Mass General Brigham
Health Plan

Medicare Advantage Provider Manual

Table of Contents

Introduction

On behalf of Mass General Brigham Medicare Advantage and our members, we thank you for your continued participation in our network.

The Provider Manual will be amended as our operational policies change. Please ensure that you are using the most up to date version of this manual by referring to the posted PDF or requesting an updated manual.

Medicare Advantage plans will be administered according to the Mass General Brigham Medicare Advantage Evidence of Coverage.

Billing claims and resources	
	Payer ID: 04293 **Paper Claim (New Claims) Address:** NHBPO Claims, PO Box #323, Glen Burnie, MD 21060
Claim Adjustments Address	**Mass General Brigham Health Plan** **Attn: Correspondence Department** 399 Revolution Drive, Suite 810 Somerville, MA 02145
Claim Appeals Address	**Mass General Brigham Health Plan** **Attn: Appeals Department** 399 Revolution Drive, Suite 810 Somerville, MA 02145
Provider Enrollment & Credentialing	PEC@allwayshealth.org Please submit all requests to update provider information timely. Any request to terminate a provider must be submitted 30 days prior to the termination.
Pharmacy Services	**CVS Caremark** **866-209-2372** 4Rx values are: RXBIN 004336 RxGrp RX165A RX165B RxPCN MEDDADV
Medical Specialty Drugs	**CVS Specialty Pharmacy / Novologix** Novologix contact for Medicare Part B PA Drug Organization Reviews: Phone: **800-932-7013** Fax: **833-898-3103**
Provider Services	**855-444-4647** providerservice@allwayshealth.org
Behavioral Health Provider Service	**Provider Express Portal:** Home (providerexpress.com) **Optum Provider Service: 844-451-3520**

Behavioral Health Claims Submission	Payer ID: 87726 Paper Claims: PO Box 30757, Salt Lake City, UT 84130-0757

Mass General Brigham Medicare Advantage Plan Information

Medicare Advantage

New for 2023, Mass General Brigham Health Plan is introducing three Medicare Advantage Plans. Enrollees are eligible to enroll in these plans if they live in the following Massachusetts Counties:

- Worcester, Middlesex, Essex, Suffolk, Norfolk, Bristol, and Plymouth

Plans are available to Medicare-eligible individuals. Plan information is available to Medicare-eligible individuals by visiting www.massgeneralbrighamadvantage.org, calling **888-828-5500** and through select Medicare brokers beginning October 1.

All Plans include:

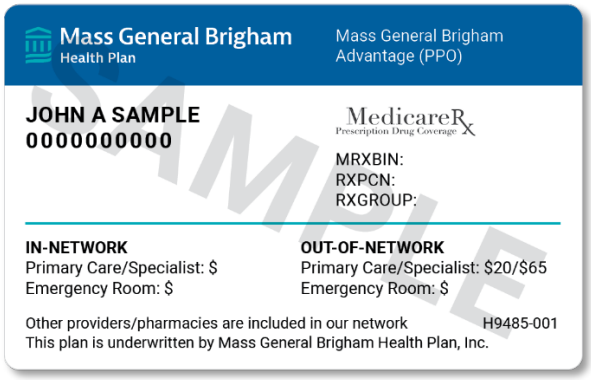
- Behavioral health benefits through Optum Behavioral Health.
- Part D benefits (prescriptions).
- Routine hearing exams and hearing aids from TruHearing.
- Preventive and comprehensive dental services through Liberty Dental.
- Routine vision exam and an eyewear allowance through EyeMed.
- Post-inpatient meals for eligible members through Community Servings.
- Over-the-counter medications and supplies through Convey Health Solutions.

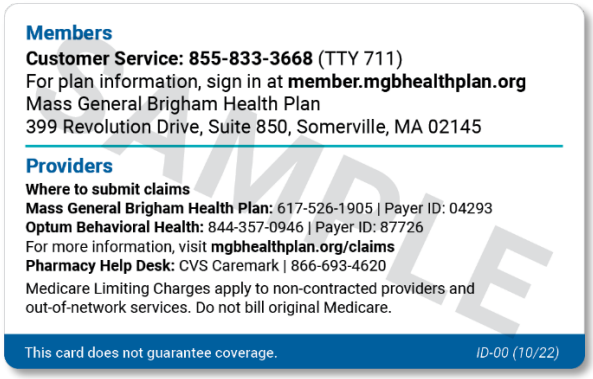
Plan	Overview
Mass General Brigham Advantage (PPO)	• Members are **not** required to select a PCP. • Referrals for specialty care are **not** required.
Mass General Brigham Advantage Secure (HMO/POS)	• Members are required to select a PCP. • Referrals for specialty care are **not** required. • The Mass General Brigham Advantage Secure HMO POS adds an "out-of-network" benefit to the traditional HMO. "Out-of-network benefit" means that a member can choose to receive covered services from a non-Participating Provider—however, these benefits could be subject to additional cost share. • For all "In-network" services, members will be required to use the Mass General Brigham Medicare Advantage Network (including physicians, Hospitals, and other Providers).
Mass General Brigham Advantage Premier (PPO)	• Members are **not** required to select a PCP. • Referrals for specialty care are **not** required.

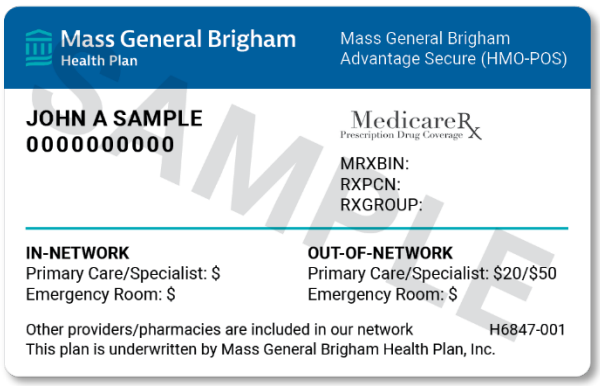
Out of network/non-contracted providers are under no obligation to treat Plan members, except in emergency situations. Please call our Customer Service number or see your Evidence of Coverage for more information, including the cost sharing information that applies to out-of-network services.

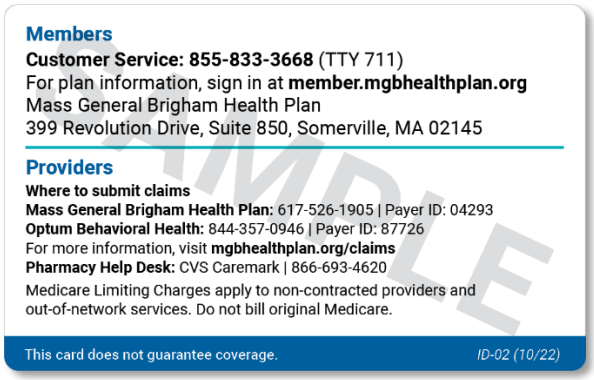
Member ID Card Examples

Each Mass General Brigham Advantage member is issued an ID card with information as shown in the samples below. Please note that actual member ID numbers are 10-digit numbers.









Credentialing, Provider Enrollment, & Data Validation

1. **Practitioner Credentialing & Recredentialing Information**
   Upon execution of a participating provider agreement with Mass General Brigham Health Plan, the enrollment team will work to credential, where applicable, and enroll providers to the system. Credentialing includes verification of primary source verification information. Determinations of credentialing are not based on the applicant(s) gender identity, race, ethnicity, age, or sexual orientation. All information used to verify credentialing and recredentialing will be retained pursuant to state and federal data storage requirements. Credentialing and recredentialing applications will only be reviewed upon receipt of a complete application.

2. **Provider Types that are Credentialed**
   Mass General Brigham Health Plan aligns with NCQA standards, CMS Standards, and state and federal law. Credentialing is required for all providers who will be marketed in the directory.
   - Physicians (MD & DOs)
   - Podiatrists
   - Chiropractors
   - Oral Surgeons
   - Acupuncturists
   - Nurse Practitioners

- Physician Assistants
- Speech, Physical, and Occupational Therapists

Not all practitioners require credentialing. However, enrollment into the Mass General Brigham Health Plan system is required prior to submission of claims.

Examples of providers that must be enrolled but might not require credentialing are:

- Hospitalists
- Emergency Medicine Providers (who provide care in the Emergency Room)
- Pathologists
- Anesthesiologists (when not practicing as Pain Management)
- Neonatologists
- Certified Registered Nurse Anesthetist
- Locum Tenens (Mass General Brigham Health Plan only enrolls Locum Tenens where the provider would be providing coverage for more than 6 months, for less than 6 months providers should bill under supervising practitioner)
- Behavioral Health Providers (these providers must work through Optum Behavioral Health)

While credentialing is not required, active and unrestricted licensure in the state where the provider delivers care is required. Failure to maintain an active and unrestricted license could result in termination from the network.

Practices are required to notify Mass General Brigham Health Plan of any changes in provider rosters, including notification when a provider is no longer an active provider.

Excluded & Precluded Individuals

If Medicare or Medicaid has sanctioned a Participating Provider, Mass General Brigham Health Plan may in its sole discretion, suspend or terminate such Participating Provider from the applicable lines of business. If Medicare or Medicaid has excluded or precluded the Participating Provider, the plan will administratively deny or terminate the Participating Provider from the plan's Medicare Network, as applicable. Participating Provider appeal rights may apply.

Notification Time Frames for Credentialing and Recredentialing Determinations

Following a complete review of the practitioner or organizational provider's credentials application, the Mass General Brigham Health Plan Credentialing Committee will approve or deny the organizational provider.

- Upon approval of a new practitioner or organizational provider applicant, the plan will notify the applicant of the approval decision and assign a provider number.
- Upon denial of a new practitioner or organizational provider applicant, the plan will notify the applicant in writing of the decision.
- Upon termination of a Participating Provider, plan will notify the Participating Provider in writing of the decision.

Denial or termination of organizational providers will not be subject to appeal.

Credentialing Approval

Upon approval of the Participating Provider, the plan shall:

- Assign a provider number.
- Notify the applicant of the approval decision within 60 calendar days of the approval date through a "welcome letter"
- Add the Participating Provider's name to the plan directory at the next publishing date.
- Provide Participating Provider and office staff orientation to plan procedures, as appropriate.

Recredentialing Approval.
Upon Participating Provider's recredentialing approval, Participating Provider shall continue to be listed in the Provider Directory.

Credentialing Denial

Upon denial of a new credentialing applicant, Mass General Brigham Health Plan shall:

- Notify the applicant and/or any affiliated practice in writing within 60 calendar days of the denial decision by the Mass General Brigham Health Plan's Chief Medical Officer or his/her designee.
- If the physician applicant applied for participation with a Medicare product, the physician will be permitted to request a review of the decision by presenting information and views on the decision.

Recredentialing Denial

Upon termination of a Participating Provider, Mass General Brigham Health Plan shall:

- Notify the Participating Provider and/or any affiliated practice/PHO in writing of the termination decision by the Mass General Brigham Health Plan's Chief Medical Officer or his/her designee.
- Advise Participating Provider of any applicable right to a hearing or review.

3. CAQH Profile & Applications

Mass General Brigham Health Plan utilizes Andros as our credentialing primary source verification. Andros can access provider CAQH profiles on behalf of Mass General Brigham Health Plan.

Keeping CAQH profiles accurate, updated, and attested to, greatly helps the credentialing process's accuracy and speed. Once the online application is complete, practitioners only need to update information that has changed or expired and attest to the accuracy of the data three times per year.

- To register with CAQH, visit proview.caqh.org and select the *Register Now* link.

4. Delegated Credentialing

Mass General Brigham Health Plan may, under its sole discretion, delegate credentialing activities to a third-party delegate to act on its behalf in matters of approval, termination, and appeal of provider credentialing. Mass General Brigham Health Plan will retain the right to overturn decisions where applicable and remain accountable for all credentialing activities. Delegated credentialing requires annual audits and an executed agreement outlining oversight responsibilities.

5. **Ongoing Monitoring**
Ongoing monitoring is the practice by which the plan monitors Participating Providers between the 2-year credentialing cycle. Adverse events such as re-admissions, unexpected death, and accessibility issues should be reported to the plan by the provider. Additionally, providers are monitored for state licensure actions and limitations, sanctions, Medicare/Medicaid Sanctions, Medicare Opt Outs, and determinations.

6. **Acceptable Accreditation** – Organizational/Institutional Credentialing
To participate in the Mass General Brigham Health Plan, the Facility/Organization Provider must meet the following requirements:
    - **Operating Certificates/Licensure/Certification:** A current and active operating certificate or licensure in the state where enrollees are serviced is required, where applicable.
    - **Participation in Medicare (Title XVIII of the Social Security Act) and Medicaid (Title XIX of the Social Security Act):** If contracted for services to Medicare and/or Medicaid Members, documentation of participation in those programs is required, where applicable.
    - **General Liability and Professional Malpractice Insurance:** Proof of general liability and professional malpractice insurance coverage is required with minimum coverage amounts of $1 million per incident and $3 million aggregate.
    - **Application and Attestation:** A completed application (excluding CAQH application) containing a signed attestation statement is required for initial credentialing and at recredentialing.

    Organizational providers must provide proof that they have been reviewed and are accredited by one of the following:

Entity	Abbreviation	Facility Type
Accreditation Association of Ambulatory HealthCare	AAAHC	Freestanding Ambulatory Surgery Centers
American College of Radiologists	ACR	Free Standing Radiology Centers
Det Norske Veritas Health Care Inc.	DNV	Hospitals/SNFs/FQHCs/SBHCs
Community Health Accreditation Program	CHAP	Home Health Care and Hospice
Clinical Laboratory Certification/Amendment Certification	CLIA	Lab
Comprehensive Bariatric Surgery Center as designated by the *American College of Surgeons* and the *American Society for Metabolic and Bariatric Surgeons (ASMBS) Metabolic and Bariatric Surgery Accreditation* and *Quality Improvement Program (MBSAQIP)*	MSBAQIP	Bariatric Surgery Centers
Foundation for the Accreditation of Cellular Therapy (FACT) for bone marrow transplants	FACT	Bone Marrow Transplants
Accreditation as a Level 1, 2, or 3 Hyperbaric Treatment Center by the Undersea and	UHMS	Hyperbaric Treatment Centers

Hyperbaric Medical Society		
Commission on the Accreditation of Rehabilitation Facilities	CARF	Day Treatment Health Centers (Adult and HIV/AIDS) and Rehabilitation Facilities
National Dialysis Accreditation Commission	NDAC	Dialysis Centers
Urgent Care Association of America	ACAOA	Urgent Care Centers
Urgent Care Association	UCA	Urgent Care Centers
National Urgent Care Center Accreditation	NUCCA	Urgent Care Centers
Council on Accreditation	COA	Behavioral Health and Substance Use Disorder Facilities/Private and Public Behavioral Health and Community-Based Social Service Agencies
American Association for Accreditation of Ambulatory Surgery	AAAASF	Freestanding Ambulatory Surgery Centers, Rural Health Clinics, Outpatient Rehabilitation
The Compliance Team	TCT	Rural Health Clinics
Center for Improvement in Healthcare Quality	CIHQ	Hospital
Accreditation Commission for Health Care	ACHC	Home Health Agency, Home Infusion
The Joint Commission	TJC	Hospital, Home Health Care, Nursing Care Center, Ambulatory Surgery Center, Behavioral Health

CMS Accreditation Organization Contact information

Non-accredited Organizational Providers will be considered for participation based on Network need as defined by Mass General Brigham Health Plan. Non-accredited Organizational Providers must supply the plan with a copy of their CMS or state review and meet any additional requirements.
The Organizational Provider must demonstrate satisfactory completion of an on-site quality assessment using Mass General Brigham Health Plan-developed assessment criteria.

7. Site Visit Policy

The Organizational Provider must meet Mass General Brigham Health Plan's facility site standards. The facility reviews focus on patient safety, access and availability, confidentiality, emergency services, credentialing processes, and quality-improvement processes. The corresponding medical record review is tailored to address the specific needs of each of these facility types.

A CMS or state review may be substituted for a Mass General Brigham Health Plan-conducted site review. If The Plan is using a state review in lieu of a Plan-conducted site visit, The Plan must verify that the review was completed within the time limits and meets The Plan site visit standards. In this instance, Organizational Provider applicants must provide a copy of the CMS or state review report performed within the previous 36 months and a copy of the organization's QI Plan and credentialing process.

Mass General Brigham Health Plan is not required to conduct a site visit if the state or CMS has not conducted a site review of critical access hospitals and the hospital is in a rural area, as defined by the U.S. Census Bureau.

For Non-Organizational Providers, a site visit may be requested due to complaints by an enrollee or their designee. Mass General Brigham Health Plan retains the right to request and perform a site visit for any provider practice.

The Provider Relations team in collaboration with the credentialing team will be responsible for site visits.

8. Compliance with Mass General Brigham Health Plan Credentialing Requirements

To participate, or continue participation, in the Mass General Brigham Health Plan's provider network all practitioners are expected to maintain credentialing requirements. This includes:

- Minimum malpractice coverage requirements.
- Current, valid, and unrestricted licensure in the relevant practice area and state in which provider is practicing.
- Current, unrestricted DEA for applicable licensure types with prescriptive authority.
- Where applicable, has clinical privileges in good standing at a licensed facility.
- Maintains no Medicare or Medicaid sanctions because of ongoing performance monitoring of practitioners between credentialing and re-credentialing cycles.

9. Continued Participation in Network, Non-Renewal, & Provider Termination

To participate in the Mass General Brigham Health Plan, the following are required:

- Current valid and unrestricted licensure in the relevant practice area and state in which provider is practicing.
- Board Certification is not required unless it is a requirement for state. licensure/certification. Mass General Brigham Health Plan recognizes American Board of Medical Specialties (ABMS).
- Providers whose scope of services include prescribing medications, including controlled substances, should have a valid DEA Certificate.
- Continued proof of current malpractice insurance coverage with applicable minimum coverage amounts.
- Completed and attested CAQH profile.
- Reasonable office hours to maintain adequate access to care.

Mass General Brigham Health Plan complies with state and federal requirements regarding the processing of complete and accurate credentialing requests.

The plan will respond to request to join the network within 60 days of receiving a completed request that has all required documentation. A credentialing approval or denial will be provided if applications are complete.

If additional documentation is required, Mass General Brigham Health Plan or Andros will outreach to the submitter to request additional details. Failure to provide updated information could result in the withdrawal of a request.

10. Federally Required Disclosure Forms

11. Credentialing and Peer Review Committee

The Mass General Brigham Health Plan Credentialing Committee reviews the credentials of both organizational and professional providers for participation in The Plan network. The credentialing committee is comprised of providers who are responsible to ensure the quality and safety of our network providers. Any significant quality of care or provider concerns identified during the onboarding or ongoing monitoring processes will be presented to the committee for peer review evaluation.

12. Behavioral Health

Mass General Brigham Health Plan carves out behavioral health benefits and network activities to Optum Behavioral Health.

Mass General Brigham Health Plan delegates these areas of responsibility to Optum:

- Claims processing and claims payment.
- Member connections and customer service.
- Provider contracting and credentialing.
- Quality management and improvement.
- Service authorization.
- Utilization management/care management.

13. Directory Listings & Change in Information

Provider directory listings are an important health plan tool for enrollees. Provider demographic data should be updated by providers upon any change in specialty, office location, or other demographic information. Failure to validate provider directory information could result in the suppression of directory information, or additional actions to ensure accuracy of provider data.

To update your provider listing – please use CAQH DirectAssure or email your provider information change form to PEC@allwayshealth.org

Mass General Brigham Health Plan requires the following to be listed in the provider directory:

- Fully executed participation agreement with Mass General Brigham Health Plan or an affiliated IPA/PHO.
- A completed and approved credentialing application that is approved by Mass General Brigham Health Plan.
- Board Certification in the specialty. Mass General Brigham Health Plan only lists the ABMS/AOA specialties and the ABMS/AOA sub-certificates of the specialties in physician specialty listings. The Plan may recognize other specialties if mandated to do so by state and/or federal regulations.

Performance Monitoring

Termination, Suspension, and Non-Renewal

Terminations: Practitioners who fail to maintain credentialing standards or comply with contractual requirements will be terminated from the network. Providers will be notified by the committee regarding the decision and the nature of the decision. Any terminations for failure to maintain credentialing standards will be offered appeal rights—the appeal must be submitted within 30 days to request a hearing or review.

Summary Suspensions: Mass General Brigham Health Plan may summarily terminate or suspend a Participating Providers' s participation in the Medicare Advantage network immediately for the reasons defined below:

- Cases involving actions or accusations that may represent imminent harm to patient care.
- A charge of fraud by a state or federal authority.
- A disciplinary action by the applicable licensing board.
- Physical or behavioral impairment that may impede or limit the Participating Provider's ability to provide appropriate medical care.

Mass General Brigham Health plan will not terminate a provider based solely on the basis that the Participating Provider has:

- Advocated on behalf of an enrollee.
- Filed a complaint against The Plan.
- Appealed any plan decision.
- Discussed treatment options with enrollees.
- Reported, in good faith, to state or federal authorities any act or practice by The Plan that jeopardizes patient health or welfare.

Reporting to Authorities

Mass General Brigham Health Plan shall report to state professional disciplinary agencies and/or the federal National Practitioner Data Bank (NPDB) as per applicable state and/or federal laws.

Review Process for Medicare Advantage Physicians

Physicians denied participation who have applied for participation with a Medicare product are permitted to present information and their views on the decision. The physician must request the review within 30 days of receipt of the denial notification letter.

Reapplication for Participation

- Practitioners who are denied participation must wait one year before they may reapply. A Participating Provider whose participation is involuntarily terminated (except for non-compliance with recredentialing) must wait a minimum of three years or as required by regulatory bodies. If terminated due to a license action, the action must be fully resolved before reapplication will be allowed.

- A Participating Provider who voluntarily resigns their participation due to an unwillingness to meet criteria or due to contractual issues will be required to wait one year before they will be allowed to reapply.
- A Participating Provider who was suspended and/or terminated due to pending criminal charges that were resolved in the Participating Provider's favor (charges that were dismissed/dropped, or the Participating Provider was acquitted of all charges) will not be subject to a waiting period for reapplication.

Practitioner Leave of Absence

A Participating Provider shall notify the plan prior to taking a leave of absence (LOA) that will last more than 90 days. The following guidelines apply to a Participating Provider taking a LOA longer than 90 days:

- LOA may be contingent upon Mass General Brigham Health Plan approval, if applicable
- The Leave of Absence can be initiated by sending a provider information change form request to PEC@allwayshealth.org at least 30 days prior to the start of their leave except in urgent or emergent circumstances.
- The specialty of the covering practitioner must fall within the Mass General Brigham Health Plan accepted covering rules.
- The Participating Provider's membership will be voluntarily suspended at the beginning of the leave.
- The Participating Provider returning from a LOA of less than 13 months will be reinstated as a Participating Provider if there has been no change to their specialty, spectrum of services provided, physical or mental health, or any other substantive change in the Participating Provider's ability to provide care to plan Members.
- The Participating Provider must provide proof of current malpractice coverage prior to reinstatement.
- The Participating Provider's LOA may not extend beyond 13 months. Practitioners returning from a LOA of more than 13 months must reapply for participation via the credentialing process.
- When a LOA extends beyond 13 months, the Participating Provider will be notified of pending termination and will be offered appropriate appeal rights as per state and federal regulations.

14. Confidentiality

Mass General Brigham Health plan complies with all applicable state and federal regulations regarding the confidentiality of practitioner data and information. Steps are taken to safeguard practitioner information include by are not limited to, maintenance of files in locked cabinets, password protected databases, limits on access to systems to only the appropriate personnel.

Provider Rights & Responsibilities

This Section is an overview of Mass General Brigham Health Plan Participating Provider roles and responsibilities for which all Participating Providers are accountable. We have created this plan Provider Policies and Payment Policies with direction and guidance around the basic operational processes for Participating Providers to help make working with Mass General Brigham Health Plan simple. Please note that Participating Provider Groups and facilities are responsible for providing access to this manual to their in-network Participating Providers. Please refer to your Provider Services Agreement or Facility Services Agreement (individually and collectively referred to herein as the "Provider Agreement") or contact a Provider Relations representative if you have any questions or need further information.

General Practitioner Rights

Mass General Brigham Health Plan does not discriminate against any qualified applicant for practitioner network membership solely because of race, color, national origin, ancestry, age, sex, religion, disability, sexual orientation or type of procedure or patient served. Mass General Brigham Health Plan's credentialing policies do not discriminate against clinicians who service "high-risk" populations or who specialize in conditions or procedures requiring costly treatment. Practitioner rights in the credentialing and recredentialing processes include:

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

For more information, contact Mass General Brigham Health Plan at 855-444-4647 or email PEC@AllwaysHealth.org.

General Practitioner & Provider Responsibilities

- Compliance with the Americans with Disabilities Act (ADA) Act of 1990 (rev. 2008)
- Language Assistance for Limited English Proficiency (LEP)
- Maintain confidentiality and comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA)
- Maintaining accurate provider rosters and provider directory accuracy
- Cultural competency training
- Maintain accurate patient records
- Providers must submit to Mass General Brigham Health Plan all data (including medical records) that are necessary to characterize the content/purpose of each visit with a member.
- Providers must also certify that any data resulting from a visit, or any other information submitted to the plan will be complete, accurate and truthful.

Primary Care Provider (PCP) Responsibilities

PCPs are responsible for monitoring the care of their Mass General Brigham Health Plan members to provide quality and cost-efficient medical management. The PCP must be able to provide integrated, accessible health care services and be accountable for addressing a large majority of personal health

needs, developing a sustained partnership with members, and practicing in the context of the family and community. The following list encompasses a common set of proficiencies for all PCPs:

- PCPs are responsible for providing or arranging the total care of their Mass General Brigham Health Plan member.

Note: The PCP must be an MD, DO, NP or PA who is appropriately trained and/or Board-certified in a primary care discipline. The PCP must be accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of the family and the community.

The PCP's role in successfully recognizing and addressing the Member's needs is key to the success and satisfaction of the member, the medical group, and Mass General Brigham Health Plan. PCP responsibilities include the following:

- Providing care in a manner consistent with recognized standards of health care and in a culturally competent manner to all Mass General Brigham Health Plan members, including those with limited English proficiency or reading skills, diverse cultural and ethnic backgrounds, and/or physical or mental disabilities.
- Being accessible to members 24 hours a day, 7 days a week via direct contact or through PCP-arranged provider alternative, another Mass General Brigham Health Plan participating provider.
- Coordinating services that allow for continuity of care and integration of services, including:
    - Continuous patient care and quality review
    - Systems to address barriers to the member's ability to maintain compliance with the practitioner's prescribed treatments or regimens
    - Procedures to ensure that members are informed by providers of specific health care needs that require follow-up care and receive care/treatment as appropriate

Specialists Roles & Responsibilities

Referrals for specialty services are not required for Mass General Brigham Health Plan members. Coordination of patient care between primary care and specialists is encouraged.
Specialists within the Mass General Brigham Health Plan network are expected to provide quality, cost-efficient health care to Mass General Brigham Health Plan members. Contracted providers must provide care in a culturally competent manner to all members, including those with limited English proficiency or reading skills, diverse cultural and ethnic backgrounds, and physical or mental disabilities.

Compliance with Mass General Brigham Protocols & Performance Monitoring

Mass General Brigham Health Plan monitors provider compliance with plan protocols such as prior authorization, inappropriate balance billing of members, failure to submit claims timely, failure to attest to provider directory information accuracy, and other plan requirements.

Complaints against a Practitioner, facility, or practice ("provider) could result in a corrective action plan, or site visit. Any Provider that receives 5 or more complaints of any type and from any source will be subject to review by the Credentialing Committee.

Network Access & Availability Standards

Mass General Brigham Health Plan must comply with all CMS requirements and ensure that all covered services including additional or supplemental services contracted for on behalf of the Medicare Member are accessible. At a minimum, all PCPs, specialists, and Ancillary Providers must meet the following standards to ensure accessibility to Members:

- Office waiting room time cannot exceed 30 minutes.
- Participating Provider should be accessible 24 hours a day, 7 days a week, and 365 days a year.
  - Such access must include an after-hours phone number published in a phone directory, on office business cards, or insurance cards which connect the Member to an answering service, a hospital switchboard, an emergency department, or a paging system.
  - An office announcement directing Members to leave a message is unacceptable.

Type of Service	Mass General Brigham Medicare Advantage
Emergent Medical (Read further for definitions of "emergency")	Immediate access
Urgent Medical (Read further for definitions of "urgent")	Within 24 hours
Non-Urgent "Sick" Visit	Within 48 hours
Routine Symptomatic: Non-Urgent, Non-Emergent	Within two weeks
Routine Asymptomatic: Non-Urgent and Preventive Care Appointments	Within 90 days
Preventive Care, Wellness Visits Including Routine Physicals	Within 90 days
Initial Assessment:	
Wait in PCP Office (Max)	30 minutes
After-Hours Care	24/7 availability or coverage
Wait in PCP Office (Max)	30 minutes
After-Hours Care	24/7 availability or coverage

Provider Portal

The Mass General Brigham Health Plan Provider Portal puts a variety of self-service tools at your fingertips:

- Submit prior authorization and referral requests.
- View authorization and referral requests.
- View claims status.
- Manage your practice information.
- View patient rosters and reports.

- View member eligibility & benefits.

You can register for the portal any time on or after your effective date. To register, go to the Mass General Brigham Medicare Advantage page, click the Account Registration tab, and follow the instructions provided.

Telehealth Responsibilities

Telehealth responsibilities in accordance with state guidelines, providers should adhere to the following standards when delivering medically necessary care via telehealth:

- For an initial appointment with a new patient, review the patient's relevant medical history and any relevant medical records with the patient before initiating the delivery of any service.
- For existing provider-patient relationships, review the patient's medical history and any available medical records with the patient during the service.
- Prior to each patient appointment, ensure the same services' standards can be delivered as in-person care and in compliance with the provider's licensure regulations and requirements, programmatic regulations, and performance specifications related to the service (e.g., accessibility and communication access).
- If the appropriate standard of care or other requirements for providing requested care via telehealth cannot be met, make this determination prior to the delivery of treatment, notify the patient of this, and advise the patient to instead seek appropriate in-person care.
- Ensure patients the same rights to confidentiality and security as provided in face-to-face services, to the extent feasible, and inform patients of any relevant privacy considerations prior to providing services via telehealth.
- Follow consent and patient information protocols consistent with the protocols followed during in person visits as well as any telehealth specific protocols.
- Inform patients of the location of the provider rendering services via telehealth (i.e., distant site) and obtain the location of the patient (i.e., originating site).
- Inform the patient how to see a clinician in-person in the event of an emergency or otherwise.

Provider Newsletter

Our **provider newsletter** is a monthly communication dedicated to providers, hospital administrators, and ancillary providers in our network. This newsletter covers everything from medical policies to code updates—plus timely announcements from Mass General Brigham Health Plan. We cover all updates in one place so that you can easily reference them when needed. In addition to business-related updates, our provider newsletter includes:

- Tools, support, and training
- Social media + blog highlights
- New programs available to your patients
- Administrative and regulatory updates that make it easier for your practice to do business with us

Mass General Brigham Health Plan distributes its **provider newsletter** by email and via the News section of the Mass General Brigham Health Plan's provider website.

To receive the newsletter by email, providers can register online in the News section of the public provider website: Providers - AllWays Health Partners

Claims

Payer ID	04293
New Paper Claims Address	Mass General Brigham Health Plan PO Box #323, Glen Burnie, MD 21060
Claim Review Submissions	Mass General Brigham Health Plan Attn: Correspondence Department 399 Revolution Drive, Suite 810 Somerville, MA 02145
Claims Appeal Requests	Mass General Brigham Health Plan Attn: Appeals Department 399 Revolution Drive, Suite 810 Somerville, MA 02145

Billing, Reimbursement, and Claims Submission & Timeliness

When using a billing agent or clearinghouse, providers are responsible for meeting all Mass General Brigham Health Plan claim submission requirements.

- Mass General Brigham Health Plan requires the submission of all paper and electronic claims within 90 days of the date of service unless otherwise contractually agreed.
- Electronic claims are highly encouraged.
- Paper claims are accepted, however, handwritten claims or handwritten corrected claims are not accepted
- Mass General Brigham Health Plan will only accept claims for services that you, your organization, or your staff perform.
- Pass-through billing is not permitted and may not be billed to our members.
- Mass General Brigham Health Plan is committed to processing clean claims within at least 30 days of receipt.

Mass General Brigham Health Plan members cannot be billed for services denied because of timely filing issues. There are two exceptions to the timely filing limitation:

- Claims that involve coordination of benefits where Mass General Brigham Health Plan is the secondary payer, have a timely filing limitation of 90 days, or as specified in your Agreement, from the date of the primary's EOB, but no more than two (2) years after the date of service.
- Claims for Worker's Compensation or No Fault are not subject to the timely filing limitation of two (2) years after the date of service, provided that Mass General Brigham Health Plan receives the claim with appropriate denials/documentation no later than the contracted filing limit.

EDI (Electronic) Claims:

Claims submitted electronically are subject to the claim edits established by Mass General Brigham Health Plan Partners' payer ID number is 04293. Companion guides are available to assist providers interested in electronic claim submissions. For questions regarding electronic claims submissions, please contact Mass General Brigham Health Plan.

Clean Claims

A Complete and Accurate Claim or "Clean Claim" is defined as a completed and accurate UB-04 or CMS 1500 claim form which does not include any erroneous or conflicting information. It is a bill containing all data necessary for processing. Participating providers must submit claims no more than 90 days after the date of discharge or 90 days after a service is rendered, unless otherwise outlined in a provider contract. Non-Clean Claims will be rejected and returned to the provider.

The claim receipt's Julian date is embedded in the Mass General Brigham Health Plan claim number as shown on the Explanation of Payment (EOP). A clean claim is defined as one that includes at least the following information:

- Full member name
- Member's date of birth
- Full Mass General Brigham Health Plan member identification number
- Date of service
- Valid diagnosis code(s)
- Valid procedure code(s)
- Valid place of service code(s)
- Charge information and units
- National provider identifier (NPI) group number
- NPI rendering provider number
- Vendor name and address
- Provider's federal tax identification number

If the provider submits a Clean Claim including all requisite information to process the claim at the time of submission, Mass General Brigham Health Plan will:

- Pay the claim or any undisputed portion of the claim within applicable regulatory timeframes.
- Notify the provider of any adverse determination, in writing, within 30 days after Mass General Brigham Health Plan's receipt of the claim.
- If a claim is denied for lack of medical records, the requested information must be resubmitted within 180 days from receipt of Mass General Brigham Health Plan's notice.
- If the Provider receives an adverse determination, the Provider may request reconsideration or appeal the denial on the member's behalf as described in this manual's claims appeals section.
- Mass General Brigham Health Plan will send the provider notice of the pended claim, along with a request for the required itemized bill. Provider must submit such itemized bill with Mass General Brigham Health Plan's request letter for claim to be processed. Failure to provide an itemized bill may result in a claim denial.

Claim Review, Appeal, & Adjustment Guidelines

An adjustment is defined as a request to correct a processing error, whether the claim was denied or modified by Mass General Brigham Health Plan erroneously, or the Provider has amended the claim for a billing error or omitted data.

- Requests for adjustments must be submitted no later than 90 days after the claim paid date.
- For all timely filing reconsiderations, we require supporting documentation to overturn a denial.

Claim Adjustments/Requests for Review

Request for a review and possible adjustment of a previously processed claim (not otherwise classified as an appeal) should be submitted to the Claim Adjustment Requests mailbox within 90 days of the EOP date on which the original claim was processed. All such requests should be submitted by completing a Request for Review Form and including any supporting documentation, with the exception of electronically submitted corrected claims.

Filing Limit Adjustments

To be considered for review, requests for review and adjustment for a claim received over the filing limit must be submitted within 90 days of the EOP date on which the claim was originally denied. Disputes received beyond 90 days will not be considered. If the initial claim submission is after the timely filing limit and the circumstances for the late submission are beyond the Provider's control, the Provider may submit a request for review by sending a letter documenting the reason(s) why the claim could not be submitted within the contracted filing limit along with any supporting documentation. Documented proof of timely submission must be submitted with any request.

Corrected Claims

Mass General Brigham Health Plan accepts both electronic and paper-corrected claims, in accordance with guidelines of the National Uniform Claim Committee (NUCC) and HIPAA EDI standards.

Corrected claims must be submitted with the most recent version of the claim to be adjusted. For example: a corrected claim to the original claim (00000E00000) should include the original claim number. A second corrected claim request should include the latest version (00000E00000A1).

Late Charge Billing

Mass General Brigham Health Plan will not accept Late Charge claims from institutional (facility) providers, including but not limited to hospitals; ambulatory surgery centers; skilled nursing facilities (SNF); hospice; home infusion agencies; or home health agencies.

Electronic Submissions

To submit a corrected facility or professional claim electronically:

- Enter the frequency code (third digit of the bill type for institutional claims; separate code for professional claims) in Loop 2300, CLM05-3 as either "7" (corrected claim), "5" (late charges), or "8" (void or cancel a prior claim).
- Enter the original claim number in Loop 2300, REF segment with an F8 qualifier. For example, for claim #12234E01234, enter REF*F8*12234E01234. Provider payment disputes that require additional documentation must be submitted on paper, using the Request for Review Form.

Behavioral Health Services Claims

Mass General Brigham Health Plan benefit is administered through Optum. Claims, appeals, and adjustment requests for behavioral health-specific services must be submitted to Optum directly.

Coordination of Benefits (COB) Guidelines

COB is the process to determine how medical, dental, and other health care services will be paid when a person is covered under more than one insurer. Providers are required to notify Mass General Brigham Health Plan when other coverage is identified. Providers are responsible for verifying eligibility at the point of service, which includes possible Medicare coverage. This is particularly important given Medicare's 12-month filing limit and the significant reductions to allowed exceptions. Please note that an EOP from another insurer no longer qualifies as one of the exceptions. The order of benefit determination is the term used for establishing the primary versus secondary insurer or carrier. The primary carrier must pay its portion of the claim first before billing the secondary carrier for review and potential payment of the balance up to its benefit or policy. Services and charges must be billed on an appropriate claim form and submitted to Mass General Brigham Health Plan within 90 days of receipt of the Explanation of Payment (EOP) or remittance advice from the primary insurance carrier.

Third-Party Liability Claims

When a Mass General Brigham Health Plan member is involved in an automobile accident, slip, and fall injury, or any accident where another party is liable for payment of related claims, Providers should notify Mass General Brigham Health Plan directly by calling the Third-Party Liability Department at 617-772- 5729 and making the proper notation on submitted claims. A Mass General Brigham Health Plan representative can assist with the process of determining which carrier should be billed for services.

When Mass General Brigham Health Plan is the secondary carrier, all claims must be submitted with a copy of the primary carrier's EOP, remittance advice, or denial letter.

Workers Compensation (WC) Claims

When a Mass General Brigham Health Plan patient is injured on the job, the employer's workers compensation carrier should be billed directly for the services. Only upon denial from the workers' compensation carrier will Mass General Brigham Health Plan consider additional claims. Any claims related to a workers compensation injury that are submitted to Mass General Brigham Health Plan should include a copy of the workers compensation carrier's EOP, remittance advice or a denial letter.

Effect of Medicare

Members must enroll in Medicare Part B upon eligibility when Medicare is determined to be the member's primary plan. If the Member fails to enroll in Part B when eligible and Medicare is primary, Mass General Brigham Health Plan will reduce product benefits by the amount Medicare would have paid for the services or care. The reduction in benefits will occur even if the Member fails to enroll in Medicare, does not pay premiums or charges to Medicare, or receives services at a hospital or from a provider that cannot bill Medicare. Medicare is considered the Secondary Payer if the Member is:

- Medicare-eligible by reason of age and the subscriber is currently employed by an employer group with 20 or more employees.
- Medicare-eligible because of end-stage renal disease (ESRD) and there is a waiting period before Medicare becomes effective.
- Disabled (by reason other than ESRD) and the subscriber is currently employed by an employer group with 100 or more employees.

Claim Auditing

Mass General Brigham Health Plan audits a random sampling of 3–5 percent of all processed claims to ensure processing accuracy.

General Claims Audits: General post-payment claims audits are conducted to identify the accuracy of charges and the consistency of claims reimbursement with Mass General Brigham Health Plan's policies, Provider Agreements, Payment Guidelines, and applicable nationally recognized medical claims reimbursement and administration policies, including, but not limited to CPT and CMS guidelines. Audits include, but are not limited to:

- Billing for services at a higher level than provided.
- Billing for services not documented and not provided.
- Incorrect coding, including unbundling component service codes, modifier usage, units of service, duplicate payments.
- Historical claim audits to include the global surgical period for codes submitted on the current claim.
- Medical necessity as based on Mass General Brigham Health Plan's and/or CMS guidelines as applicable to the member benefit plan.

For claim overpayments greater than $500, the provider is notified in writing from Mass General Brigham Health Plan 30 or more days prior to the retraction of any monies— identifying claim discrepancies totaling over $500 per vendor that have been identified by Mass General Brigham Health Plan's post-payment audit resulting in claim adjustments. All adjustments are processed against future payments. Unless otherwise instructed, providers should not issue a refund to Mass General Brigham Health Plan for overpayments identified by Mass General Brigham Health Plan. However, this does not alter the Provider's obligation under Federal or State Law to report and return any overpayments. If the Provider disagrees with the adjustments, a letter of appeal or a completed Mass General Brigham Health Plan's Provider Audit Appeal Form may be submitted to Mass General Brigham Health Plans' Appeals department within 90 days of receipt (or 30 days if requesting an extension), along with comprehensive documentation to support the dispute of relevant charges. Mass General Brigham Health Plan will review the appeal and, when appropriate, consult with Mass General Brigham Health Plan's clinicians or subject matter experts in the areas under consideration. To the extent that the Provider fails to submit evidence of why the adjustment is being disputed, the Provider will be notified of Mass General Brigham Health Plan's inability to thoroughly review the appeal request. The provider can resubmit (provided this occurs within the 90 days EOP window) and the appeal's receipt date will be consistent with the date Mass General Brigham Health Plan's received the additional documentation. Mass General Brigham Health Plan will review the appeal and, when appropriate, consult with clinicians or subject matter experts in the areas under consideration. The appeal determination will be final and if the determination is favorable to the Provider, the claims in question will be adjusted accordingly within 10 calendar days of the final determination notification.

Special Investigations Unit (SIU)

Special Investigations Unit Insurance laws require Mass General Brigham Health Plan to establish and maintain a process to investigate potential occurrences of health care fraud, waste, and/or abuse. The Special Investigations Unit's (SIU) mission is to assist Mass General Brigham Health Plan in detecting and addressing situations where fraud and/or abuse may have occurred. SIU uses a formal process for detecting, investigating, and preventing these types of activities. The investigation process includes

investigators and nurses with backgrounds in insurance fraud investigations and medical claim reviews. The SIU staff surveys and evaluates claim data—including provider/facility history, specialty profiles, common fraud schemes, waste and/or abuse, and claim patterns that differ from past history or peer norms for a given condition or specialty. SIU's investigative process also includes the use of high-tech software, Health Care Fraud Shield to detect, track, analyze, and report instances of health care fraud, abuse, or misrepresentation. It may be necessary for SIU to obtain medical records in order to complete its investigation as efficiently and accurately as possible. However, if SIU requests information from your practice, it does not necessarily indicate a problem exists. Mass General Brigham Health Plan also relies on our participating facilities, providers, and their office staff to help us fight insurance fraud, waste and/or abuse. All information will be kept confidential.

Appeals Process

If a Practitioner chooses to appeal a network participation decision made by Mass General Brigham Health Partners, the request must be made in writing within 30 calendar days from Mass General Brigham Health Plan's notification. The notification should include whether the Practitioner will bring an attorney or another person of his or her choice. Pending the completion of the appeal process and unless specified otherwise, the initial decision of the credentialing committee remains in full force and effect. Upon timely receipt of the request, a meeting is scheduled with Mass General Brigham Health Plan's Appeals Panel to review the appeal. The Appeals Panel consists of: Mass General Brigham Health Plan's Vice President of Provider Network Management, Mass General Brigham Health Plan's Chief Medical Officer or designee, Director of Enrollment and Legal Regulatory and Compliance. Each panel member can appoint a designee of his or her choice, and Mass General Brigham Health Plan's legal counsel will be present when deemed appropriate. The Practitioner is notified of the Appeals Panel decision in writing, including the specific reasons for the decision.

Appeals Process

Member Appeals and Complaints (Grievance)

A "general issue" is a type of expressed dissatisfaction that does not involve attitude, access, or quality of services received. It does not involve an initial determination (e.g., denied claim or referral) and there is no further financial liability from the Member or the Member's representative. Mass General Brigham Health Plan will document and investigate all general issues brought to our attention either by phone or mail. All findings and actions taken will be reported to the Member as expeditiously as necessary, but no later than 30 days by either phone or mail. A "Grievance" is a complaint a Member makes if they have any other type (except for an appeal) of problem with Mass General Brigham Health Plan or Network Provider. Appeal determinations are not considered grievances. For example, they would file a grievance regarding things such as:

- The quality of their care
- Wait times for appointments or in the waiting room
- The way their doctors or others behave
- Being able to reach someone by phone or get the information they need; or
- The cleanliness or condition of the doctor's office
- An "appeal" is a Member request for Mass General Brigham Health Plan to reconsider and change a decision made about what services are covered or what will be paid for a service. Specifically, the Member has the right to appeal if:

- Mass General Brigham Health Plan refuses to cover or pay for services they think should be covered.
- Mass General Brigham Health Plan or one of their plan providers refuses to give them a service they think should be covered
- Mass General Brigham Health Plan or one of their plan providers reduces or cuts back on services they have been receiving.
- The Member thinks Mass General Brigham Health Plan is stopping coverage of a service too soon.

Medicare Grievance Process

If the Member has a Grievance regarding attitude, access, or quality of service received, Mass General Brigham Health Plan encourages them to call the Mass General Brigham Medicare Advantage Customer Care Center at **855-833-3668**. Mass General Brigham Health Plan will try to resolve their grievance over the phone. If the grievance cannot be resolved over the phone, a formal procedure called the "Grievance Procedure" is used to review the grievance. The member may also submit a grievance in writing to the Member Service—Grievances Department, 399 Revolution Drive, Suite 850, Somerville, MA 02145. The grievance must be filed within 60 calendar days of the incident and include a description of the incident or events that led to the grievance. A Member may file his or her own Grievance or the Member may appoint a representative. To appoint a representative:

- In writing, the Member must provide their name, Medicare number, and a statement that appoints an individual as their representative. For example, "I [member name] appoint [name of representative] to act as my representative in requesting a grievance from Mass General Brigham Health Plan regarding (service/claim)."
- The Member and the representative must sign and date the statement.
- The authorization statement must be submitted with the grievance.

Medicare Standard Grievances

Mass General Brigham Health Plan will acknowledge the Quality of Care and Quality of Service Grievance within 3 days of receipt. Mass General Brigham Health Plan will respond to the Member's concern within 30 days from receipt of the grievance, by letter. In some instances, Mass General Brigham Health Plan may need more than 30 days to properly address the Member's concern. If more than 30 days is necessary, Mass General Brigham Health Plan will notify the Member and explain why additional time is required.

Appeals Process

Expedited "Fast" Grievances

A Member may file an expedited grievance if they disagree with Mass General Brigham Health Plan's decision not to expedite an appeal, not to expedite a request for approval made by a provider or if they disagree with Mass General Brigham Health Plan request for more time to complete an appeal or request for more time to approve a service requested by a provider. Mass General Brigham Health Plan will respond to these requests within 24 hours.

Appeals Mass General Brigham Health Plan

- Customer Service Professional at **855-833-3668**
- Monday – Friday from 8 AM – 8 PM. From Oct. 1 – Mar. 31, call seven days a week, 8 AM – 8 PM (TTY: 1-800-662-1220).

- Members may also write to us at: Mass General Brigham Health Plan, Attn: Member Appeals, 399 Revolution Drive, Suite 850, Somerville, MA 02145. Members are then given the opportunity to submit written comments, documents or other information related to the appeal. A decision must be provided to the Member within 30 calendar days from receipt of a pre-service non-urgent appeal and within 60 calendar days of a post-service appeal. However, if the Member requests it, or if Mass General Brigham Health Plan finds that some information is missing which can help them, Mass General Brigham Health Plan can take up to an additional 14 calendar days to make the decision for a pre-service appeal. No extension is allowed for post service appeals. The substance of the appeal and any actions taken are documented in the Member's file. If Mass General Brigham Health Plan does not notify the Member of the decision within 30 calendar days or by the end of the extended time period for a pre-service appeal, or within 60 calendar days for a post-service appeal, the request will automatically go to Medicare's External Review Organization, currently Maximus Federal Services, for review of the case. If a member is notified orally of the decision, The Member is then notified in writing within three (3) calendar days of the decision. If the decision is unfavorable, the notice will also include information advising them that the case has been forwarded to Maximus Federal Services who will render an appeal decision.

Expedited Appeals Process

An expedited appeal may be initiated verbally or in writing by the Member, the Members appropriately appointed representative or a provider acting on behalf of the Member. If any party requests an expedited decision, he or she must do the following:

File a verbal or written request for an expedited (fast) appeal, specifically stating that they want an expedited appeal, fast appeal, or 72-hour appeal, or that they believe that their health could be seriously harmed by waiting 30 days for a standard appeal. *(continued)*

1. To file a verbal request, the Member or the Members appropriately appointed representative can call Mass General Brigham Health Plan Medicare Customer Service at **855-833-3668.**
2. A hand delivered request can be received at the following addresses: 399 Revolution Drive, Somerville, MA 02145. A 72-hour review time will begin when the request for appeal is received by Mass General Brigham Health Plan.
3. To fax a request, our fax number is **617-526-1980**. If the Member is in a hospital or a nursing facility, he or she may request assistance in having the written appeal transmitted to Mass General Brigham Health Plan by use of a fax machine.
4. The Member must file the request within 60 calendar days of the date of the initial denial.
5. The expedited appeal process applies only to pre-service appeals.

Appeals Process

If a member requests a 72-hour expedited (fast) appeal, Mass General Brigham Health Plan's Medical Director will decide if an expedited appeal is appropriate. If it is not appropriate, the appeal will be processed within 30 days. Mass General Brigham Health Plan will notify the Member verbally and in writing of the decision not to expedite the appeal within 72 hours. If any physician supports the need for a fast appeal, it must be granted. For this process, Medicare defines a physician as any Medical Doctor, Doctor of Osteopathic Medicine, or a Doctor of Podiatry. Mass General Brigham Health Plan will decide and notify the Member and Participating Provider within 72 hours or sooner if the Member's health condition is required, from receipt of the expedited request. A written confirmation of the decision will be sent to the Member and Participating Provider within 24 hours from the date of the appeal decision.

However, if the Member requests it, or if Mass General Brigham Health Plan finds that some information is missing which can help them, Mass General Brigham Health Plan can take up to an additional 14 calendar days to make the decision. If Mass General Brigham Health Plan does not inform the Member or the Provider of the decision within 72 hours (or by the end of the extended time period), their request will automatically go to Medicare's External Review Organization, currently Maximus Federal Services, for review of the case. The Member is notified in writing within 24 hours that the decision was unfavorable, and the case has been forwarded to Maximus Federal Services who will render an appeal decision. If the decision is not fully in favor of the Member's request, Mass General Brigham Health Plan will automatically forward the appeal to Maximus Federal Services for an independent review decision. Maximus will notify the Member and Mass General Brigham Health Plan of their decision within 72 hours from receipt of the appeal. If necessary, Maximus may require an extension up to 14 additional days.

Utilization Management

Overview

Mass General Brigham Health Plan is committed to improving the quality and safety of care and services to its patients. This commitment is demonstrated through the maintenance of a comprehensive Quality Management Program. The program's goals support the mission and objectives of Mass General Brigham Health Plan, relevant state and federal regulations, Mass General Brigham Health Plan contract with Medicare, accrediting agency standards (such as the National Committee on Quality Assurance [NCQA]), and the Massachusetts Division of Insurance's licensure requirements. The intent of the Quality Management Program is to improve the quality and safety of clinical care and services provided to patients and clinicians. It is based on the fundamentals of quality management: plan, monitor, improve, and evaluate, and the "Plan-Do-Study-Act" cycle approach to continuous performance improvement.

The Quality Management Program ensures a comprehensive, systematic, coordinated, integrated, and formal process for continuous assessing, monitoring, evaluating, and improving the quality of clinical care and quality of services provided to members. (Use of the term "monitoring" shall refer to the monitoring, evaluation, and quality improvement cycle).

Quality monitoring and improvement activities are oriented around routine reporting, management, and analysis of complaints and grievances; specific quality improvement projects; peer review; and the implementation and evaluation of the quality improvement plan. Quality management and improvement activities are aimed at creating highly integrated collaborative partnerships, both internally and externally, to ensure excellence in care and service—as well as to establish and share best practices. The Advisory Commission on Consumer Protection and Quality in the Health Care Industry recommends that all health care organizations make it their explicit purpose to continually reduce the burden of illness, injury, and disability, and to improve the health and functioning of the people of the United States. In Crossing the Quality Chasm: A New Health System for the 21 Century (Committee on Quality Health Care in America, Institute in America, Institute of Medicine, 2001), the Institute of Medicine called upon all health care organizations to pursue six major aims and that, specifically, health care should possess the following qualities:

- Safety—Avoiding injuries to patients from the care that is intended to help them.
- Effectiveness—Providing services based on scientific knowledge to all who could benefit and refraining from providing services to those not likely to benefit (avoiding underuse and overuse).

- Patient-centeredness—Providing care that is respectful of and responsive to individual patient preferences, needs, and values and ensuring that patient values guide all clinical decisions.
- Timeliness—Reducing waits and sometimes harmful delays for both those who receive and those who give care.
- Efficiency—Avoiding waste, in particular waste of equipment, supplies, ideas, and energy.
- Equity—Providing care that does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location, and socioeconomic status.

Mass General Brigham Health Plan is committed to achieving each of these quality aims, and the Quality Management Program provides the specifications for that effort. Clinicians are expected to collaborate with Mass General Brigham Health Plan in all quality management efforts.

InterQual

InterQual Criteria are applied to all medical and surgical acute inpatient admissions and subsequent inpatient days. The criteria may be applied to assist in determining the most appropriate level of care for Mass General Brigham Medicare Advantage members. These criteria are based on the use of the severity of illness and/or the intensity of service being provided. In general, the severity of illness criteria is used for the day of admission and the intensity of service criteria are applied to continued stay days. However, both sets of criteria are flexible and can be used at any point during an acute stay. InterQual criteria are used to facilitate communication with the provider about a member's health status for the coordination of care. These criteria do not replace Medicare or MassHealth (Medicaid) coverage guidelines. Where available, Medicare and or Medicaid coverage guidelines must be used when making coverage determinations. InterQual criteria are also used for medical necessity determinations related to inpatient admissions.

Quality Improvement

Quality Management Program

The quality management program includes, but is not limited to, compliance with Leapfrog Safety Measures for reducing hospital injuries and managing serious errors. More information on these safety standards is available at: https://leapfroghospitalsurvey.org/about-the[1]survey.

Scope

The scope of the Quality Management Program, which speaks to each of the goals, is designed to continuously monitor, evaluate, and improve the clinical care and service provided to its patients. The Quality Management Program is also designed to support and reflect Mass General Brigham Health Plan's commitment to continuous performance improvement in all aspects of care and services provided to its members. The program is continuous, broad-based, and collaborative, involving all departments, programs, and staff. The components of the program are implemented by the actions of the leadership, directors, clinicians, and support staff that design, measure, assess and improve their work processes. Other sources of guidance include input from patients, external benchmarks, and aggregate data.

The review and evaluation of these components are coordinated by the Quality and Compliance Department to demonstrate that the process is cross-functional, multi-disciplinary, integrated, and effective in demonstrating improvements in the quality of clinical care and services provided. The quality management program includes quality planning, measurement, and improvement functions. Each area

of improvement focuses on the measurement and assurance of effective patient-centered care. All quality management and improvement activities can be viewed as a process, and processes link together to form a system. The linkage of the processes enables the focus of quality improvement to be on the processes in the organization and not on the individual departments or people. As such, the organization measures and improves the performance of important processes in all organizational functions. Those processes that have the greatest impact on outcomes and customer satisfaction are given the highest priority. Quality Management retains responsibility and oversight for any quality management function that falls within the scope of the program and delegated to another entity.

The Quality Management Program maintains a strong linkage with Mass General Brigham's Care Management Program, fostering ongoing and enhanced quality improvement collaborations and interactions.

Continuity of Care

Communication is an essential component for quality medical care. Written or verbal communication between PCPs, Specialists, and other Participating Providers helps provide effective follow-up care and improves patient safety. Mass General Brigham Health Plan collects and analyzes data in order to identify opportunities to improve the continuity of care our members receive from Participating Providers. Mass General Brigham Health Plan evaluates the differences between Participating Providers and/or the usage of an electronic medical record and those that have not taken these steps, to see if these efforts had an impact on Member utilization of emergency rooms for non-emergent and non-urgent care.

Hospital Quality Report

Mass General Brigham Health Plan offers the Healthgrades rating tool as part of our online directory of Participating Providers to help Members make educated decisions about their care. Healthgrades assign up to five stars to rate the quality of clinical services and patient safety at hospitals and other health care facilities nationwide. It also offers estimated costs for medical procedures and treatments at each facility. A link to these reports is available on Healthgrades. Providers may also call their Provider Relations representative for more information on these reports, or to request a copy of the report.

Mass General Brigham Health Plan Board of Directors

Mass General Brigham Health Plan Board of Directors is responsible for Mass General Brigham Health Plan's Quality Improvement Program. The Board delegates oversight responsibility for quality of care and services to the Quality Program Committee, which is chaired by the Senior Medical Director of Quality, and the Director of Quality Assurance & Performance Improvement. This committee reports to the Mass General Brigham Health Plan Executive Committee.

Quality Improvement Committee (QIC)

This committee develops, implements, and monitors the Quality Improvement (QI) program and functions by ensuring that Mass General Brigham Health Plan performance improvement activities meet the needs of its members to support population health, and external regulatory requirements. QIC members include decision makers who represent stakeholders within the Quality Department as well as representatives from other departments including Clinical Operations, Customer Service, Pharmacy Operations, Marketing, and Behavioral Health. Each member is responsible for contributing subject matter expertise to ensure a balanced discussion of Quality Improvement programs and improvement initiatives at Mass General Brigham Health Plan.

Quality Program Committee (QPC)

This committee is responsible for the development, implementation, and oversight of Mass General Brigham Health Plan' Quality Improvement program, including oversight of other organizational committees involved in Quality Improvement initiatives. QPC members include decision makers who represent stakeholders within the Quality Department as well as representatives from other departments including Clinical Operations, Pharmacy Operations, Commercial Sales, Regulatory Affairs/Compliance, the Medicaid Office, and Behavioral Health. Each member is responsible for contributing subject matter expertise to ensure a balanced discussion of Quality Improvement programs and improvement initiatives at Mass General Brigham Health Plan. In addition to internal participants, QPC includes members from external organizations including Optum and participating network providers.

Care Management

Mass General Brigham Health Plan's Care Management Program fosters ongoing and enhanced quality improvement collaborations and interactions, including:

- Identifying opportunities to improve care and service and develop quality improvement interventions.
- Translating quality into measurable terms and using data to drive improvements.
- Identifying and addressing instances of substandard care including patient safety, member complaints, and sanctioned providers.
- Promoting a collaborative approach to performance improvement that uses the concepts and tools of Continuous Quality and Performance Improvement.
- Measuring and evaluating the effectiveness of planned interventions in improving care and service.
- Tracking the implementation and outcomes of quality improvement interventions.
- Measuring and evaluating the effectiveness and impact of the enhancement of comprehensive health management programs in the areas of health promotion, asthma, diabetes, depression, and high-risk pregnancy.
- Identifying opportunities to improve on the well-being and quality of life of our members.

The care management programs strive to:

- Support the relationship between practitioners and their patients with a plan of care.
- Emphasize prevention of exacerbations and complications using evidence-based guidelines.
- Promote patient empowerment strategies such as motivational coaching and self-management as well as the continuous evaluation of clinical, social, and economic outcomes with the aim of improving overall health.
- Maintain a multi-disciplinary, continuum-based approach to health care management that focuses on populations at risk for selected conditions. The Quality Management Program encompasses the entire organization and includes the following components:
    - Evaluation of population-based systems of care that address the needs of vulnerable patients
    - Access improvements, including provider availability and cultural competence
    - Promotion of compliance with current preventive health recommendations
    - Evaluation of care coordination activities
    - Development and approval of clinical guidelines and standards

- Assessment of member perceptions of health care and service quality
- Member complaints and appeals
- Provider complaints and appeals
- Credentialing of physicians and other providers
- Evaluation of provider performance
- Medical record review
- Policies supporting members' rights, responsibilities, and confidentiality
- Assessment of new technology
- Development of a data collection system to evaluate outcomes of care, services, and processes
- Risk management activities
- Structure and Quality Management Program oversight

Improving the All-Cause Hospital Readmission Rate

Mass General Brigham Health Plan works continuously to reduce readmissions through various projects across the service area. One example is Mass General Brigham Health Plan's Care Management Program in our Population Health Department. This program provides support to Members who are at risk for hospital readmission. The Mass General Brigham Health Plan Care Managers will outreach to Members post-hospitalization or skilled nursing stay, to assist them in overcoming major "barriers to care".

Durable Medical Equipment (DME)

DME purchases and rentals must be requested by the member's treating provider or an approved vendor. DME under the $1,000 threshold does not require prior authorization from Mass General Brigham Health Plan. DME Providers must be Medicare-approved providers. DME prior authorization requests for DME over $1,000 should be submitted through Provider.MassGeneralBrighamHealthPlan.org. The physician's prescription and supportive documentation for the requested DME must be attached to the electronic request. A valid authorization request, supportive documentation, and a physician's prescription are required before a requested service can be approved. Mass General Brigham Health Plan works directly with the vendors to insure efficient and timely filling of requests.

Supplemental Benefit Vendors

Dental Provider

Liberty Dental is the dental provider for Mass General Brigham Medicare Advantage plans. Mass General Brigham Medicare Advantage plans includes coverage for preventive and comprehensive dental services through a Liberty Dental contracted provider. Members may see a dental provider who is not contracted with Liberty Dental, however higher cost sharing will apply.

Vision Provider

EyeMed is the vision provider for Mass General Brigham Medicare Advantage plans. Mass General Brigham Medicare Advantage plans include vision coverage through EyeMed. Members are eligible for a $0 copay routine vision exam through a contracted EyeMed provider and have an annual allowance for eyewear.

Hearing Provider

TruHearing is the hearing provider for Mass General Brigham Medicare Advantage plans. Mass General Brigham Medicare Advantage plans include hearing coverage through TruHearing. Members may receive a routine vision exam every year for a $0 copay. Members are also eligible to purchase up to 2 hearing aids every year at a discounted copay between $699 and $999 through TruHearing.

Over-the-Counter Medication Provider

Convery Health Solutions will administer Mass General Brigham Medicare Advantage plan's over-the-counter program. Members are provided with a quarterly allowance they may use to purchase CMS-approved over-the-counter medications and supplies through Convey Health Solutions' mail order program.

Post-inpatient Meals

Community Servings will administer Mass General Brigham Medicare Advantage's post-inpatient meals program. After a discharge from an inpatient stay at a hospital, members may be eligible to have up to two weeks (five days per week, two meals per day) for 20 days per of fully prepared, nutritious meals delivered to their home to help them recover from their illness/injuries and or manage their health conditions. Upon discharge, Mass General Brigham Health Plan's Care Management team will coordinate the meal benefit with the member's health care provider to determine if it meets the criteria to receive medically tailored meals (meals must be ordered by a licensed health care provider or a Mass General Brigham Health Plan Care Manager). If the criteria are met, meals are prepared and delivered to the member's home by a plan approved vendor at no cost.

Pharmacy

Pharmacy Access

Members have access to thousands of participating pharmacies, including all major pharmacy chains. Prescriptions filled at non-contracted pharmacies are covered only in certain situations.

Find a Pharmacy for Medicare Recipients

Prescription Drug Benefit

Mass General Brigham Health Plan offers multiple different prescription drug benefit options.

Most drug plans have prior authorization, step therapy, or quantity limit requirements on select medications. Refer to the Mass General Brigham Health Plan formularies below for a complete list of drugs that are subject to pharmacy management programs.

Please navigate to the drug coverage website at the following link to obtain additional information regarding step therapy medical necessity guidelines, and prior authorization medical necessity guidelines. Please use this link to ensure you are viewing the most accurate and up to date information https://massgeneralbrighamadvantage.org/rx-information

Medicare Part D Formulary

A Formulary is a list of covered drugs selected by Mass General Brigham Medicare Advantage in consultation with a team of health care providers, which represents the prescription therapies believed to be a necessary part of a quality treatment program.

Mass General Brigham Health Plan will generally cover the drugs listed in our Formulary as long as the drug is medically necessary, the prescription is filled at a Mass General Brigham Health Plan network pharmacy, and other plan rules are followed.

Mass General Brigham Health Plan Medicare Part D Formulary

Navigate to the following site for the formulary lookup: Formulary Search (medicareplanrx.com)

For Inquiries regarding Part D, please contact CVS Caremark:
1-866-209-2372 and the 4Rx values are:
RXBIN
004336
RxGrp
RX165A
RX165B
RxPCN
MEDDADV

Fax: 1-855-230-5549
Write: CVS Caremark
PO BOX 52066
Phoenix, Arizona 85072-2066

Mail Order Pharmacy

Mass General Brigham Health Plan Members may use the mail service option when filling prescriptions. Mail service includes home delivery of medications. In most cases, there are Member co-copayment savings by ordering a 90-day supply. When prescribing a drug eligible for the mail order program for the initial order, the Mass General Brigham Health Plan Member may ask the provider to send two electronic prescriptions. One is for up to 30 days to be filled at a local pharmacy. The other can last up to 90 days, with refills for up to one year, and can be filled through the CVS Health Mail Order Pharmacy, part of the CVS Health family of pharmacies. Mass General Brigham Health Plan recommends that an order be placed two to three weeks before medications are needed to save on rush delivery charges and avoid possible problems if the shipment is delayed. Not all prescription drugs are eligible to be filled through the Mail Order Pharmacy. Please refer to the Mass General Brigham Health formularies to determine if the drug is eligible to be filled through the Mail Order Pharmacy.

Brand/Generic Difference Program

When a health care provider writes a prescription for a brand name drug and indicates "dispense as written" and there is a Food and Drug Administration (FDA) approved generic equivalent, the Member will be responsible for paying the generic co-pay plus the difference between the cost of the brand and generic drug. This Brand/Generic Difference program helps encourage the use of generic drugs over brand name drugs. This does not apply to all Mass General Brigham Health Plan prescription benefits.

CVS Specialty Pharmacy

Members may utilize specialty pharmacies when required. Mass General Brigham Health Plan's preferred pharmacy is CVS Specialty Pharmacy/Novologix. Many specialty medications require prior authorization, which is obtained directly from Mass General Brigham Health Plan through the process described above. Refer to the Mass General Brigham Health Plan Formularies to determine if a medication must be obtained from a specialty pharmacy. Once the order is placed, the specialty pharmacy will contact the Member to set up an account and arrange for delivery.

Medicare Part B Prescription Drug Coverage

Providers or Enrollees may request authorization for medications covered under the Medicare Part B Benefit via phone call, fax, mail, or portal (for providers). These requests can be submitted 24/7 (including holidays).

Enrollees will be notified of organization determinations as required. The medications that are covered under the Part B medical benefit that require prior authorization through CVS Specialty Pharmacy/Novologix are posted on the website.

Medications Covered under Medicare Part B include:

1. Drugs that are not usually self-administered by patient (injected or infused into the patient in an Outpatient or Physician setting)
2. Drugs administered through DME (such as nebulizers)
3. Clotting factors that are patient administered via injection for the treatment of hemophilia
4. Certain oral anti-cancer drugs and anti-nausea drugs
5. Certain drugs associated with the treatment of end-stage renal disease (ESRD)
6. Certain injectable and infusion medications
7. Some vaccines (many are also covered under Part D at no cost)

Mass General Brigham Health Plan will also cover some vaccines under our Part B and Part D prescription drug benefit. Our plan covers most Part D vaccines at no cost to members, even if members haven't reached the deductible.

Pharmaceutical Assistance Programs

If your patients require assistance with prescription drugs costs, please have them outreach directly to Prescription Advantage to see if they qualify for assistance:

Prescription Advantage
P.O. Box 15153
Worcester, MA 01615-0153
800-243-4636, Monday – Friday, 9:00 AM – 5:00 PM

Confidentiality & Privacy Policies

Confidentiality Privacy Policies

Mass General Brigham Health Plan Network of Participating Providers and supplemental benefit vendors rendering care and services to Mass General Brigham Health Plan Members share responsibility for protecting PHI. In compliance with HIPAA privacy and security rules, Mass General Brigham Health Plan has established policies describing how and by whom Mass General Brigham Health Plan Members' PHI is handled.

Please see the Notice of Privacy Practices and Compliance at
https://resources.allwayshealthpartners.org/members/privacy-practices.pdf

Glossary

Access
The extent to which a patient can obtain services (telephone access and scheduling an appointment) at the time they are needed.

Access90 Program
Access90 provides Mass General Brigham Health Plan members with a 90-day supply of certain maintenance medications when purchased through participating pharmacies.

Administratively Necessary Day
A day of acute inpatient hospitalization on which a member's care needs to be provided in a setting other than acute inpatient hospital and on which a member is clinically ready for discharge but for whom an appropriate setting is not available.

Advance Directives
Advance directives are documents signed by a competent person giving direction to health care providers about treatment choices in certain circumstances. There are two types of advance directives. A durable power of attorney for healthcare ("durable power") allows a Member to name a "patient advocate" to act for them and carry out their wishes. A living will allows a member to state their wishes in writing, but does not name a patient advocate.

Adverse Determination
A determination by Mass General Brigham Health Plan or its designees, based upon a review of information provided, to deny, reduce, modify, or terminate an admission, continued inpatient stay, or the availability of any other health care services, for failure to meet the requirements for coverage based on medical necessity, appropriateness of health care setting and level of care, or effectiveness.

Mass General Brigham Health Plan Care Manager
Mass General Brigham Health Plan-employed health care professional that communicates and collaborates with the member and the member's health care team in the delivery of coordinated and appropriate quality health care services under Mass General Brigham Health Plan care management programs, applying standard protocols, policies, and procedures.

Mass General Brigham Health Plan Nurse Partner
A Mass General Brigham Health Plan-employed Registered Nurse who is assigned to a high-volume inpatient facility to work collaboratively with primary care providers and Mass General Brigham Health Plan Nurse Case Managers to arrange for effective discharge planning for Mass General Brigham Health Plan Members.

Ancillary Services
Additional services related to care, such as laboratory work, x-ray, and anesthesia.

Appeal
A formal request by a Member or Provider for reconsideration of a decision, either clinical or Administrative, with documentation supporting the request for re-consideration.

Authorization
The review and approval by clinicians of certain services for determination of whether the services are medically appropriate and can reasonably be expected to improve the member's condition or prevent future regression.

Authorization Number
A number issued to a provider signifying receipt of a request for services requiring prior authorization. All requests are assigned an authorization identification number for tracking purposes independent of the approval status.

Availability
The extent to which an organization geographically distributes practitioners of the appropriate type and number to meet the needs of its membership.

Benefit Period
The way your plan measures your use of hospital and skilled nursing facility (SNF) services. A benefit period begins the day you go into a hospital or skilled nursing facility. The benefit period ends when you haven't received any inpatient hospital care (or skilled care in a SNF) for 60 days in a row. If you go into a hospital or a skilled nursing facility after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods.

Business Days
See "Working Days"

Care Management
A collaborative process of assessment, planning, facilitating, care coordination, evaluation, and advocacy for options and services to meet an individual's and family's comprehensive health needs through communication and available resources to promote quality cost-effective outcomes. * *From Standards of Practice for Case Management, copyright by Case Management Society of America.

CDS
Controlled dangerous substance

Clean Claim
A claim that can be processed without obtaining more information from the provider of the service.

Clinical Reviewer
A health care professional who has the appropriate clinical expertise in treating the medical condition, performing the procedure, or providing the treatment that is the subject of an adverse action or clinically related grievance and who was not involved in the matter being appealed or grieved.

Co-morbid Disorders
The simultaneous manifestation of a physical disorder and a behavioral health disorder, or two different physical disorders.

Continuing Services
Mass General Brigham Health Plan covered services that were previously authorized by Mass General Brigham Health Plan and are the subjects of an internal appeal involving a decision by Mass General Brigham Health Plan terminate, suspend, or reduce the previous authorization and which are provided by Mass General Brigham Health Plan pending the resolution of the internal.

Coordination of Benefits (COB)
A process by which it is determined how medical, dental, or other care services will be paid when a person is covered under more than one health plan.

Covered Services
Those medically necessary hospitals, medical and other health care services to which a member is entitled under the terms of his or her Mass General Brigham Health Plan Subscriber Group Agreement.

CMS
Centers for Medicare and Medicaid Services

Credentialing
Credentialing is the process of obtaining, verifying, and assessing the qualifications of a Practitioner to provide care or services in or for a health care organization via a Credentialing Verification Organization (CVO). Credentials are documented evidence of licensure, education, training, experience, or other qualifications.

Cultural Competence
A set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals that enables effective work in cross-cultural situations. "Culture" refers to integrated patterns of human behavior that include the language, thoughts, communications, actions, customs, beliefs, values, and institutions of racial, ethnic, religious, or social groups including, but not limited to, ASL-using deaf, hard-of-hearing, and deaf/blind person. "Competence" implies having the capacity to function effectively as an individual and an organization within the context of the cultural beliefs, behaviors, and needs presented by consumers and their communities, as defined in the National Standards for Culturally and Linguistically Appropriate Services in Health Care.

DEA
Drug Enforcement Administration

Durable Medical Equipment (DME)
Equipment which can stand repeated use is primarily used to serve a medical purpose, generally is not useful to a person in the absence of illness or injury and is appropriate for use in the home.

Early Intervention (EI) Services
A comprehensive program for children three years of age and younger whose developmental patterns are atypical, or they're at serious risk of becoming atypical through biological or environmental components. Early intervention services are family-centered and community-based in order to facilitate developmental progress.

Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)
Delivery of health care services to members under age 21.

Emergency Medical Condition
A medical condition that manifests itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

- Placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy,
- Serious impairment to bodily functions, or
- Serious dysfunction of any bodily organ or part.

Emergency Services
Covered inpatient and outpatient services that are furnished to a member by a provider that is qualified to furnish such services under Title XIX of the Social Security Act and are needed to evaluate or stabilize a member's emergency medical condition.

E-prescribing
The transmission, using electronic media, of prescription or prescription-related information, between a prescriber, dispenser, pharmacy benefit manager, or health plan, either directly or through an intermediary, including an e-prescribing network.

EPSDT (Early Periodic Screening, Diagnosis, and Treatment)
Periodicity Schedule Screening procedures arranged according to the intervals or age levels at which each procedure is to be provided.

Ethnicity
Identity with or membership in a particular racial, national, or cultural group and observance of that group's customs, beliefs, and language.

GIC (Group Insurance Commission)
An employer group that provides and administers health insurance and other benefits to the Commonwealth's employees and retirees, and their dependents and survivors.

Grievance
Any expression of dissatisfaction by a member or member's representative about any action or inaction by Mass General Brigham Health Plan. Possible subjects for grievances include, but are not limited to, quality of care or services provided, aspects of interpersonal relationships such as rudeness of a provider or employee of Mass General Brigham Health Plan, or failure to respect the member's rights.

HealthCare Administrative Solutions, Inc. (HCAS)
A non-profit entity founded in 2007 with collaboration from several Massachusetts health plans to streamline the credentialing and re-credentialing processes.

Health Care Agent
A health care agent is a person a member has chosen in advance to make health care decisions in the event that the member becomes unable to do so.

Health Insurance Portability and Accountability Act of 1996 (HIPAA)
Federal legislation enacted to improve the continuity of health insurance coverage in group and individual markets, combat waste, fraud, and abuse in health insurance and health-care delivery, simplify the administration of health insurance and protect the confidentiality and security of individually identifiable health information.

Health Maintenance Organization (HMO)
An entity that provides, offers, or arranges for coverage of health services which emphasize preventive care and consists of a network of physicians and other providers who deliver those services to plan members.

Healthcare Effectiveness Data and Information Set (HEDIS)
A set of standardized performance measures designed to provider purchasers and consumers with the information they need to reliably compare the performance of managed care organizations.

Health Risk Assessment (HRA)
A tool that identifies and quantifies a member's physical and behavioral health status, and morbidity and mortality risk derived from the collection and review of demographic, physical and behavioral health, and lifestyle information. This tool should identify the communication method used by deaf, hard-of-hearing, and deaf /blind members, and the need for ASL Interpreters or Communication Access Real Time Translation (CART) services.

Inquiry
Any oral or written question by a member to Mass General Brigham Health Plan regarding any aspect of Mass General Brigham Health Plan's operations that does not express dissatisfaction about Mass General Brigham Health Plan or its operations, processes, services, benefits, or providers.

Inpatient Medical Care
Inpatient medical care includes hospital or clinic treatment that requires at least one overnight stay.

Joint Commission on the Accreditation of Health Organizations (JCAHO)
A standards-setting and accrediting body in health care which evaluates and accredits approximately 17,000 US health care organizations and programs.

Living Will
A legal document that a person uses to make known his or her wishes regarding life prolonging medical treatments. It can also be referred to as an advance directive, health care directive, or a physician's directive.

MA
Acronym for Medicare Advantage

MassHealth
MassHealth is the Medicaid program in Massachusetts that pays part or all of health care insurance costs for people who qualify.

Managed Care
A system of health care delivery that is provided and coordinated by a primary care provider. The goal is a system that delivers value by giving people access to quality, cost-effective health care.

Managed Care Organization (MCO)
Any entity that provides, or arranges for the provision of, covered services under a capitated payment arrangement, that is licensed and accredited by the Massachusetts Division of Insurance as a health maintenance organization, or is organized primarily for the purpose of providing health care services, makes the services it provides to its members as accessible (in terms of timeliness, amount, duration, and scope) as those services are to other members within the area served by the entity.

Medically Necessary
Health care services or supplies needed to prevent, diagnose, or treat an illness, injury, condition, disease, or its symptoms and that meet accepted standards of medicine.

Member
A person by whom or on whose behalf periodic payment has been made to and accepted by Mass General Brigham Health Plan and who is thereby entitled to receive covered services, and who has chosen or been assigned a specific physician as his or her primary care provider.

Member Representative
Any individual that has been authorized by the member in writing to act on the member's behalf. Members with Special Health Care Needs Includes (1) adults with complex/chronic medical conditions requiring specialized health care services, including persons with physical, mental/substance use, and/or developmental disabilities, such as persons with cognitive, intellectual, mobility, psychiatric, and/or sensory disabilities described below, and including such persons who are homeless; and (2) children/adolescents who have, or are at increased risk for, chronic physical, developmental, behavioral, or emotional conditions and who also require health and related services of a type and amount beyond that required by children generally.

Cognitive Disability
A condition that leads to disturbances in brain functions, such as memory, orientation, awareness, perception, reasoning, and judgement. Many conditions can cause cognitive disabilities, including but not limited to Alzheimer's disease, bipolar disorder, Parkinson disease, traumatic injury, stroke, depression, alcoholism, and chronic fatigue syndrome.

Intellectual Disability
A disability characterized by significant limitations both in intellectual functioning and in adaptive behavior that affect many everyday social and practical skills.

Mobility Disability
An impairment or condition that limits or makes difficult the major life activity of moving a person's body or a portion of his or her body. "Mobility disability" includes, but is not limited to, orthopedic and neuro-motor disabilities and any other impairment or condition that limits an individual's ability to walk, maneuver around objects, ascend or descend steps or slopes, and/or operate controls. An individual with a mobility disability may use a wheelchair or other assistive device for mobility or may be semi-ambulatory.

Psychiatric Disability
A mental disorder that is a health condition characterized by alterations in thinking, mood, or behavior (or some combination thereof) associated with distress and/or impaired functioning. Examples include, but are not limited to, depression, bipolar disorder, anxiety disorder, schizophrenia, and addiction.

Sensory Disability
Any condition that substantially affects hearing, speech, or vision.

Minor
A child who is under the age of 18, considered the age of majority in Massachusetts.

National Committee on Quality Assurance (NCQA)
An entity that evaluates and accredits over half of the nation's health maintenance organizations on key clinical and administrative processes, preventive care measures,
and member satisfaction.

National Practitioner Data Bank (NPDB)
An alert system intended to facilitate a comprehensive review of health care practitioners' professional credentials.

Network
The facilities, providers, and suppliers your health insurer or plan has contracted with to provide health care services.

Non-Symptomatic Care
A member encounter with a provider that is not associated with presenting any medical signs. Examples include well-child visits and annual adult physical examinations.

Non-Urgent Symptomatic Care
A member encounter with a provider that is associated with presenting medical signs and symptoms, but that does not require urgent or immediate medical attention.

Notification
The process by which Mass General Brigham Health Plan is informed of the delivery of specific services. Notification is a requirement for reimbursement of specific services under Mass General Brigham Health Plan Utilization Management program.

Optum Health
The behavioral health organization contracted by Mass General Brigham Health Plan to work in collaboration with the Mass General Brigham Health Plan's Behavioral Health Department to administer Mass General Brigham Health Plan 's behavioral health program.

Organ Donation Card
A card which indicates a person's willingness to "help someone to live after death." The card functions like a personal consent form for organ donation and indicates to both the relatives and medical personnel his or her willingness to donate organs for transplantation. The presence of the card does not imply that aggressive life-saving measures will not be performed in case of emergency, it is considered only after the diagnosis of brain death has been made.

Participating Provider
Participating provider groups, primary care providers, specialists, hospitals, or other providers who have entered into an agreement with Mass General Brigham Health Plan to provide covered services to members.

Part D
Part D is a program that helps pay for prescription drugs for people with Medicare who join a plan that includes Medicare prescription drug coverage.

Primary Care Provider (PCP)
A Physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine), Nurse Practitioner, Clinical Nurse Specialist or Physician Assistant, as allowed under State Law, who provides, coordinates or helps a patient access a range of health care services.

Skilled Nursing Facility (SNF) Care
Skilled nursing care and rehabilitation services provided on a continuous, daily basis, in a skilled nursing facility. Examples of skilled nursing facility care include physical therapy or intravenous injections that can only be given by a Registered Nurse or Doctor.