You **MAY NOT** limit your practice because of a Member's medical (physical or mental) condition or the expectation for the need of frequent or high-cost care.
2. You **MUST** post in a conspicuous location in your office, a Nondiscrimination Notice. A sample of the Nondiscrimination Notice that you will post can be found on the Member pages of Senior Whole Health's website at https://www.molinahealthcare.com/members/ny/en-us/mem/Swh/Medicare.aspx.
3. You **MUST** post in a conspicuous location in your office, a Tagline Document, that explains how to access non-English language services. A sample of the Tagline Document that you will post can be found on the Member pages of Senior Whole Health's website at https://www.molinahealthcare.com/members/ny/en-us/mem/Swh/Medicare.aspx.

4. If a Senior Whole Health Member is in need of language assistance services while at your office, and you are a recipient of Federal Financial Assistance, you **MUST** take reasonable steps to make your services accessible to persons with limited English proficiency ("LEP"). You can find resources on meeting your LEP obligations at https://www.hhs.gov/civil-rights/for-individuals/special-topics/limited-english-proficiency/index.html; See also, https://www.hhs.gov/civil-rights/for-providers/clearance-medicare-providers/technical-assistance/limited-english-proficiency/index.html.
5. If a Senior Whole Health Member complains of discrimination, you **MUST** provide them with the following information so that they may file a complaint with Senior Whole Health's Civil Rights Coordinator or the HHS-OCR:

Civil Rights Coordinator Molina Healthcare, Inc. 200 Oceangate, Suite 100 Long Beach, CA 90802 Phone (866) 606-3889 TTY/TDD, 711 civil.rights@MolinaHealthcare.com	Office of Civil Rights U.S. Department of Health and Human Services 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201 Website: https://ocrportal.hhs.gov/ocr/smartscreen/main.jsf Complaint Form: https://www.hhs.gov/ocr/complaints/index.html

If you or a Senior Whole Health Member needs additional help or more information, call (800) 368-1019 or TTY/TDD (800) 537-7697.

Cultural Competency

Senior Whole Health is committed to reducing health care disparities. Training employees, Providers and their staff, and quality monitoring are the cornerstones of successful culturally competent service delivery. Senior Whole Health integrates cultural competency training into the overall Provider training and quality-monitoring programs. An integrated quality approach enhances the way people think about our Members, service delivery and program development so that cultural competency becomes a part of everyday thinking.

Provider and Community Training

Senior Whole Health offers educational opportunities in cultural competency concepts for Providers, their staff, and Community Based Organizations. Senior Whole Health conducts Provider training during Provider orientation with annual reinforcement training offered through Provider Services and/or online/web-based training modules.

Training modules, delivered through a variety of methods, include:

1. Provider written communications and resource materials.
2. On-site cultural competency training.
3. Online cultural competency Provider training modules.
4. Integration of cultural competency concepts and nondiscrimination of service delivery into Provider communications.

Integrated Quality Improvement – Ensuring Access

Senior Whole Health ensures member access to language services such as oral interpretation, American Sign Language (ASL), and written translation. Senior Whole Health must also ensure access to programs, aids, and services that are congruent with cultural norms. Senior Whole Health supports members with disabilities and assists Members with LEP.

Senior Whole Health develops member materials according to plain language guidelines. Members or Providers may also request written member materials in alternate languages and formats (i.e., Braille, audio, large print), leading to better communication, understanding and member satisfaction. Online materials can be found at https://www.molinahealthcare.com/members/ny/en-us/mem/Swh/swh.aspx and information delivered in digital form meet Section 508 accessibility requirements to support Members with visual impairments.

Key member information, including Appeal and Grievance forms, are also available in threshold languages on the Senior Whole Health member website.

Access to Interpreter Services

Providers may request interpreters for Members whose primary language is other than English by calling Senior Whole Health's Provider Contact Center toll free at (877) 353-9819. If Provider Contact Center representatives are unable to interpret in the requested language, the Representative will immediately connect you and the Member to a qualified language service Provider.

Senior Whole Health Providers must support Member access to telephonic interpreter services by offering a telephone with speaker capability or a telephone with a dual headset. Providers may offer Senior Whole Health Members interpreter services if the Members do not request them on their own. Please remember it is never permissible to ask a family member, friend or minor to interpret.

Documentation

As a contracted Senior Whole Health Provider, your responsibilities for documenting Member language services/needs in the Member's medical record are as follows:

- Record the Member's language preference in a prominent location in the medical record. This information is provided to you on the electronic member lists that are sent to you each month by Senior Whole Health.
- Document all Member requests for interpreter services.
- Document who provided the interpreter service. This includes the name of Senior Whole Health's internal staff or someone from a commercial interpreter service vendor. Information should include the interpreter's name, operator code, and vendor.
- Document all counseling and treatment done using interpreter services.
- Document if a Member insists on using a family member, friend, or minor as an interpreter, or refuses the use of interpreter services after notification of their right to have a qualified interpreter at no cost.

Members Who Are Deaf or Hard of Hearing

Senior Whole Health provides a TTY/TDD connection accessible by dialing 711. This connection provides access to Member Contact Center, Quality, Health Care Services, and all other health plan functions.

Assistive listening devices enhance the sound of the Provider's voice to facilitate a better interaction with the Member.

Senior Whole Health will provide face-to-face service delivery for ASL to support our Members who are deaf or hard of hearing. Requests should be made three business days in advance of an appointment to ensure availability of the service. In most cases, Members will have made this request via the Senior Whole Health Care Manager and Care Management Team.

Nurse Advice Line

Senior Whole Health provides Nurse Advice services for Members 24 hours per day, seven days per week. The Nurse Advice Line provides access to 24 hour interpretive services. Members may call Senior Whole Health's Nurse Advice Line directly: English line (877) 353-0185, or TTY/TDD 711. The Nurse Advice Line telephone numbers are also printed on membership cards.

Program and Policy Review Guidelines

Senior Whole Health conducts assessments at regular intervals of the following information to ensure its programs are most effectively meeting the needs of its Members and Providers:

- Annual collection and analysis of race, ethnicity, and language data from:
  - Eligible individuals to identify significant culturally and linguistically diverse populations within a plan's membership.
  - Contracted Providers to assess gaps in network demographics.
- Revalidate data at least annually.
- Local geographic population demographics and trends derived from publicly available sources (Community Health Measures and State Rankings Report).

- Applicable national demographics and trends derived from publicly available sources.
- Assessment of Provider Network.
- Collection of data and reporting for the Diversity of Membership HEDIS® measure.
- Annual determination of threshold languages and processes in place to provide Members with vital information in threshold languages.
- Identification of specific cultural and linguistic disparities found within the plan's diverse populations.
- Analysis of HEDIS® and CAHPS®/Qualified Health Plan Enrollee Experience survey results for potential cultural and linguistic disparities that prevent members from obtaining the recommended key chronic and preventive services.

5. MEMBER RIGHTS AND RESPONSIBILITIES

Providers must comply with the rights and responsibilities of Senior Whole Health Members as outlined on the Senior Whole Health website. The most current Member Rights and Responsibilities can be accessed via the following link: MolinaHealthcare.com/members/ny/en-us/mem/Swh/overvw/quality/rights.aspx

State and Federal Law requires that health care Providers and health care facilities recognize Member rights while the Members are receiving medical care, and that Members respect the health care Provider's or health care facility's right to expect certain behavior on the part of the Members.

For additional information, please contact Senior Whole Health at (877) 353-0185, Monday through Friday, 8 a.m. to 8 p.m., local time. TTY/TDD users, please call 711.

6. ELIGIBILITY, ENROLLMENT, DISENROLLMENT

Eligibility Inquiry

Senior Whole Health recommends that Providers confirm member eligibility prior to every scheduled service. For emergency services, Providers should verify eligibility as soon as possible following provision of the service.

Providers who contract with Senior Whole Health may verify a Member's eligibility by checking the following:

- Senior Whole Health Provider Services automated IVR system at (877) 353-0185
- Availity Essentials portal at provider.MolinaHealthcare.com

Referring Prospective Members

Participating Providers who wish to communicate with their patients about managed care options must direct patients to the State's Enrollment broker for education on all plan options. Participating Providers shall not advise patients in any manner that could be construed as steering towards any managed care product type. Participating Providers are prohibited from displaying Senior Whole Health outreach materials.

Senior Whole Health Eligibility

In order to quality for membership in Senior Whole Health Managed Long Term Care Plan, an individual must:

- Be eligible for New York State Medicaid and be 21 years of age or older.
- Reside in the Senior Whole Health service area for at least six months each calendar year. The service area includes Bronx, Kings, New York, Queens, and Westchester counties.
- Their health care needs can be safely met in their home and/or community
- Assessed as requiring at least one of the following long-term care services and care management for a continuous period of more than 120 days from the date of enrollment:
  - Nursing services in the home
  - Therapies in the home
  - Home health aide services
  - Adult day health care
  - Personal care services in the home
  - Private duty nursing
  - Consumer-Directed Personal Assistance Services

A Senior Whole Health Outreach Representative will further assess eligibility and assist the applicant with enrollment.

Enrollment and Disenrollment

New Senior Whole Health Members are enrolled effective the first day of a month.

Upon enrollment, new Members are screened by Senior Whole Health staff to identify needs for community long-term care and social support services. Those who are deemed to be at risk or who may be nursing home certifiable are further screened in their homes by a Nurse Care Manager.

All new Members receive a welcome call in their own language from Senior Whole Health Member Services.

Involuntary Disenrollment

Senior Whole Health may disenroll a Member involuntarily for a number of reasons. The most common reason for involuntary disenrollment is loss of Medicaid eligibility. Senior Whole Health regularly monitors a Member's Medicaid eligibility. If a Member needs to complete a redetermination application for Medicaid, we 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.

Reasons for Voluntary Disenrollment	Reasons for Involuntary Disenrollment
• Wishes to change plans • Wishes to return to fee-for-service Medicaid and Medicare coverage • Wishes to see a PCP not participating in the Senior Whole Health network	• Loss of Medicaid eligibility • Remained out of Senior Whole Health service area for more than six consecutive months • Permanent relocation out of Senior Whole Health service area • Fraud or Abuse

Transfers

Members can try Senior Whole Health MLTC plan for 90 days. They may leave Senior Whole Health and join another health plan at any time during that time. If they do not leave in the first 90 days, they must stay in Senior Whole Health for nine more months, unless they have a good reason (good cause). Some examples of good cause include:

- They move out of our service area.
- The Member, the plan, and their county Department of Social Services or the New York State Department of Health all agree that leaving (Senior Whole Health) is best for them.
- Their current home care Provider does not work with our plan.
- We have not been able to provide services to them as we are required to under our contract with the State.

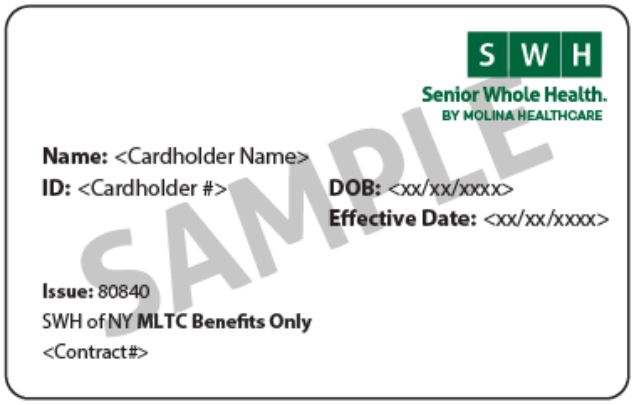
It could take between two and six weeks for their enrollment into a new plan to become active. They will get a notice from New York Medicaid Choice telling them the date they will be enrolled in their new plan. Senior Whole Health will provide the care they need until then.

Member Identification Cards

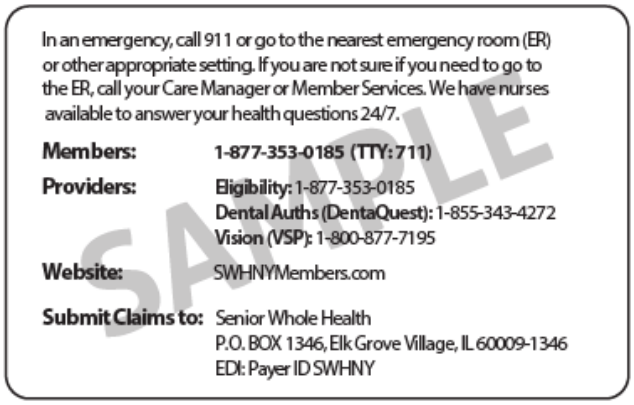
Possession of a Senior Whole Health ID Card does not mean a recipient is eligible for services. A Provider should verify a recipient's eligibility each time the recipient receives services. The verification sources can be used to verify a recipient's enrollment. The name and telephone number of the plan are given along with other eligibility information.

Sample Member ID Card

Card Front



Card Back



7. BENEFITS AND COVERED SERVICES

Senior Whole Health covers the services outlined on the Senior Whole Health website at MolinaHealthcare.com/members/ny/en-us/mem/Swh/benefits-and-services.aspx. If there are questions as to whether a service is covered or requires prior authorization, please reference the Prior Authorization tools located on the MolinaHealthcare.com website and Availity Essentials portal.

For additional information, please contact Senior Whole Health at (877) 353-0185, Monday through Friday, 8 a.m. to 8 p.m., local time. TTY/TDD users, please call 711.

Coverage Determinations

Providers who are uncertain whether a service is covered, or who recommend a course of treatment that is not covered, please call the Senior Whole Health Clinical department at (877) 635-3101 for a coverage determination. Providers will be asked to provide pertinent information via fax or telephone call. If we make an adverse determination, the Member and Provider making the request will be informed in writing in accordance with New York State and Federal regulatory guidelines.

Coverage determinations are also required for reductions, terminations, or suspensions of services. Providers will be asked to provide pertinent information via fax or telephone call. If Senior Whole Health makes an adverse determination, the Member will be informed in writing in accordance with New York State and federal regulatory guidelines.

Medicare guidelines are followed in regard to responses to coverage determination requests.

Non-Covered Services

Prior to delivering any non-covered service, a Provider must advise the Member and the Member must agree in writing that the service is not covered by Senior Whole Health and that the Member is liable for payment in full.

Links to Senior Whole Health Benefit Materials

Senior Whole Health Members are eligible to receive all the benefits of Medicare, Medicaid Advantage or Medicaid Advantage Plus (depending on eligibility), and the Medicare Part D Prescription Drug Program. Senior Whole Health can also offer other benefits, as medically necessary, not typically available through Medicare and/or Medicaid but identified by the Member's Personal Care Team as important to maintaining their independence at home.

Copayments, Coinsurance, Deductibles

The Senior Whole Health benefit offers members payment in full for all covered services.

- No copayments (including no copayments for drugs unless required by regulation)
- No deductibles
- No coinsurance

Preventative Health and Disease Management

Senior Whole Health offers several disease management programs to optimize patient care. To refer a patient, contact your nurse care manager. Programs Include: Congestive heart failure, diabetes management and chronic obstructive pulmonary disease.

Transitions of Care

Senior Whole Health promotes continuity of care between care settings to assist Member transitions of care and to reduce the potential for hospital/facility readmission during a period of high vulnerability. Senior Whole Health Care Managers actively engage in transition planning and follow up including facilitation of physician communication, and follow-up visits and medication management. Services are provided for all Members; you do not need to make a request.

Non-Emergency Transportation

The Senior Whole Health medical transportation benefit is handled directly between Senior Whole Health transportation vendor and our Members, with no paperwork required from the Provider. Members may call (855) 558-1638 to request transportation to/from medical appointments. Providers who believe a Member may need transportation services to keep medical appointments may call Modivcare at (855) 5581638, or TTY (866) 288-3133

Reservation: Ride Assist (Where's My Ride): 877-718-4220

Facility line: (866) 428-2351

Member Non-Liability

Senior Whole Health Members, as New York State Medicaid beneficiaries, cannot be held liable for payments. Providers may not bill or collect payment for a covered service from Members for any reason. Please contact Provider Relations if you have questions. A Senior Whole Health Member has at least 120 calendar days to submit a claim for billed out-of-network services in accordance with INS §§ 4305(1) and 4306(n).

Home Infusion Services

Self-administered home infusion supplies, and products require Prior Authorization. In some cases, they will be made available through a vendor designated by Senior Whole Health.

Access to Care Management

Care Management services are available 24 hours per day, seven days per week for information, emergency consultation services, and response in the community, if necessary.

Senior Whole Health's Nurse Advice Line is available 24 hours, seven days a week for advice on health conditions which can include mental health or substance abuse needs. The services provided will be confidential.

Emergency Mental Health or Substance Abuse Services

Members are directed to call 988, 911, or go to the nearest emergency room if they need Emergency Services mental health or substance abuse. Examples of emergency mental health or substance abuse problems are:

- Danger to self or others.
- Not being able to carry out daily activities.
- Things that will likely cause death or serious bodily harm.

Emergency Transportation

When a Member's condition is life-threatening and requires use of special equipment, life support systems, and close monitoring by trained attendants while en route to the nearest appropriate facility, emergency transportation is thus required. Emergency transportation includes, but is not limited to, ambulance, air, or boat transports.

Immunizations

Members may receive immunizations as recommended by the Centers for Disease Control and prescribed by the member's PCP.

Nurse Advice Line

Members may call the Nurse Advise Line anytime they are experiencing symptoms or need health care information. Registered nurses are available 24 hours a day, seven days a week, 365 days a year, to assess symptoms and help make good health care decisions.

Senior Whole Health is committed to helping our Members:

- Prudently use the services of your office.
- Understand how to handle routine health problems at home.
- Avoid making non-emergent visits to the emergency room (ER).

These registered nurses do not diagnose. They assess symptoms and guide the patient to the most appropriate level of care following specially designed algorithms unique to the Nurse Advice Line. The Nurse Advice Line may refer back to the PCP, a specialist, 911 or the ER. By educating patients, it reduces costs and over utilization on the health care system.

Health Management Programs

Senior Whole Health offers programs to help our Members and their families manage various health conditions. For additional information, please contact Senior Whole Health Care Management.

Telehealth and Telemedicine Services

Senior Whole Health Members may obtain physical and behavioral health Covered Services by Participating Providers, through the use of Telehealth and Telemedicine services. Not all Participating Providers offer these services. The following additional provisions apply to the use of Telehealth and Telemedicine services:

- Services must be obtained from a Participating Provider.
  - Members have the option of receiving PCP services through telehealth. If they choose to use this option, the Member must use a Network Provider who offers telehealth.
- Services are a method of accessing Covered Services, and not a separate benefit.
- Services are not permitted when the member and Participating Provider are in the same physical location.
- Member cost sharing may apply based on the applicable Member Handbook.
- Services must be coded in accordance with applicable reimbursement policies and billing guidelines.
- Rendering Provider must comply with applicable federal and state guidelines for telehealth service delivery.

For additional information on Telehealth and Telemedicine Claims and billing, please refer to the Claims and Compensation section of this Provider Manual.

8. HEALTH CARE SERVICES

Introduction

Health Care Services is comprised of Utilization Management (UM) and Care Management (CM) departments that work together to achieve an integrated model based upon empirically validated best practices that have demonstrated positive results. Research and experience show that a higher-touch, Member-centric care environment for at-risk Members supports better health outcomes. Senior Whole Health provides care management services to Members to address a broad spectrum of needs, including chronic conditions that require the coordination and provision of health care services. Elements of the Senior Whole Health utilization management program include pre-service authorization review and inpatient authorization management that includes pre-admission, admission and concurrent review, medical necessity review, and restrictions on the use of out-of-network Providers.

Utilization Management (UM)

Senior Whole Health ensures the service delivered is medically necessary and demonstrates an appropriate use of resources based on the level of care needed for a Member. This program promotes the provision of quality, cost-effective, and medically appropriate services that are offered across a continuum of care as well as integrating a range of services appropriate to meet individual needs. Senior Whole Health's UM program maintains flexibility to adapt to changes in the Member's condition and is designed to influence Member's care by:

- Managing available benefits effectively and efficiently while ensuring quality care.
- Evaluating the medical necessity and efficiency of health care services across the continuum of care.
- Defining the review criteria, information sources, and processes that are used to review and approve the provision of items and services, including prescription drugs.
- Coordinating, directing, and monitoring the quality and cost effectiveness of health care resource utilization.
- Implementing comprehensive processes to monitor and control the utilization of health care resources.
- Ensuring services are available in a timely manner, in appropriate settings, and are planned, individualized, and measured for effectiveness.
- Reviewing processes to ensure care is safe and accessible.
- Ensuring qualified health care professionals perform all components of the UM processes.
- Ensuring UM decision making tools are appropriately applied in determining medical necessity decision.

Key Functions of the UM Program

All prior authorizations are based on a specific standardized list of services. The key functions of the UM program are outlined below:

- Eligibility and Oversight
  - Eligibility verification
  - Benefit administration and interpretation
  - Verification that authorized care correlates to Member's medical necessity need(s) & benefit plan
  - Verifying of current Physician/hospital contract status
- Resource Management
  - Prior Authorization and referral management
  - Pre-admission, Admission, and Inpatient Review
  - Referrals for Discharge Planning and Care Transitions
  - Staff education on consistent application of UM functions
- Quality Management
  - Satisfaction evaluation of the UM program using member and Provider input
  - Utilization data analysis
  - Monitor for possible over- or under-utilization of clinical resources
  - Quality oversight
  - Monitor for adherence to CMS, NCQA, State and health plan UM standards

For more information about Senior Whole Health's UM program, or to obtain a copy of the HCS Program description, clinical criteria used for decision making, and how to contact a UM reviewer, access the Senior Whole Health website or contact the UM department.

Medical Groups/IPAs and delegated entities who assume responsibility for UM must adhere to Senior Whole Health's UM Policies. Their programs, policies and supporting documentation are reviewed by Senior Whole Health's Health Services Committee at least annually.

UM Decisions

A decision is any determination made by Senior Whole Health or the delegated Medical Group/IPA or other delegated entity with respect to the following:

- Determination to authorize, provide or pay for services (favorable determination).
- Determination to delay, modify, or deny authorization or payment of request (adverse determination).
- Discontinuation of a payment or authorization for a service.

Senior Whole Health follows a hierarchy of medical necessity decision making with Federal and State regulations taking precedence. Senior Whole Health covers all services and items required by State and Federal regulations.

Board certified licensed Providers from appropriate specialty areas are utilized to assist in making determinations of medical necessity, as appropriate. All utilization decisions are made in a timely manner to accommodate the clinical urgency of the situation, in accordance with Federal regulatory requirements and NCQA standards.

Requests for authorization not meeting criteria are reviewed by a designated Senior Whole Health Medical Director or other appropriate clinical professional. Only a licensed physician or

pharmacist, doctoral level clinical psychologist or certified addiction medicine specialist as appropriate may determine to delay, modify, or deny authorization of services to a Member.

Providers can contact Senior Whole Health's Healthcare Services department at (877) 635-3101 to obtain Senior Whole Health's UM Criteria.

Where applicable, Senior Whole Health Corporate Policies can be found on the public website at MolinaClinicalPolicy.com. Please note that Senior Whole Health follows state-specific criteria, if available, before applying Senior Whole Health-specific criteria.

Medical Necessity

"**Medically Necessary**" or "**Medical Necessity**" means: Necessary to prevent, diagnosed, correct or cure conditions in the member that cause acute suffering, endanger life, result in illness or infirmity, interfere with such member's capacity for normal activity, or threaten some significant handicap.

This is for the purpose of preventing, evaluating, diagnosing, or treating an illness, injury, disease, or its symptoms. Those services must be deemed by Senior Whole Health to be:

1. In accordance with generally accepted standards of medical practice;
2. Clinically appropriate and clinically significant, in terms of type, frequency, extent, site and duration. They are considered effective for the patient's illness, injury, or disease; and,
3. Not primarily for the convenience of the patient, physician, or other health care Provider. The services must not be more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury, or disease.

For these purposes, "generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature. This literature is generally recognized by the relevant medical community, physician specialty society recommendations, the views of physicians practicing in relevant clinical areas and any other relevant factors.

The fact that a Provider has prescribed, recommended, or approved medical or allied goods or services does not, in itself, make such care, goods or services medically necessary, a medical necessity or a covered service/benefit.

MCG Cite for Guideline Transparency and MCG Cite AutoAuth

Senior Whole Health has partnered with MCG Health to implement Cite for Guideline Transparency. Providers can access this feature through the Availity Essentials portal. With MCG Cite for Guideline Transparency, Senior Whole Health can share clinical indications with Providers. The tool operates as a secure extension of Senior Whole Health's existing MCG investment and helps meet regulations around transparency for delivery of care:

- Transparency – Delivers medical determination transparency.
- Access – Clinical evidence that payers use to support member care decisions.
- Security – Ensures easy and flexible access via secure web access.

MCG Cite for Guideline Transparency does not affect the process for notifying Senior Whole Health of admissions or for seeking Prior Authorization approval. To learn more about MCG or Cite for Guideline Transparency, visit MCG's website or call (888) 464-4746.

Senior Whole Health has also partnered with MCG Health, to extend our Cite AutoAuth self-service method for all lines of business to submit advanced imaging prior authorization (PA) requests.

Cite AutoAuth can be accessed via the Availity Essentials portal and is available 24 hours per day/7 days per week. This method of submission is strongly encouraged as your primary submission route, existing fax/phone/email processes will also be available. Clinical information submitted with the PA will be reviewed by Senior Whole Health. This system will provide quicker and more efficient processing of your authorization request, and the status of the authorization will be available immediately upon completion of your submission.

What is Cite AutoAuth and how does it work?

By attaching the relevant care guideline content to each PA request and sending it directly to Senior Whole Health, health care providers receive an expedited, often immediate, response. Through a customized rules engine, Cite AutoAuth compares Senior Whole Health's specific criteria to the clinical information and attached guideline content to the procedure to determine potential for auto authorization.

Self-services available in the Cite AutoAuth tool include, but are not limited to, MRIs, CTs, PET scans. To see the full list of imaging codes that require PA, refer to the PA code Look-Up Tool at MolinaHealthcare.com.

Medical Necessity Review

Senior Whole Health only reimburses for services that are medically necessary. Medical necessity review may take place prospectively, as part of an outpatient and or inpatient admission notification/concurrent review, or retrospectively. To determine medical necessity, in conjunction with independent professional medical judgment, Senior Whole Health uses nationally recognized evidence-based guidelines, third party guidelines, CMS guidelines, State guidelines, guidelines from recognized professional societies, and advice from authoritative review articles and textbooks.

Levels of Administrative and Clinical Review

The Senior Whole Health review process begins with administrative review followed by clinical review if appropriate. Administrative review includes verifying eligibility, appropriate vendor or

Participating Provider, and benefit coverage. The Clinical review includes medical necessity and level of care.

All UM requests that may lead to a medical necessity adverse determination are reviewed by a health care professional at Senior Whole Health (medical director, pharmacy director, or appropriately licensed health professional).

Senior Whole Health's Provider training includes information on the UM processes and Authorization requirements.

Clinical Information

Senior Whole Health requires copies of clinical information be submitted for documentation. Clinical information includes but is not limited to physician emergency department notes, inpatient history/physical exams, discharge summaries, physician progress notes, physician office notes, physician orders, nursing notes, results of laboratory or imaging studies, therapy evaluations and therapist notes. Senior Whole Health does not accept clinical summaries, telephone summaries or inpatient case manager criteria reviews as meeting the clinical information requirements unless State or Federal regulations allows such documentation to be acceptable.

Prior Authorization

Senior Whole Health requires prior authorization for specified services as long as the requirement complies with Federal or State regulations and the Senior Whole Health Hospital or Provider Services Agreement. The list of services that require prior authorization is available in narrative form, along with a more detailed list by CPT and HCPCS codes. Senior Whole Health prior authorization documents are customarily updated quarterly, but may be updated more frequently as appropriate, and are posted on the Senior Whole Health website at MolinaHealthcare.com.

Providers are encouraged to use the Senior Whole Health Prior Authorization Form provided on the Senior Whole Health web site. If using a different form, the prior authorization request must include the following information:

- Member demographic information (name, date of birth, Senior Whole Health ID number).
- Provider demographic information (referring Provider and referred to Provider/facility, including address and NPI number).
- Member diagnosis and ICD-10 codes.
- Requested service/procedure, including all appropriate CPT and HCPCS codes.
- Location where service will be performed.
- Clinical information sufficient to document the medical necessity of the requested service is required including:
    - Pertinent medical history (include treatment, diagnostic tests, examination data).
    - Requested length of stay (for inpatient requests).

- Rationale for expedited processing.

Services performed without authorization may not be eligible for payment. Services provided emergently (as defined by Federal and State Law) are excluded from the prior authorization requirements. Obtaining authorization does not guarantee payment. Senior Whole Health retains the right to review benefit limitations and exclusions, beneficiary eligibility on the date of service, correct coding, billing practices, and whether the service was provided in the most appropriate and cost effective setting of care. Senior Whole Health does not retroactively authorize services that require PA.

Senior Whole Health makes UM decisions in a timely manner to accommodate the urgency of the situation as determined by the member's clinical situation. The definition of expedited/urgent is when the standard time frame or decision making process could seriously jeopardize the life or health of the Member, the health or safety of the member or others, due to the member's psychological state, or in the opinion of the Provider with knowledge of the member's medical or behavioral health condition, would subject the member to adverse health consequences without the care or treatment that is subject of the request or could jeopardize the Member's ability to regain maximum function. Supporting documentation is required to justify the expedited request.

For expedited organization determinations/pre-service authorization request, Senior Whole Health will make a determination as promptly as the Member's health requires, and no later than contractual and regulatory requirements, after we receive the initial request for service in the event a Provider indicates, or if we determine that a standard authorization decision timeframe could jeopardize a Member's life or health. Additional information on service authorization and appeals timeframe comparison, please visit the New York State Department of Health website at New York State Medicaid Managed Care Service Authorization and Appeals Timeframe Comparison (ny.gov). For a standard authorization request, Senior Whole Health makes the determination and provides notification no later than contractual requirements.

Providers who request prior authorization approval for patient services and/or procedures may request to review the criteria used to make the final decision. Senior Whole Health has a full-time Medical Director available to discuss medical necessity decisions with the requesting Provider at (877) 353-0185.

Upon approval, the requestor will receive an authorization number. The number may be provided by telephone or fax. If a request is denied, the requestor and the member will receive a letter explaining the reason for the denial and additional information regarding the grievance and appeals process. Denials also are communicated to the Provider via fax.

Peer-to-Peer Review

Upon receipt of an adverse determination, the Provider (peer) may request a peer-to-peer discussion within five business days of the decision.

A “peer” is considered a physician, physician assistant, or nurse practitioner who is directly providing care to the Member. Contracted external parties, administrators, or facility UM staff can request that a peer-to-peer telephone communication be arranged and performed.

When requesting a peer-to-peer discussion, please be prepared with the following information:

- Member name and ID#
- Auth ID#
- Requesting Provider Name and contact number, best times to call

If a Medical Director is not immediately available, the call will be returned within two business days. Every effort will be made to return calls as expeditiously as possible.

Requesting Prior Authorization

Notwithstanding any provision in the Provider Agreement that requires Provider to obtain a prior authorization directly from Senior Whole Health, Senior Whole Health may choose to contract with external vendors to help manage prior authorization requests.

For additional information regarding the prior authorization of specialized clinical services, please refer to the Prior Authorization tools located on the MolinaHealthcare.com website:

- Prior Authorization Code Look-up Tool
- Prior Authorization Code Matrix
- Prior Authorization Guide

The most current Prior Authorization Guidelines and the Prior Authorization Request Form can be found on the Senior Whole Health website at MolinaHealthcare.com.

Availity Essentials portal: Participating Providers are encouraged to use the Availity Essentials portal for prior authorization submissions whenever possible. Instructions for how to submit a prior authorization request are available on the Availity Essentials portal. The benefits of submitting your prior authorization request through the Availity Essentials portal are:

- Create and submit Prior Authorization Requests.
- Check status of Authorization Requests.
- Receive notification of change in status of Authorization Requests.
- Attach medical documentation required for timely medical review and decision making.

Fax: The Prior Authorization Request Form can be faxed to Senior Whole Health at: (855) 818-4871 (OP).

Phone: Prior authorizations can be initiated by contacting Senior Whole Health’s Healthcare Services department at (877) 353-0185. It may be necessary to submit additional documentation before the authorization can be processed.

Open Communication about Treatment

Senior Whole Health prohibits contracted Providers from limiting Provider or member communication regarding a member's health care. Providers may freely communicate with, and act as an advocate for their patients. Senior Whole Health requires provisions within Provider contracts that prohibit solicitation of members for alternative coverage arrangements for the primary purpose of securing financial gain. No communication regarding treatment options may be represented or construed to expand or revise the scope of benefits under a health plan or insurance contract.

Senior Whole Health and its contracted Providers may not enter into contracts that interfere with any ethical responsibility or legal right of Providers to discuss information with a member about the member's health care. This includes, but is not limited to, treatment options, alternative plans, or other coverage arrangements.

Delegated Utilization Management Functions

Senior Whole Health may delegate UM functions to qualifying Medical Groups/IPAs and delegated entities. They must have the ability to meet, perform the delegated activities and maintain specific delegation criteria in compliance with all current Senior Whole Health policies and regulatory and certification requirements. For more information about delegated UM functions and the oversight of such delegation, please refer to the Delegation section of this Provider Manual.

Communication and Availability to Members and Providers

During business hours HCS staff is available for inbound and outbound calls through an automatic rotating call system triaged by designated staff by calling (877) 635-3101 during normal business hours, Monday through Friday (except for holidays) from 8:30 > a.m. to 5:30 p.m. All staff Members identify themselves by providing their first name, job title, and organization. Care Manager on Call services and access is available 24/7 365 days including holidays and weekends

Senior Whole Health offers TTY/TDD services for Members who are deaf, hard of hearing, or speech impaired. Language assistance is also always available for Members.

After business hours, Providers can also utilize fax and the Availity Essentials portal for UM access.

Senior Whole Health's Nurse Advice Line is available to Members 24 hours a day, seven days a week at (877) 353-0185. Senior Whole Health's Nurse Advice Line may handle after-hours UM calls.

Emergency Services

Emergency Condition means: a medical or behavioral condition, the onset of which is sudden, that manifests itself by symptoms of sufficient severity, including severe pain, that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect

the absence of immediate medical attention to result in: (a) placing the health of the person affected with such condition in serious jeopardy, or in the case of a behavioral condition placing the health of such person or others in serious jeopardy; (b) serious impairment to such person's bodily functions; (c) serious dysfunction of any bodily organ or part of such person; or (d) serious disfigurement of such person.

A medical screening exam performed by licensed medical personnel in the emergency department and subsequent Emergency Services rendered to the member do not require prior authorization from Senior Whole Health.

Emergency Services are covered on a 24-hour basis without the need for prior authorization for all members experiencing an Emergency Medical Condition.

Senior Whole Health also provides members a 24-hour Nurse Advice Line for medical advice. The 911 information is given to all members at the onset of any call to the plan.

For members within our service area: Senior Whole Health contracts with vendors that provide 24-hour Emergency Services for ambulance and hospitals. An out-of-network emergency hospital stay will be covered until the member has stabilized sufficiently to transfer to a participating facility. Services provided after stabilization in a non-participating facility are not covered and the member will be responsible for payment.

Members over-utilizing the emergency department will be contacted by Senior Whole Health Care Managers to provide assistance whenever possible and determine the reason for using Emergency Services.

Care Managers will also contact the PCP to ensure that Members are not accessing the emergency department because of an inability to be seen by the PCP.

Inpatient Management (Note: Hospitalization is not a covered MLTC benefit)

Elective Inpatient Admissions

Senior Whole Health requires prior authorization for all elective inpatient admissions and procedures to any facility. Facilities are required to also notify Senior Whole Health within 24 hours or by the following business day once the admission has occurred for concurrent review. Elective inpatient admission services performed without prior authorization may not be eligible for payment.

Emergent Inpatient Admissions

Senior Whole Health requires notification of all emergent inpatient admissions within 24 hours of admission or by the following business day. Notification of admission is required to verify eligibility, authorize care, including level of care (LOC), and initiate concurrent review and discharge planning. Senior Whole Health requires that notification includes member demographic information, facility information, date of admission and clinical information

sufficient to document the medical necessity of the admission. Emergent inpatient admission services performed without meeting admission notification, medical necessity requirements or failure to include all of the needed clinical documentation to support the need for an inpatient admission will result in a denial of authorization for the inpatient stay.

Inpatient at time of Termination of Coverage

If a Member's coverage with Senior Whole Health terminates during a hospital stay, all services received after their termination of eligibility are not covered services, unless Law or Government Program requirements mandate otherwise.

Inpatient/Concurrent Review

Senior Whole Health performs concurrent inpatient review to ensure medical necessity of ongoing inpatient services, adequate progress of treatment and development of appropriate discharge plans. Performing these functions requires timely clinical information updates from inpatient facilities. Senior Whole Health will request updated clinical records from inpatient facilities at regular intervals during a Member's inpatient stay. Senior Whole Health requires that requested clinical information updates be received by Senior Whole Health from the inpatient facility within 24 hours of the request.

Failure to provide timely clinical information updates may result in denial of authorization for the remainder of the inpatient admission dependent on the Provider contract terms and agreements.

Senior Whole Health will authorize hospital care as an inpatient, when the clinical record supports the medical necessity for the need for continued hospital stay. It is the expectation that observation has been tried in those patients that require a period of treatment or assessment, pending a decision regarding the need for additional care, and the observation level of care has failed. Upon discharge the Provider must provide Senior Whole Health with a copy of Member's discharge summary to include demographic information, date of discharge, discharge plan and instructions, and disposition.

Inpatient Status Determinations

Senior Whole Health's UM staff follow CMS guidelines to determine if the collected clinical information for requested services are "reasonable and necessary for the diagnosis or treatment of an illness or injury or to improve the functioning of malformed body member" by meeting all coverage, coding, and medical necessity requirements (refer to the Medical Necessity section of this Provider Manual).

Discharge Planning

The goal of discharge planning is to initiate cost-effective, quality-driven treatment interventions for post-hospital care at the earliest point in the admission.

CM and UM staff work closely with the hospital discharge planners to determine the most appropriate discharge setting for our members. The clinical staff review medical necessity and appropriateness for home health, infusion therapy, durable medical equipment (DME), skilled nursing facility and rehabilitative services.

Readmissions

Readmission review is an important part of Senior Whole Health's Quality Improvement Program to ensure that Senior Whole Health Members are receiving hospital care that is compliant with nationally recognized guidelines as well as Federal and State regulations.

Senior Whole Health will conduct readmission reviews when both admissions occur at the same acute inpatient facility within the state regulatory requirement dates.

When a subsequent admission to the same facility with the same or similar diagnosis occurs within 24 hours of discharge, the hospital will be informed that the readmission will be combined with the initial admission and will be processed as a continued stay.

When a subsequent admission to the same facility occurs within 30 days of discharge, and it is determined that the readmission is related to the first admission and determined to be preventable, then a single payment may be considered as payment in full for both the first and second hospital admissions.

- A Readmission is considered potentially preventable if it is clinically related to the prior admission and includes the following circumstances:
  - Premature or inadequate discharge from the same hospital.
  - Issues with transition or coordination of care from the initial admission.
  - For an acute medical complication plausibly related to care that occurred during the initial admission.
- Readmissions that are excluded from consideration as preventable readmissions include:
  - Planned readmissions associated with major or metastatic malignancies, multiple trauma, and burns.
  - Neonatal and obstetrical Readmissions.
  - Initial admissions with a discharge status of "left against medical advice" because the intended care was not completed.
  - Behavioral Health readmissions.
  - Transplant related readmissions.

Post Service Review

Failure to obtain authorization when required will result in denial of payment for those services. The only possible exception for payment as a result of post-service review is if information is received indicating the Provider did not know nor reasonably could have known that patient was a Senior Whole Health member or there was a Senior Whole Health error, a Medical Necessity review will be performed. Decisions, in this circumstance, will be based on medical

need, appropriateness of care guidelines defined by UM policies and criteria, regulation, guidance and evidence-based criteria sets.

Specific Federal or State requirements or Provider contracts that prohibit administrative denials supersede this policy.

Affirmative Statement About Incentives

All medical decisions are coordinated and rendered by qualified physicians and licensed staff unhindered by fiscal or administrative concerns. Senior Whole Health and its delegated contractors do not use incentive arrangements to reward the restriction of medical care to Members.

Senior Whole Health requires that all utilization-related decisions regarding Member coverage and/or services are based solely on appropriateness of care and service and existence of coverage. Senior Whole Health does not specifically reward Practitioners or other individuals for issuing denials of coverage or care. And, Senior Whole Health does not receive financial incentives or other types of compensation to encourage decisions that result in underutilization.

Out-of-Network Providers and Services

Senior Whole Health maintains a contracted network of qualified health care professionals who have undergone a comprehensive credentialing process in order to provide medical care to Senior Whole Health Members. Senior Whole Health requires Members to receive medical care within the participating, contracted network of Providers unless it is for Emergency Services as defined by Federal Law. If there is a need to go to a non-contracted Provider, all care provided by non-contracted, non-network Providers must be prior authorized by Senior Whole Health. Non-network Providers may provide Emergency Services for a member who is temporarily outside the service area, without prior authorization or as otherwise required by Federal or State Laws or regulations.

Avoiding Conflict of Interest

The HCS department affirms its decision-making is based on appropriateness of care and service and the existence of benefit coverage.

Senior Whole Health does not reward Providers or other individuals for issuing denials of coverage or care. Furthermore, Senior Whole Health never provides financial incentives to encourage authorization decision makers to make determinations that result in under-utilization. Senior Whole Health also requires our delegated medical groups/IPAs to avoid this kind of conflict of interest.

Coordination of Care and Services

Senior Whole Health HCS staff work with Providers to assist with coordinating referrals, services and benefits for Members who have been identified for Senior Whole Health's Integrated Care Management (ICM) program via assessment or referral such as, self-referral, Provider referral, etc. In addition, the coordination of care process assists Senior Whole Health Members, as necessary, in transitioning to other care when benefits end.

Senior Whole Health staff provide an integrated approach to care needs by assisting Members with identification of resources available to the Member, such as community programs, national support groups, appropriate specialists, and facilities, identifying best practice or new and innovative approaches to care. Care coordination by Senior Whole Health staff is done in partnership with Providers, Members and/or their authorized representative(s) to ensure efforts are efficient and non-duplicative.

Continuity of Care and Transition of Members

It is Senior Whole Health's policy to provide Members with advance notice when a Provider they are seeing will no longer be in-network. Members and Providers are encouraged to use this time to transition care to an in-network Provider. The Provider leaving the network shall provide all appropriate information related to course of treatment, medical treatment, etc. to the Provider(s) assuming care. Under certain circumstances, Members may be able to continue treatment with the out of network Provider for a given period of time and provide continued services to Members undergoing a course of treatment by a Provider that has terminated their contractual agreement if the following conditions exist at the time of termination.

- Acute condition or serious chronic condition – Following termination, the terminated Provider will continue to provide covered services to the member up to 90 days or longer if necessary, for a safe transfer to another Provider as determined by Senior Whole Health or its delegated Medical Group/IPA.
- High risk of second or third trimester pregnancy – The terminated Provider will continue to provide services following termination until postpartum services related to delivery are completed or longer if necessary, for a safe transfer.

For additional information regarding continuity of care and transition of Members, please contact Senior Whole Health at (877) 353-0185.

Continuity and Coordination of Provider Communication

Senior Whole Health stresses the importance of timely communication between Providers involved in a Member's care. This is especially critical between specialists, including behavioral health Providers, and the Member's PCP. Information should be shared in such a manner as to facilitate communication of urgent needs or significant findings.

Reporting of Suspected Abuse and/or Neglect

A vulnerable adult is a person who is receiving or may be in need of receiving community care services by reason of mental or other disability, age, or illness; and who is or may be, unable to

take care of themself, or unable to protect themself against significant harm or exploitation. When working with children one may encounter situations suggesting abuse, neglect and/or unsafe living environments.

Every person who knows or has reasonable suspicion that a child or adult is being abused or neglected must report the matter immediately. Specific professionals mentioned under the law as mandated reporters are:

- Physicians, dentists, interns, residents, or nurses.
- Public or private school employees or child care givers.
- Psychologists, social workers, family protection workers, or family protection specialists.
- Attorneys, ministers, or law enforcement officers.

Suspected abuse and/or neglect should be reported as follows:

Adult Protective Services

The Adult Protective Services Program (APS) provides services for physically and/or mentally impaired adults. APS works to help at-risk clients live safely in their homes. APS clients can be referred by anyone. Find more information on referrals or make a referral at https://a069-apscris.nyc.gov/cris/, or call (212) 630-1853. If an individual is eligible, a home visit will be made in three business days or in 24 hours if the situation is life-threatening. Complete a web referral at http://nyc.gov/apsrefer. Send an email to: APSrefer@hra.nyc.gov. Telephone the APS Central Intake Unit at (212) 630-1853.

In addition, Conditions for Elder Abuse reporting requirements to Senior Whole Health are stated in the Senior Whole Health Operating Standards and Continuity Care Responsibilities – General Provisions Operating Responsibilities to Providers. To request a copy, please contact your Senior Whole Health Care Manager at SWHNY-CareMgmt@MolinaHealthcare.com.

Senior Whole Health's HCS teams will work with PCPs and Medical Groups/IPA and other delegated entities who are obligated to communicate with each other when there is a concern that a member is being abused. Final actions are taken by the PCP/Medical Group/IPA, other delegated entities, or other clinical personnel. Under State and Federal Law, a person participating in good faith in making a report or testifying about alleged abuse, neglect, abandonment, financial exploitation, or self-neglect of a vulnerable adult in a judicial or administrative proceeding may be immune from liability resulting from the report or testimony.

Senior Whole Health will follow up with Members that are reported to have been abused, exploited, or neglected to ensure appropriate measures were taken, and follow up on safety issues. Senior Whole Health will track, analyze, and report aggregate information regarding abuse reporting to the Health Care Services Committee and the proper State agency.

PCP Responsibilities in Care Management Referrals

The Member's PCP is involved in the coordination and direction of services for the Member. The case manager provides the PCP with the Member's Person Centered Service Plans (PCSP), interdisciplinary care team (ICT) updates, and information regarding the Member's progress through the PSCP when requested by the PCP. The PCP is responsible for the provision of preventive services and for the primary medical care of Members.

Care Manager Responsibilities

The care manager collaborates with the Member and any additional participants as directed by the Member to develop an PCSP that includes recommended interventions from Member's ICT, as applicable. PCSP interventions include the appropriate information to address medical and psychosocial needs and/or barriers to accessing care, care coordination to address Member's health care goals, health education to support self-management goals, and a statement of expected outcomes. Jointly, the care manager and the Member/authorized representative(s) are responsible for implementing the plan of care. Additionally, the care manager:

- Assesses the Member to determine if the Member's needs warrant care management.
- Monitors and communicates the progress of the implemented PCSP to the Member's ICT, as Member needs warrant.
- Serves as a coordinator and resource to the Member, their representative and ICT participants throughout the implementation of the PCSP, and revises the plan as suggested and needed.
- Coordinates appropriate education and encourages the Member's role in self-management.
- Monitors progress toward the Member's achievement of PCSP goals in order to determine an appropriate time for the Member's graduation from the ICM program.

Health Management

The tools and services described here are educational support for Senior Whole Health members and may be changed at any time as necessary to meet the needs of Senior Whole Health members. Level 1 members can be engaged in the program for up to 60 days depending on member preferences and the clinical judgement of the Health Management team.

Level 1 Health Management

Senior Whole Health offers programs to help our members and their families manage various health conditions. The programs include telephonic outreach from our clinical staff and health educators that includes condition specific triage assessment, care plan development and access to tailored educational materials. Members are identified via Health Risk assessments and Identification and Stratification. You can also directly refer Members who may benefit from these program offerings, details are available on our website at https:www.MolinaHealthcare.com/members/ny/en-us/mem/Swh/dm.aspx.com/members/ny/en-us/mem/Swh/dm.aspx. Members can request to be enrolled or disenrolled in these programs at any time. Our Senior Whole Health My Health programs include:

- Living with Asthma
- Living with Diabetes
- Living with High blood Pressure
- Living with Heart Failure (HF)
- Living with COPD
- Living with Depression
- Weight Management
- Tobacco Cessation
- Nutrition

For more information about these programs, please call (877) 353-0185, or (TTY/TDD: 711).

Maternity Screening and High Risk Obstetrics

Senior Whole Health offers to all pregnant Members prenatal health education with resource information as appropriate and screening services to identify high risk pregnancy conditions. Care managers with specialized OB training provide additional care coordination and health education for Members with identified high risk pregnancies to assure best outcomes for Members and their newborns during pregnancy, delivery and through their sixth week post-delivery. Pregnant Member outreach, screening, education, and care management are initiated by Provider notification to Senior Whole Health, Member self-referral, and internal Senior Whole Health notification processes. Providers can notify Senior Whole Health of pregnant/high risk pregnant Members via faxed Pregnancy Notification Report Forms.

Member Newsletters

Member Newsletters are posted on the MolinaHealthcare.com website at least once a year. The articles are about topics asked by Members. The tips are aimed to help Members stay healthy.

Member Health Education Materials

Members can access our easy-to-read evidenced-based educational materials about nutrition, preventive services guidelines, stress management, exercise, cholesterol management, asthma, diabetes, depression, and other relevant health topics identified during our engagement with Members. Materials are available through the Member Portal, direct mail as requested, email, and the My Molina mobile app.

Program Eligibility Criteria and Referral Source

Health Management (HM) Programs are designed for Senior Whole Health Members with a confirmed diagnosis. Identified Members will receive targeted outreach such as educational materials, telephonic outreach, or other materials to access information on their condition. Members can contact Senior Whole Health Member Services at any time and request to be removed from the program.

Members may be identified for or referred to HM programs from multiple pathways which may include the following:

- Pharmacy Claims data for all classifications of medications.
- Encounter Data or paid Claims with a relevant CMS-accepted diagnosis or procedure code.
- Member Services welcome calls made by staff to new member households and incoming member calls have the potential to identify eligible program participants. Eligible members are referred to the program registry.
- Member Assessment calls made by staff for the initial Health Risk Assessments (HRA) for newly enrolled members.
- External referrals from Provider(s), caregivers, or community-based organizations.
- Internal referrals from Nurse Advice Line, Medication Management, or Utilization Management.
- Member self-referral due to general plan promotion of program through member newsletter or other member communications.

Provider Participation

Provider resources and services may include:

- Annual Provider feedback letters containing a list of patients identified with the relevant disease.
- Clinical resources such as patient assessment forms and diagnostic tools.
- Patient education resources.
- Provider Newsletters promoting the Health Management Programs, including how to enroll patients and outcomes of the programs.
- Clinical Practice Guidelines
- Preventive Health Guidelines
- Case Management collaboration with the Member's Provider
- Faxing a Provider Collaboration Form to the Member's Provider when indicated

Additional information on Health Management Programs is available from your local Senior Whole Health Healthcare Services department toll free at (877) 353-0185.

Primary Care Providers

Senior Whole Health provides a panel of PCPs to care for its Members. Providers in the specialties of Family Medicine, Internal Medicine and Obstetrics and Gynecology are eligible to serve as PCPs. Members may choose a PCP or have one selected for them by Senior Whole Health. Senior Whole Health's Members are required to see a PCP who is part of the Senior Whole Health Network. Senior Whole Health's Members may select or change their PCP by contacting Senior Whole Health's Care Management Team.

Specialty Providers

Senior Whole Health maintains a network of specialty Providers to care for its Members. Some specialty care Providers may require a referral for a member to receive specialty services; however, no prior authorization is required. Members are allowed to directly access women health specialists for routine and preventive health without a referral for services.

Senior Whole Health will help to arrange specialty care outside the network when Providers are unavailable or the network is inadequate to meet a Member's medical needs. To obtain such assistance contact the Senior Whole Health UM department. Referrals to specialty care outside the network require prior authorization from Senior Whole Health.

Care Management (CM)

Senior Whole Health provides a comprehensive ICM program to all Members who meet the criteria for services. The ICM program focuses on coordinating the care, services, and resources needed by Members throughout the continuum of care. Senior Whole Health adheres to Case Management Society of America Standards of Practice Guidelines in its execution of the program.

The Senior Whole Health care managers may be licensed professionals and are educated, trained, and experienced in Senior Whole Health's ICM high touch program. The ICM program is based on a person centered approach, designed, and administered to assure the Member value-added coordination of health care and services, to increase continuity and efficiency, and to produce optimal outcomes. The ICM program is individualized to accommodate a Member's needs with collaboration and input from the Member's PCP. The Senior Whole Health care manager will assess the Member upon engagement after identification for ICM enrollment, assist with arrangement of individual services for Members whose needs include ongoing medical care, home health care, rehabilitation services, and preventive services. The Senior Whole Health care manager is responsible for assessing the Member's appropriateness for the ICM program and for notifying the PCP of ICM program enrollment, as well as facilitating and assisting with the development of the Member's PCSP Person centered Care Plan.

Referral to Care Management: Members with high-risk medical conditions and/or other care needs may be referred by their PCP or specialty care Provider to the ICM program. The care manager works collaboratively with the Member and all participants of the ICT when warranted, including the PCP and specialty Providers, such as, discharge planners, ancillary Providers, the local Health Department, or other community-based resources when identified. The referral source should be prepared to provide the care manager with demographic, health care and social data about the Member being referred.

Members with the following conditions qualify for Care Management and are provided ICM touch points services and Care Coordination by the care management team

- Catastrophic or end-stage medical conditions (e.g. neoplasm, organ/tissue transplants, End Stage Renal Disease)
- Comorbid chronic illnesses (e.g. asthma, diabetes, COPD, CHF, etc.)

- High-technology home care requiring more than two weeks of treatment
- Member accessing emergency department services inappropriately

Referrals to the ICM program may be made by contacting Senior Whole Health at:

Phone: (877) 353-0185
Fax: (855) 818-4871

Care Management Model

Our Care Model is grounded in the philosophy of fully coordinated comprehensive care which is person centered and outcome driven and includes the following:

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

Team-based Care

The SWH Care Management team staff actively work to assist and facilitate member goals and outcomes through service planning and comprehensive care management interventions and care coordination of both covered and non-covered services with the members PCP and participating specialist. Our approach is person centered and evidenced driven with the member at the center of the care management team's navigation of care and services. Person Centered Service Plans (PCSPs) are developed based on the member Health Risk assessment and risk stratification and are tailored to achieve high quality member goals and individual outcomes. Care management interactions may be by telephone Face to Face teleconference or written. The Primary component of the care management team is the Member, the care team pod, and/or the Member-designated representative; other participants can be included based on the Member condition needs:

- Member
- Care Manager
- Community Connector
- Designated representative as approved by the member
- Other Members - The PCP and other coordinating Specialist are integral care coordinating members of the member CMT

Role of the Community PCP and coordinating Specialist

The role of the community PCP and coordination specialist is to coordinate care with the member, caregivers, and the members of the Care Management Team

Each Senior Whole Health member is required to have a community Primary Care Physician. Upon enrollment and for ongoing care management the care management team will work with the member to find and assign the member a community PCP.

Role of the Care Manager

Each Senior Whole Health member is assigned an Senior Whole Health Nurse Care Manager who is available 24/7 through a toll-free line. The Care Manager is the liaison between the Member, caregivers, PCP, and all other involved parties. These professionals facilitate, integrate, and monitor all facets of the care plan, regardless of the care setting. The Care Manager is the "glue that holds the pieces together" to ensure all aspects of the care plan are in place and that the member's questions and preferences are addressed. This role provides the coordination component that supports the Provider and is traditionally not reimbursed by insurers.

Role of the Senior Whole Health Pharmacist

Senior Whole Health's Pharmacy Department works closely with Care Managers and providers to assist in the management of care for Senior Whole Health members. Goals of pharmacy care management are safety, access, compliance, education, and optimization of therapy. As a Provider, you can request a medication review for your members. Additionally, the Pharmacy department is actively engaged in programs related to medication management and medication reconciliation.

Role of the Senior Whole Health Member Services Representative (MSR)

Senior Whole Health serves a linguistically and culturally diverse population making health care delivery more challenging. To address this, Senior Whole Health has incorporated Member Services into the clinical arena with multilingual staff representing major language groups. The Member Services Representative (MSR) has a role that goes beyond traditional Member Services in providing personal, high touch telephonic communication. MSRs are available to respond quickly to questions and concerns. They educate the member upon enrollment and have a roster of Members they contact regularly to verify health status or identify changing care needs. MSRs coordinate community-based services with local agencies, Providers, and the Care Manager to ensure clinical and community resources are effectively linked.

Care Management Process

Senior Whole Health is committed to empowering its members and their families in the participation of short- and long-term planning to support community living as long and safely as possible. The health statuses and care needs of individuals are fluid. Senior Whole Health

incorporates systems to ensure ongoing reevaluation and restructuring of care services to respond to changing needs.

Health Risks and Multi-Dimensional Assessments

Senior Whole Health conducts Health Risks and multidimensional assessments of our members to have baseline information about the member's health, services, and unmet needs; to stratify for risk to ensure adequate care management oversight for continuity of existing services upon enrollment; to ensure continuity of existing services upon enrollment in Senior Whole Health; as part of the on-going member management; and to develop appropriate person-centered care plans. Health Risk and other assessments are conducted upon enrollment, annually, and upon triggered events as part of the members' on-going monitoring and identification of changes in members condition status Assessments Domains Include:

- Diagnostic conditions
- Functional status: ADL and IADL
- Psychosocial status
- Information and formal support systems

Intake and Initial Assessment

An initial assessment and reassessment is a comprehensive assessment that serves as the basis for the member PCSP and includes an evaluation of clinical, functional, and nutritional status; physical well-being; medical history, including family and illness; screenings for mental health status, tobacco, alcohol, and drug use; and an assessment of the need for long-term care services, including the availability of informal support and social determinants of health barriers.

Transitions of Care

Senior Whole Health promotes continuity of care between care settings to assist member transitions of care and to reduce the potential for hospital/facility readmission during a period of high vulnerability. Care setting transitions may include home, hospital, SNF, rehab, etc. Responsibility for assuring a smooth transition from one setting to another resides with the Interdisciplinary Care Team (IDT) and the Senior Whole Health Nurse Care Manager. The Care Manager actively engages in transition planning and follow-up, including facilitation of physical communication and follow-up visits, as well as medication management.

In accordance with PHL § 4903.3, Senior Whole Health will make post-hospital home care services determinations within one business day or 72 hours (about 3 days) of a request that was made on a holiday or weekend, provided that all information required was submitted by the Provider prior to discharge.

The SWH NY Care Manager:

- Discusses, plans reviews, and obtains agreement on the care plan and transfer arrangements with the PCP IDT the member and/or the caregiver.
- Collaborates with the team to arrange services prescribed in the care plan, e.g., transportation, home care nursing, physical therapy, personal care, etc., and assures services are in place and staff is notified as appropriate
- As part of a care transitions outreach, contacts staff in the new care setting to determine status of member and services.
- Contacts the hospital/nursing home specialist to arrange for an on-site visit or telephonic contact when appropriate
- Schedules reassessments for IDT review of the member care plan following transfer for up to three weeks and quarterly thereafter unless there is a change in status. The table below describes the transitions of care responsibilities for different care settings.

Transition of Care	Task/Responsibilities
Hospital to SNF/LTAC/Rehab	SWH Care Manager-UM: • Identifies participating nursing home providers, directs the hospital discharge planner to participating facility • Notifies the SWH Care Manager-SNF of the impending transition • Notifies SWH Care Manager-Community of transition • Establishes admission level of care and services with facility • Enters authorization into the authorization application
SNF/LTAC/Rehab to Hospital	SNF Staff: • Contacts PCP when Member's condition changes • Transfers member in an emergency to the nearest facility as appropriate • Contacts SWH Care Manager-SNF to report transfer SWH Care Manager-SNF: • Monitors inpatient admission • Coordinates discharge planning with hospital and nursing facility staff • Enters authorization into authorization application
Hospital to Home	SWH Care Manager-UM: • Ascertains Member's condition and status

Transition of Care	Task/Responsibilities
	• Coordinates post discharge care plan with hospital discharge planner • Authorizes needed services • Enter authorization into authorization application • Communicates with appropriate SWH Care Manager-Community to alert Care Manager of need for post-hospital follow up • Communicates with Client Services to notify to resume home- and community-based services SWH Care Manager-Community: • Conducts member post-discharge phone call or home visit 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)
	Facility or member/caregiver/home care nurse or PCP contacts SWH Care Manager-UM/Community
	
	SWH Care Manager-Community:
	• Discusses admission with the PCP
	• Contacts admitting physician to perform medical necessity review of admission and procedure
	• Arranges, as appropriate:
	  ○ Pre-procedure conditioning programs
	  ○ Nursing facility site visits
	  ○ Home evaluation for DME
	  ○ Skilled service needs in the home
	  ○ Availability of family/care support post discharge
	  ○ Community-based services in place prior to admission
	• Enters authorization into the authorization application
	• Monitors progress of inpatient stay

Transition of Care	Task/Responsibilities
	• Coordinates discharge plan with hospital staff
Home to SNF	SWH Care Manager-SNF: • Ascertains Member's condition and status • Arranges for discharge planning meeting at facility, including participants of the ICT (member and/or caregiver, Care Manager-Community) • Develops care and service plans • Arranges for both skilled and non-skilled services, including home and community-based services • Verify that authorized services are in place • Requests medication reconciliation from Pharmacy Team and review at discharge • Confirms member/care has filled prescriptions, understands medication changes • Confirms member follow-up appointment with the appropriate physician • Completes a nursing home checklist to be used for post-discharge calls

9. BEHAVIORAL HEALTH

Care Coordination and Continuity of Care

Discharge Planning

Discharge planning begins upon admission to an inpatient or residential behavioral health facility. Members who were admitted to an inpatient or residential behavioral health setting must have an adequate outpatient follow-up appointment scheduled with a behavioral health Provider prior to discharge.

Interdisciplinary Care Coordination

In order to provide care for the whole person, Senior Whole Health emphasizes the importance of collaboration amongst all Providers on the Member's treatment team. Behavioral Health, Primary Care, and other specialty Providers shall collaborate and coordinate care amongst each other for the benefit of the Member. Collaboration of the treatment team will increase communication of valuable clinical information, enhance the Member's experience with service delivery, and create opportunity for optimal health outcomes. Senior Whole Health's Care Management program may assist in coordinating care and communication amongst all Providers of a Member's treatment team.

National Suicide Lifeline

988 is the National Suicide Lifeline. Anyone in need of suicide or mental health crisis support (or anyone worried about someone else), can receive free and confidential support 24 hours a day, 7 days a week, 365 days per year, by dialing 988 from any phone.

10. QUALITY

Maintaining Quality Improvement Processes and Programs

Senior Whole Health works with Members and Providers to maintain a comprehensive Quality Improvement Program. You can contact the Senior Whole Health Quality department toll free at (877) 353-9819.

This Provider Manual contains excerpts from the Senior Whole Health Quality Improvement Program. For a complete copy of Senior Whole Health's Quality Improvement Program, you can contact your Provider Services representative or call the telephone number above to receive a written copy.

Senior Whole Health has established a Quality Improvement Program that complies with regulatory requirements and accreditation standards. The Quality Improvement Program provides structure and outlines specific activities designed to improve the care, service, and health of our members. In our quality program description, we describe our program governance, scope, goals, measurable objectives, structure, and responsibilities.

Senior Whole Health does not delegate Quality Improvement activities to Medical Groups/IPAs. However, Senior Whole Health requires contracted Medical Groups/IPAs to comply with the following core elements and standards of care. Senior Whole Health Medical Groups/IPAs must:

- Have a Quality Improvement Program in place.
- Comply with and participate in Senior Whole Health's Quality Improvement Program including reporting of Access and Availability survey and activity results and provision of medical records as part of the HEDIS® review process and during potential Quality of Care and/or Critical Incident investigations.
- Cooperate with Senior Whole Health's quality improvement activities that are designed to improve quality of care and services and member experience.
- Allow Senior Whole Health to collect, use and evaluate data related to Provider performance for quality improvement activities, including but not limited to focus areas, such as clinical care, care coordination and management, service, and access and availability.
- Allow access to Senior Whole Health Quality personnel for site and medical record review processes.

Quality Program Overview

Senior Whole Health takes pride in its ability to establish programs that reward partner providers for exceeding goals. As such, our Quality Improvement Program (QIP) includes both clinical and non-clinical measures increasing the potential an agency can earn in the quality program. When an agency earns quality payments it signals that our members are receiving the highest quality care with the best member experience and health outcomes.

Quality Program

The Senior Whole Health Quality Program for Licensed Home Care Service Agencies (QP-LHCSA) aims at:

- Improving quality services MLTC members receive from their LHCSA
- Aligning incentives for the LHCSA with the Plan goals leading to best care for Senior Whole Health members
- Senior Whole Health Approach – measure each LHCSA performance based on member data

Patient Safety Program

Senior Whole Health's Patient Safety Program identifies appropriate safety projects and error avoidance for Senior Whole Health Members in collaboration with their PCPs. Senior Whole Health continues to support safe personal health practices for our Members through our safety program, pharmaceutical management and care management/disease management programs and education. Senior Whole Health monitors nationally recognized quality index ratings for facilities including adverse events and hospital acquired conditions as part of a national strategy to improve health care quality mandated by the Patient Protection and Affordable Care Act (ACA), Health and Human Services (HHS) to identify areas that have the potential for improving health care quality to reduce the incidence of events.

The Tax Relief and Health Care Act of 2006 mandates that the Office of Inspector General report to Congress regarding the incidence of "never events" among Medicare beneficiaries, the payment for services in connection with such events, and the Centers for Medicare & Medicaid Services (CMS) processes to identify events and deny payment.

Quality of Care

Senior Whole Health has established a systematic process to identify, investigate, review, and report any Quality of Care, Adverse Event/Never Event, Critical Incident (as applicable), and/or service issues affecting member care. Senior Whole Health will research, resolve, track, and trend issues. Confirmed Adverse Events/Never Events are reportable when related to an error in medical care that is clearly identifiable, preventable and/or found to have caused serious injury or death to a patient. Some examples of never events include:

- Surgery on the wrong body part.
- Surgery on the wrong patient.
- Wrong surgery on a patient.

Senior Whole Health is not required to pay for inpatient care related to "never events."

Medical Records

Senior Whole Health requires that medical records are maintained in a manner that is current, detailed and organized to ensure that care rendered to Members is consistently documented

and that necessary information is readily available in the medical record. All entries will be indelibly added to the Member's record. PCPs should maintain the following medical record components that include but are not limited to:

- Medical record confidentiality and release of medical records within medical and behavioral health care records.
- Medical record content and documentation standards, including preventive health care.
- Storage maintenance and disposal processes
- Process for archiving medical records and implementing improvement activities.

Medical Record Keeping Practices

Below is a list of the minimum items that are necessary in the maintenance of the Member's Medical records:

- Each patient has a separate record.
- Medical records are stored away from patient areas and preferably locked.
- Medical records are available at each visit and archived records are available within 24 hours.
- If hard copy, pages are securely attached in the medical record and records are organized by dividers or color-coded when thickness of the record dictates.
- If electronic, all those with access have individual passwords.
- Record keeping is monitored for Quality and HIPAA compliance.
- Storage maintenance for the determined timeline and disposal per record management processes.
- Process for archiving medical records and implementing improvement activities.
- Medical records are kept confidential and there is a process for release of medical records including behavioral health care records.

Content

Providers must remain consistent in their practices with Senior Whole Health's medical record documentation guidelines. Medical records are maintained and should include the following information:

- Each page in the record contains the patient's name or ID number.
- Member name, date of birth, sex, marital status, address, employer, home and work telephone numbers, and emergency contact.
- Legible signatures and credentials of Provider and other staff members within a paper chart.
- All Providers who participate in the Member's care.
- Information about services delivered by these Providers.
- A problem list that describes the Member's medical and behavioral health conditions.
- Presenting complaints, diagnoses, and treatment plans, including follow-up visits and referrals to other Providers.

- Prescribed medications, including dosages and dates of initial or refill prescriptions.
- Medication reconciliation within 30 days of an inpatient discharge should include evidence of current and discharge medication reconciliation and the date performed.
- Allergies and adverse reactions (or notation that none are known).
- Documentation that Advance Directives, Power of Attorney and Living Will have been discussed with Member, and a copy of Advance Directives when in place.
- Past medical and surgical history, including physical examinations, treatments, preventive services, and risk factors.
- Treatment plans that are consistent with diagnosis.
- A working diagnosis that is recorded with the clinical findings.
- Pertinent history for the presenting problem.
- Pertinent physical exam for the presenting problem.
- Lab and other diagnostic tests that are ordered as appropriate by the Provider.
- Clear and thorough progress notes that state the intent for all ordered services and treatments.
- Notations regarding follow-up care, calls or visits. The specific time of return is noted in weeks, months or as needed, included in the next preventative care visit when appropriate.
- Notes from consultants if applicable.
- Up-to-date immunization records and documentation of appropriate history.
- All staff and Provider notes are signed physically or electronically with either name or initials.
- All entries are dated.
- All abnormal lab/imaging results show explicit follow up plan(s).
- All ancillary services reports.
- Documentation of all emergency care provided in any setting.
- Documentation of all hospital admissions, inpatient and outpatient, including the hospital discharge summaries, hospital history and physicals and operative report.
- Labor and Delivery Record for any child seen since birth.
- A signed document stating with whom protected health information may be shared.

Organization

- The medical record is legible to someone other than the writer.
- Each patient has an individual record.
- Chart pages are bound, clipped, or attached to the file.
- Chart sections are easily recognized for retrieval of information.
- A release document for each member authorizing Senior Whole Health to release medical information for facilitation of medical care.

Retrieval

- The medical record is available to Provider at each encounter.

- The medical record is available to Senior Whole Health for purposes of Quality improvement.
- The medical record is available to the applicable State and/or Federal agency and the External Quality Review Organization upon request.
- The medical record is available to the member upon their request.
- A storage system for inactive member medical records which allows retrieval within 24 hours, is consistent with State and Federal requirements, and the record is maintained for not less than 10 years from the last date of treatment or for a minor, one year past their 20th birthday but, never less than 10 years.
- An established and functional data recovery procedure in the event of data loss.

Confidentiality

Senior Whole Health Providers shall develop and implement confidentiality procedures to guard member protected health information, in accordance with HIPAA privacy standards and all other applicable Federal and State regulations. This should include, and is not limited to, the following:

- Ensure that medical information is released only in accordance with applicable Federal or State Law in pursuant to court orders or subpoenas.
- Maintain records and information in an accurate and timely manner.
- Ensure timely access by Members to the records and information that pertain to them.
- Abide by all Federal and State Laws regarding confidentiality and disclosure of medical records or other health and enrollment information.
- Medical Records are protected from unauthorized access.
- Access to computerized confidential information is restricted.
- Precautions are taken to prevent inadvertent or unnecessary disclosure of protected health information.
- Education and training for all staff on handling and maintaining protected health care information.

Additional information on medical records is available from your local Senior Whole Health Quality department. For additional information regarding HIPAA, see the Compliance section of this Provider Manual.

Access to Care

Senior Whole Health maintains access to care standards and processes for ongoing monitoring of access to health care provided by contracted PCPs and participating specialists. Providers surveyed include OB/GYN (high-volume specialists), Oncologist (high-impact specialists), and behavioral health Providers. Providers are required to conform to the Access to Care appointment standards listed below to ensure that health care services are provided in a timely manner. The standards are based on 80 percent availability for Emergency Services and 80

percent or greater for all other services. The PCP or their designee must be available 24 hours a day, seven days a week to Members.

Appointment Access

All Providers who oversee the Member's health care are responsible for providing the following appointments to Senior Whole Health Members in the timeframes noted.

Medical Appointment

Appointment Types	Standard
Routine, office visit	Within two weeks
Office visit, non-urgent	Within 48-72 hours
Office Visit-Urgent Care	Within 24 hours
Emergency	Immediately upon presentation at office
After-Hours Care	24 hours/day; 7 day/week availability
Specialty Care, non-urgent	Within 4-6 weeks (about 1 and a half months)
Urgent Specialty Care	Within 24 hours

Additional information on appointment access standards is available from your local Senior Whole Health Quality department.

After Hours

All Providers must have back-up (on call) coverage after hours or during the Provider's absence or unavailability. Senior Whole Health requires Providers to maintain a 24-hour telephone service, seven days a week. This access may be through an answering service or a recorded message after office hours. The service or recorded message should instruct Members with an Emergency to hang up and call 911 or go immediately to the nearest emergency room. Voicemail alone after-hours is not acceptable.

Monitoring Access for Compliance with Standards

Access to care standards is reviewed, revised as necessary, and approved by the Quality Improvement Committee on an annual basis.

Provider Network adherence to access standards is monitored via one or more of the following mechanisms:

1. Provider access studies – Provider office assessment of appointment availability, after-hours access, Provider ratios, and geographic access.
2. Member complaint data – assessment of member complaints related to access and availability of care.
3. Member satisfaction survey – evaluation of members' self-reported satisfaction with appointment and after-hours access.

Analysis of access data includes assessment of performance against established standards, review of trends over time, and identification of barriers. Results of analysis are reported to the Quality Improvement Committee at least annually for review and determination of opportunities for improvement. Corrective actions are initiated when performance goals are not met and for identified Provider-specific and/or organizational trends. Performance goals are reviewed and approved annually by the Quality Improvement Committee.

Quality of Provider Office Sites

Senior Whole Health Providers are to maintain office-site and medical record keeping practice standards. Senior Whole Health continually monitors member appeals and complaints/grievances for all office sites to determine the need of an office site visit and will conduct office site visits as needed. Senior Whole Health assesses the quality, safety, and accessibility of office sites where care is delivered against standards and thresholds. A standard survey form is completed at the time of each visit. This includes an assessment of:

- Physical Accessibility
- Physical Appearance
- Adequacy of Waiting and Examining Room Space

Physical Accessibility

Senior Whole Health evaluates office sites as applicable, to ensure that Members have safe and appropriate access to the office site. This includes, but is not limited to, ease of entry into the building, accessibility of space within the office site, and ease of access for patients with physical disabilities.

Physical Appearance

The site visits include, but are not limited to, an evaluation of office site cleanliness, appropriateness of lighting, and patient safety as needed.

Adequacy of Waiting and Examining Room Space

During the site visit as required, Senior Whole Health assesses waiting and examining room spaces to ensure that the office offers appropriate accommodations to Members. The evaluation includes, but is not limited to, appropriate seating in the waiting room areas and availability of exam tables in exam rooms.

Administration & Confidentiality of Facilities

Facilities contracted with Senior Whole Health must demonstrate an overall compliance with the guidelines listed below:

- Office appearance demonstrates that housekeeping and maintenance are performed appropriately on a regular basis, the waiting room is well-lit, office hours are posted, and parking area and walkways demonstrate appropriate maintenance.
- Accessible parking is available, the building and exam rooms are accessible with an incline ramp or flat entryway, and the restroom is accessible with a bathroom grab bar.
- Adequate seating includes space for an average number of patients in an hour and there is a minimum of two office exam rooms per Provider.
- Basic emergency equipment is located in an easily accessible area. This includes a pocket mask and Epinephrine, plus any other medications appropriate to the practice.
- At least one CPR certified employee is available.
- Yearly OSHA training (Fire, Safety, Blood-borne Pathogens, etc.) is documented for offices with 10 or more employees.
- A container for sharps is located in each room where injections are given.
- Labeled containers, policies, and contracts evidence of a hazardous waste management system in place.
- Patient check-in systems are confidential. Signatures on fee slips, separate forms, stickers, or labels are possible alternative methods.
- Confidential information is discussed away from patients. When reception areas are unprotected by sound barriers, scheduling and triage phones are best placed at another location.
- Medical records are stored away from patient areas. Record rooms and/or file cabinets are preferably locked.
- A CLIA waiver is displayed when the appropriate lab work is run in the office.
- Prescription pads are not kept in exam rooms.
- Narcotics are locked, preferably double-locked. Medication and sample access is restricted.
- System in place to ensure expired sample medications are not dispensed and injectables and emergency medication are checked monthly for outdates.
- Drug refrigerator temperatures are documented daily.

Advance Directives (Patient Self-Determination Act)

Senior Whole Health complies with the advance directive requirements of the States in which the organization provides services. Responsibilities include ensuring Members receive information regarding advance directives and that contracted Providers and facilities uphold executed documents.

Advance Directives are a written choice for health care. There are two types of Advance Directives:

- **Durable Power of Attorney for Health Care**: allows an agent to be appointed to carry out health care decisions.
- **Living Will**: allows choices about withholding or withdrawing life support and accepting or refusing nutrition and/or hydration.

When There Is No Advance Directive: The Member's family and Provider will work together to decide on the best care for the member based on information they may know about the Member's end-of-life plans.

Providers must inform adult Senior Whole Health Members, 18 years old and up, of their right to make health care decisions and execute Advance Directives. It is important that Members are informed about Advance Directives.

Members who would like more information are instructed to contact Member Services or are directed to the CaringInfo website at caringinfo.org/planning/advance-directives/ for forms available to download. Additionally, the Senior Whole Health website offers information to both Providers and Members regarding advance directives, with a link to forms that can be downloaded and printed.

PCPs must discuss Advance Directives with a member and provide appropriate medical advice if the member desires guidance or assistance.

Senior Whole Health network Providers and facilities are expected to communicate any objections they may have to a member directive prior to service when possible. Members may select a new PCP if the assigned Provider has an objection to the Member's desired decision. Senior Whole Health will facilitate finding a new PCP or specialist as needed.

In no event may any Provider refuse to treat a member or otherwise discriminate against a member because the member has completed an Advance Directive. CMS Law gives members the right to file a complaint with Senior Whole Health or the State survey and certification agency if the member is dissatisfied with Senior Whole Health's handling of Advance Directives and/or if a Provider fails to comply with Advance Directives instructions.

Senior Whole Health will notify the Provider of an individual Member's Advance Directives identified through Care Management, Care Coordination or Case Management. Providers are instructed to document the presence of an Advance Directive in a prominent location of the Medical Record. Auditors will also look for copies of the Advance Directive form. Advance Directive forms are State specific to meet State regulations.

Senior Whole Health will look for documented evidence of the discussion between the Provider and the member during routine Medical Record reviews.

Monitoring for Compliance with Standards

Senior Whole Health monitors compliance with the established performance standards as outlined above at least annually. Performance below Senior Whole Health's standards may result in a Corrective Action Plan (CAP) with a request the Provider submit a written corrective action plan to Senior Whole Health within 30 calendar days. Follow-up to ensure resolution is conducted at regular intervals until compliance is achieved. The information and any response made by the Provider are included in the Provider's permanent credentials file. If compliance is

not attained at follow-up, an updated CAP will be required. Providers who do not submit a CAP may be terminated from network participation or closed to new Members.

Quality Improvement Activities and Programs for Senior Whole Health MLTC

Senior Whole Health maintains an active Quality Improvement Program. The Quality Improvement Program provides structure and key processes to carry out our ongoing commitment to improvement of care and service. The goals identified are based on an evaluation of programs and services; regulatory, contractual and accreditation requirements; and strategic planning initiatives.

Health Management and Care Management

The Senior Whole Health, Health Management and Care Management Programs provide for the identification, assessment, stratification, and implementation of appropriate interventions for Members with chronic diseases.

For additional information, please see the Health Management and Care Management headings in the Health Care Services section of this Provider Manual.

Clinical Practice Guidelines

Senior Whole Health adopts and disseminates Clinical Practice Guidelines (CPG) to reduce inter-Provider variation in diagnosis and treatment. CPG adherence is measured at least annually. All guidelines are based on scientific evidence, review of medical literature and/or appropriately established authority. Clinical Practice Guidelines are reviewed at least annually and more frequently as needed when clinical evidence changes and are approved by the Quality Improvement Committee.

Senior Whole Health Clinical Practice Guidelines include the following:

- Acute Stress and Post-Traumatic Stress Disorder (PTSD)
- Anxiety/Panic Disorder
- Asthma
- Attention Deficit Hyperactivity Disorder (ADHD)
- Autism
- Bipolar Disorder
- Children with Special Health Care Needs
- Chronic Kidney Disease
- Chronic Obstructive Pulmonary Disease (COPD)
- Depression
- Diabetes
- Heart Failure in Adults
- Homelessness-Special Health Care Needs
- Hypertension

- Obesity
- Opioid Management
- Perinatal Care
- Pregnancy Management
- Schizophrenia
- Sickle Cell Disease
- Substance Abuse Treatment
- Suicide Risk
- Trauma-Informed Primary Care

The adopted CPGs are distributed to the appropriate Providers, Provider groups, staff model facilities, delegates and Members by the Quality, Provider Services, Health Education and Member Services departments. The guidelines are disseminated through Provider newsletters, electronic Provider bulletins and other media and are available on the Senior Whole Health website. Individual Providers or Members may request copies from your local Senior Whole Health Quality department.

Preventive Health Guidelines

Senior Whole Health provides coverage of diagnostic preventive procedures based on recommendations published by the U.S. Preventive Services Task Force (USPSTF), Centers for Disease Control and Prevention (CDC) in accordance with Centers for Medicare & Medicaid Services (CMS) guidelines. Diagnostic preventive procedures include but are not limited to:

- Adult Preventive Services Recommendations
- Recommended Adult Immunization Schedule for ages 19 Years or Older, United States, 2021

All guidelines are updated at least annually and more frequently as needed when clinical evidence changes and are approved by the Quality Improvement Committee. On an annual basis, Preventive Health Guidelines are distributed to Providers at MolinaHealthcare.com and the Provider Manual. Notification of the availability of the Preventive Health Guidelines is published in the Senior Whole Health Provider Newsletter.

Cultural and Linguistic Services

Senior Whole Health works to ensure all Members receive culturally competent care across the service continuum to reduce health disparities and improve health outcomes. For additional information about Senior Whole Health's program and services, please see the Cultural Competency and Linguistic Services section of this Provider Manual.

Measurement of Clinical and Service Quality

Senior Whole Health monitors and evaluates the quality of care and services provided to Members through the following mechanisms:

- MLTC Quality Measures
- Healthcare Effectiveness Data and Information Set (HEDIS®)
- Behavioral Health Satisfaction Assessment
- Provider Satisfaction Survey
- Effectiveness of Quality Improvement Initiatives

Senior Whole Health evaluates continuous performance according to, or in comparison with objectives, measurable performance standards and benchmarks at the national, regional and/or at the local/health plan level.

Contracted Providers and facilities must allow Senior Whole Health to use its performance data collected in accordance with the Provider's or facility's contract. The use of performance data may include, but is not limited to, the following: (1) development of Quality Improvement activities; (2) public reporting to consumers; (3) preferred status designation in the network; (4) and/or reduced member cost sharing.

Senior Whole Health's most recent results can be obtained from your local Senior Whole Health Quality department or by visiting our website at MolinaHealthcare.com.

MLTC Quality Measures (Clinical Quality Incentive Program Goals)

- Licensed Home Care Service Agencies (LHCSA) must have an education program in place
- 90% of reassessments associated with LHCSA on Time
- Top tier results on all of the Department of Health (DOH) measures
- Additional payout may be earned when Potentially Avoidable Hospitalization (PAH) measure as defined by DOH is achieved: PAH includes primary diagnosis of heart failure, respiratory infection, electrolyte imbalance, sepsis, anemia, or urinary tract infection
    - The data for this measure will be used in the bonus and increase the potential payment retroactively
    - Robust Incentive Payments for Success

Healthcare Effectiveness Data and Information Set (HEDIS®)

Senior Whole Health utilizes the NCQA HEDIS® as a measurement tool to provide a fair and accurate assessment of specific aspects of managed care organization performance. HEDIS® is an annual activity conducted in the spring. The data comes from on-site medical record review and available administrative data. All reported measures must follow rigorous specifications and are externally audited to assure continuity and comparability of results. The HEDIS® measurement set currently includes a variety of health care aspects including immunizations, women's health screening, diabetes care, well check-ups, medication use, and cardiovascular disease.

HEDIS® results are used in a variety of ways. The results are the measurement standard for many of Senior Whole Health's clinical quality activities and health improvement programs. The

standards are based on established clinical guidelines and protocols, providing a firm foundation to measure the success of these programs.

Selected HEDIS® results are provided to regulatory and accreditation agencies as part of our contracts with these agencies. The data are also used to compare to established health plan performance benchmarks.

Behavioral Health Satisfaction Assessment

Molina obtains feedback from Members about their experience, needs, and perceptions of accessing behavioral health care services. This feedback is collected at least annually to understand how our members rate their experiences in getting treatment, communicating with their clinicians, receiving treatment and information from the plan, and perceived improvement in their conditions, among other areas.

Provider Satisfaction Survey

Recognizing that HEDIS® and CAHPS®/Qualified Health Plan Enrollee Experience Survey both focus on member experience with health care Providers and health plans, Senior Whole Health conducts a Provider Satisfaction Survey annually. The results from this survey are very important to Senior Whole Health, as this is one of the primary methods used to identify improvement areas pertaining to the Senior Whole Health Provider Network. The survey results have helped establish improvement activities relating to Senior Whole Health's specialty network, inter-Provider communications, and pharmacy authorizations. This survey is fielded to a random sample of Providers each year. If your office is selected to participate, please take a few minutes to complete and return the survey.

Effectiveness of Quality Improvement Initiatives

Senior Whole Health monitors the effectiveness of clinical and service activities through metrics selected to demonstrate clinical outcomes and service levels. The plan's performance is compared to that of available national benchmarks indicating "best practices." The evaluation includes an assessment of clinical and service improvements on an ongoing basis. Results of these measurements guide activities for the successive periods.

In addition to the methods described above, Senior Whole Health also compiles complaint and appeals data as well as requests for out-of-network services to determine opportunities for service improvements.

What Can Providers Do?

- Ensure patients are up to date with their annual physical exam and preventive health screenings, including related lab orders and referrals to specialists, such as ophthalmology.
- Review the HEDIS® preventive care listing of measures for each patient to determine if anything applicable to your patients' age and/or condition has been missed.

- Check that staff are properly coding all services provided.
- Be sure patients understand what *they* need to do.

Senior Whole Health has additional resources to assist Providers and their patients. For access to tools that can assist, please visit the Availity Essentials portal. There are a variety of resources, including: HEDIS® CPT/CMS-approved diagnostic and procedural code sheets. To obtain a current list of HEDIS® and CAHPS®/Qualified Health Plan Enrollee Experience survey Star Ratings measures, contact your local Senior Whole Health Quality department.

HEDIS® and CAHPS® are registered trademarks of the National Committee for Quality Assurance (NCQA).

11. RISK ADJUSTMENT MANAGEMENT PROGRAM

What is Risk Adjustment?

The Centers for Medicare & Medicaid Services (CMS) defines Risk Adjustment as a process that helps to accurately measure the health status of a plan's membership based on medical conditions and demographic information.

This process helps ensure health plans receive accurate payment for services provided to Senior Whole Health Members and prepares for resources that may be needed in the future to treat member who have multiple clinical conditions.

Why is Risk Adjustment Important?

Senior Whole Health relies on our Provider Network to take care of our members based on their health care needs. Risk Adjustment looks at several clinical data elements of a member's health profile to determine any documentation gaps from past visits and identifies opportunities for gap closure for future visits. In addition, Risk Adjustment allows us to:

- Focus on quality and efficiency.
- Recognize and address current and potential health conditions early.
- Identify Members for Care Management referral.
- Ensure adequate resources for the acuity levels of Senior Whole Health Members.
- Have the resources to deliver the highest quality of care to Senior Whole Health Members

Your Role as a Provider

As a Provider, your complete and accurate documentation in a Member's medical record and submitted Claims are critical to a Member's quality of care. We encourage Providers to code all diagnoses to the highest specificity as this will ensure Senior Whole Health receives adequate resources to provide quality programs to you and our members.

For a complete and accurate medical record, all Provider documentation must:

- Address clinical data elements (e.g., diabetic patient needs an eye exam or multiple comorbid conditions) provided by Senior Whole Health and reviewed with the Member.
- Be compliant with CMS correct coding initiative.
- Use the correct ICD-10 code by coding the condition to the highest level of specificity.
- Only use diagnosis codes confirmed during a Provider visit with a Member. The visit may be face-to-face, or telehealth, depending on state or CMS requirements.
- Contain a treatment plan and progress notes.
- Contain the Member's name and date of service.
- Have the Provider's signature and credentials.

Interoperability

Provider agrees to deliver relevant clinical documents (Clinical Document Architecture (CDA) or Continuity of Care Document (CCD) format) at encounter close for Senior Whole Health Members by using one of the automated methods available and supported by Provider's electronic medical records (EMR), including, but not limited to, Direct protocol, Secure File Transfer Protocol (sFTP), query or Web service interfaces such as Simple Object Access Protocol (External Data Representation) or Representational State Transfer (Fast Healthcare Interoperability Resource). CCDA or CCD document should include signed clinical note or conform with the United States Core Data for Interoperability (USCDI) common data set and Health Level 7 (HL7) CCDA standard.

Provider will also enable HL7 v2 Admission/Discharge/Transfer (ADT) feed for all patient events for Senior Whole Health Members to the interoperability vendor designated by Senior Whole Health.

Provider will participate in Senior Whole Health's program to communicate Clinical Information using the Direct Protocol. Direct protocol is the Health Insurance Portability and Accountability Act (HIPAA) compliant mechanism for exchanging healthcare information that is approved by the Office of the National Coordinator for Health Information Technology (ONC).

- If the Provider does not have Direct Address, Provider will work with its EMR vendor to set up a Direct Account, which also supports the Centers for Medicare & Medicare Services (CMS) Requirement of having Provider's Digital Contact Information added in the National Plan and Provider Enumeration System (NPPES).
- If Provider's EMR does not support the Direct Protocol, Provider will work with Senior Whole Health's established interoperability partner to get an account established.

RADV Audits

As part of the regulatory process, State and/or Federal agencies may conduct Risk Adjustment Data Validation (RADV) audits to ensure that the diagnosis data submitted by Senior Whole Health is appropriate and accurate. All Claims/Encounters submitted to Senior Whole Health are subject to State and/or Federal and internal health plan auditing. If Senior Whole Health is selected for a RADV audit, Providers will be required to submit medical records in a timely manner to validate the previously submitted data.

Contact Information

For questions about Senior Whole Health's Risk Adjustment programs, please contact your Senior Whole Health Provider Services representative.

12. COMPLIANCE

Fraud, Waste, and Abuse

Introduction

Senior Whole Health is dedicated to the detection, prevention, investigation, and reporting of potential health care fraud, waste, and abuse. As such, Senior Whole Health's Compliance department maintains a comprehensive plan, which addresses how Senior Whole Health will uphold and follow State and Federal statutes and regulations pertaining to fraud, waste, and abuse. Senior Whole Health also addresses fraud, waste and abuse prevention and detection along with the education of appropriate employees, vendors, Providers, and associates doing business with Senior Whole Health.

Senior Whole Health's Special Investigation Unit (SIU) supports Compliance in its efforts to detect, deter and prevent fraud, waste, and abuse by conducting investigations aimed at identifying suspect activity and reporting these findings to the appropriate regulatory and/or Law enforcement agency.

Mission Statement

Our mission is to pay claims correctly the first time, and that mission begins with the understanding that we need to proactively detect fraud, waste, and abuse, correct it, and prevent it from reoccurring. Since not all fraud, waste, or abuse can be prevented Senior Whole Health employs processes that retrospectively address fraud, waste, or abuse that may have already occurred. Senior Whole Health strives to detect, prevent, investigate, and report suspected health care fraud, waste, and abuse to reduce health care costs and to promote quality health care.

Regulatory Requirements

13. SELF-DISCLOSURE PROGRAM

Medicaid entities/Providers are required to report, return, and explain any overpayments they have received to the New York State Office of the Medicaid Inspector General (OMIG) Self-Disclosure Program within sixty (60) days of identification, or by the date any corresponding cost report was due, whichever is later. See Social Services Law (SOS) § 363-d(6).

Identification

Pursuant to SOS § 363-d (6)(b), an overpayment has been identified when a Medicaid entity/Provider has, or should have, through the exercise of reasonable diligence, determined that a Medicaid fund overpayment was received, and they have quantified the amount of the overpayment.

Medicaid entities/Providers who have a compliance program should be utilizing routine internal audits to review compliance with Medicaid requirements and identify any Medicaid fund overpayments that may have been received. Additionally, if a Medicaid entity/Provider is the subject of a government audit, part of that Medicaid entity's/Provider's due diligence is to review the results of the audit and look at past and future periods - not covered in the audit scope - to identify any overpayments resulting from similar issues. If overpayments exist, Medicaid entities/Providers are obligated to take corrective action, which includes reporting and returning any Medicaid overpayment identified to OMIG's Self-Disclosure Program.

Please Note: Voiding or adjusting claims does not satisfy the Medicaid entity's/Provider's obligation to report and explain the identified overpayment.

Timeframes

While both Federal and State regulations require a Medicaid entity/Provider to report, return, and explain an overpayment within sixty (60) days from identification, the actual timeframes for processing can vary. A Medicaid entity's/Provider's 60-day time frame will be tolled, or paused, when a completed Self-Disclosure Full Statement is received from an eligible Medicaid entity/Provider. The time frame to repay will remain tolled during OMIG's review.

More Information

Visit the New York State Office of the Medicaid Inspector General's Website

Self-Disclosure | Office of the Medicaid Inspector General (ny.gov)

Other Disclosures

Pursuant to Title 18 of the New York Codes Rules and Regulations, Section 504.3, providers are required to prepare and maintain contemporaneous records demonstrating their right to receive payment under the medical assistance program and furnish the records, upon request. If a provider becomes aware that their records have been damaged, lost or destroyed they are required to report that information to the Self-Disclosure Program as soon as practicable, but no later than thirty (30) calendar days after discovery.

Submission Process

Follow the steps outlined below or visit our website where you will also find our process and required form for submission.

Self- Disclosure Program (molinahealthcare.com)

Step 1

Timely report any Medicaid overpayments to the New York State Office of the Medicaid Inspector General (OMIG) via two pathways, full process, or abbreviated process, both of which are located at the link below.

Self-Disclosure Submission Information and Instructions | Office of the Medicaid Inspector General (ny.gov)

Timely report damaged, lost and/ or destroyed records to the New York State Office of the Medicaid Inspector General (OMIG) via the submission of a complete Statement of Damaged, Lost or Destroyed Records and Certification, both of which are located at the link below.

Self-Disclosure Submission Information and Instructions | Office of the Medicaid Inspector General (ny.gov)

Step 2

Damaged/ Lost/ Destroyed Records

- Notify Molina Healthcare's Compliance Department via email MNY.Compliance@molinahealthcare.com
    - Subject Line: **Damaged/ Lost/ Destroyed Records <Insert Entity Name>**
    - Body of the Email: include all details provided to the New York State Office of the Medicaid Inspector General
- A member of the Compliance Department will respond directly to you for next steps
- If this is not applicable to your situation, skip to Step 3

Step 3

Self-Disclosures

- Complete Molina's "Provider Early Reversal Permission Form"
    - In the Comments please indicate "Self-Disclosure as reported to the New York State Office of the Medicaid Inspector General"
- Fax and/ or mail the completed form and refund to Molina Healthcare's lockbox for processing (fax/ mail information is located within the form)
- Notify Molina Healthcare's Compliance Department of the Medicaid overpayment
    - Subject Line: **Self-Disclosure <Insert Entity Name>**
    - Body of the Email: confirm you have completed the steps outlined above
- A member of the Compliance Department will respond directly to you

14. CERTIFICATION STATEMENT FOR PROVIDER BILLING MEDICAID (ETIN)

It is a requirement of The New York State Office of the Medical Inspector General (OMIG) that participating MCO providers supply a copy of their Certification Statement for Provider Billing Medicaid (ETIN) form to each MCO for which they are a participating provider upon signing the provider agreement with the MCO, and annually thereafter.

Submission Process:

Step 1

Obtain a copy of your completed "Certification Statement for Provider Billing Medicaid" form.

- Ensure all twelve (12) spaces of required information are filled in
- If a clean copy is needed, click this link and download the PDF

Step 2

Obtain a copy of Molina's Attestation

- Click this link and download the PDF
- Ensure all seven (7) spaces of required information are filled in

Step 3

Attach the following documents to an email and send them to MNY.Compliance@molinahealthcare.com

- Certification Statement for Provider Billing Medicaid form
- Molina's Attestation

Federal False Claims Act

The False Claims Act is a Federal statute that covers fraud involving any Federally funded contract or program. The act establishes liability for any person who knowingly presents or causes to be presented a false or fraudulent Claim to the U.S. government for payment.

The term "knowing" is defined to mean that a person with respect to information:

- Has actual knowledge of falsity of information in the Claim;
- Acts in deliberate ignorance of the truth or falsity of the information in a Claim; or,
- Acts in reckless disregard of the truth or falsity of the information in a Claim.

The act does not require proof of a specific intent to defraud the U.S. government. Instead, health care Providers can be prosecuted for a wide variety of conduct that leads to the submission of fraudulent Claims to the government, such as knowingly making false statements, falsifying records, double-billing for items or services, submitting bills for services never performed or items never furnished or otherwise causing a false Claim to be submitted.

Deficit Reduction Act

The Deficit Reduction Act (DRA) aims to cut fraud, waste and abuse from the Medicare and Medicaid programs.

As a contractor doing business with Senior Whole Health, Providers and their staff have the same obligation to report any actual or suspected violation of funds either by fraud, waste, or abuse. Entities must have written policies that inform employees, contractors, and agents of the following:

- The Federal False Claims Act and State Laws pertaining to submitting false Claims.
- How Providers will detect and prevent fraud, waste, and abuse.
- Employee protection rights as whistleblowers.

These provisions encourage employees (current or former) and others to report instances of fraud, waste, or abuse to the government. The government may then proceed to file a lawsuit against the organization/individual accused of violating the False Claims Act. The whistleblower may also file a lawsuit independently. Cases found in favor of the government will result in the whistleblower receiving a portion of the amount awarded to the government.

Whistleblower protections state that employees who have been discharged, demoted, suspended, threatened, harassed, or otherwise discriminated against due to their role in disclosing or reporting a false Claim are entitled to all relief necessary to make the employee whole including:

- Employment reinstatement at the same level of seniority.
- Two times the amount of backpay plus interest.
- Compensation for special damage incurred by the employee as a result of the employer's inappropriate actions.

Affected entities who fail to comply with the Law will be at risk of forfeiting all payments until compliance is met. Senior Whole Health will take steps to monitor Senior Whole Health contracted Providers to ensure compliance with the Law.

Anti-Kickback Statute (42 U.S.C. § 1320a-7b(b))

Anti-Kickback Statute ("AKS") is a criminal law that prohibits the knowing and willful payment of "remuneration" to induce or reward patient referrals or the generation of business involving any item or service payable by the Federal health care programs (e.g., drugs, supplies, or health care services for Medicare or Medicaid patients). In some industries, it is acceptable to reward those who refer business to you. However, in the Federal health care programs, paying for referrals is a crime. The statute covers the payers of kickbacks-those who offer or pay remuneration- as well as the recipients of kickbacks-those who solicit or receive remuneration.

Senior Whole Health conducts all business in compliance with Federal and State Anti-Kickback Statutes (AKB) statutes and regulations and Federal and State marketing regulations. Providers are prohibited from engaging in any activities covered under this statute.

What is AKB?

AKB statutes and regulations prohibit paying or receiving anything of value to induce or reward patient referrals or the generation of business involving any item or service payable by Federal and State health care programs. The phrase "anything of value" can mean cash, discounts, gifts, excessive compensation, contracts not at fair market value, etc. **Examples** of prohibited AKB actions include a health care Provider who is compensated based on patient volume, or a Provider who offers remuneration to patients to influence them to use their services.

Under **Senior Whole Health's policies**, Providers may not offer, solicit an offer, provide, or receive items of value of any kind that are intended to induce referrals of Federal health care program business. Providers must not, directly, or indirectly, make or offer items of value to any third party, for the purpose of obtaining, retaining, or directing our business. This includes giving, favors, preferential hiring, or anything of value to any government official.

Marketing Guidelines and Requirements

Providers must conduct all marketing activities in accordance with the relevant contractual requirements and marketing statutes and regulations – both State and Federal.

Under **Senior Whole Health's policies**, Marketing means any communication, to a beneficiary who is not enrolled with Senior Whole Health, that can reasonably be interpreted as intended to influence the beneficiary to enroll with Senior Whole Health's Medicaid, Marketplace, or Medicare products. This also includes communications that can be interpreted to influence a beneficiary to not enroll in or to disenroll from another Health Plan's products.

Restricted marketing activities vary from state-to-state but generally relate to the types and form of communications that health plans, Providers and others can have with Members and prospective Members. Examples of such communications include those related to enrolling Members, Member outreach, and other types of communications.

Stark Statute

Similar to the Anti-Kickback Statute, but more narrowly defined and applied. It applies specifically to services provided only by Practitioners, rather than by all health care Providers.

The Sarbanes–Oxley Act of 2002

Requires certification of financial statements by both the Chief Executive Officer and the Chief Financial Officer. The Act states that a corporation must assess the effectiveness of its internal controls and report this assessment annually to the Securities and Exchange Commission.

Definitions

Fraud: means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to themself or some other person. It includes any act that constitutes fraud under applicable Federal or State Law. (42 CFR § 455.2)

Waste: means health care spending that can be eliminated without reducing the quality of care. Quality waste includes overuse, underuse, and ineffective use. Inefficiency waste includes redundancy, delays, and unnecessary process complexity. An example would be the attempt to obtain reimbursement for items or services where there was no intent to deceive or misrepresent, however the outcome resulted in poor or inefficient billing methods (e.g. coding) causing unnecessary costs to State and Federal health care programs.

Abuse: means Provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in unnecessary costs to State and Federal health care programs, or in reimbursement for services that are not Medically Necessary or that fail to meet professionally recognized standards for health care. It also includes recipient practices that result in unnecessary cost to State and Federal health care programs. (42 CFR § 455.2)

Examples of Fraud, Waste, and Abuse by a Provider

The types of questionable Provider schemes investigated by Senior Whole Health include, but are not limited to the following:

- A Provider knowingly and willfully referring a member to health care facilities in which or with which the Provider has a financial relationship. (Stark Law)
- Altering Claims and/or medical record documentation in order to get a higher level of reimbursement.
- Balance billing a Senior Whole Health member for Covered Services. This includes asking the member to pay the difference between the discounted and negotiated fees, and the Provider's usual and customary fees.
- Billing and providing for services to Members that are not Medically Necessary.
- Billing for services, procedures and/or supplies that have not been rendered.
- Billing under an invalid place of service in order to receive or maximize reimbursement.
- Completing certificates of Medical Necessity for Members not personally and professionally known by the Provider.
- Concealing a Member's misuse of a Senior Whole Health identification card.
- Failing to report a Member's forgery or alteration of a prescription or other medical document.
- False coding in order to receive or maximize reimbursement.
- Inappropriate billing of modifiers in order to receive or maximize reimbursement.
- Inappropriately billing of a procedure that does not match the diagnosis in order to receive or maximize reimbursement.
- Knowingly and willfully soliciting or receiving payment of kickbacks or bribes in exchange for referring patients.
- Not following incident to billing guidelines in order to receive or maximize reimbursement.
- Overutilization
- Participating in schemes that involve collusion between a Provider and a member that result in higher costs or charges.
- Questionable prescribing practices.
- Unbundling services in order to get more reimbursement, which involves separating a procedure into parts and charging for each part rather than using a single global code.
- Underutilization, which means failing to provide services that are Medically Necessary.
- Upcoding, which is when a Provider does not bill the correct code for the service rendered, and instead uses a code for a like services that costs more.
- Using the adjustment payment process to generate fraudulent payments.

Examples of Fraud, Waste, and Abuse by a Member

The types of questionable member schemes investigated by Senior Whole Health include, but are not limited to, the following:

- Benefit sharing with persons not entitled to the Member's benefits.

- Conspiracy to defraud State and Federal health care programs.
- Doctor shopping, which occurs when a Member consults a number of Providers for the purpose of inappropriately obtaining services.
- Falsifying documentation in order to get services approved.
- Forgery related to health care.
- Prescription diversion, which occurs when a Member obtains a prescription from a Provider for a condition that they do not suffer from and the Member sells the medication to someone else.

Review of Provider Claims and Claims System

Senior Whole Health Claims Examiners are trained to recognize unusual billing practices, which are key in trying to identify fraud, waste, and abuse. If the Claims Examiner suspects fraudulent, abusive, or wasteful billing practices, the billing practice is documented and reported to the SIU through our Compliance Alertline/reporting repository.

The Claims payment system utilizes system edits and flags to validate those elements of Claims are billed in accordance with standardized billing practices; ensure that Claims are processed accurately and ensure that payments reflect the service performed as authorized.

Senior Whole Health performs auditing to ensure the accuracy of data input into the Claims system. The Claims department conducts regular audits to identify system issues or errors. If errors are identified, they are corrected, and a thorough review of system edits is conducted to detect and locate the source of the errors.

Prepayment Fraud, Waste, and Abuse Detection Activities

Through implementation of Claims edits, Senior Whole Health's Claims payment system is designed to audit Claims concurrently, in order to detect and prevent paying Claims that are inappropriate.

Senior Whole Health has a pre-payment Claims auditing process that identifies frequent correct coding billing errors ensuring that Claims are coded appropriately according to State and Federal coding guidelines. Code edit relationships and edits are based on guidelines from specific State Medicaid Guidelines, Centers for Medicare & Medicaid Services (CMS), Federal CMS guidelines, AMA, and published specialty specific coding rules. Code Edit Rules are based on information received from the National Physician Fee Schedule Relative File (NPFS), the Medically Unlikely Edit (MUE) table, the National Correct Coding Initiative (NCCI) files, Local Coverage Determination/National Coverage Determination (LCD/NCD), and State-specific policy manuals and guidelines as specified by a defined set of indicators in the Medicare Physician Fee Schedule Data Base (MPFSDB).

Additionally, Senior Whole Health may, at the request of a State program or at its own discretion, subject a Provider to prepayment reviews whereupon Provider is required to submit supporting source documents that justify an amount charged. Where no supporting documents

are provided, or insufficient information is provided to substantiate a charge, the Claim will be denied until such time that the Provider can provide sufficient accurate support.

Post-payment Recovery Activities

The terms expressed in this section of this Provider Manual are incorporated into the Provider Agreement, and are intended to supplement, rather than diminish, any and all other rights and remedies that may be available to Senior Whole Health under the Provider Agreement or at Law or equity.

In the event of any inconsistency between the terms expressed here and any terms expressed in the Provider Agreement, the parties agree that Senior Whole Health shall in its sole discretion exercise the terms that are expressed in the Provider Agreement, the terms that are expressed here, its rights under Law and equity, or some combination thereof.

Provider will provide Senior Whole Health, governmental agencies and their representatives or agents, access to examine, audit, and copy any and all records deemed by Senior Whole Health, in Senior Whole Health's sole discretion, necessary to determine compliance with the terms of the Provider Agreement, including for the purpose of investigating potential fraud, waste and abuse. Documents and records must be readily accessible at the location where Provider provides services to any Senior Whole Health Members. Auditable documents and records include, but are not limited to, medical charts; patient charts; billing records; and coordination of benefits information. Production of auditable documents and records must be provided in a timely manner, as requested by Senior Whole Health and without charge to Senior Whole Health. In the event Senior Whole Health identifies fraud, waste or abuse, Provider agrees to repay funds or Senior Whole Health may seek recoupment.

If a Senior Whole Health auditor is denied access to Provider's records, all of the Claims for which Provider received payment from Senior Whole Health is immediately due and owing. If Provider fails to provide all requested documentation for any Claim, the entire amount of the paid Claim is immediately due and owing. Senior Whole Health may offset such amounts against any amounts owed by Senior Whole Health to Provider. Provider must comply with all requests for documentation and records timely (as reasonably requested by Senior Whole Health) and without charge to Senior Whole Health. Claims for which Provider fails to furnish supporting documentation during the audit process are not reimbursable and are subject to chargeback.

Provider acknowledges that HIPAA specifically permits a covered entity, such as Provider, to disclose protected health information for its own payment purposes (see 45 CFR 164.502 and 45 CFR 154.501). Provider further acknowledges that in order to receive payment from Senior Whole Health, Provider is required to allow Senior Whole Health to conduct audits of its pertinent records to verify the services performed and the payment claimed, and that such audits are permitted as a payment activity of Provider under HIPAA and other applicable privacy Laws.

Claim Auditing

Senior Whole Health shall use established industry Claims adjudication and/or clinical practices, State, and Federal guidelines, and/or Senior Whole Health's policies and data to determine the appropriateness of the billing, coding, and payment.

Provider acknowledges Senior Whole Health's right to conduct pre and post-payment billing audits. Provider shall cooperate with Senior Whole Health's Special Investigations Unit and audits of Claims and payments by providing access at reasonable times to requested Claims information, all supporting medical records, Provider's charging policies, and other related data as deemed relevant to support the transactions billed. Providers are required to submit, or provide access to, medical records upon Senior Whole Health's request. Failure to do so in a timely manner may result in an audit failure and/or denial, resulting in an overpayment.

In reviewing medical records for a procedure, Senior Whole Health may select a statistically valid random sample, or smaller subset of the statistically valid random sample. This gives an estimate of the proportion of Claims that Senior Whole Health paid in error. The estimated proportion, or error rate, may be projected across all Claims to determine the amount of overpayment.

Provider audits may be telephonic, an on-site visit, internal Claims review, client-directed/regulatory investigation and/or compliance reviews and may be vendor assisted. Senior Whole Health asks that you provide Senior Whole Health, or Senior Whole Health's designee, during normal business hours, access to examine, audit, scan and copy any and all records necessary to determine compliance and accuracy of billing.

If Senior Whole Health's Special Investigations Unit suspects that there is fraudulent or abusive activity, Senior Whole Health may conduct an on-site audit without notice. Should you refuse to allow access to your facilities, Senior Whole Health reserves the right to recover the full amount paid or due to you.

Provider Education

When Senior Whole Health identifies through an audit or other means a situation with a Provider (e.g., coding, billing) that is either inappropriate or deficient, Senior Whole Health may determine that a Provider education visit is appropriate.

Senior Whole Health will notify the Provider of the deficiency and will take steps to educate the Provider, which may include the Provider submitting a corrective action plan (CAP) to Senior Whole Health addressing the issues identified and how it will cure these issues moving forward.

Reporting Fraud, Waste, and Abuse

If you suspect cases of fraud, waste, or abuse, you must report it by contacting the Senior Whole Health AlertLine. AlertLine is an external telephone and web-based reporting system hosted by NAVEX Global, a leading Provider of compliance and ethics hotline services. AlertLine

telephone and web-based reporting is available 24 hours a day, seven days a week, 365 days a year. When you make a report, you can choose to remain confidential or anonymous. If you choose to call AlertLine, a trained professional at NAVEX Global will note your concerns and provide them to the Senior Whole Health Compliance department for follow-up. If you elect to use the web-based reporting process, you will be asked a series of questions concluding with the submission of your report. Reports to AlertLine can be made from anywhere within the United States with telephone or internet access.

Senior Whole Health AlertLine can be reached toll free at (866) 606-3889 or you may use the service's website to make a report at any time at MolinaHealthcare.alertline.com

You may also report cases of fraud, waste, or abuse to Senior Whole Health's Compliance department. You have the right to have your concerns reported anonymously without fear of retaliation.

Molina Healthcare, Inc.
Attn: Compliance
200 Oceangate Blvd, Suite 100
Long Beach, CA 90810

Remember to include the following information when reporting:

- Nature of complaint.
- The names of individuals and/or entity involved in suspected fraud and/or abuse including address, phone number, Senior Whole Health member ID number and any other identifying information.

Suspected fraud and abuse may also be reported directly to the State at:

NYS Medicaid Inspector General Toll Free Phone: 1-877-87FRAUD (1-877-873-7283)

HIPAA Requirements and Information

HIPAA (Health Insurance Portability and Accountability Act)

Senior Whole Health's Commitment to Patient Privacy

Protecting the privacy of Members' personal health information is a core responsibility that Senior Whole Health takes very seriously. Senior Whole Health is committed to complying with all Federal and State Laws regarding the privacy and security of Members' protected health information (PHI).

Provider Responsibilities

Senior Whole Health expects that its contracted Provider will respect the privacy of Senior Whole Health members (including Senior Whole Health members who are not patients of the

Provider) and comply with all applicable Laws and regulations regarding the privacy of patient and member PHI. Senior Whole Health provides its members with a privacy notice upon their enrollment in our health plan. The privacy notice explains how Senior Whole Health uses and discloses their PHI and includes a summary of how Senior Whole Health safeguards their PHI.

Telehealth/Telemedicine Providers: Telehealth transmissions are subject to HIPAA-related requirements outlined under State and Federal Law, including:

- 42 C.F.R. Part 2 Regulations
- Health Information Technology for Economic and Clinical Health Act, (HITECH Act)

Applicable Laws

Providers must understand all State and Federal health care privacy Laws applicable to their practice and organization. Currently, there is no comprehensive regulatory framework that protects all health information in the United States; instead there is a patchwork of Laws that Providers must comply with. In general, most health care Providers are subject to various Laws and regulations pertaining to privacy of health information, including, without limitation, the following:

1. **Federal Laws and Regulations**
   - HIPAA
   - The Health Information Technology for Economic and Clinical Health Act (HITECH)
   - 42 C.F.R. Part 2
   - Medicare and Medicaid Laws
   - The Affordable Care Act

2. **State Medical Privacy Laws and Regulations**

   Providers should be aware that HIPAA provides a floor for patient privacy, but that State Laws should be followed in certain situations, especially if the State Law is more stringent than HIPAA. Providers should consult with their own legal counsel to address their specific situation.

Uses and Disclosure of PHI

Member and patient PHI should only be used or disclosed as permitted or required by applicable Law. Under HIPAA, a Provider may use and disclose PHI for their own treatment, payment, and health care operations activities (TPO) without the consent or authorization of the patient who is the subject of the PHI. Uses and disclosures for TPO apply not only to the Provider's own TPO activities, but also for the TPO of another covered entity[1]. Disclosure of PHI by one covered entity to another covered entity, or health care Provider, for the recipient's TPO is specifically permitted under HIPAA in the following situations:

[1] See Sections 164.506(c) (2) & (3) of the HIPAA Privacy Rule.

1. A covered entity may disclose PHI to another covered entity or a health care Provider for the payment activities of the recipient. Please note that "payment" is a defined term under the HIPAA Privacy Rule that includes, without limitation, utilization review activities, such as preauthorization of services, concurrent review, and retrospective review of "services[2]."

2. A covered entity may disclose PHI to another covered entity for the health care operations activities of the covered entity that receives the PHI, if each covered entity either has or had a relationship with the individual who is the subject of the PHI being requested, the PHI pertains to such relationship, and the disclosure is for the following health care operations activities:

    - Quality Improvement
    - Disease Management
    - Care Management and Care Coordination
    - Training Programs
    - Accreditation, Licensing, and Credentialing

Importantly, this allows Providers to share PHI with Senior Whole Health for our health care operations activities, such as HEDIS® and Quality improvement.

Confidentiality of Substance Use Disorder Patient Records

Federal Confidentiality of Substance Use Disorder Patients Records regulations apply to any entity or individual providing federally-assisted alcohol or drug abuse prevention treatment. Records of the identity, diagnosis, prognosis, or treatment of any patient which are maintained in connection with substance use disorder treatment or programs are confidential and may be disclosed only as permitted by 42 CFR Part 2. Although HIPAA protects substance use disorder information, the Federal Confidentiality of Substance Use Disorder Patients Records regulations are more restrictive than HIPAA and they do not allow disclosure without the Member's written consent except as set forth in 42 CFR Part 2.

Inadvertent Disclosures of PHI

Senior Whole Health may, on occasion, inadvertently misdirect or disclose PHI pertaining to Senior Whole Health Member(s) who are not the patients of the Provider. In such cases, the Provider shall return or securely destroy the PHI of the affected Senior Whole Health Members in order to protect their privacy. The Provider agrees to not further use or disclose such PHI and further agrees to provide an attestation of return, destruction, and non-disclosure of any such misdirected PHI upon the reasonable request of Senior Whole Health.

Written Authorizations

[2] See the definition of Payment, Section 164.501 of the HIPAA Privacy Rule

Uses and disclosures of PHI that are not permitted or required under applicable Law require the valid written authorization of the patient. Authorizations should meet the requirements of HIPAA and applicable State Law.

Patient Rights

Patients are afforded various rights under HIPAA. Senior Whole Health Providers must allow patients to exercise any of the below-listed rights that apply to the Provider's practice:

1. **Notice of Privacy Practices**
   Providers that are covered under HIPAA and that have a direct treatment relationship with the patient should provide patients with a notice of privacy practices that explains the patient's privacy rights and the process the patient should follow to exercise those rights. The Provider should obtain a written acknowledgment that the patient received the notice of privacy practices.

2. **Requests for Restrictions on Uses and Disclosures of PHI**
   Patients may request that a health care Provider restrict its uses and disclosures of PHI. The Provider is not required to agree to any such request for restrictions.

3. **Requests for Confidential Communications**
   Patients may request that a health care Provider communicate PHI by alternative means or at alternative locations. Providers must accommodate reasonable requests by the patient.

4. **Requests for Patient Access to PHI**
   Patients have a right to access their own PHI within a Provider's designated record set. Personal representatives of patients have the right to access the PHI of the subject patient. The designated record set of a Provider includes the patient's medical record, as well as billing and other records used to make decisions about the Member's care or payment for care.

5. **Request to Amend PHI**
   Patients have a right to request that the Provider amend information in their designated record set.

6. **Request Accounting of PHI Disclosures**
   Patients may request an accounting of disclosures of PHI made by the Provider during the preceding six year period. The list of disclosures does not need to include disclosures made for treatment, payment, or health care operations or made prior to April 14, 2003.

HIPAA Security

Providers must implement and maintain reasonable and appropriate safeguards to protect the confidentiality, availability, and integrity of Senior Whole Health member and patient PHI. As more Providers implement electronic health records, Providers need to ensure that they have

implemented and maintain appropriate cybersecurity measures. Providers should recognize that identity theft – both financial and medical -- is a rapidly growing problem and that their patients trust their health care Providers to keep their most sensitive information private and confidential.

Medical identity theft is an emerging threat in the health care industry. Medical identity theft occurs when someone uses a person's name and sometimes other parts of their identity –such as health insurance information—without the person's knowledge or consent to obtain health care services or goods. Medical identity theft frequently results in erroneous entries being put into existing medical records. Providers should be aware of this growing problem and report any suspected fraud to Senior Whole Health.

HIPAA Transactions and Code Sets

Senior Whole Health strongly supports the use of electronic transactions to streamline health care administrative activities. Senior Whole Health Providers are encouraged to submit Claims and other transactions to Senior Whole Health using electronic formats. Certain electronic transactions in health care are subject to HIPAA's Transactions and Code Sets Rule including, but not limited to, the following:

- Claims and Encounters
- Member eligibility status inquiries and responses
- Claims status inquiries and responses
- Authorization requests and responses
- Remittance advices

Senior Whole Health is committed to complying with all HIPAA Transaction and Code Sets standard requirements. Providers should refer to Senior Whole Health's website at MolinaHealthcare.com for additional information regarding HIPAA standard transactions.

1. Click on the area titled "I'm a Health Care Professional"
2. Click the tab titled "HIPAA"
3. Click on the tab titled "HIPAA Transactions" or "HIPAA Code Sets"

Code Sets

HIPAA regulations require that only approved code sets may be used in standard electronic transactions.

National Provider Identifier (NPI)

Providers must comply with the National Provider Identifier (NPI) Rule promulgated under HIPAA. The Provider must obtain an NPI from the National Plan and Provider Enumeration System (NPPES) for itself or for any subparts of the Provider. The Provider must report its NPI and any subparts to Senior Whole Health and to any other entity that requires it. Any changes in its NPI or subparts information must be reported to NPPES within 30 days and should also be

reported to Senior Whole Health within 30 days of the change. Providers must use their NPI to identify it on all electronic transactions required under HIPAA and on all Claims and Encounters submitted to Senior Whole Health.

Additional Requirements for Delegated Providers

Providers that are delegated for Claims and Utilization Management activities are the "business associates" of Senior Whole Health. Under HIPAA, Senior Whole Health must obtain contractual assurances from all business associates that they will safeguard member PHI. Delegated Providers must agree to various contractual provisions required under HIPAA's Privacy and Security Rules.

Reimbursement for Copies of PHI

Senior Whole Health does not reimburse Providers for copies of PHI related to our Members. These requests may include, although are not limited to, the following purposes:

- Utilization Management
- Care Coordination and/or Complex Medical Care Management Services
- Claims Review
- Resolution of an Appeal and/Grievance
- Anti-Fraud Program Review
- Quality of Care Issues
- Regulatory Audits
- Risk Adjustment
- Treatment, Payment and/or Operation Purposes
- Collection of HEDIS® medical records

Information Security and Cybersecurity

Note: This section (Information Security and Cybersecurity) is only applicable to Providers who are delegated Providers and have been delegated by Senior Whole Health to perform a health plan function.

1. Definitions:

   (a) "Senior Whole Health Information" means any information provided by Senior Whole Health to Provider, accessed by Provider or available to Provider on Senior Whole Health's Information Systems, or any information with respect to Senior Whole Health or any of its consumers developed by Provider or other third parties in Provider's possession, including without limitation any Senior Whole Health Nonpublic Information.

   (b) "Cybersecurity Event" means any act or attempt, successful or, to the extent known by Provider, unsuccessful, to gain unauthorized access to, disrupt or

misuse an Information System or information stored on such Information System.

(c) "HIPAA" means the Health Insurance Portability and Accountability Act, as may be amended from time to time.

(d) "HITECH" means the Health Information Technology for Economic and Clinical Health Act, as may be amended from time to time.

(e) "Industry Standards" mean the current standards and benchmarks set forth and maintained by the following, in accordance with the latest revisions and/or amendments:

i. Center for Internet Security - http://www.cisecurity.org
ii. Payment Card Industry/Data Security Standards ("PCI/DSS") - http://www.pcisecuritystandards.org/
iii. National Institute for Standards and Technology ("NIST") Special Publications 800.53 Rev.4 and 800.171 Rev. 1, or as currently revised - http://csrc.nist.gov
iv. Federal Information Security Management Act ("FISMA") - http://csrc.nist.gov
v. ISO/ IEC 27001 - http://www.iso27001security.com/
vi. HIPPA and HITECH
vii. HITRUST Common Security Framework
viii. Federal Risk and Authorization Management Program ("FedRamp")
ix. NIST Special Publication 800-34 Revision 1 – "Contingency Planning Guide for Federal Information Systems."
x. International Organization for Standardization (ISO) 22301 – "Societal security – Business continuity management systems – Requirements."

(f) "Information Systems" means a discrete set of electronic information resources organized for the collection, processing, storage, maintenance, use, sharing, transfer, dissemination, or disposition of electronic information, as well as any specialized system such as industrial or process controls systems, telephone switching and private branch exchange systems, and environmental control systems.

(g) "Multi-Factor Authentication" means authentication through verification of at least two of the following types of authentication factors: (1) knowledge factors, such as a password; (2) possession factors, such as a token or text message on a mobile phone; or (3) inherence factors, such as a biometric characteristic.

(h) "Nonpublic Information" means information that is not publicly available information and is:

A. business related information of Senior Whole Health, the tampering with which, or unauthorized disclosure, access, or use of which, would cause a material adverse impact to the business, operations, or security of Senior Whole Health;

B. any information concerning a consumer which because of name, number, personal mark, or other identifier can be used to identify such consumer, in combination with any one or more of the following data elements:

i. social security number;
ii. driver's license number or nondriver identification card number;
iii. account number, credit, or debit card number;
iv. security code, access code, or password that would permit access to a consumer's financial account; or,
v. biometric records.

C. any information or data, except age or gender, in any form or medium created by or derived from a health care Provider or a consumer and that relates to:
i. the past, present, or future physical, mental, or behavioral health or condition of a consumer or a member of the consumer's family;
ii. the provision of health care to a consumer; or,
iii. payment for the provision of health care to a consumer.

2. Information Security and Cybersecurity Measures. Provider shall implement, and at all times maintain, appropriate administrative, technical, and physical measures to protect and secure the Information Systems and Senior Whole Health Information, including Nonpublic Information, that are accessible to, or held by, Provider.

(a) Policies, Procedures & Practices. Provider must have policies, procedures and practices that address its information security and cybersecurity measures, safeguards, and standards, which Senior Whole Health shall be permitted to audit via written request, and which shall include at least the following:
i. Access Controls. Access controls, including Multi-Factor Authentication, to limit access to the Information Systems, Senior Whole Health Information, and Nonpublic Information accessible to or held by Provider;
ii. Encryption. Use of encryption to protect Senior Whole Health Information and Nonpublic Information, in transit and at rest, accessible to or held by Provider;
iii. Security. Safeguarding the security of the Information Systems, Senior Whole Health Information and Nonpublic Information accessible to or held by Provider, which shall include hardware and software protections such as network firewall provisioning, intrusion, and threat detection, regular (three or more annually) third party vulnerability assessments, physical security controls, and personnel training programs that include phishing recognition and proper data management hygiene; and,
iv. Software Maintenance. Software maintenance, support, updates, upgrades, 3rd party software components and bug fixes such that the software is, and remains, secure from vulnerabilities in accordance with the applicable Industry Standards.

(b) Technical Standards. Provider shall comply with the following requirements and technical standards related to network and data security.

(i) Network Security. Network security shall conform to generally recognized industry standards and best practices. Generally recognized industry standards include, but are not limited to, the applicable Industry Standards.

(ii) Data Storage. Provider agrees that any and all Senior Whole Health Information, including Senior Whole Health Nonpublic Information, will be stored, processed, and maintained solely on designated target servers and that no Senior Whole Health Information, including Senior Whole Health Nonpublic Information, at any time will be processed on or transferred to any portable or laptop computing device or any portable storage medium, unless that device or storage medium is in use as part of the Provider's designated backup and recovery processes and is encrypted in accordance with the requirements set forth herein.

(iii) Data Encryption. Provider agrees to store all Senior Whole Health Information, including Senior Whole Health Nonpublic Information, as part of its designated backup and recovery processes in encrypted form, using a commercially supported encryption solution. Provider further agrees that any and all Senior Whole Health Information, including Senior Whole Health Nonpublic Information, stored on any portable or laptop computing device or any portable storage medium be likewise encrypted. Encryption solutions will be deployed with no less than a 128-bit key for symmetric encryption, a 1024 (or larger) bit key length for asymmetric encryption, and the Federal Information Processing Standard Publication 140-2 ("FIPS PUB 140-2").

(iv) Data Transmission. Provider agrees that any and all electronic transmission or exchange of system and application data with Senior Whole Health and/or any other parties expressly designated by Senior Whole Health shall take place via secure means (using HTTPS or SFTP or equivalent) and solely in accordance with FIPS PUB 140-2 and the Data Re-Use requirements set forth herein.

(v) Data Re-Use. Provider agrees that any and all Senior Whole Health Information exchanged shall be used expressly and solely for the purposes enumerated in the Agreement and this Attachment. Data shall not be distributed, repurposed, or shared across other applications, environments, or business units of Provider. Provider further agrees that no Senior Whole Health data of any kind shall be transmitted, exchanged, or otherwise passed to other affiliates, contractors or interested parties, except on a case-by-case basis as specifically agreed to in advance and in writing by Senior Whole Health.

3. Business Continuity ("BC") and Disaster Recovery ("DR"). Provider shall have documented procedures in place to ensure continuity of Provider's business operations, including disaster recovery, during a potentially disruptive incident that could impact Provider's delivery of services to Senior Whole Health.

(a) Resilience Questionnaire. Provider shall complete a questionnaire provided by Senior Whole Health to establish Provider's resilience capabilities.

(b) BC/DR Plan.

(i) Provider's procedures addressing continuity of business operations, including disaster recovery, shall be collected and/or summarized in a documented BC and DR plan or plans ("BC/DR Plan").

(ii) The BC/DR Plan shall identify the service level agreement(s) established between Provider and Senior Whole Health.

(iii) The BC/DR Plan shall include all information systems that support services provided to Senior Whole Health.

(iv) Provider shall develop information technology disaster recovery or systems contingency plans consistent with applicable Industry Standards and in accordance with all applicable laws.

(c) Senior Whole Health Notification. Provider shall notify Senior Whole Health's Chief Information Security Officer by telephone and email (provided herein) as promptly as possible, but not to exceed 24 hours of Provider's discovery of any potentially disruptive incident that may impact or interfere with the delivery of services to Senior Whole Health or that detrimentally affects Senior Whole Health's Information Systems or Senior Whole Health's Information, including Nonpublic Information.

(d) BC and DR Testing. For all services provided to Senior Whole Health, Provider shall exercise its BC/DR Plan at least once each calendar year, and shall provide Senior Whole Health a written report in electronic format upon request. At a minimum, the written report shall include the date of the test(s), a description of activities performed, results of the activities, corrective actions identified, and modifications to plans based on results of the exercise(s).

4. Cybersecurity Events.

(a) Provider agrees to comply with all applicable laws governing Cybersecurity Events. Senior Whole Health will decide on further action including, but not limited to, notification to affected individuals or government entities, except where Provider is solely responsible and required to notify such individuals or government entities by Law.

(b) In the event a Cybersecurity Event threatens or affects Senior Whole Health's Information Systems (in connection with Provider having access to such Information Systems), Provider's Information Systems, or Senior Whole Health Information accessible to or held by Provider, Provider shall notify Senior Whole Health's Chief Information Security Officer of such event by telephone and email as provided below (with follow-up notice by mail) as promptly as possible, but in no event later than 24 hours from Provider's discovery of the Cybersecurity Event. In addition to the foregoing, Provider shall notify Senior Whole Health's Chief Information Security Officer (by telephone and email, with follow-up notice

by mail) within 24 hours following payment of a ransom that involves or may involve Senior Whole Health Information

(c) Notification to Senior Whole Health's Chief Information Security Officer shall be provided to:

Molina Chief Information Security Officer
Telephone: (844) 821-1942
Email: CyberIncidentReporting@molinahealthcare.com

Chief Information Security Officer
Molina Healthcare, Inc.
200 Oceangate Blvd., Suite 100
Long Beach, CA 90802

(d) Following notification of a Cybersecurity Event, Provider must promptly provide Senior Whole Health any documentation requested by Senior Whole Health to complete an investigation, or, upon request by Senior Whole Health, complete an investigation.

(e) Provider must provide Senior Whole Health requested information regarding a Cybersecurity Event in electronic form and as directed by Senior Whole Health. Provider shall have a continuing obligation to update and supplement the initial and subsequent notifications to Senior Whole Health concerning the Cybersecurity Event.

(f) Provider shall maintain records concerning all Cybersecurity Events for a period of at least five years from the date of the Cybersecurity Event or such longer period as required by applicable laws and produce those records upon Senior Whole Health's request.

5. Right to Conduct Assessments; Provider Warranty. Provider agrees to fully cooperate with any security risk assessments performed by Senior Whole Health and/or any designated representative or vendor of Senior Whole Health. Provider agrees to promptly provide accurate and complete information with respect to such security risk assessments. If Senior Whole Health performs a due diligence/security risk assessment of Provider, Provider (i) warrants that the services provided pursuant to the Agreement will be in compliance with generally recognized industry standards and as provided in Provider's response to Senior Whole Health's due diligence/security risk assessment questionnaire; (ii) agrees to inform Senior Whole Health promptly of any material variation in operations from what was provided in Provider's response to Senior Whole Health's due diligence/security risk assessment; and (iii) agrees that any material deficiency in operations from those as described in the Provider's response to the Senior Whole Health's due diligence/security risk assessment questionnaire may be deemed a material breach of the Provider Agreement.

6. Conflicting Provisions. In the event provisions of this section conflict with provisions of any other agreement between Senior Whole Health and Provider, the stricter of the conflicting provisions will control.

15. CLAIMS AND COMPENSATION

Payer ID	**SWHNY**
Availity Essentials portal	**provider.MolinaHealthcare.com**
Clean Claim Timely Filing	**90 calendar day after the discharge for inpatient services or the Date of Service for outpatient services**

Electronic Claims Submission

Senior Whole Health strongly encourages participating Providers to submit Claims electronically, including secondary Claims. Electronic Claims submission provides significant benefits to the Provider including:

- Helps to reduce operation costs associated with paper Claims (printing, postage, etc.).
- Increases accuracy of data and efficient information delivery.
- Reduces Claim delays since errors can be corrected and resubmitted electronically.
- Eliminates mailing time and Claims reach Senior Whole Health faster.

Senior Whole Health offers the following electronic Claims submission options:

- Submit Claims directly to Senior Whole Health via the Availity Essentials portal.
- Submit Claims to Senior Whole Health via your regular EDI clearinghouse.

Availity Essentials portal

The Availity Essentials portal is a no cost online platform that offers a number of Claims processing features:

- Submit Professional (CMS-1500) and Institutional (CMS-1450 [UB04]) Claims with attached files.
- Correct/Void Claims.
- Add attachments to previously submitted Claims.
- Check Claims status.
- View Electronic Remittance Advice (ERA) and Explanation of Payment (EOP).
- Create and manage Claim Templates.
- Create and submit a Claim Appeal with attached files.

Clearinghouse

Senior Whole Health uses SSI Claimsnet as its gateway clearinghouse. SSI Claimsnet has relationships with hundreds of other clearinghouses. Typically, Providers can continue to submit Claims to their usual clearinghouse.

If you do not have a clearinghouse, Senior Whole Health offers additional electronic Claims submissions options as shown by logging on to the Availity Essentials portal.

Senior Whole Health accepts EDI transactions through our gateway clearinghouse for Claims via the 837P for Professional and 837I for institutional. It is important to track your electronic transmissions using your acknowledgement reports. The reports assure Claims are received for processing in a timely manner.

When your Claims are filed via a Clearinghouse:

- You should receive a 999 acknowledgement from your clearinghouse.
- You should also receive 277CA response file with initial status of the Claims from your clearinghouse.
- You should refer to the Senior Whole Health Companion Guide for information on the response format and messages.
- You should contact your local clearinghouse representative if you experience any problems with your transmission.

EDI Claims Submission Issues

Providers who are experiencing EDI Submission issues should work with their clearinghouse to resolve this issue. If the Provider's clearinghouse is unable to resolve, the Provider should contact their Provider Services representative for additional support.

Timely Claim Filing

Provider shall promptly submit to Senior Whole Health Claims for Covered Services rendered to Members. All Claims shall be submitted in a form acceptable to and approved by Senior Whole Health and shall include all medical records pertaining to the Claim if requested by Senior Whole Health or otherwise required by Senior Whole Health's policies and procedures. Claims must be submitted by Provider to Senior Whole Health within 90 calendar days after the discharge for inpatient services or the Date of Service for outpatient services. If Senior Whole Health is not the primary payer under coordination of benefits or third party liability, Provider must submit Claims to Senior Whole Health within 90 calendar days after final determination by the primary payer. Except as otherwise provided by Law or provided by Government Program requirements, any Claims that are not submitted to Senior Whole Health within these timelines shall not be eligible for payment and Provider hereby waives any right to payment.

Claim Submission

Participating Providers are required to submit Claims to Senior Whole Health with appropriate documentation. Providers must follow the appropriate State and CMS Provider billing guidelines. Providers must utilize electronic billing though a clearinghouse or the Availity Essentials portal whenever possible and use current HIPAA compliant ANSI X 12N format (e.g., 837I for institutional Claims, 837P for professional Claims, and 837D for dental Claims).

Providers must bill Senior Whole Health for services with the most current CMS approved diagnostic and procedural coding available as of the date the service was provided, or for inpatient facility Claims, the date of discharge.

National Provider Identifier (NPI)

A valid NPI is required on all Claim submissions. Providers must report any changes in their NPI or subparts to Senior Whole Health as soon as possible, not to exceed 30 calendar days from the change.

Required Elements

Electronic submitters should use the Implementation Guide and Senior Whole Health Companion Guide for format and code set information when submitting or receiving files directly with Senior Whole Health. In addition to the Implementation Guide and Companion Guide, electronic submitters should use the appropriate state specific Companion Guides and Provider Manuals. These documents are subject to change as new information is available. Please check the Senior Whole Health website at under EDI>Companion Guides for regularly updated information regarding Senior Whole Health's companion guide requirements. Be sure to choose the appropriate State from the drop-down list on the top of the page. In addition to the Senior Whole Health Companion Guide, it is also necessary to use the State Health Plan specific companion guides, which are also available on our Senior Whole Health website for your convenience (remember to choose the appropriate state from the drop-down list).

Electronic Claim submissions will adhere to specifications for submitting medical Claims data in standardized Accredited Standards Committee (ASC) X12N 837 formats. Electronic Claims are validated for Compliance SNIP levels 1 to 5.

The following information must be included on every Claim, whether electronic or paper:

- Member name, date of birth and Senior Whole Health member ID number.
- Member's gender.
- Member's address.
- Date(s) of service.
- Valid International Classification of Diseases diagnosis and procedure codes.
- Valid revenue, CPT or HCPCS for services or items provided.
- Valid Diagnosis Pointers.
- Total billed charges.
- Place and type of service code.
- Days or units as applicable (anesthesia Claims require minutes).
- Provider tax identification number (TIN).
- 10-digit National Provider Identifier (NPI) or Atypical Provider Identifier (API).
- Rendering Provider information when different than billing.
- Billing/Pay-to Provider name and billing address.

- Place of service and type (for facilities).
- Disclosure of any other health benefit plans.
- National Drug Code (NDC), unit of measure and quantity for medical injectibles.
- E-signature.
- Service Facility Location information.
- Any other state-required data.

Provider and Member data will be verified for accuracy and active status. Be sure to validate this data in advance of Claims submission. This validation will apply to all Provider data submitted and also applies to atypical and out-of-state Providers.

Inaccurate, incomplete, or untimely submissions and re-submissions may result in denial of the Claim.

EDI (Clearinghouse) Submission

Corrected Claim information submitted via EDI submission are required to follow electronic Claim standardized Accredited Standards Committee (ASC) X12N 837 formats. Electronic Claims are validated for Compliance SNIP levels 1 to 5. The 837 Claim format allows you to submit changes to Claims that were not included on the original adjudication.

The 837 Implementation Guides refer to the National Uniform Billing Data Element Specifications Loop 2300 CLM05-3 for explanation and usage. In the 837 formats, the codes are called “Claim frequency codes.” Using the appropriate code, you can indicate that the Claim is an adjustment of a previously submitted finalized Claim. Use the below frequency codes for Claims that were previously adjudicated.

Claim Frequency Code	Description	Action
7	Use to replace an entire Claim.	Senior Whole Health will adjust the original Claim. The corrections submitted represent a complete replacement of the previously processed Claim.
8	Use to eliminate a previously submitted Claim.	Senior Whole Health will void the original Claim from records based on request.

When submitting Claims noted with Claim frequency code 7 or 8, the original Claim number, must be submitted in Loop 2300 REF02 – Payer Claim Control Number with qualifier F8 in REF01. The original Claim number can be obtained from the 835 Electronic Remittance Advice (ERA). Without the original Claim number, adjustment requests will generate a compliance error and the Claim will reject.

Claim corrections submitted without the appropriate frequency code will deny as a duplicate and the original Claim number will not be adjusted.

Paper Claim Submissions

Participating Providers should submit Claims electronically. If electronic Claim submission is not possible, please submit paper Claims to the following address:

Senior Whole Health by Molina Healthcare
PO Box 22637
Long Beach, CA 90801

Please keep the following in mind when submitting paper Claims:

- Paper Claim submissions are not considered to be "accepted" until received at the appropriate Claims PO Box; Claims received outside of the designated PO Box will be returned for appropriate submission.
- Paper Claims are **required** to be submitted on original red and white CMS-1500 and CMS-1450 (UB-04) Claim forms.
- Paper Claims not submitted on the required forms will be rejected and returned. This includes black and white forms, copied forms, and any altering to include Claims with handwriting.
- Claims must be typed with either 10 or 12 point Times New Roman font, using black ink.
- Link to paper Claims submission guidance from CMS: https://www.cms.gov/Medicare/Billing/ElectronicBillingEDITrans/1500

Corrected Claim Process

Providers may correct any necessary field of the CMS-1500 and CMS-1450 (UB-04) forms.

Senior Whole Health strongly encourages participating Provider to submit Corrected Claims electronically via EDI, or the Availity Essentials portal.

All Corrected Claims:

- Must be free of handwritten or stamped verbiage (paper Claims).
- Must be submitted on a standard red and white CMS-1450 (UB-04) or CMS-1500 Claim form (paper Claims).
- Original Claim number must be inserted in field 64 of the CMS-1450 (UB-04) or field 22 of the CMS-1500 of the paper Claim, or the applicable 837 transaction loop for submitting corrected claims electronically.
- The appropriate frequency code/resubmission code must also be billed in field 4 of the CMS-1450 (UB-04) and 22 of the CMS-1500.

Note: The frequency/resubmission codes can be found in the NUCC (National Uniform Claim Committee) manual for CMS-1500 Claim forms or the UB Editor (Uniform Billing Editor) for CMS-1450 (UB-04) Claim forms.

Corrected Claims must be sent within 30 calendar days of the original Claim Remittance Advice (RA) date.

Corrected Claims submission options:

- Submit Corrected Claims directly to Senior Whole Health via the Availity Essentials portal.
- Submit corrected Claims to Senior Whole Health via your regular EDI clearinghouse.

Coordination of Benefits (COB) and Third Party Liability (TPL)

Third party liability refers to any other health insurance plan or carrier (e.g., individual, group, employer-related, self-insured, or self-funded, or commercial carrier, automobile insurance, and worker's compensation) or program that is or may be liable to pay all or part of the health care expenses of the Member.

COB

Medicaid is always the payer of last resort and Providers shall make reasonable efforts to determine the legal liability of third parties to pay for services furnished to Senior Whole Health Members. If third party liability can be established, Providers must bill the primary payer and submit a primary explanation of benefits (EOB) to Senior Whole Health for secondary Claim processing. In the event that coordination of benefits occurs, Provider shall be reimbursed based on the state regulatory COB methodology. Primary carrier payment information is required with the Claim submission. Providers can submit Claims with attachments, including EOB and other required documents. Senior Whole Health will pay Claims for prenatal care and preventive pediatric care (EPSDT) and then seek reimbursement from third parties. If services and payment have been rendered prior to establishing third party liability, an overpayment notification letter will be sent to the Provider requesting a refund including third party policy information required for billing.

Subrogation – Senior Whole Health retains the right to recover benefits paid for a Member's health care services when a third party is responsible for the Member's injury or illness to the extent permitted under State and Federal law and the Member's benefit plan. If third party liability is suspected or known, please refer pertinent case information to Senior Whole Health's vendor at:

- All states except KY – Optum: submitreferrals@optum.com
- KY – Conduent: tplefaxes@conduent.com

Hospital-Acquired Conditions and Present on Admission Program

The Deficit Reduction Act of 2005 (DRA) mandated that Medicare establish a program that would modify reimbursement for fee for service beneficiaries when certain conditions occurred as a direct result of a hospital stay that could have been reasonably prevented by the use of evidenced-based guidelines. CMS titled the program "Hospital-Acquired Conditions and Present on Admission Indicator Reporting" (HAC and POA).

The following is a list of CMS Hospital Acquired Conditions. CMS reduces payment for hospitalizations complicated by these categories of conditions that were not present on admission (POA):

1) Foreign Object Retained After Surgery
2) Air Embolism
3) Blood Incompatibility
4) Stage III and IV Pressure Ulcers
5) Falls and Trauma
    a) Fractures
    b) Dislocations
    c) Intracranial Injuries
    d) Crushing Injuries
    e) Burn
    f) Other Injuries
6) Manifestations of Poor Glycemic Control
    a) Hypoglycemic Coma
    b) Diabetic Ketoacidosis
    c) Non-Ketotic Hyperosmolar Coma
    d) Secondary Diabetes with Ketoacidosis
    e) Secondary Diabetes with Hyperosmolarity
7) Catheter-Associated Urinary Tract Infection (UTI)
8) Vascular Catheter-Associated Infection
9) Surgical Site Infection Following Coronary Artery Bypass Graft – Mediastinitis
10) Surgical Site Infection Following Certain Orthopedic Procedures:
    a) Spine
    b) Neck
    c) Shoulder
    d) Elbow
11) Surgical Site Infection Following Bariatric Surgery Procedures for Obesity
    a) Laparoscopic Gastric Restrictive Surgery
    b) Laparoscopic Gastric Bypass
    c) Gastroenterostomy
12) Surgical Site Infection Following Placement of Cardiac Implantable Electronic Device (CIED)
13) Iatrogenic Pneumothorax with Venous Catheterization
14) Deep Vein Thrombosis (DVT)/Pulmonary Embolism (PE) Following Certain Orthopedic Procedures
    a) Total Knee Replacement
    b) Hip Replacement

What this means to Providers

- Acute IPPS Hospital Claims will be returned with no payment if the POA indicator is coded incorrectly or missing

- No additional payment will be made on IPPS hospital Claims for conditions that are acquired during the patient's hospitalization.

If you would like to find out more information regarding the Medicare HAC/POA program, including billing requirements, the following CMS site provides further information: cms.hhs.gov/HospitalAcqCond/

Senior Whole Health Coding Policies and Payment Policies

Frequently requested information on Senior Whole Health's Coding Policies and Payment Policies are available on the MolinaHealthcare.com website under the Policies tab. Questions can be directed to your Provider Services representative.

Reimbursement Guidance and Payment Guidelines

Providers are responsible for submission of accurate Claims. Senior Whole Health requires coding of both diagnoses and procedures for all Claims as follows:

- For diagnoses, the required coding schemes are the International Classification of Diseases, 10th Revision, Clinical Modification ICD-10-CM.
- For procedures:
  - Professional and outpatient Claims require the Healthcare Common Procedure Coding System Level 1 (CPT codes), Level 2 and 3 Healthcare Common Procedure Coding System (HCPCS codes).
  - Inpatient hospital Claims require ICD-10-PCS (International Classification of Diseases, 10th Revision, Procedure Coding System).

Furthermore, Senior Whole Health requires that all Claims be coded in accordance with the HIPAA transaction code set guidelines and follow the guidelines within each code set.

Senior Whole Health utilizes a Claims adjudication system that encompasses edits and audits that follow State and Federal requirements as well as administers payment rules based on generally accepted principles of correct coding. These payment rules include, but are not limited to, the following:

- Manuals and Relative Value Unit (RVU) files published by the Centers for Medicare & Medicaid Services (CMS), including:
  - National Correct Coding Initiative (NCCI) edits, including procedure-to-procedure (PTP) bundling edits and Medically Unlikely Edits (MUE). In the event a State benefit limit is more stringent/restrictive than a Federal MUE, Senior Whole Health will apply the State benefit limit. Furthermore, if a professional organization has a more stringent/restrictive standard than a Federal MUE or State benefit limit the professional organization standard may be used.
  - In the absence of State guidance, Medicare National Coverage Determinations (NCD).
  - In the absence of State guidance, Medicare Local Coverage Determinations (LCD).
  - CMS Physician Fee Schedule RVU indicators.

- Current Procedural Technology (CPT) guidance published by the American Medical Association (AMA).
- ICD-10 guidance published by the National Center for Health Statistics.
- State-specific Claims reimbursement guidance.
- Other coding guidelines published by industry-recognized resources.
- Payment policies based on professional associations or other industry-recognized guidance for specific services. Such payment policies may be more stringent than State and Federal guidelines.
- Senior Whole Health policies based on the appropriateness of health care and medical necessity.
- Payment policies published by Senior Whole Health.

Telehealth Claims and Billing

Providers must follow CMS guidelines as well as State-level requirements.

All telehealth Claims for Senior Whole Health Members must be submitted to Senior Whole Health with correct codes for the plan type in accordance with applicable billing guidelines. For guidance, please refer to the resources located at https://www.health.ny.gov/health_care/medicaid/program/update/2019/feb19_mu_speced.pdf and https://www.health.ny.gov/health_care/medicaid/program/update/2021/no07_2021-06_covid-19_telehealth.htm

National Correct Coding Initiative (NCCI)

CMS has directed all Federal agencies to implement NCCI as policy in support of Section 6507 of the Patient Affordable Care Act. Senior Whole Health uses NCCI standard payment methodologies.

NCCI Procedure to Procedure edits prevent inappropriate payment of services that should not be bundled or billed together and to promote correct coding practices. Based on NCCI Coding Manual and CPT guidelines, some services/procedures performed in conjunction with an evaluation and management (E&M) code will bundle into the procedure when performed by the same physician and separate reimbursement will not be allowed if the sole purpose for the visit is to perform the procedures. NCCI editing also includes Medically Unlikely Edits (MUE) which prevent payment for an inappropriate number/quantity of the same service on a single day. An MUE for a HCPCS/CPT code is the maximum number of units of service under most circumstances reportable by the same Provider for the same patient on the same date of service. Providers must correctly report the most comprehensive CPT code that describes the service performed, including the most appropriate modifier when required.

General Coding Requirements

Correct coding is required to properly process Claims. Senior Whole Health requires that all Claims be coded in accordance with the HIPAA transaction code set guidelines and follow the guidelines within each code set.

CPT and HCPCS Codes

Codes must be submitted in accordance with the chapter and code-specific guidelines set forth in the current/applicable version of the AMA CPT and HCPCS codebooks. In order to ensure proper and timely reimbursement, codes must be effective on the date of service (DOS) for which the procedure or service was rendered and not the date of submission.

Modifiers

Modifiers consist of two alphanumeric characters and are appended to HCPCS/CPT codes to provide additional information about the services rendered. Modifiers may be appended only if the clinical circumstances justify the use of the modifier(s). For example, modifiers may be used to indicate whether a:

- Service or procedure has a professional component.
- Service or procedure has a technical component.
- Service or procedure was performed by more than one physician.
- Unilateral procedure was performed.
- Bilateral procedure was performed.
- Service or procedure was provided more than once.
- Only part of a service was performed.

For a complete listing of modifiers and their appropriate use, consult the AMA CPT and the HCPCS code books.

ICD-10-CM/PCS Codes

Senior Whole Health utilizes International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM) and International Classification of Diseases 10th Revision, Procedure Coding System (ICD-10-PCS) billing rules and will deny Claims that do not meet Senior Whole Health's ICD-10 Claim Submission Guidelines. To ensure proper and timely reimbursement, codes must be effective on the dates of service (DOS) for which the procedure or service was rendered and not the date of submission. Refer to the ICD-10 CM/PCS Official Guidelines for Coding and Reporting on the proper assignment of principal and additional diagnosis codes.

Place of Service (POS) Codes

Place of Service Codes (POS) are two-digit codes placed on health care professional Claims (CMS 1500) to indicate the setting in which a service was provided. CMS maintains POS codes used throughout the health care industry. The POS should be indicative of where that specific

procedure/service was rendered. If billing multiple lines, each line should indicate the POS for the procedure/service on that line.

Type of Bill

Type of bill is a four-digit alphanumeric code that gives three specific pieces of information after the first digit, a leading zero. The second digit identifies the type of facility. The third classifies the type of care. The fourth indicates the sequence of this bill in this particular episode of care, also referred to as a "frequency" code. For a complete list of codes, reference the National Uniform Billing Committee's (NUBC) Official CMS-1450 (UB-04) Data Specifications Manual.

Revenue Codes

Revenue codes are four-digit codes used to identify specific accommodation and/or ancillary charges. There are certain revenue codes that require CPT/HCPCS codes to be billed. For a complete list of codes, reference the NUBC's Official CMS-1450 (UB-04) Data Specifications Manual.

Diagnosis Related Group (DRG)

Facilities contracted to use DRG payment methodology submit Claims with DRG coding. Claims submitted for payment by DRG must contain the minimum requirements to ensure accurate Claim payment.

Senior Whole Health processes DRG Claims through DRG software. If the submitted DRG and system-assigned DRG differ, the Senior Whole Health-assigned DRG will take precedence. Providers may appeal with medical record documentation to support the ICD-10-CM principal and secondary diagnoses (if applicable) and/or the ICD-10-PCS procedure codes (if applicable). If the Claim cannot be grouped due to insufficient information, it will be denied and returned for lack of sufficient information.

National Drug Code (NDC)

The National Drug Code number (NDC) must be reported on all professional and outpatient Claims when submitted on the CMS-1500 Claim form, CMS-1450 (UB-04) or its electronic equivalent.

Providers will need to submit Claims with both HCPCS and NDC codes with the exact NDC that appears on the medication packaging in the 5-4-2 digit format (i.e., xxxxx-xxxx-xx) as well as the NDC units and descriptors. Claims submitted without the NDC number will be denied.

Coding Sources

Definitions

CPT – Current Procedural Terminology 4th Edition; an American Medical Association (AMA) maintained uniform coding system consisting of descriptive terms and codes that are used primarily to identify medical services and procedures furnished by physicians and other health care professionals. There are three types of CPT codes:

- Category I Code – Procedures/Services
- Category II Code – Performance Measurement
- Category III Code – Emerging Technology

HCPCS – HealthCare Common Procedural Coding System; a CMS maintained uniform coding system consisting of descriptive terms and codes that are used primarily to identify procedure, supply and durable medical equipment codes furnished by physicians and other health care professionals.

ICD-10-CM – International Classification of Diseases, 10th revision, Clinical Modification ICD-10-CM diagnosis codes are maintained by the National Center for Health Statistics, Centers for Disease Control (CDC) within the Department of Health and Human Services (HHS).

ICD-10-PCS - International Classification of Diseases, 10th revision, Procedure Coding System used to report procedures for inpatient hospital services.

Claim Auditing

Senior Whole Health shall use established industry Claims adjudication and/or clinical practices, State, and Federal guidelines, and/or Senior Whole Health's policies and data to determine the appropriateness of the billing, coding, and payment.

Provider acknowledges Senior Whole Health's right to conduct pre and post-payment billing audits. Provider shall cooperate with Senior Whole Health's Special Investigations Unit and audits of Claims and payments by providing access at reasonable times to requested Claims information, all supporting medical records, Provider's charging policies, and other related data as deemed relevant to support the transactions billed. Providers are required to submit, or provide access to, medical records upon Senior Whole Health's request. Failure to do so in a timely manner may result in an audit failure and/or denial, resulting in an overpayment.

In reviewing medical records for a procedure, Senior Whole Health may select a statistically valid random sample, or smaller subset of the statistically valid random sample. This gives an estimate of the proportion of Claims Senior Whole Health paid in error. The estimated proportion, or error rate, may be projected across all Claims to determine the amount of overpayment.

Provider audits may be telephonic, an on-site visit, internal Claims review, client-directed/regulatory investigation and/or compliance reviews and may be vendor assisted. Senior Whole Health asks that you provide Senior Whole Health, or Senior Whole Health's

designee, during normal business hours, access to examine, audit, scan and copy any and all records necessary to determine compliance and accuracy of billing.

If Senior Whole Health's Special Investigations Unit suspects that there is fraudulent or abusive activity, we may conduct an on-site audit without notice. Should you refuse to allow access to your facilities, Senior Whole Health reserves the right to recover the full amount paid or due to you.

Timely Claim Processing

Claims processing will be completed for contracted Providers in accordance with the timeliness provisions set forth in the Provider's contract. Unless the Provider and Senior Whole Health have agreed in writing to an alternate schedule, Senior Whole Health will process the Claim for service within 30 days after receipt of Clean Claims.

The receipt date of a Claim is the date Senior Whole Health receives notice of the Claim.

Electronic Claim Payment

Participating Providers are required to enroll for Electronic Funds Transfer (EFT) and Electronic Remittance Advice (ERA). Providers who enroll in EFT payments will automatically receive ERAs as well. EFT/ERA services allow Providers to reduce paperwork, provides searchable ERAs, and Providers receive payment and ERA access faster than the paper check and RA processes. There is no cost to the Provider for EFT enrollment, and Providers are not required to be in-network to enroll. Senior Whole Health uses a vendor to facilitate the HIPAA compliant EFT payment and ERA delivery. Additional information about EFT/ERA is available at MolinaHealthcare.com or by contacting our Provider Relations department.

Overpayments and Incorrect Payments Refund Requests

If, as a result of retroactive review of Claim payment, Senior Whole Health determines that it has made an Overpayment to a Provider for services rendered to a Member, it will make a Claim for such Overpayment. Providers will receive an overpayment request letter if the overpayment is identified in accordance with State and CMS guidelines. Providers will be given the option to either:

1. Submit a refund to satisfy overpayment,
2. Submit request to offset from future claim payments, or
3. Dispute overpayment findings.

Instructions will be provided on the overpayment notice and overpayments will be adjusted and reflected in your remittance advice. The letter timeframes are Senior Whole Health standards and may vary depending on applicable state guidelines and contractual terms.

Overpayments related to TPL/COB will contain primary insurer information necessary for rebilling including the policy number, effective date, term date, and subscriber information. For

Members with Commercial COB, Senior Whole Health will provide notice within 270 days from the Claim's paid date if the primary insurer is a Commercial plan. For Members with Medicare COB Molina will provide notice within 540 days from the Claim's paid date if the primary insurer is a Medicare plan. A Provider may resubmit the Claim with an attached primary EOB after submission to the primary payer for payment. Senior Whole Health will adjudicate the Claim and pay or deny the Claim in accordance with Claim processing guidelines.

A Provider shall pay a Claim for an Overpayment made by Senior Whole Health which the Provider does not contest or dispute within the specified number of days on the refund request letter mailed to the Provider. If a Provider does not repay or dispute the overpaid amount within the timeframe allowed Senior Whole Health may offset the overpayment amount(s) against future payments made to the Provider.

Payment of a Claim for Overpayment is considered made on the date payment was received or electronically transferred or otherwise delivered to Senior Whole Health, or the date that the Provider receives a payment from Senior Whole Health that reduces or deducts the overpayment.

Claim Disputes/Reconsiderations/Appeals

Information on Claim Disputes/Reconsiderations/Appeals is located in the Complaints, Grievance, and Appeals Process section of this Provider Manual.

Balance Billing

The Provider is responsible for verifying eligibility and obtaining approval for those services that require prior authorization.

Providers agree that under no circumstance shall a Member be liable to the Provider for any sums that are the legal obligation of Senior Whole Health to the Provider. Balance billing a Member for Covered Services is prohibited, except for the Member’s applicable copayment, coinsurance, and deductible amounts.

Fraud, Waste, and Abuse

Failure to report instances of suspected fraud, waste, and abuse is a violation of the Law and subject to the penalties provided by Law. Please refer to the Compliance section of this Provider Manual for more information.

Encounter Data

Each Provider, capitated Provider, or organization delegated for Claims processing is required to submit Encounter data to Senior Whole Health for all adjudicated Claims. The data is used for many purposes, such as regulatory reporting, rate setting and risk adjustment, hospital rate setting, the Quality Improvement program and HEDIS® reporting.

Encounter data must be submitted at least weekly and within 180 days from the date of service in order to meet State and CMS encounter submission threshold and quality measures. Encounter data must be submitted via HIPAA compliant transactions, including the ANSI X12N 837I – Institutional, 837P – Professional, and 837D – Dental. Data must be submitted with Claims level detail for all non-institutional services provided.

Senior Whole Health has a comprehensive automated and integrated Encounter data system capable of supporting all 837 file formats and proprietary formats if needed.

Providers must correct and resubmit any encounters which are rejected (non-HIPAA compliant) or denied by Senior Whole Health. Encounters must be corrected and resubmitted within 15 days from the rejection/denial.

Senior Whole Health has created 837P, 837I, and 837D Companion Guides with the specific submission requirements available to Providers.

When Encounters are filed electronically Providers should receive two types of responses:

- First, Senior Whole Health will provide a 999 acknowledgement of the transmission.
- Second, Senior Whole Health will provide a 277CA response file for each transaction.

16. COMPLAINTS, GRIEVANCE, AND APPEALS PROCESS

Filing an Appeal or Grievance on Behalf of a Member

A physician may, when acting on behalf of a Member and with the Member's written consent, file an appeal or a grievance. In accordance with PHL §§ 4906 (2), 4914, and 4917, if a Provider is appealing on his/her own behalf and not as a designee of the Member, the cost of the external appeal shall be paid by the party who lost the appeal. If a partial determination is made, then Senior Whole Health and the Provider share the cost evenly. Senior Whole Health and an Article 28 facility can agree to an alternative dispute resolution mechanism to resolve adverse medical necessity determinations. A Provider requesting an external appeal, either on a Member's behalf or on the Provider's behalf, is prohibited from seeking payment from the Member for services determined to not be medically necessary.

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. To obtain a form, call Senior Whole Health at (877) 353-0185 and ask for the Quality department. You may also download the form here: MolinaHealthcare.com/providers/ny/swh/home.aspx

A signed Appointment of Representation form is valid for one year from the date of signature. To file an appeal or grievance on behalf of a Member, call or write the Senior Whole Health Quality department at:

Senior Whole Health by Molina Healthcare
Attn: Quality Department
15 MetroTech, 11th Floor
Brooklyn, NY 11201

Appeals

Any Member has the right to appeal a service decision made by Senior Whole Health 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 calendar days of the date of receipt. If a delay is in the interest of the Member, a 14 calendar-day extension may be requested. If information from the physician or other sources indicates that waiting the 30 calendar days could jeopardize the Member's life, health, or ability to regain maximum function, the appeal will be expedited.

Second-Level Appeals

If, on appeal, Senior Whole Health upholds our original decision, the Member is entitled to a second-level appeal. Members can make second-level appeals to the following:

Hospital/SNF/Home Care Stays	Island Peer Review Organization Attn: Medicare Federal Healthcare Assessment 1979 Marcus St. Lake Success, NY 11042
For Medicaid Only Benefits	Fair Hearing Section NYS Office of Temporary and Disability Assistance Office of Administrative Hearings Managed Care Unit PO Box 22023 Albany, NY 12201-2023 Or Office of Temporary and Disability Assistance Office of Administrative Hearings 14 Boerum Place, 1st Floor Brooklyn, New York 11201 **WALK IN (NEW YORK CITY ONLY)**
For Medicare Part C Benefits	Maximus Federal Services Medicare Part C QIC 50 Square Drive, Suite 210 Victor, NY 14564
For Medicare Part D Benefits	Maximus Federal Services Medicare Part D QIC 860 Cross Keys Office Park Fairport, NY 14450

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 of, appropriateness of, access to and/or setting of a provided service, procedure, or item.

A Provider, when assigned by a Member, may file a grievance on behalf of the Member within 60 calendar days of the even which precipitated the grievance.

Grievance Procedures

Typically, Senior Whole Health Member Services handles routine matters and attempts to resolve problems immediately.

If the grievance cannot be immediately resolved or is more complicated, the Provider may be asked to submit additional information and must do so within 14 calendar days of the request.

If the grievance is in regard to quality of care, it will be investigated by the Quality department. Senior Whole Health will notify the Member or their designated representative in writing of the findings. The Member and their designated representative will be notified of the outcome within 45 calendar days of the filing of the grievance, or more if an extension was granted. Expedited grievances will be completed within 24 hours of receipt of the compliant. A Notice of Plan's Decision Regarding a Grievance is sent for all quality of care grievances and/or if a written response is specifically requested.

Provider Claims Dispute (Adjustment Request)

Providers disputing a claim previously adjudicated must request such action within 90 days of Senior Whole Health's original remittance advice date. Regardless of type of denial/dispute (service denied, incorrect payment, administrative, etc.); all written Claim disputes must be submitted on the Senior Whole Health Provider Dispute Form found on Provider website and the Availity Essentials portal. The form must be filled out completely in order to be processed.

Additionally, the item(s) being resubmitted should be clearly marked as a Claim Payment Dispute and must include the following:

- Any documentation to support the dispute
- The Claim number clearly marked on all supporting documents
- Copy of Authorization form (if applicable)

Submission Process

- Availity Essentials portal
- Fax: (315) 234-9812
- Mail: Senior Whole Health by Molina Healthcare
  Attention: Provider Appeals and Grievances Department
  1776 Eastchester Road
  Bronx NY 10461

The Provider will be notified of Senior Whole Health's decision in writing within 60 calendar days of receipt of the Claims Dispute request and all necessary supporting information.

Reporting

Grievance and appeal trends are reported to the Quality Improvement Committee quarterly. This trend report includes a quantitative review of trends, qualitative or barriers analysis, and identification of interventions that address key drivers. An annual evaluation of grievance and appeal analysis is then completed and presented to the Quality Improvement Committee for evaluation. If required by the state or CMS, reporting is submitted to the Appropriate Agency as needed.

17. CREDENTIALING AND RECREDENTIALING

The purpose of the Credentialing Program is to assure that Molina Healthcare Inc. and its subsidiaries (Senior Whole Health of New York) network consists of quality Providers who meet clearly defined criteria and standards. It is the objective of Senior Whole Health to provide superior health care to the community. Additional information is available in the Credentialing Policy and Procedure which can be requested by contacting your Senior Whole Health Provider Relations representative.

The decision to accept or deny a credentialing applicant is based upon primary source verification, secondary source verification and additional information as required. The information gathered is confidential and disclosure is limited to parties who are legally permitted to have access to the information under State and Federal Law.

The Credentialing Program has been developed in accordance with State and Federal requirements and the standards of the National Committee for Quality Assurance (NCQA). The Credentialing Program is reviewed annually, revised, and updated as needed.

Non-Discriminatory Credentialing and Recredentialing

Senior Whole Health does not make credentialing and recredentialing decisions based on an applicant's race, ethnic/national identity, gender, gender identity, age, sexual orientation, ancestry, religion, marital status, health status, or patient types (e.g. Medicaid) in which the Practitioner specializes. This does not preclude Senior Whole Health from including in its network Practitioners who meet certain demographic or specialty needs; for example, to meet cultural needs of Members.

Types of Practitioners Credentialed & Recredentialed

Practitioners and groups of Practitioners with whom Senior Whole Health contracts must be credentialed prior to the contract being implemented.

Practitioner types requiring credentialing include but are not limited to:

- Acupuncturists
- Addiction medicine specialists
- Audiologists
- Behavioral health care practitioners who are licensed, certified, or registered by the State to practice independently
- Chiropractors
- Clinical Social Workers
- Dentists
- Doctoral or master's-level psychologists
- Licensed/Certified Midwives (Non-Nurse)
- Massage Therapists

- Master's-level clinical social workers
- Master's-level clinical nurse specialists or psychiatric nurse practitioners
- Medical Doctors (MD)
- Naturopathic Physicians
- Nurse Midwives
- Nurse Practitioners
- Occupational Therapists
- Optometrists
- Oral Surgeons
- Osteopathic Physicians (DO)
- Pharmacists
- Physical Therapists
- Physician Assistants
- Podiatrists
- Psychiatrists and other physicians
- Speech and Language Pathologists
- Telemedicine Practitioners

HIV/AIDS Specialist

On an annual basis, Senior Whole Health will ensure all HIV Specialist PCPs meet the following qualifications for HIV Specialist PCP as defined in State of New York Medicaid Managed Care Model Contract:

"HIV Specialist PCP" (for HIV SNPs only) means an HIV experienced Primary Care Provider who has met the criteria of one of the following recognized bodies:

- The HIV Medicine Association (HIVMA) definition of an HIV-experienced Provider, or
- HIV Specialist accorded by the American Academy of HIV Medicine (AAHIVM)
- Advanced AIDS Credited Registered Nurse Credential given by the HIV/AIDS Nursing Certification Board (HANCB)

Criteria for Participation in the Senior Whole Health Network

Senior Whole Health has established criteria and the sources used to verify these criteria for the evaluation and selection of Practitioners for participation in the Senior Whole Health network. These criteria have been designed to assess a Practitioner's ability to deliver care. This policy defines the criteria that are applied to applicants for initial participation, recredentialing and ongoing participation in the Senior Whole Health network. To remain eligible for participation, Practitioners must continue to satisfy all applicable requirements for participation as stated herein and in all other documentations provided by Senior Whole Health.

Senior Whole Health reserves the right to exercise discretion in applying any criteria and to exclude Practitioners who do not meet the criteria. Senior Whole Health may, after considering

the recommendations of the Professional Review Committee, waive any of the requirements for network participation established pursuant to these policies for good cause if it is determined such waiver is necessary to meet the needs of Senior Whole Health and the community it serves. The refusal of Senior Whole Health to waive any requirement shall not entitle any Practitioner to a hearing or any other rights of review.

Practitioners must meet the following criteria to be eligible to participate in the Senior Whole Health network. The Practitioner shall have the burden of producing adequate information to prove they meet all criteria for initial participation and continued participation in the Senior Whole Health network. If the Practitioner does not provide this information, the credentialing application will be deemed incomplete and it will result in an administrative denial or administrative termination from the Senior Whole Health network. Practitioners who fail to provide this burden of proof do not have the right to submit an appeal.

- **Application** – Practitioners must submit to Senior Whole Health a complete credentialing application either from CAQH ProView or other State mandated practitioner application. The attestation must be signed within 120 days. Application must include all required attachments.
- **License, Certification or Registration** – Practitioners must hold a current and valid license, certification, or registration to practice in their specialty in every State in which they will provide care and/or render services for Senior Whole Health Members. Telemedicine practitioners are required to be licensed in the state where they are located and the State the member is located.
- **DEA or CDS Certificate** – Practitioners must hold a current, valid, unrestricted Drug Enforcement Agency (DEA) or Controlled Dangerous Substances (CDS) certificate. Practitioners must have a DEA or CDS in every State where the Practitioner provides care to Senior Whole Health Members. If a Practitioner has never had any disciplinary action taken related to their DEA and/or CDS and has a pending DEA/CDS certificate or chooses not to have a DEA and/or CDS certificate, the Practitioner must then provide a documented process that allows another Practitioner with a valid DEA and/or CDS certificate to write all prescriptions requiring a DEA number.
- **Specialty** – Practitioners must only be credentialed in the specialty in which they have adequate education and training. Practitioners must confine their practice to their credentialed area of practice when providing services to Senior Whole Health Members.
- **Education** – Practitioners must have graduated from an accredited school with a degree required to practice in their designated specialty.
- **Residency Training** – Practitioners must have satisfactorily completed residency programs from accredited training programs in the specialties in which they are practicing. Senior Whole Health only recognizes residency training programs that have been accredited by the Accreditation Council of Graduate Medical Education (ACGME) and the American Osteopathic Association (AOA) in the United States or by the College of Family Physicians of Canada (CFPC), the Royal College of Physicians and Surgeons of Canada. Oral Surgeons must complete a training program in Oral and Maxillofacial Surgery accredited by the Commission on Dental Accreditation (CODA). Training must be successfully completed prior to

completing the verification. It is not acceptable to verify completion prior to graduation from the program. As of July 2013, podiatric residencies are required to be three years in length. If the podiatrist has not completed a three-year residency or is not board certified, the podiatrist must have five years of work history practicing podiatry.

- **Fellowship Training** – If the Practitioner is not board certified in the specialty in which they practice and has not completed a residency program in the specialty in which they practice, they must have completed a fellowship program from an accredited training program in the specialty in which they are practicing.
- **Board Certification** – Board certification in the specialty in which the Practitioner is practicing is not required. Initial applicants who are not board certified will be considered for participation if they have satisfactorily completed a residency program from an accredited training program in the specialty in which they are practicing. Senior Whole Health recognizes board certification only from the following Boards:
  - American Board of Medical Specialties (ABMS)
  - American Osteopathic Association (AOA)
  - American Board of Foot and Ankle Surgery (ABFAS)
  - American Board of Podiatric Medicine (ABPM)
  - American Board of Oral and Maxillofacial Surgery
  - American Board of Addiction Medicine (ABAM)
  - College of Family Physicians of Canada (CFPC)
  - Royal College of Physicians and Surgeons of Canada (RCPSC)
  - Behavioral Analyst Certification Board (BACB)
  - National Commission on Certification of Physician Assistants (NCCPA)
- **General Practitioners** – Practitioners who are not board certified and have not completed a training program from an accredited training program are only eligible to be considered for participation as a General Practitioner in the Senior Whole Health network. To be eligible, the Practitioner must have maintained a primary care practice in good standing for a minimum of the most recent five years without any gaps in work history. Senior Whole Health will consider allowing a Practitioner who is/was board certified and/or residency trained in a specialty other than primary care to participate as a General Practitioner, if the Practitioner is applying to participate as a Primary Care Physician (PCP), Urgent Care or as an Wound Care Practitioner. General Practitioners providing only wound care services do not require five years of work history as a PCP.
- **Nurse Practitioners & Physician Assistants** – In certain circumstances, Senior Whole Health may credential a Practitioner who is not licensed to practice independently. In these instances, the Practitioner providing the supervision and/or oversight must also be contracted and credentialed with Senior Whole Health.
- **Work History** – Practitioners must supply most recent five-years of relevant work history on the application or curriculum vitae. Relevant work history includes work as a health professional. If a gap in employment exceeds six months, the Practitioner must clarify the gap verbally or in writing. The organization will document a verbal clarification in the Practitioner's credentialing file. If the gap in employment exceeds one year, the Practitioner must clarify the gap in writing.

- **Malpractice History** – Practitioners must supply a history of malpractice and professional liability claims and settlement history in accordance with the application. Documentation of malpractice and professional liability claims, and settlement history is requested from the Practitioner on the credentialing application. If there is an affirmative response to the related disclosure questions on the application, a detailed response is required from the Practitioner.
- **State Sanctions, Restrictions on Licensure or Limitations on Scope of Practice** – Practitioner must disclose a full history of all license/certification/registration actions including denials, revocations, terminations, suspension, restrictions, reductions, limitations, sanctions, probations, and non-renewals. Practitioner must also disclose any history of voluntarily or involuntarily relinquishing, withdrawing, or failure to proceed with an application in order to avoid an adverse action or to preclude an investigation or while under investigation relating to professional competence or conduct. If there is an affirmative response to the related disclosure questions on the application, a detailed response is required from the Practitioner. At the time of initial application, the Practitioner must not have any pending or open investigations from any State or governmental professional disciplinary body[3]. This would include Statement of Charges, Notice of Proposed Disciplinary Action, or the equivalent.
- **Medicare, Medicaid and other Sanctions and Exclusions** – Practitioner must not be currently sanctioned, excluded, expelled, or suspended from any State or Federally funded program including but not limited to the Medicare or Medicaid programs. Practitioner must disclose all Medicare and Medicaid sanctions. If there is an affirmative response to the related disclosure questions on the application, a detailed response is required from the Practitioner. Practitioner must disclose all debarments, suspensions, proposals for debarments, exclusions, or disqualifications under the non-procurement common rule, or when otherwise declared ineligible from receiving Federal contracts, certain subcontracts, and certain Federal assistance and benefits. If there is an affirmative response to the related disclosure questions on the application, a detailed response is required from the Practitioner.
- **Medicare Opt Out** – Practitioners currently listed on the Medicare Opt-Out Report may not participate in the Senior Whole Health network for any Medicare or Duals (Medicare/Medicaid) lines of business.
- **Social Security Administration Death Master File** – Practitioners must provide their Social Security number. That Social Security number should not be listed on the Social Security Administration Death Master File.

[3] If a practitioner's application is denied solely because a practitioner has a pending Statement of Charges, Notice of Proposed Disciplinary Action, Notice of Agency Action or the equivalent from any state or governmental professional disciplinary body, the practitioner may reapply as soon as practitioner is able to demonstrate that any pending Statement of Charges, Notice of Proposed Disciplinary Action, Notice of Agency Action, or the equivalent from any state or governmental professional disciplinary body is resolved, even if the application is received less than one year from the date of original denial.

- **Medicare Preclusion List** – Practitioners currently listed on the Preclusion List may not participate in the Senior Whole Health network for any Medicare or Duals (Medicare/Medicaid) lines of business.
- **Professional Liability Insurance** – Practitioner must have and maintain professional malpractice liability insurance with limits that meet Senior Whole Health criteria. This coverage shall extend to Senior Whole Health Members and the Practitioners activities on Senior Whole Health's behalf. Practitioners maintaining coverage under Federal tort or self-insured policies are not required to include amounts of coverage on their application for professional or medical malpractice insurance.
- **Inability to Perform** – Practitioner must disclose any inability to perform essential functions of a Practitioner in their area of practice with or without reasonable accommodation. If there is an affirmative response to the related disclosure questions on the application, a detailed response is required from the Practitioner.
- **Lack of Present Illegal Drug Use** – Practitioner must disclose if they are currently using any illegal drugs/substances.
- **Criminal Convictions** – Practitioners must disclose if they have ever had any of the following:
    - Criminal convictions including convictions, guilty pleas or adjudicated pretrial diversions for crimes against person such as murder, rape, assault, and other similar crimes.
    - Financial crimes such as extortion, embezzlement, income tax evasion, insurance fraud and other similar crimes.
    - Any crime that placed the Medicaid or Medicare program or its beneficiaries at immediate risk, such as a malpractice suit that results in a conviction of criminal neglect or misconduct.
    - Any crime that would result in mandatory exclusion under section 1128 of the Social Security Act.
    - Any crime related to fraud, kickbacks, healthcare fraud, claims for excessive charges, unnecessary services or services which fail to meet professionally recognized standards of healthcare, patient abuse or neglect, controlled substances, or similar crimes.

  At the time of initial credentialing, Practitioners must not have any pending criminal charges in the categories listed above.
- **Loss or Limitations of Clinical Privileges** – At initial credentialing, Practitioner must disclose all past and present issues regarding loss or limitation of clinical privileges at all facilities or organizations with which the Practitioner has had privileges. If there is an affirmative response to the related disclosure questions on the application, a detailed response is required from the Practitioner. At recredentialing, Practitioner must disclose past and present issues regarding loss or limitation of clinical privileges at all facilities or organizations with which the Practitioner has had privileges since the previous credentialing cycle.
- **Hospital Privileges** – Practitioners must list all current hospital privileges on their credentialing application. If the Practitioner has current privileges, they must be in good standing.

- **NPI** – Practitioners must have a National Provider Identifier (NPI) issued by the Centers for Medicare & Medicaid Services (CMS).

Notification of Discrepancies in Credentialing Information & Practitioner's Right to Correct Erroneous Information

Senior Whole Health will notify the Practitioner immediately if credentialing information obtained from other sources varies substantially from that submitted by the Practitioner. Examples include but are not limited to actions on a license, malpractice claims history, board certification actions, sanctions, or exclusions. Senior Whole Health is not required to reveal the source of information if the information is obtained to meet organization credentialing verification requirements or if disclosure is prohibited by Law.

Practitioners have the right to correct erroneous information in their credentials file. Practitioner's rights are published on the Senior Whole Health website and are included in this Provider Manual.

The notification sent to the Practitioner will detail the information in question and will include instructions to the Practitioner indicating:

- Their requirement to submit a written response within 10 calendar days of receiving notification from Senior Whole Health.
- In their response, the Practitioner must explain the discrepancy, may correct any erroneous information, and may provide any proof that is available.
- The Practitioner's response must be sent to Molina Healthcare, Inc., Attention: Credentialing Director, PO Box 2470, Spokane, WA 99210.

Upon receipt of notification from the Practitioner, Senior Whole Health will document receipt of the information in the Practitioner's credentials file. Senior Whole Health will then re-verify the primary source information in dispute. If the primary source information has changed, correction will be made immediately to the Practitioner's credentials file. The Practitioner will be notified in writing that the correction has been made to their credentials file. If the primary source information remains inconsistent with the Practitioner's information, the Credentialing department will notify the Practitioner.

If the Practitioner does not respond within 10 calendar days, their application processing will be discontinued and network participation will be administratively denied or terminated.

Practitioner's Right to Review Information Submitted to Support Their Credentialing Application

Practitioners have the right to review their credentials file at any time. Practitioner's rights are published on the Senior Whole Health website and are included in this Provider Manual.

The Practitioner must notify the Credentialing department and request an appointment time to review their file and allow up to seven calendar days to coordinate schedules. A Medical Director and the Director responsible for Credentialing or the Quality Improvement Director will be present. The Practitioner has the right to review all information in the credentials file except peer references or recommendations protected by Law from disclosure.

The only items in the file that may be copied by the Practitioner are documents, which the Practitioner sent to Senior Whole Health (e.g., the application and any other attachments submitted with the application from the Practitioner). Practitioners may not copy any other documents from the credentialing file.

Practitioner's Right to be Informed of Application Status

Practitioners have the right, upon request, to be informed of the status of their application by telephone, email, or mail. Practitioner's rights are published on the Senior Whole Health website and included in this Provider Manual. Senior Whole Health will respond to the request within two working days. Senior Whole Health will share with the Practitioner where the application is in the credentialing process to include any missing information or information not yet verified.

Notification of Credentialing Decisions

Within 60 days of receiving a completed initial application to participate in the network, Senior Whole Health will send a letter notifying the Practitioner ~~to~~ of the following:

- Whether they are credentialed, or;
- Additional time is needed to complete credentialing due to necessary documentation needed from a third party. Upon receipt of the requested information, Senior Whole Health will make its final determination regarding credentialing of the Practitioner within 21 days of receipt of such required information.

Recredentialing

Senior Whole Health recredentials every Practitioner at least every 36 months.

Excluded Providers

Excluded Provider means an individual Provider, or an entity with an officer, director, agent, manager, or individual who owns or has a controlling interest in the entity who has been convicted of crimes as specified in section 1128 of the SSA, excluded from participation in the Medicare or Medicaid program, assessed a civil penalty under the provisions of section 1128, or has a contractual relationship with an entity convicted of a crime specified in section 1128.

Pursuant to section 1128 of the SSA, Senior Whole Health and its Subcontractors may not subcontract with an Excluded Provider/person. Senior Whole Health and its Subcontractors

shall terminate subcontracts immediately when Senior Whole Health and its Subcontractors become aware of such excluded Provider/person or when Senior Whole Health and its Subcontractors receive notice. Senior Whole Health and its Subcontractors certify that neither it nor its Provider is presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from participation in this transaction by any Federal department or agency. Where Senior Whole Health and its Subcontractors are unable to certify any of the statements in this certification, Senior Whole Health and its Subcontractors shall attach a written explanation to this Agreement.

Ongoing Monitoring of Sanctions and Exclusions

Senior Whole Health monitors the following agencies for Practitioner sanctions and exclusions between recredentialing cycles for all Practitioner types and takes appropriate action against Practitioners when occurrences of poor quality are identified. If a Senior Whole Health Practitioner is found to be sanctioned or excluded, the Practitioner's contract will immediately be terminated effective the same date as the sanction or exclusion was implemented.

- **The United States Department of Health & Human Services (HHS), Office of Inspector General (OIG) Fraud Prevention and Detection Exclusions Program** – Monitor for individuals and entities that have been excluded from Medicare and Medicaid programs.
- **State Medicaid Exclusions** – Monitor for state Medicaid exclusions through each state's specific Program Integrity Unit (or equivalent).
- **Medicare Exclusion Database (MED)** – Senior Whole Health monitors for Medicare exclusions through the Centers for Medicare & Medicaid Services (CMS) MED online application site.
- **Medicare Preclusion List** – Monitor for individuals and entities that are reported on the Medicare Preclusion List.
- **National Practitioner Database** – Senior Whole Health enrolls all credentialed Practitioners with the NPDB Continuous Query service to monitor for adverse actions on license, DEA, hospital privileges and malpractice history between credentialing cycles.
- **System for Award Management (SAM)** – Monitor for Practitioners sanctioned by SAM.

Senior Whole Health also monitors the following for all Practitioner types between the recredentialing cycles.

- Member Complaints/Grievances
- Adverse Events
- Medicare Opt Out
- Social Security Administration Death Master File

Provider Appeal Rights

In cases where the Credentialing Committee suspends or terminates a Practitioner's contract based on quality of care or professional conduct, a certified letter is sent to the Practitioner

describing the adverse action taken and the reason for the action, including notification to the Practitioner of the right to a fair hearing when required pursuant to Laws or regulations.

18. DELEGATION

Delegation is a process that gives another entity the ability to perform specific functions on behalf of Senior Whole Health. Senior Whole Health may delegate:

1. Utilization Management
2. Credentialing and Recredentialing
3. Claims
4. Complex case management
5. CMS Preclusion List Monitoring
6. Other clinical and administrative functions

When Senior Whole Health delegates any clinical or administrative functions, Senior Whole Health remains responsible to external regulatory agencies and other entities for the performance of the delegated activities, including functions that may be sub-delegated. To become a delegate, the Provider/Accountable Care Organization (ACO)/vendor must be in compliance with Senior Whole Health's established delegation criteria and standards. Senior Whole Health's Delegation Oversight Committee (DOC), or other designated committee, must approve all delegation and sub-delegation arrangements. To remain a delegate, the Provider/ACO/vendor must maintain compliance with Senior Whole Health's standards and best practices.

Delegation Reporting Requirements

Delegated entities contracted with Senior Whole Health must submit monthly and quarterly reports. Such reports will be determined by the function(s) delegated and will be reviewed by Senior Whole Health Delegation Oversight staff for compliance with performance expectations within the timeline indicated by Senior Whole Health.

Corrective Action Plans and Revocation of Delegated Activities

If it is determined that the delegate is out of compliance with Senior Whole Health's guidelines or regulatory requirements, Senior Whole Health may require the delegate to develop a corrective action plan designed to bring the delegate into compliance. Senior Whole Health may also revoke delegated activities if it is determined that the delegate cannot achieve compliance or if Senior Whole Health determines that is the best course of action.

If you have additional questions related to delegated functions, please contact your Senior Whole Health Contract Manager.