Mass General Brigham
Health Plan

Mass General Brigham SCO and One Care 2025 Provider Manual

Table of Contents

Introduction

On behalf of Mass General Brigham Senior Care Options ("SCO") and Mass General Brigham One Care health plans and our members, we thank you for your 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 provider manual.

Mass General Brigham SCO and One Care plans will be administered according to the Mass General Brigham SCO and One Care Evidence of Coverage.

Billing Claims and Resources	
Claim Submission Address	**Payer ID:** 04293 **Paper Claim (New Claims) Address:** Mass General Brigham Health Plan 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	healthplanPEC@mgb.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	**OptumRx** **Phone:** 844-368-8732 **RXBIN:** 610011 **RxPCN:** CTRXMEDD **RXGroup:** MGBH0777 (SCO) | MGBH1611 (One Care)
Part B Medical Drugs	**Prime Therapeutics** Phone: 833-895-2611 Fax: 888-656-6671
Provider Services	**855-444-4647** HealthPlanDSNPProvider@mgb.org

Behavioral Health Provider Service	**Provider Express Portal:** Home (providerexpress.com) **Optum Behavioral Health 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 SCO and One Care Information

SCO and One Care
Mass General Brigham Health Plan offers two Medicare Advantage Fully Integrated Dual Eligible Special Need Plans (DSNP): Senior Care Options ("SCO") and One Care. Members are eligible to enroll in these plans if they meet the eligibility requirements detailed below and live in the following Massachusetts Counties:

- Bristol, Dukes, Middlesex, Essex, Suffolk, Nantucket, Norfolk, and Plymouth

Plan information is available to eligible individuals by visiting: https://mgbadvantage.org/SCO (for SCO) and https://mgbadvantage.org/onecare (for One Care) or by calling **888-816-6000** and through select Medicare brokers.

All Plans include:

- Behavioral health benefits through Optum Behavioral Health.
- Part D benefits (prescription drug coverage) through Optum Rx.
- Preventive and comprehensive dental services through DentaQuest.
- Routine vision exam and eyewear through EyeMed.
- Home delivered meals through Community Servings (SCO only).
- Over-the-counter medications/supplies, and fitness supplies through Convey Health Solutions (for SCO only).
- Non-Emergent Medical and Non-Emergent non-Medical transportation through Coordinated Transportation Solutions (CTS).

SCO Member Eligibility
Mass General Brigham SCO is for individuals who:

- Are age 65 or older or turning 65 years of age during the month in which the SCO enrollment would first be effective.
- Are eligible for Medicare and MassHealth Standard.
- Do not have presumptive eligibility.
- Will not be enrolled in a home and community-based services (HCBS) waiver other than the Frail Elder Waiver (FEW) as described in Department 130 of the Code of Massachusetts Regulations, Section 519.007(B).
- Have no other comprehensive private or public health insurance, other than Medicare.
- Members cannot reside in an Intermediate Care Facility operated by the Massachusetts Department of Developmental Services (DDS).
- Are not subject to a six-month deductible period under MassHealth regulations.

Note:

- *Individuals enrolled in HCBS waivers other than the Frail Elder Waiver ("FEW") who meet the eligibility criteria for SCO may enroll in the SCO plan with SCO enrollment taking effect on the first day of the first month following the individual's disenrollment from such HCBS waiver.*
- *Individuals enrolled in PACE, another Medicare Advantage Plan, or a Medicare Part D Plan may enroll in a SCO Plan, with SCO enrollment taking effect on the first day of the first month following the individual's disenrollment from their PACE, Medicare Advantage, or Part D Plan.*
- *For more information on SCO please visit:* Senior Care Options (SCO) | Mass.gov

One Care Member Eligibility

Mass General Brigham One Care is for individuals who:

- Are age 21 through 64 at the time of enrollment.
  - Members who reach 65 years of age while enrolled may actively opt to remain in One Care if they meet other eligibility criteria.
- Reside in the Commonwealth in an area or county served by a One Care plan.
- Have a qualifying disability.
- Have Medicare Parts A and B.
- Qualify for Medicare Part D.
- Are eligible for and receiving MassHealth Standard or CommonHealth.
- Do not have other private health insurance.
- Do not have presumptive eligibility.
- Are not subject to a six-month deductible period under Department 130 of the Code of Massachusetts Regulations, Section 520.028.
- Are not a refugee described in Department 130 of the Code of Massachusetts Regulations, Section 522.002.
- Are not excluded on the One Care Effective Enrollment Date.
- Do not reside in an Intermediate Care Facility operated by Massachusetts Department of Developmental Services (DDS).

Note:

- *One Care will not currently enroll people who are in a PACE or waiver program. For more information on One Care please visit:* One Care | Mass.gov

Plan	Overview
Mass General Brigham SCO and Mass General Brigham One Care (DSNP HMOs)	• Members are required to select an in-network PCP. • Members are required to have a designated care coordinator. • Referrals for specialty care are **not** required. • SCO and One Care do not have an do not have "out-of-network" benefit compared to a traditional HMO. Prior authorization is required for out-of-network services, unless the service is urgent/emergent.

Out of network/non-contracted providers are required to obtain prior authorization for services, except in urgent/emergent situations. Please call our Member Services number or see the SCO and One Care Evidence of Coverage/Member Handbook for more information.

Member ID Card Examples
Each Mass General Brigham SCO and One Care member is issued an ID card with information as shown in the samples linked below. Please note that actual member ID numbers are 10-digit numbers.

Product reference | Mass General Brigham Health Plan

Member Rights and Responsibilities

Mass General Brigham members are entitled to specific rights, including accessing and correcting medical records information, as shown below.

Members must be allowed to freely apply these rights without negatively affecting how they are treated by providers and/or Mass General Brigham Health Plan. In addition, providers must treat Mass General Brigham members with fairness, honesty, and respect, including refraining from any biases based on race, color, national origin, age, disability, sex, religion, ancestry, marital status, veteran status, occupation, claims experience, duration of coverage, pre-existing condition, expected health status, or ability to pay for services.

Mass General Brigham SCO and One Care members have the right to:

- Receive information about Mass General Brigham Health Plan, our services, our providers and practitioners, their covered benefits, and their rights and responsibilities as a member of Mass General Brigham Health Plan.
- Receive documents in alternative formats and/or oral interpretation services free of charge for any materials in any language.
- Have their questions and concerns answered completely and courteously.
- Bet treated with respect and with consideration for their dignity.

- Have privacy during treatment and expect confidentiality of all records and communications.
- Discuss and receive information regarding their treatment options, regardless of cost or benefit coverage, with their provider in a way which is understood by them. Members may be responsible for payment of services not included in the Covered Services list for their coverage type.
- Be included in all decisions about their healthcare, including the right to refuse treatment and the right to receive a second opinion on a medical procedure at no cost to them.
- Access to emergency care 24 hours a day, seven days a week.
- Change their PCP.
- Access an easy process to voice their concerns and expect follow-up by Mass General Brigham Health Plan.
- File a grievance or appeal if they've had an unsatisfactory experience with Mass General Brigham Health Plan or with any of our contracted providers, or if they disagree with certain decisions made by Mass General Brigham Health Plan.
- Make recommendations regarding Mass General Brigham Plan "Member Rights and Responsibilities".
- Create and apply an advance directive, such as a will or a healthcare proxy, if they are over 18 years of age. Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.
- Freely apply their rights without negatively affecting the way Mass General Brigham Health Plan and/or their provider treats them.
- Ask for and receive a copy of their health record and request that it be changed or corrected as explained in the Notice of Privacy Practices in the Member Handbook.
- Receive the Covered Services they are eligible for.

Mass General Brigham SCO and One Care members have the responsibility to:

- Choose a primary care provider (PCP), the provider responsible for managing their care.
- Call their PCP when they need healthcare.
- Tell any healthcare provider that they are a Mass General Brigham SCO or One Care member.
- Give complete and accurate health information that Mass General Brigham Health Plan or their provider need to provide care.
- Understand the role of their PCP in providing their care and arranging other healthcare services that they may need.
- To the degree possible, understand their health problems and take part in making decisions about their healthcare and in developing treatment goals with their provider.
- Follow the plans and instructions agreed to by them and their provider.
- Understand their benefits and know what is covered and what is not covered.

- Call their PCP within 48 hours of any emergency or out-of-network treatment. If they experienced a behavioral health emergency, they should contact their behavioral health provider if they have one.
- Notify Mass General Brigham Health Plan of any changes in personal information such as address, telephone, marriage, additions to the family, eligibility of other health insurance coverage, etc.
- Understand that they may be responsible for payment of services they receive that are not included in the Covered Services.

Assistance with Interpretation and Communication

When applicable, Mass General Brigham Health Plan contracted practices must provide interpreter services free of charge to limited English proficiency (LEP) members, including but not limited to over the phone communication. This requirement is in keeping with Title VI of the Civil Rights Act of 1964 that requires recipients of federal financial assistance to provide translation or interpretation services as a means of ensuring that their programs and activities normally provided in English are accessible to LEP persons, and thus do not discriminate on the basis of national origin. The provision of translation or interpreter services must comply with applicable state and federal mandates and take into account relevant guidance issued by the Department of Health and Human Services Offices of Civil Rights Minority Health, as well as the Massachusetts Office of Health Equity.

Mass General Brigham Health Plan contracted providers must have the capacity to communicate with members in languages other than English, communicate with individuals with special health care needs (including with those who are deaf, hard-of-hearing, or deaf blind), and make materials and information available in alternative formats.

The following resources are available to assist providers in meeting this obligation:

- The US Department of Health and Human Services Office of Minority Health's publication, "A Patient- Centered Guide to Implementing Language Access Services in Healthcare Organizations," can be found at: www.minorityhealth.hhs.gov. This website also includes information on interpreter services, regulations, and requirements.
- Additional information on Executive Order 13166, "Improving Access to Services for Persons with Limited English Proficiency," and its applicability to healthcare providers can be found at www.lep.gov.

NOTE: Providers shall not allow family members or other caregivers to serve as the interpreter except in instances of an emergency or if the provider will have to deny care, and that if the Provider allows a family member or other caregiver to serve as the interpreter. The Provider shall document it in the record as well as the reason an interpreter was not available.

Privacy Rights

Mass General Brigham Health Plan believes strongly in safeguarding the personal and health information of our members and expects all providers to fully comply with applicable state and federal regulations regarding confidentiality of health information, including but not limited to the privacy and security regulations promulgated under the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

It is important that privacy regulations do not impact patient treatment or quality of care. Absent specific authorization from the patient, HIPAA allows for the exchange of information needed for treatment, payment, and healthcare operations. Examples that are applicable to the relationship between Mass General Brigham Health Plan and providers include, but are not limited to:

- *Payment* - The exchange of information needed to ensure that appropriate payment is made for services provided to members, including fulfilling authorization requirements, rendering payment, and conducting retrospective audits.
- *Healthcare operations* - The collection of information for quality assessment and improvement activities such as Healthcare Effectiveness Data and Information Set (HEDIS) audits, medical record reviews, the investigation of grievances, quality of care issues, or suspected fraud and abuse. The exchange of information that enables the coordination of medical care for Mass General Brigham Health Plan member by our team of Care Managers or the provision of information to our providers concerning their patients' utilization of medical services.

Mass General Brigham SCO and One Care members are informed of their privacy rights, including how Mass General Brigham Health Plan uses their information, by distribution of our Notice of Privacy Practices.

Advance Directives

Mass General Brigham SCO and One Care members have the right to execute advance directives such as healthcare agents and healthcare proxies, living wills, and organ donation cards to inform healthcare providers what to do if they become unable to make decisions about their care.

When applicable, providers should discuss with patients their wishes for an advance directive as part of office visits. The discussion should be documented in the patient's medical record and updated regularly, including whether the patient chooses to execute an advance directive. If a patient establishes a written advance directive, it is advised that a provider maintain a copy of this in the patient's medical record. Additional information on advance directives is available at www.caringinfo.org.

Providers must maintain written policies and procedures on Advance Directives as defined in the requirements of 42 CFR Part 489, Subpart I and 42 CFR 422.128, relating to the maintenance of written policies and procedures regarding advance directives; and the requirements of 130 CMR 450.112 and 42 CFR 438.3(j). The provider shall provide adult Enrollees with written information on advance directives policies, including a description of

applicable state law. The information shall reflect changes in State law as soon as possible, but no later than 90 days after the effective date of the change. Mass General Brigham Health Plan reserves the right to audit medical records to verify the presence and documentation of advance directives.

Continuity of Care

Out-of-network providers: MGBHP will honor covered services provided by an out-of-network provider during the Continuity of Care (COC) period. This is through the first 90 days, or until an assessment has been completed with an associated agreed upon care plan, whichever comes first.

Contracted providers: You are required to assist in the redirection to an in-network provider for services to continue after the COC period, if services are still considered medically necessary.

Communicating with Patients

Effective patient-provider communication is vital to good health outcomes and patient satisfaction. Low literacy rates can sometimes compromise a patient's understanding, despite the clinician's efforts. Many patients struggle with understanding; patients with limited health literacy are more likely to be hospitalized or more frequently use emergency services. Limited English proficiency and/or a patient's medical and emotional health can also affect communication between patients and medical practice staff.

Patients should be educated at the first visit as to what to expect from providers and their office staff. Information such as missed appointments and other practice policies, Patient Rights and Responsibilities, turnaround for returning phone calls, and the process for filling prescriptions must be covered early on to ensure a mutual understanding of expectations. The patient must receive a clear explanation (preferably in writing) of what is acceptable and what is not acceptable behavior for effective patient-provider interactions. Provider office staff should also receive adequate training for dealing with patients up to and including:

- Respecting the Patient Bill of Rights
- Avoiding using the caregiver status as a threat to the patient
- Incorrect assumptions about contributing factors to patient behaviors
- Dismissive verbal or body language that can fuel anger
- Adequate communication of acceptable and unacceptable patient behavior
- Depersonalizing patient behavior

Escalating Protocols

Partnering with the patient in their care is key to effective patient-provider relationships. It is recommended that clinicians start by creating rapport with the patient, asking for their goals in seeking Communicating with Patients care and understanding the impact of the illness on the patient's life. Conveying empathy, verbally and non- verbally, delivering the diagnosis in

terms of their original concerns, and educating the patient are key to successfully completing an office visit.

When communicating with limited English proficiency patients, using trained medical interpreters (versus a minor, family member, or non-trained personnel) can result in a more accurate diagnosis, greater patient compliance, and in some cases, a bridge to address patient-provider cultural gaps. Ideally this need is determined at the time of registration so that an interpreter can be involved early on and be scheduled for all the patients' appointments. Otherwise, an interpreter should be called immediately when the need is discovered.

There should be a brief discussion between the interpreter and the clinician beforehand to clarify the goals of the visit. When meeting with the patient, clinicians should speak directly to the patient and not to the interpreter. A trained medical interpreter should use the first person, thus speaking as the doctor and the patient. For effective interpretation, sentences should be kept short and simple, avoiding use of complicated medical terminology, and repeating critical information such as medication names and/or dosage as requested.

When dealing with patients, understanding factors affecting their behavior can help greatly in developing a plan to effectively manage them. It is sometimes possible to predict patients who may become easily agitated, irrational, or violent, depending on their medical condition.

Rushing through a visit can be counter-productive. Providers are encouraged to pay close attention to the patient's words, voice, or attitude to pick up anger signs or levels that might express fear, anger, or violence. Providers should directly address their patient's underlying feelings, making eye contact always, and address the patient in a respectful manner using their preferred title and name.

Terminating a Patient from Your Practice

Mass General Brigham Health Plan recognizes the critical importance of a positive therapeutic relationship and is committed to working with provider practices in developing and maintaining strong provider-patient relationships. However, we recognize that at times the relationship may be jeopardized by the actions of a member and that on rare occasions, a provider may contemplate terminating a member from the practice. A patient's behavior isn't always indicative of being angry at their health care providers. Validating a patient's frustration and concerns may go a long way in improving therapeutic relationships. Termination from a practice while a member is in an emergent or urgent care situation, in the latter stages of pregnancy or is not mentally competent, is rarely justifiable.

Medical office staff should be trained to maintain a professional demeanor and when appropriate, leave the room after conveying empathy with the patient's situation, giving him or her time to think about what is happening.

Mass General Brigham Health Plan is committed to collaborating closely with the provider and the member. This includes but is not limited to:

- Facilitating access to behavioral health treatment and community resources
- Participating in case conferences upon request
- Providing intensive care management

Providers are expected to make every effort to resolve incompatible patient relationships and to proactively notify Mass General Brigham Health Plan of unresolved patient issues as they are identified by emailing Provider Services at HealthPlanProvidersService@mgb.org.

The notification must include the patient's name and date of birth in addition to copies of documented attempts made to address the patient's behavior prior to reaching the decision and any other supporting documentation. Mass General Brigham Health Plan staff will acknowledge receipt, and the provider will be contacted directly if additional information is needed to review the request.

To avoid delays in the review of submitted requests, please do not submit these to MassHealth directly. MassHealth will not process practice-level disenrollment requests submitted to them directly.

As part of our thorough review of these cases, MGBHP may request additional and/or missing information, including a copy of the practice's patient rights and responsibilities or code of conduct policy, when applicable. If it is jointly determined that the issues cannot be addressed to the satisfaction of all parties and that the only alternative is terminating the patient from the practice, the decision should not be communicated to the member until after coordinating with Mass General Brigham Health Plan. This will ensure effective continuity of care and that these decisions are made in an objective and fair manner.

Notification to Member

The provider is responsible for communicating, in writing, first to Mass General Brigham Health Plan and then to the member the reason for the decision and the effective date of termination. Except in instances of imminent danger, the member must be provided with at least 30-days' advance notice to transition their care to another provider. At a minimum, the letter should include:

- The reason for the decision
- The effective date of termination
- A summary of previous attempts made by the provider's practice to work with the patient prior to reaching the decision
- The option to continue care for at least 30 days while the patient makes other arrangements

- Process for the transfer of medical records
- Instructions to contact Mass General Brigham Health Plan Customer Service for assistance selecting a new provider, when applicable

Covered Services

As a fully integrated dual eligible special needs plan (D-SNP), Mass General Brigham SCO integrates standard Medicare with MassHealth, with additional supplemental benefits. Below is a high-level summary of the benefits covered. Please go to https://mgbadvantage.org/SCO for details on covered, non-covered benefits, and exclusions and refer to the Mass General Brigham SCO (HMO D-SNP):

- 2026 Summary of Benefits and
- 2026 Evidence of Coverage / Member Handbook

Inpatient Hospital Care
- Medical and Surgical Admissions
- Behavioral Health/Psych Admissions

Skilled Nursing Facility Care
Home Health
Outpatient Services
- Ambulatory and Outpatient Surgery
- Lab
- Radiology
- Part B drugs
- Behavioral and Mental Health services

Rehabilitation Services
Urgent and Emergency Care
Primary and Specialty Care
Dental
Vision
Chiropractic Care and Acupuncture
Over-the-Counter (OTC)
Physical Activity / Fitness
Durable Medical Equipment (DME)
Therapy
- PT, OT, Speech

Home and Community Based Services
- Adult day health
- Adult foster care and Group Adult foster care
- Home delivered meals, Adult Companion
- Laundry, Homemaker, Peer Support, Home

Personal Care Attendant (PCA) services
BH Diversionary Services
Transportation
- Ambulance
- Non-emergent Medical
- Non-emergent non-Medical

Part D (Retail) Drugs

Mass General Brigham One Care Covered Services

As a fully integrated dual eligible special needs plan (D-SNP), Mass General Brigham One Care integrates standard Medicare with MassHealth, with additional supplemental benefits. Below is a high-level summary of the benefits covered. Please go to https://mgbadvantage.org/onecare for details on covered and non-covered benefits and refer to the Mass General Brigham One Care (HMO D-SNP):

- 2026 One Care Summary of Benefits
- 2026 One Care Evidence of Coverage /Member Handbook

Inpatient Hospital Care
Medical and Surgical Admissions
Behavioral Health/Psych Admissions
Skilled Nursing Facility Care
Home Health
Outpatient Services
Ambulatory and Outpatient Surgery
Lab
Radiology
Part B drugs
Behavioral and Mental Health services
Rehabilitation Services
Urgent and Emergency Care
Primary and Specialty Care
Dental
Vision
Chiropractic Care and Acupuncture
Durable Medical Equipment (DME)
Therapy
PT, OT, Speech
Home and Community Based Services
Adult day health
Adult foster care
Personal Care Attendant (PCA) services
BH Diversionary Services
Transportation
Ambulance
Non-emergent Medical
Non-emergent non-Medical
Part D (Retail) Drugs

Non-Covered Services

A full list of non-covered services and exclusions can be found in the SCO and One Care Member Handbooks which you can find at https://mgbadvantage.org/SCO and https://mgbadvantage.org/onecare. Below are key services our plan does not cover under any circumstances and we do not pay for these benefits.

Non-Covered Services:

- Services considered not “reasonable and medically necessary”, according to Medicare and MassHealth (Medicaid) standards, unless we list these as covered services.
- Experimental medical and surgical treatments, items, and drugs, unless Medicare, a Medicare-approved clinical research study, or our plan covers them. Experimental treatment and items are those that aren’t generally accepted by the medical community.
- Surgical treatment for morbid obesity, except when medically necessary and Medicare pays for it.
- A private room in a hospital, except when medically necessary.
- Private duty nurses.
- Personal items in a member’s room at a hospital or a nursing facility, such as a telephone or television.
- Full-time nursing care in a member’s home.

- Fees charged by a member's immediate relatives or members of the Member's household.
- Routine foot care, except as described in Podiatry services in the Benefits Chart in **the Member Handbook.**
- Elective or voluntary enhancement procedures or services (including weight loss, hair growth, sexual performance, athletic performance, cosmetic purposes, anti-aging and behavioral performance), except when medically necessary.
- Cosmetic surgery or other cosmetic work, unless it's needed because of an accidental injury or to improve a part of the body that isn't shaped right. However, we cover reconstruction of a breast after a mastectomy and for treating the other breast to match it.
- Chiropractic care, other than manual manipulation of the spine consistent with coverage guidelines.
- Orthopedic shoes, unless the shoes are part of a leg brace and are included in the cost of the brace, or the shoes are for a person with diabetic foot disease.
- Supportive devices for the feet, except for orthopedic or therapeutic shoes for people with diabetic foot disease.
- Radial keratotomy, LASIK surgery, and other low-vision aids.
- Reversal of sterilization procedures and non-prescription contraceptive supplies.
- Naturopath services (the use of natural or alternative treatments).
- Services provided to veterans in Veterans Affairs (VA) facilities. However, when a veteran gets emergency services at a VA hospital and the VA cost-sharing is more than the cost-sharing under our plan, we'll reimburse the veteran for the difference. Members are still responsible for applicable cost-sharing amounts.
- Newborns and infants are not covered under the SCO or One Care programs. In accordance with MassHealth requirements, providers are responsible for assisting families in enrolling newborns into an alternative MassHealth program. The delivering provider is responsible for completing and submitting the Notification of Birth (NOB-1) to MassHealth. The form can be faxed to MassHealth's NOB unit at 617-887-8777. The form must be completed promptly to ensure there is no gap in coverage for the newborn.

Credentialing, Provider Enrollment, and 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 and/or EOHHS 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)
- Community Based Organization Providers
- Behavioral Health Providers (these providers must work through Optum Behavioral Health)

While credentialing may not be 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.

Frail Elder Waiver Performance Measures (SCO)

- Licensure Compliance:
  All contracted waiver service providers must maintain current licensure as required by

waiver and state regulations. This ensures that providers meet all legal and professional standards necessary to deliver safe and effective services to frail elders. Licensure confirms that the provider operates within the rules established by regulatory authorities.

- Non-Licensed Provider Qualifications:
  Non-licensed waiver service providers must meet qualification specifications in accordance with applicable state requirements. Even if a provider does not hold a formal license, they must still demonstrate appropriate training, experience, or certifications as defined by the state to guarantee quality and competency in care.
- Non-Certified Provider Qualifications:
  Non-certified waiver service providers are required to adhere to qualification standards as specified by state regulations. Similar to non-licensed providers, those without formal certification must meet alternative qualification standards that ensure they are capable of delivering necessary services safely and effectively.
- Criminal Background Checks:
  All staff employed by contracted waiver service providers must undergo Criminal Offender Record Information (CORI) checks at designated times as required by policy. Conducting background checks helps protect vulnerable elders by ensuring that service providers do not have a history of criminal behavior that could endanger clients or compromise care quality.

Excluded & Precluded Individuals

Mass General Brigham Health Plan has a process in place to provide ongoing performance monitoring of practitioners between credentialing and recredentialing cycles. In addition to monitoring practitioner performance through member complaints and grievances, at least twice a month Mass General Brigham Health Plan' Credentialing staff checks state licensing boards' disciplinary action lists for license restrictions/sanctions and the Office of the Inspector General's latest Exclusion and Reinstatement Lists of individuals and organizations excluded from Medicare/Medicaid/federal programs. On a monthly basis Mass General Brigham also has a process to monitor practitioners listed on the CMS Preclusion List. Complaints received by Mass General Brigham Health Plan and sentinel events regarding practitioners are also compiled periodically for review.

If Medicare or MassHealth 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 MassHealth 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.

Provider Enrollment

Mass General Brigham Health Plan requires that, when applicable, all providers be credentialed or enrolled prior to rendering care. Mass General Brigham Health Plan does not recognize interim or provisional credentialing of practitioners still in training.

Services rendered prior to a practitioner's enrollment by Mass General Brigham Health Plan cannot be honored. Practitioners seeking enrollment with Mass General Brigham Health Plan, and employed by an Mass General Brigham Health Plan contracted group, must submit a request through Mass General Brigham Health Plan' Provider Enrollment Portal or a completed HCAS Enrollment Form to Mass General Brigham Health Plan with preliminary information about the practitioner and his/her practice.

Provider sites can review a list of all clinicians enrolled in Mass General Brigham Health Plan, including original effective dates of the affiliation via the Provider Roster reports available from the Mass General Brigham Health Plan Provider Portal

For new Mass General Brigham Health Plan providers, the practitioner is notified (by letter) of his/her ability to begin rendering care upon approval for network participation by Mass General Brigham Health Plan' Credentialing Committee.

For questions on a clinician's enrollment status, email Mass General Brigham Health Plan at HealthPlanPEC@mgb.org or contact Mass General Brigham Health Plan Provider Service at 855-444- 4647.

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, the plan will notify the Participating Provider in writing of the decision.

Denial or termination of organizational providers <u>will not be subject to appeal</u>.

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 their 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 every 90 days.

- 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 readmissions, 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 or MassHealth 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 members are serviced is required, where applicable.
   - **Participation in Medicare (Title XVIII of the Social Security Act) and MassHealth (Title XIX of the Social Security Act):** If contracted for services to Medicare and/or MassHealth 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
Accreditation Commission for Health Care	ACHC	ASC, CAH, ESRD Facilities, HHA, HIT, Hospice, Hospital
American Association for Accreditation of Ambulatory Surgery Facilities (QUAD A)	QUAD A	ASC, OPT, RHC
American College of Radiologists	ACR	Free Standing Radiology Centers
Community Health Accreditation Program	CHAP	Home Health Care and Hospice
Clinical Laboratory Certification/Amendment Certification	CLIA	Lab
DNV – Healthcare	DNV	CAH, Hospital, Psychiatric Hospital

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 Hyperbaric Medical Society	UHMS	Hyperbaric Treatment Centers
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
The Joint Commission	TJC	Hospital, Home Health Care, Nursing Care Center, Ambulatory Surgery Center, Behavioral Health, FQHC,

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 EOHHS 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 EOHHS 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 EOHHS 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 the 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 MassHealth 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 the provider is practicing.
- Board Certification is not required unless it is a requirement for the 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 requests 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.

Provider Terminations For providers terminating from a practice, Mass General Brigham Health Plan requires written notification at least 60 days prior to the practitioner's termination date unless otherwise agreed upon. The notification must be submitted through the Provider Enrollment Portal on the Mass General Brigham Health Plan Provider Portal, on the standardized provider information change form, or using a similar document on the provider's stationery that includes at a minimum:

- The provider's name
- NPI number
- Effective date of termination
- Reason for termination
- If PCP, panel re-assignment instructions
- Signature and title of the person submitting the notification

Upon receipt of the notification, Mass General Brigham Health Plan' staff will work with affected members, the provider's office, and when applicable, specialty providers, to ensure continuity of care. Involuntary terminations (those initiated by Mass General Brigham Health Plan) will include notification to the provider and the practice as needed. Except when a provider's termination is based upon quality related issues or fraud, Mass General

Brigham Health Plan may allow continuation of treatment for covered services for:

- Up to 30 days following the effective date of the termination if the provider is a PCP
- Up to 90 days for members undergoing active treatment for a chronic or acute medical condition; or through the lesser of the current period of active treatment with the treating provider
- Members in their second or third trimester of pregnancy with the provider treating the member in conjunction with said pregnancy through the initial post-partum visit.
- Services for members who are terminally ill until their death.

The provider must accept payment at the applicable fee schedule as payment in full and must not seek any payment from the member for covered services. The provider must adhere to Mass General Brigham Health Plan' quality assurance programs and other Mass General Brigham Health Plan policies and procedures including, but not limited to, procedures regarding prior authorization and notification.
For members who will continue receiving care from the provider, Mass General Brigham Health Plan Clinical staff will contact the provider to obtain more information including confirmation of any scheduled services to be authorized on an out-of- network basis, with the provider being notified accordingly.

Claims for members who continue to see a terminated provider without Mass General Brigham Health Plan' knowledge will be automatically denied. Disputes in these cases can be addressed through Mass General Brigham Health Plan' administrative appeals process and, depending on the outcome, the provider will be reimbursed for services rendered at the applicable fee schedule.

10. Federally Required Disclosure Forms

Federally Required Disclosure Forms for MassHealth are documents that providers, fiscal agents, and managed care entities (MCEs) must submit to disclose certain information to MassHealth as required by federal regulations. These disclosures relate to business ownership, control, transactions, and criminal convictions. The forms are used to ensure transparency and compliance with MassHealth regulations.

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 for ensuring the quality and safety of our network providers. Any significant quality of care or provider concerns identified during the on boarding 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 Behavioral Health:

- 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 members. 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 via CAQH for Providers or email your provider information change form to healthplanPEC@mgb.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 Individual Physician Association (IPA)/Physician Hospital Organization (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.

14. Confidentiality

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

Performance Monitoring

Termination, Suspension, and Non-Renewal

Termination: 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 Suspension: Mass General Brigham Health Plan may summarily terminate or suspend a Participating Providers' participation in the SCO and One Care 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, or as a result of an internal Mass General Brigham Health Plan investigation.
- A disciplinary action by the applicable licensing board.
- Physical or behavioral impairment which may impede or limit the Participating Provider's ability to provide appropriate medical care.

Mass General Brigham Health plan will not terminate a Participating 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 members.
- 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 SCO and One Care 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 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

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 LOA can be initiated by sending a provider information change form request to healthplanPEC@mgb.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.
- 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.
- Participating Provider must provide proof of current malpractice coverage prior to reinstatement.
- Participating Provider LOAs 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.

Provider Rights and Responsibilities

This section is an overview of Mass General Brigham Health Plan's Participating Provider roles and responsibilities for which all Participating Providers are accountable. We have created 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 Provider 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 healthplanPEC@mgb.org.

General Practitioner and Provider Responsibilities

- Providers may not refuse to serve Mass General Brigham Health Plan members based on the member's payment status, e.g. receiving assistance with Medicare cost-sharing from a State Medicaid program.
- 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.
- Cultural competency training.
- Mass General Brigham Health Plan complies with 42 USC 1396u-2(b)(3) and 42 CRF 438.102 and will not prohibit, or otherwise restrict, a health care professional acting

within the lawful scope of practice, from advising or advocating on behalf of a member who is their patient.
- 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.
- To remain active in Mass General Brigham Health Plan provider directories, Participating Providers must submit data and attest in CAQH (https://proview.caqh.org/Login) at least every 90 days. Examples of information that providers need to collect and update in CAQH include:
    - provider race and ethnicity
    - open/closed patient panel status
    - ages and genders treated
    - cultural groups and special populations treated
    - telehealth modalities
    - practice group name and location
    - appointment scheduling telephone number
    - practice email address
    - hospital affiliation
    - website address

Primary Care Provider (PCP) Responsibilities

PCPs are responsible for monitoring the care of their Mass General Brigham SCO and One Care 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, or 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 and Responsibilities

Referrals for specialty services are not required for most Mass General Brigham SCO and One Care members; however, prior authorization may be required – depending on the type of service being rendered. 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 SCO and One Care 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.

Provider Responsibilities as part of the Interdisciplinary Care Team (ICT):

Every MGBHP SCO or One Care member must select a PCP prior to or upon enrollment. The role of the PCP is to provide primary care and participate in either the development, review, or sign off of the member's Individualized Care Plan (ICP). ICT meetings may be held to discuss highly complex members at the request of the PCP or Health Plan and may also be held at the request of the member. The frequency of these meetings depends on the members' overall acuity and level of need.

Key tasks of the PCP include the following:

- Providing overall clinical direction and serving as a key participant in integration and coordination of all covered service
- Delivering primary medical services, including acute and preventive care
- Participating in ICT meetings, during which changes to the ICP are reviewed and approved
- Promoting independent functioning of the member in the most appropriate, least restrictive environment with the proper supports in place
- Assisting in the designation of a health care proxy, if the member wants one, along with any other advanced directives

- Complete and attest to the annual Model of Care training
- Communicating with the member and member's care coordinator and/or caregiver/s about their medical, social and behavioral needs

Compliance with 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 Mass General Brigham Health Plan Credentialing Committee.

Behavioral Health Services Providers

Coordination of Care Between Behavioral Health Providers and Primary Care Physicians or Other Health Professionals:
MGBHP expects behavioral health providers to coordinate care with the member's primary care physician as well as other treating medical or behavioral health providers. A signed release of information should be maintained in the clinical record. The Exchange of Information form can be found on ProviderExpress.com at https://public.providerexpress.com/content/dam/ope-provexpr/us/pdfs/adminResourcesMain/forms/eoi.pdf. In the event a member declines consent to the release of information, their refusal should be documented, along with the reason for refusal. In either case, education you provide regarding benefits and risks of coordinated care should be noted.

Coordination Between Behavioral Health Providers and State Agencies:
Behavioral health providers are expected to coordinate care with any relevant state agencies that are working with a member or member's family. This includes but is not limited to the Department of Children and Families (DCF), Department of Youth Services (DYS), Department of Mental Health (DMH), Department of Transitional Assistance (DTA), Department of Developmental Services (DDS), Department of Corrections (DOC), Probation, Parole, AGE, and local education authorities.

Protocols for Transitioning Members from One Behavioral Health Provider to Another:
If a member transfers from one behavioral health provider to another, the transferring provider must obtain a release of information from the member and send a case summary, including the reason for the transition to the new provider.

The Qualified Medicare Beneficiary (QMB) program:
is one of four Medicare Savings Programs for dual eligible beneficiaries funded by the federal government and managed by state Medicaid agencies. The QMB program is designed to help people who are eligible for Medicare and Medicaid and meet certain income requirements pay for Part A and/or Part B premiums, deductibles, coinsurance, and copayments.

Federal law prohibits all Medicare FFS and Medicare Advantage providers and suppliers from charging individuals enrolled in the QMB program for any Medicare Part A and B cost sharing. Providers who do not follow the QMB billing prohibition are in violation of their Provider Agreement with Mass General Brigham Health Plan and may be subject to sanctions.

Program information:

- **Cost sharing:** Medicare beneficiaries enrolled in the QMB program have no legal obligation to pay Medicare Part A or Part B deductibles, coinsurance, or copays for any Medicare-covered items and services. Medicare providers, suppliers, and pharmacies cannot balance bill QMB eligible individuals for any Medicare Part A or Part B services.

- **Prescriptions:** QMB billing protections apply only to those prescriptions covered under Part B. Under Part D, QMB eligible individuals may be subject to copays; however, Low-Income Subsidy (LIS) or "Extra Help" may limit the amount a QMB program participant pays for Part D prescriptions.

- For more information, please refer to the Medicare Learning Network (MLN): https://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnmattersarticles/downloads/se1128.pdf

Identifying Individuals Participating in the QMB Program:
Mass General Brigham Health Plan has ways to help you identify members in the QMB Program.

- On the weekly Remittance Advice, claims for members in the program will be flagged to indicate calculated plan cost sharing (copayment or coinsurance) that should not be collected from or billed to the member.

- In the provider portal.

- Through submission of a 270 (Eligibility Inquiry) and receipt of the 271 (Eligibility Response).

- Call MGBHP's Provider Services at 855-444-4647 from 8:00 – 5:00 EST Monday to Friday.

- The state Medicaid program and Medicare may also have resources to help providers identify program participants.

What Providers should do:

1. Do not bill the member for any cost sharing or balance bill amounts.
2. If you have previously billed a QMB participant for cost sharing, stop billing immediately.
    - If you collected cost sharing from a program participant, refund them immediately;
    - If you have initiated collection efforts against a member who is an eligible QMB, stop collection services immediately.
3. Refer to the MLN article to learn more about billing the state Medicaid program for unpaid Medicare cost sharing.
4. Most importantly, continue to provide members with access to care and services.

Network Access and Availability Standards

Mass General Brigham Health Plan must comply with all CMS and EOHHS requirements and ensure that all covered services, including additional or supplemental services contracted for, or on behalf of the 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 Providers 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 Health Plan SCO / One Care
Emergent Medical	Immediate access
PCP Urgent Care	Within 48 hours
PCP Non-Urgent Symptomatic Care	Within 10 calendar days
PCP Non-Symptomatic Care	Within 45 calendar days

Specialty Urgent Care	Within 48 hours
Specialty Non-Urgent Symptomatic Care	Within 30 calendar days
Specialty Non-Symptomatic Care	Within 60 calendar days

You can register for access to the Provider Portal any time on or after your effective date. To register, go to the Mass General Brigham Health Plan Provider Portal, click the Account Registration tab, and follow the instructions provided.

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's 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 have 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 Training

At Mass General Brigham Health Plan, we are committed to ensuring that our network providers deliver exceptional care to our members. To support this commitment, we recognize that continuous provider training and communication is essential for maintaining the highest standards of healthcare delivery.

As a part of our ongoing commitment to provider education, we will:

- Provide MGBHP Model of Care training
- Review Provider Portal and Engagement Channels overview
- Review Claims, Billing and Authorization Process
- Review Utilization Management including medical necessity guidelines
- Review Quality Improvement including health equity and practice guidelines
- Provide Engagement Channels
- Offer a comprehensive education program
- Ensure accessibility and convenience
- Update training based on regulatory requirements and evidence-based practices
- Monitor and evaluate provider performance
- Foster collaboration and peer learning

We are dedicated to supporting our providers by offering in-depth educational tools and resources during provider onboarding. News, events and various webinars are available through our "Provider resources | Mass General Brigham Health Plan ".

To accommodate different learning styles, training is offered via live and recorded webinars, self-paced online modules, and regional seminars. To learn more about all the training options available to you and to learn how to enroll for your preferred option, go to "Provider resources | Mass General Brigham Health Plan". To receive credit for attending the training, you will need to follow a link provided at the end of the module to attest to completion of the training.

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.
- Submit claims and claims correspondence.
- View claims status.
- Submit appeals.
- Manage your practice information.
- View patient rosters and reports.
- View member eligibility & benefits.

Provider Newsletter

The Mass General Brigham Health Plan 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 and 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: https://massgeneralbrighamhealthplan.org/admin-newsletter

Claims and Billing Procedures

Claims Submission Guidance and Requirements

Providers are responsible for meeting all Mass General Brigham Health Plan claim submission requirements whether they are submitting themselves or when using a billing agent or clearinghouse.

- 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.
- Mass General Brigham Health Plan is committed to processing clean claims within at least 30 days of receipt.

Paper Claims Claims/Appeals Submissions	
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

Electronic (EDI) Claims

Claims submitted electronically are subject to the claim edits established by Mass General Brigham Health Plan. Companion guides are available to assist providers interested in electronic claim submissions. For questions regarding electronic claims submissions, providers may contact their Mass General Brigham Health Plan Provider Relations representative.

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's contract. Non-clean claims will be rejected and returned to the provider.

A clean claim 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

When a 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 60 days after Mass General Brigham Health Plan's receipt of the claim.

- If the Provider receives an adverse determination, the Provider may dispute the denial on the member's behalf as described in this manual's claims appeals section.
- Mass General Brigham Health Plan requires the submission of all paper and electronic claims within 90 days of the date of service, unless otherwise indicated in the Provider Agreement.
- Mass General Brigham SCO and One Care 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.

Balance billing
The practice where a provider charges a member for the difference between what the Health Plan pays and the provider's billed charges. It is never acceptable to balance bill a Mass General Brigham SCO or One Care member, as providers are prohibited from balance billing any Medicare beneficiary. Further, MassHealth prohibits providers from billing any individual enrolled in Medicaid.

Mass General Brigham Senior Care Options and One Care members are dually eligible for Medicare and MassHealth, have no cost-share obligation for covered services and are not subject to balance billing by any provider or facility. Any attempt by a provider or facility to balance bill a Mass General Brigham SCO
A claim received by Mass General Brigham Health Plan which is missing any supporting information required to process the claim may be pended for provider outreach.

- Mass General Brigham Health Plan will send the provider notice of the pended claim, along with a request for the missing supporting documentation which is required to finalize the claim.
    - Failure to respond timely to these requests or to provide supporting documentation 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.

- If a claim is denied for lack of medical records, the requested supporting documentation must be submitted within 180 days from receipt of Mass General Brigham Health Plan's notice.
    - Providers must submit missing information, such an itemized bill or medical records, with Mass General Brigham Health Plan's request letter for claim to be processed.
- Requests for adjustments must be submitted no later than 90 days after the claim's original paid date following the issuance of an Explanation of Payment (EOP)/Remittance Advice.
- For all timely filing resubmissions, we require supporting documentation for the untimeliness in order to overturn a denial; not all requests will be honored.
- 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.
- 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.

Timely Filing Limit Adjustment Requests

To be considered for a timely filing limit adjustment, requests for review of 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 from the original denial date 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 **all** requests.

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 reference to the most recent version of the Claim ID to be adjusted. For example, a correction to original Claim ID (00000E00000) must include the original Claim ID number. A second corrected claim request should include the Claim ID for the latest version of the claim (00000E00000A1).

Corrected Electronic (EDI) 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.

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.

Behavioral Health Services Claims

Mass General Brigham SCO and One Care behavioral health benefits are administered through Optum Behavioral Health (Optum BH). Claims, appeals, and adjustment requests for behavioral health-specific services must be submitted to OptumBH directly.

Behavioral Health Provider Services:
Provider Express Portal: Home (providerexpress.com)
Optum Behavioral Health Provider Services: 844-451-3520

Coordination of Benefits and Other Insurance

Coordination of Benefits (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 limits.

When a member enrolls with Mass General Brigham Health Plan through an employer plan, Mass General Brigham Health Plan will coordinate benefits as applicable to determine primary

or secondary coverage. All payments for covered Mass General Brigham Health Plan services rendered are considered as payment in full.
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.

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, or as specified in your Provider Agreement, but no more than two (2) years after the date of service.

Third-Party Liability Claims
When a Mass General Brigham Health Plan member is involved in an automobile accident, has a 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.

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.

Waste Identification, Reimbursement Validation and Recoveries

Mass General Brigham Health Plan's Payment Integrity department is responsible for identifying waste and for validating all claims reimbursements. The department is responsible for identifying and recovering claim overpayments, which may be the result of billing errors, payment errors, unbundling, duplicates, retroactive contract reviews, or other claims payment anomalies. The department performs several operational activities to ensure the accuracy of providers' billing submissions, and of claims payments. The Payment Integrity department also utilizes internal and external resources to prevent incorrect payment of claims and will initiate recovery if and when overpaid claims are identified.

Mass General Brigham Health Plan has established an overpayment identification and reimbursement validation audit process to verify the accuracy of charges and payments appearing on Provider (facility, physician and ancillary Provider) claims and to ensure that all charges and payments are consistent with Mass General Brigham Health Plan's Provider Agreements, Mass General Brigham Health Plan's policies and procedures, and applicable nationally recognized medical, claims administration and claims reimbursement policies.

Mass General Brigham Health Plan's policies, which include but not limited to medical policies; claims administration rules; and payment guidelines; apply to all reimbursement and claims matters. In any matter where Mass General Brigham Health Plan does not maintain an applicable policy, Mass General Brigham Health Plan adopts and follows industry standards and policies relating to procedural coding, medical claims administration, and medical claims reimbursement which are recognized by governmental payers, such as the Centers for Medicare and Medicaid Services (CMS) as well as national health insurance carrier organizations, and the American Medical Association (AMA).

Mass General Brigham Health Plan may conduct reimbursement validation audits on claims that Mass General Brigham Health Plan has paid during the current fiscal year or has paid during the two (2) prior fiscal years. Mass General Brigham Health Plan may also initiate reimbursement validation audits up to six (6) years after a claim payment to investigate whether a Provider has engaged in billing practices that may constitute fraud or abuse.

Provider reimbursement validation audits can take place in two (2) audit venues: on-site and/or off-site audits. Mass General Brigham Health Plan determines the venue, or combination of venues that its Audit Specialists shall employ in an audit.

On-site Auditing

In the on-site audit, a Mass General Brigham Health Plan Audit Specialist or designated party conducts the audit of designated medical records at the Provider's site. For on-site audits, Mass General Brigham Health Plan requests that the Provider make a suitable work area for the Audit Specialist to perform the audit activities while on-site during the duration of the audit.
Mass General Brigham Health Plan requires that a Provider schedule an audit at a mutually convenient time for Mass General Brigham Health Plan's Audit Specialist, medical records department, and the patient account representative. The Provider and Mass General Brigham Health Plan agree that cancellation of a scheduled audit requires written notification no less than fifteen (15) business days prior to the scheduled audit and should be sent to Mass General Brigham Health Plan's Manager of Provider Audit and the designated facility representative.

The inspection and copying of medical records are conducted in compliance with the Provider's standard policies that govern such processes and that are applied uniformly to all payers. Along with the medical records, the Provider must make available the pharmacy profile and corresponding fee book. The fee book must include all updated versions in electronic format suitable for use on a personal computer (Excel or other program), unless the Provider makes other arrangements with the Mass General Brigham Health Plan Manager of Provider Audit. All designated records must be produced within twenty-one (21) days of the request by Mass General Brigham Health Plan. Unless the parties agree otherwise, the Provider must schedule the audit to occur no later than thirty (30) business days from the request.

At the conclusion of the audit, and if the Provider agrees with the findings, the Audit Specialist provides the Provider with a dated copy of the signed, finalized Discrepancy Report. If the

Provider does not agree with the audit findings at the time of the exit interview, the Provider has thirty (30) business days to submit additional supporting documentation. Mass General Brigham Health Plan's Claims department retracts all audit discrepancies thirty (30) days after the signed, finalized Discrepancy Report. If the Provider fails to provide additional supporting documentation and/or does not respond within thirty (30) days, Mass General Brigham Health Plan's Claims department retracts all audit discrepancies.

Off-site Auditing

The second reimbursement validation audit venue is the off-site audit in which the Mass General Brigham Health Plan Audit Specialist or designated party requests specific medical record information from the Provider be sent to Mass General Brigham Health Plan for review.

Pursuant to Mass General Brigham Health Plan's Provider agreements, Mass General Brigham Health Plan has the right to inspect, review and make copies of records related to an audit. All requests to inspect, review and make copies of medical records are submitted to the Provider in writing. Mass General Brigham Health Plan specifies whether the Provider must make the original medical records or copies of the requested records available for inspection.

Claim Auditing

Mass General Brigham Health Plan audits a random sample 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 and/or EOHHS 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, and duplicate payments.
- Historical claim audits to include the global surgical period for codes submitted on the current claim.
- Medical necessity is based on Mass General Brigham Health Plan's and/or CMS and/or EOHHS guidelines as applicable to the member benefit plan.

When an overpayment event is identified, Mass General Brigham Health Plan Payment Integrity will begin its overpayment recovery process by sending written notification to the provider containing instructions for the process ("Notification of Audit"). In the event the provider does not agree with the identified overpayment amount, the provider should follow the process described in the "Provider Audit Appeals" section of the Provider Manual. If providers do not agree with Payment Integrity's findings, providers should follow the appeal process outlined

within the overpayment notification or findings letter to ensure their appeal rights are preserved and appropriately addressed.

Providers who remain unsatisfied upon resolution of the appeal should refer to the instructions outlined within the dispute determination letter.

If Mass General Brigham Health Plan does not hear from the provider within 30 days from either the initial written overpayment notification or the dispute determination notification, the final overpayment amount will be offset from future claims payments. In cases where recovery through offsetting will take longer than six months, Mass General Brigham Health Plan reserves the right to seek additional legal recourse such as referral to a collection service.

Overpayments

Providers are obligated by State and Federal law to self-disclose identified overpayments in writing to Mass General Brigham Health Plan within 60 days of identifying the overpayment. Providers must indicate whether they prefer that MGBHP deduct the overpayment from future claims until the overpayment balance is $0, or if they prefer to send a check for the overpayment of services.

- Deductions from future claim payments should be submitted with the Request for Review Form, and must include written detail describing the discrepancy in payment - clearly indicating each claim impacted by the overpayment, the amount each claim was overpaid, and copies of the corresponding EOPs must be attached.
- If a provider prefers to issue and mail a check for the identified overpayment, they must include with the check written detail describing the discrepancy in payment - clearly indicating each claim impacted by the overpayment, the amount each claim was overpaid, and copies of the corresponding EOPs.
- Notification, documentation, or repayment must be sent to:

  Mass General Brigham Health Plan
  Attention: Claims Disputes
  399 Revolution Drive, Suite 810
  Somerville, MA 02145

When MGBHP identifies claim overpayments greater than $500, the provider is notified in writing 30 or more days prior to the retraction of any monies. All adjustments are processed against future payments. Unless otherwise instructed, providers should not issue a refund to MGBHP for overpayments identified by MGBHP. 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 Request for Review Form may be submitted to The MGBHP requesting Department (Claim Disputes, Fraud, Waste & Abuse, Provider Audit, Program Integrity, etc.). When Claims Disputes issues the notification, disputes should be sent to:

Mass General Brigham Health Plan
Attention: Claims Disputes
399 Revolution Drive, Suite 810
Somerville, MA 02145

Mass General Brigham SCO and One Care Member Cost-Sharing Responsibilities

SCO and One Care members are both Medicare beneficiaries and MassHealth members, therefore, providers are **prohibited** from billing dual-eligible members, regardless of claims payment or denial.

- Providers must accept Mass General Brigham Health Plan payments as payment in full, as detailed in the provider's contract with Mass General Brigham Health Plan.
- Providers shall not seek or accept payment from a Mass General Brigham SCO or One Care member for any covered service.

Fraud, Waste and Abuse

Fraud Prevention

Mass General Brigham Health Plan expects providers to comply with all federal and state regulations that prohibit fraudulent behavior, including but not limited to:

- Recording clear and accurate documentation of all services rendered in a timely manner as close as possible to the date of service.
- Not signing blank certification forms that are used by suppliers to justify payment for home oxygen, wheelchairs, and other medical equipment.
- Being suspicious of any vendor offering discounts, free services, or cash in exchange for referrals.
- Refusing to certify the need for medical supplies for patients not seen and/or examined.
- Specifying the diagnosis when ordering a particular service (e.g., lab test).
- Knowing and adhering to the practice's billing policies and procedures.
- Verifying the identity of patients since insurance cards can be borrowed, stolen, and fabricated.
- Carefully scrutinizing requests for controlled substances, particularly with new patients.

Reporting Health Care Fraud

Providers who suspect health care fraud should report any suspicions to their organization's Compliance Office or Executive Director.

Suspicions or concerns involving a Mass General Brigham Health Plan member or clinician can be reported to Mass General Brigham Health Plan's Compliance Office in writing or by email. These concerns can also be reported anonymously to the Mass General Brigham Health Plan Compliance Hotline 24 hours a day, seven days a week. The Hotline is operated by an independent company and is not staffed by Mass General Brigham Health Plan employees.

Fraudulent acts or suspicions may be reported as follows:

Mail:

Mass General Brigham Health Plan Legal, Regulatory and Compliance Department
399 Revolution Drive, Suite 810
Boston, MA 02210

Phone:

Mass General Brigham Health Plan
Legal, Regulatory & Compliance Department 800-433-5556
(then dial 0 to have your call directed)
Mass General Brigham Health Plan Compliance Hotline (anonymous) 844-556-2925

Website:

Submit a report through our Compliance website using this link:
EthicsPoint - Mass General Brigham Health Plan

False Claims Act

In complying with our obligations under the Deficit Reduction Act of 2005, Mass General Brigham Health Plan provides detailed information to our employees, contractors, and agents regarding the False Claims Act and comparable state antifraud statutes, including whistleblower protections. To that end, Mass General Brigham Health Plan has developed and continues to refine our policies and procedures regarding fraud and abuse detection, prevention, and reporting including but not limited to the following documents:

- Code of Ethics
- Compliance Hotline Policy
- Non-Retaliation for Reporting of Compliance Violations
- Fraud Reporting and Whistleblower Protections Policy

Fraud, Waste and Abuse and the Special Investigations Unit

Mass General Brigham Health Plan receives state and federal funding for payment of services provided to our members. In accepting claims payment from Mass General Brigham Health Plan, health care providers are receiving state and federal program funds and are therefore subject to all applicable federal and/or state laws and regulations relating to this program.

Violations of these laws and regulations may be considered fraud or abuse against the Medicaid program. As a provider, you are responsible for knowing and abiding by all applicable state and federal regulations.

Mass General Brigham Health Plan is dedicated to eradicating fraud and abuse from its programs and cooperates in fraud and abuse investigations conducted by state and/or federal agencies, including: the Attorney General's Office; the Federal Bureau of Investigation; the Drug Enforcement Administration; the Health and Human Services Office of Inspector General; as well as local authorities. As part of Mass General Brigham Health Plan's responsibilities, the Payment Integrity department is responsible for identifying and recovering claim overpayments resulting from a variety of issues. The department performs several operational activities to detect and prevent fraudulent, abusive, or wasteful activities.

Examples of fraudulent/abusive activities include, but are not limited to:

- Billing for services not rendered or not medically necessary.
- Submitting false information to obtain authorizations to furnish services or items to Medicaid recipients.
- Prescribing items or referring services which are not medically necessary.
- Misrepresenting services rendered.
- Submitting a claim for provider services on behalf of an individual who is unlicensed, or who has been excluded from participation in the Medicare and Medicaid programs.
- Retaining Medicaid funds that were improperly paid.
- Billing Medicaid recipients for covered services.

Mass General Brigham Health Plan, through its Special Investigations Unit, investigates all reports of fraud and/or abuse committed by members and providers. Credible allegations of fraud or abuse will be reported to our partners within the government. Mass General Brigham Health Plan may also take any number of actions to resolve fraud or abuse allegations, including medical record audits, instituting prepayment review of a provider's claims, stopping payment on a provider's claims, provider education, and/or demanding recovery for discovered overpayments. Moreover, depending on the severity of the fraud/abuse finding, Mass General Brigham Health Plan reserves the right to impose sanctions, including and up to terminating the provider from Mass General Brigham Health Plan's network. As stated above, Mass General Brigham Health Plan seeks recovery of all excess payments discovered as a result of its fraud and abuse operational efforts.

When an overpayment event is identified, Mass General Brigham Health Plan will begin its overpayment recovery process by sending written notification to the provider containing instructions for the process ("Notification of Audit"). In the event the provider does not agree with the identified overpayment amount, the provider should follow the process described in the "Provider Audit Appeals" section of the Provider Manual. If Mass General Brigham Health Plan does not hear from the provider in 30 days from either the initial written overpayment notification or the dispute determination notification, the final

overpayment amount will be offset from future claims payments. In cases where recovery through offsetting will take longer than six months, Mass General Brigham Health Plan reserves the right to seek additional legal recourse such as referral to a collection service.

Preservation of Records and Data

In accordance with the provider agreement, network providers and Mass General Brigham Health Plan shall each preserve all books, records, and data that are required to be maintained for a period of seven years or longer, as required by law from the date of final payment under the agreement for any specific contract year.

During the term of this agreement, access to these items shall be provided at the designated facility or Mass General Brigham Health Plan offices in Massachusetts at reasonable times. The facility and Mass General Brigham Health Plan shall retain such documents that are pertinent to adjudicatory proceedings, audits, or other actions, including appeals, commenced during seven years, or longer as required by law after any specific contract year, until such proceedings have reached final disposition or until resolution of all issues if such disposition or resolution occurs beyond the end of the seven-year period.

If any litigation, claim, negotiation, audit, or other action involving the records is initiated before the expiration of the applicable retention period, all records shall be retained until completion of the action, and resolution of all issues that arise from it, or until the end of the retention period, whichever is later.

Furthermore, any such records shall be maintained upon any allegation of fraud or abuse or upon request by Mass General Brigham Health Plan or any state or federal government agency, for potential use in a specific purpose or investigation or as otherwise required by law. These records shall be maintained for a period of time determined by the requesting entity and at least as long as until completion of the action and resolution of all issues that arise from it or until the end of the retention period, whichever is later.

"Hold Harmless" Provision

Providers contractually agree that in no event, including, but not limited to, non-payment by Mass General Brigham Health Plan, Mass General Brigham Health Plan's insolvency, or breach of the Provider Agreement, should a provider or any of its medical personnel bill, charge, collect a deposit from, or have any recourse against any Mass General Brigham Health Plan patient or person, other than Mass General Brigham Health Plan, acting on their behalf for services provided. The provider must not solicit or require from any member, or in any other way, payment of any additional fee as a condition for receiving care. Providers must look solely to Mass General Brigham Health Plan for payment with respect to covered services rendered to all Mass General Brigham Health Plan members.

This provision does not prohibit collection of supplemental charges or copayments on Mass General Brigham Health Plan's behalf made in accordance with the terms of the applicable Subscriber Group Agreement between Mass General Brigham Health Plan and the member.

Provider Marketing Activities

Any activities occurring at or originating from a provider site whereby Mass General Brigham Health Plan staff or designees, including physicians and office staff, personally present Mass General Brigham Plan marketing materials or other marketing materials to members that can reasonably be determined to influence the patient to enroll in Mass General Brigham Plan or to disenroll from Mass General Brigham Plan are prohibited. This includes direct mail campaigns sent by the provider site to its patients who are members. The exception is posting of written materials that have been pre-approved by EOHHS at provider sites and posting written promotional marketing materials at network provider sites throughout the Mass General Brigham Health Plan service area.

Code of Ethics

Concerns regarding Mass General Brigham Health Plan' adherence to our Code of Ethics should be reported to Mass General Brigham Health Plan's Compliance Office in writing or by email. These concerns can also be reported anonymously to the Mass General Brigham Health Plan Compliance Hotline 24 hours a day, seven days a week.

Appeals and Grievance Process

Appeals Process

The **One Care and or SCO provider appeals process** refers to the procedure healthcare providers follow to dispute a denial or payment decision, made on the members behalf, by Mass General Brigham Health Plan.

Appeals are accepted either orally or in writing within 65 calendar days after receipt of the notice of Adverse Action. Appeals filed later than 65 calendar days from the notice of Adverse Action may be rejected. Mass General Brigham Health Plan will send a written acknowledgement of the receipt of the Appeal within one business day. Providers, at the direction of the member, are permitted to file an Appeal on behalf of a member. When acting on behalf of a member, an Authorization of Representative (AOR) form or other applicable document may need to be provided for the appeal to be processed.

Mass General Brigham Health Plan follows all State and Federal guidelines regarding appropriate review of Appeals, including timeliness of decision making and decisioning staff and providers. Standard Appeals for pre-service and post-service requests will be resolved within 30 calendar days of receipt and of receipt. Expediting an Appeal may be appropriate if applying the standard timeframe for making a redetermination could seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function. If an expedited request is

received meeting the criteria, the Appeal will be processed within 72 hours. In some instances, Mass General Brigham Health Plan may need more than the stated timeframes to properly address the Member's concern. If more than 30 days are necessary, Mass General Brigham Health Plan will notify the submitter and explain why additional time is required.

Notification will be provided in writing of the decision. If the decision is not fully in favor of the request, Mass General Brigham Health Plan will automatically forward the appeal to Maximus Federal Services for an independent review decision if the services for Medicare and Medicaid overlap. For Appeals for services covered by MassHealth only, may be appealed to the MassHealth Board of Hearings after the initial plan level Appeal has been completed.

Grievance Process

A "Grievance" is expressed dissatisfaction or concern with any other type (except for an appeal) of problem with Mass General Brigham Health Plan or Network Provider. Appeal determinations are not considered grievances; it does not involve an initial determination. Mass General Brigham Health Plan will document and investigate all Grievances brought to our attention either by phone or mail. All findings and actions taken will be communicated to the submitter no later than 30 days after receipt, by either phone or mail.

A grievance may be filed regarding things such as:

- The quality of care
- Waiting times
- Behavior
- Access
- Facility Conditions

If there is a Grievance regarding attitude, access, or quality of service received, Mass General Brigham Health Plan encourages them to call the Mass General Brigham SCO and One Care Member Services at **888-816-6000**. Mass General Brigham Health Plan will try to resolve the grievance over the phone. If the grievance cannot be resolved over the phone, a formal procedure is used to review the grievance. The grievance may also be submitted in writing to the Member Service—Grievances Department, 399 Revolution Drive, Suite 850, Somerville, MA 02145. The grievance can be filed anytime and must include a description of the incident or events that led to the grievance. A Member may file their own Grievance or the Member may appoint a representative. Providers, at the direction of the member, are permitted to file a grievance on behalf of a member. When acting on behalf of a member, an Authorization of Representative (AOR) Forms and resources | Mass General Brigham Health Plan or other applicable document may need to be provided for the grievance to be processed.

Mass General Brigham Health Plan will acknowledge the Quality of Care and Quality of Service Grievance within 1 day of receipt. Mass General Brigham Health Plan will respond to the 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 submitter and explain why additional time is required.

An expedited grievance may be filed if there is disagreement 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.

Contact Information for Appeal or Grievance Submission

- Member Services Professional at **888-816-6000**
  Monday – Friday from 8 AM – 8 PM. From Oct. 1 – Mar. 31, call seven days a week, 8 am – 8 pm (TTY: 711).
- HealthPlanDSNPMAAppealsGrievances@mgb.org
- Mass General Brigham Health Plan
  Attn: Member Appeals
  399 Revolution Drive, Suite 850
  Somerville, MA 02145

Utilization Management

Overview

The Utilization Management (UM) program is designed to ensure the provision of the highest quality of health care to Mass General Brigham One Care and SCO members while at the same time promoting appropriate, efficient, and cost-effective resource utilization. As such, the UM program focuses on:

- Evaluating requests for services by determining the medical necessity, appropriateness, and effectiveness of the requested services
- Promoting continuity of patient care through the facilitation and coordination of patient services to ensure a smooth transition for members across the continuum of health care
- Analyzing utilization statistics to identify trends and opportunities for improvement
- Reviewing, revising, and developing medical coverage guidelines to ensure that utilization management criteria are objective and based on medical evidence and that Mass General Brigham D-SNP members have appropriate access to new and emerging efficacious technologies.

Prior authorization, concurrent review, and discharge planning are all elements of the utilization management program. As underutilization of medically appropriate services has the potential to adversely affect patients' health and wellness, Mass General Brigham Health Plan promotes appropriate utilization of services. Utilization management decisions are based on appropriateness of care and service and the existence of coverage.

The treating provider, in conjunction with the member or designee, is responsible for making all clinical decisions regarding the care and treatment of the member. Mass General Brigham Health Plan clinicians are responsible for making all utilization decisions in accordance with the patient's plan of covered benefits and established medical necessity criteria.

Requesting and Obtaining an Authorization

Prior authorization requirements for general services, Surgical Day Care (SDC), DME, HomeCare, and Home and Community Based Services are available on: Provider resources | Mass General Brigham Health Plan (https://massgeneralbrighamhealthplan.org/provider/resources)

How to submit an Authorization request

Authorization requests can be submitted through Mass General Brigham Health Plan online authorization tool, accessed through the provider portal, Mass General Brigham Health Plan Provider Portal Provider resources | Mass General Brigham Health Plan (https://massgeneralbrighamhealthplan.org/provider/resources). Clinical documentation to support authorization requests can also be submitted via the provider portal.
Authorization requests can also be faxed or mailed in. To expedite decision making, complete clinical information supporting medical necessity should be included with all authorization requests.

Authorization or referral requests to a non-Mass General Brigham Health Plan network provider cannot be submitted through the provider portal and requires fax submission: Fax 617-586-1700

Valid Prior Authorization Requests

A valid prior authorization request is defined as one where:

- The request is initiated by the primary care provider (PCP), treating specialist, or the treating provider.
- The patient is actively enrolled with Mass General Brigham Health Plan at the time of the service.
- The appropriate authorization template is completed for those service requests that require submission through the Mass General Brigham Health Plan Provider Portal.
- The appropriate authorization form is completed for service requests that are still faxed or mailed.
- A physician prescription is included with a request for enteral formulas, infusion therapy and DME.
- Clinical documentation to support medical necessity is included.

Confirmation of Requested Authorizations

Mass General Brigham Health Plan providers obtain confirmation of received authorization requests and UM decision-making from the Provider resources | Mass General Brigham Health Plan (https://massgeneralbrighamhealthplan.org/provider/resources), including the authorization identification number, authorization decision, number of days/visits, and the duration approved or denied. Authorization reports specific to a member, individual authorization, or an aggregate of all requests made by the servicing provider are available through the provider portal.

Only those requests made by the requesting servicing provider may be viewed by the requesting servicing provider. Existence of an authorization identification number does not ensure that a request has been approved. All requests are assigned an authorization identification number for tracking purposes independent of the approval status. It is imperative that providers validate the status of a specific authorization request.

The *Service Authorization Report* informs the provider that a request was either:

- Approved (A) based on medical necessity, benefit coverage and member eligibility,
- Closed (C) due to a change in level of care (i.e., an observation stay that escalates to an inpatient admission) or administrative error,
- Denied (D) based on medical necessity or administrative guidelines, or
- Pended (P) awaiting clinical review or more information.
- Medreview (M) awaiting clinical review or more information.

All authorization decisions resulting in an adverse determination are also communicated to the requesting provider by phone and in writing. If the adverse determination is for HCBS or FEW services, coordination with the ICT care management team will take place prior to provider notification.

Utilization Management Methods

Prior Authorization (Prospective Review)

Prior authorization allows for the efficient use of covered health care services and helps to ensure that members receive the most appropriate level of care in the most appropriate setting.

Mass General Brigham Health Plan identifies certain services as requiring prior medical necessity review and approval subsequent to meeting established criteria. Prior authorization processes support care management involvement by connecting the Utilization Management Care Manager with the provider and member prior to the delivery of services. Certain requested services, procedures, or admissions require prior authorization. Prior authorizations are based on medical necessity and are not a guarantee of payment. Requests for services requiring prior authorization must be submitted prior to delivery of service. Failure to obtain required prior authorization can result in a denial of payment to the provider.

Prior authorization is not required for:

- Emergency room care
- Observation

Requests for prior authorization services are forwarded to a Utilization Management Care Manager for review. The Utilization Management Care Manager will determine whether the requested service meets established review criteria guidelines. The Utilization Management Care Manager will contact the servicing provider or PCP whenever there is a question regarding the requested type of service or setting. Additional clinical information may be required in order to make a medical necessity decision.

Prior authorization approvals are made by Mass General Brigham Health Plan Utilization Management Care Managers based on medical necessity criteria. Prior authorization denials (adverse determination) for medical necessity are made only by the Deputy Chief Medical Officer, a Mass General Brigham Health Plan Medical Director, or a designated physician reviewer, based upon medical necessity criteria, the specific needs of the individual member and the availability of local resources.

Prior Authorization Requests Submitted Directly to a Delegated Entity

eviCore Healthcare

The following elective outpatient services require prior authorization through eviCore Healthcare Selected Molecular & Genetic Testing.

When these services are rendered as part of a hospital emergency room, observation stay, surgical care or inpatient stay, they are not subject to prior authorization requirements. Submit requests directly to eviCore by:

- Accessing online services at **Homepage | EviCore by Evernorth**. After a quick and easy one-time registration, you can initiate a request, check status, review guidelines, and more.
- Calling eviCore toll-free, 8 AM to 9 PM ET at: 888-693-3211.

Once approved, an authorization number is faxed to the ordering/referring practitioner and the rendering/performing provider. eviCore approves by the specific facility performing the study and by the specific CPT code(s). It is the responsibility of the rendering/performing facility to confirm that they are the approved facility for rendering the service and the specific study authorized by CPT code. Any change in the authorized study or provider requires a new authorization. Failure to obtain authorization or submit supporting documentation to establish medical necessity could result in a denial of services to the provider.

Sleep Studies and Therapy Management

CareCentrix

Mass General Brigham Health Plan partners with CareCentrix, Inc. (CCX) to provide sleep study and therapy management services. Testing may be approved in the patient's home, using a Home Sleep Test (HST) or in an in-network sleep lab.

Submit requests directly to CareCentrix by:

- Visiting the CareCentrix website www.carecentrixportal.com and accessing the secure Sleep Portal to submit the request.

- Phoning CareCentrix, Monday through Friday, 8AM to 5:00 PM, EST, at: (886)-827-5861.

Criteria for medical necessity decision making is available on the Mass General Brigham Health Plan Provider Portal: Provider resources | Mass General Brigham Health Plan

Concurrent Review

Concurrent review is required for subsequent days of care or visits or services beyond the initial authorization. Concurrent review can be conducted via the Mass General Brigham Health Plan Provider Portal: Provider resources | Mass General Brigham Health Plan where indicated. For services that cannot be conducted via the Provider Portal, you may fax or mail.

Follow the provider portal User Guide for concurrent review authorizations. All concurrent requests must be supported by clinical documentation to determine medical necessity. Failure to obtain authorization or submit supporting documentation to establish medical necessity could result in a denial of services to the provider.

Concurrent review includes utilization management, discharge planning, and quality of care activities that take place during an inpatient stay, an ongoing outpatient course of treatment or ongoing home care course of treatment (for example, acute hospital, skilled nursing facilities, skilled home care, continuous DME supplies/equipment, and/or Personal Care Services).

The concurrent review process also includes:

- Collecting relevant clinical information by chart review, assignment of certified days and estimated length of stay, application of professionally developed medical necessity criteria, assignment of level of care, and benefit review. These criteria are not absolute and are used in conjunction with an assessment of the needs of the member and the availability of local health care resources.
- Obtaining a request from the appropriate facility staff, practitioners, or providers for authorization of services.
- Reviewing relevant clinical information to support the medical necessity.
- Determining benefit coverage for authorization of service

- Communication with the health care team involved in the member's care, the member and/or their representative and the provider
- Notifying facility staff, practitioners, and providers of coverage determinations in the appropriate manner and time frame
- Identifying discharge planning needs and facilitating timely discharge planning.
- Identifying and referring potential quality of care concerns, Never Events/Serious Reportable Events and Hospital Acquired Conditions for additional review
- Identifying members for referral to Mass General Brigham Health Plan's Care Management specialty programs.

All existing services will be continued without liability to the member until the member has been notified of an adverse determination. However, denial of payment to the facility and/or attending physician may be made when days of care or visits do not support medically necessary care.

UM Time Frame for Decision- Making and Notification

Authorizations are made as expeditiously as possible, but no later than within the designated time frames below.

SCO and One Care members will receive written notification of prior authorization and concurrent authorization approvals.

Type	Processing Timeframe	Timeframe With Extension
Request for Item or Service: Standard (non-urgent)	7 calendar days	21 days
Part B Drug: Standard (non-urgent)	72 hours	N/A
Request for Item or Service: Expedited/Urgent	72 hours	17 days
Part B Drug: Expedited/Urgent	24 hours	N/A

Clinical Criteria

As part of the utilization management (UM) process for D-SNP, a defined clinical review hierarchy is followed to ensure consistency, equity and alignment with regulatory requirements and evidence-based practices. The UM review hierarchy includes, but is not limited to, the following sources:

- CMS Coverage Guidelines: Medicare Coverage Guidance Documents | CMS
- MassHealth Clinical Guidelines: MassHealth Guidelines for Medical Necessity Determination | Mass.gov
- InterQual Clinical Criteria Guidelines, a nationally recognized evidence-based criteria: InterQual Criteria Guidelines®
- Mass General Brigham Health Plan Internal Clinical Guidelines: Mass General Brigham Health Plan Medical Policies

These guidelines are applied in accordance with the member's benefit plan, federal and state regulatory requirements, and contractual obligations. When criteria conflict, the most member favorable or state-mandated standard will apply, particularly for Medicaid and Dual-Eligible populations.

Clinical review decisions are made by appropriately licensed and qualified clinical staff, and determinations are guided by current standards of care, peer-reviewed literature and clinical best practices. Where appropriate, input from treating providers and specialists is considered to support holistic and person-centered decision-making.

Coverage Decisions

A coverage decision is the determination made by the Plan regarding whether a requested service, supply, or prescription drug is covered, and the extent of payment for that item or service. Providers must follow Plan processes to ensure compliance and protect members from unexpected financial liability.

- Confirm coverage for all non-emergent services before rendering care.
- Submit a formal coverage decision request if coverage is uncertain.
- Out-of-network referrals require prior authorization or formal Plan approval.
- If no authorization is obtained and the service is not covered, the member may be financially responsible only if advance notice and consent are documented.
- Certain services are never covered under Medicare or MassHealth; members may be billed only with prior written consent acknowledging financial responsibility.
- Denials are issued in writing to both the provider and member; providers may assist members with the appeal process if appropriate.
- Providers are responsible for verifying coverage, obtaining required authorizations, and informing members of potential financial liability in advance.

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://www.leapfroggroup.org/data-users/leapfrog-hospital-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 Departments 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, 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 on the well-being and quality of life of our members.

Quality Improvement Measures and Activities

Mass General Brigham Health Plan is accountable for providing high-value, cross-continuum care, across a range of measures that improve member experience, quality, and outcomes. EOHHS will regularly evaluate measures and determine whether measures should be added, modified, or removed. EOHHS's SCO or One Care quality measures cover a host of domains including but not limited to prevention and primary care, chronic disease management, substance use disorder, medication adherence and more. There is a particular focus on

measures that span across the healthcare continuum to ensure proper coordination of care. Such measures include those related to hospital readmissions and follow-up care following inpatient discharges.

In addition, the Mass General Brigham Health Plan Quality & Accreditation team proactively tracks and trends clinical performance for the purposes of implementing multi-year performance improvement projects. These projects are developed in close collaboration with EOHHS and are intended to improve the overall health of the population. Additionally, the health plan actively evaluates clinical performance across key disparity groups to ensure the equitable delivery of care.

Hospital Quality Report

Mass General Brigham Health Plan offers several tools to help members make educated decisions about their care. In addition to incorporating member reviews directly into the online provider directory of participating providers, Mass General Brigham hospitals are also rated by Healthgrades. 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. These reports are publicly 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 Deputy Chief Medical Officer, and the Director of Quality & Accreditation. 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 MassHealth 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 OptumBH and participating network providers.

Care Management

Collaboration between the PCP and Mass General Brigham Health Plan's care team is crucial to successful management of members. Our care teams assist the PCP in accessing the ICP and implementing by scheduling appointments or arranging for long term services and supports. The centralized enrollee record (CER) is a single, centralized electronic record used to facilitate communication among the ICT. Our care teams document in the CER and providers are able to review and communicate with the care team either directly through the CER or the provider portal. This exchange of clinical information helps ensure a member's ICP is accurate and addresses their needs. More detailed information on the care management model is offered through the annual Model of Care training.

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 the well-being and quality of life of our members.

The care management programs strive to:

- Support the relationship between members and their practitioners with a plan of care.
- Emphasize prevention of exacerbations and complications using evidence-based guidelines.
- Promote member 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 multidisciplinary, 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. Mass General Brigham Health Plan covers medically necessary FDA approved DME for members that meet General Eligibility Coverage Criteria and any applicable DME-

specific criteria outlined in specific Mass General Brigham Health Plan medical policies or other plan documents found on https://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 ensure efficient and timely filling of requests.

Benefit Vendors

Dental Provider

DentaQuest is the dental provider for Mass General Brigham Health Plan SCO and One Care plans. Mass General Brigham Health Plan SCO and One Care plans include coverage for preventive and comprehensive dental services through a DentaQuest contracted provider. See the Summary of Benefits and Evidence of Coverage /Member Handbook for coverage details by visiting: https://mgbadvantage.org/SCO (for SCO) and https://mgbadvantage.org/onecare (for One Care).

Transportation Provider

Coordinated Transportation Solutions, Inc. (CTS) will be the provider for non-emergency medical transportation and non medical transportation for Mass General Brigham One Care and Mass General Brigham SCO.

Vision Provider

EyeMed is the vision provider for Mass General Brigham SCO and One Care plans. Mass General Brigham SCO includes 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.

Over-the-Counter Medication Provider (SCO Only)

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

Home Delivered Meals (SCO Only)

Community Servings will administer Mass General Brigham SCO 's meals program. Upon determination of member need, 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 home delivered 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 members' 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:

https://www.medicareplanrx.com/jccf/MassGeneralBrighamHealthPlan_pharmacy_25.html

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

Part B Medical Drug Prior Authorization Requirements

Prime Therapeutics uses Local Coverage Determinations (LCDs), National Coverage Determinations (NCDs), and Medicare interpretive manuals (e.g., the Medicare Benefit Policy Manual) to make coverage determinations for Mass General Brigham Health Plan SCO and One Care members.

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

Fax: 833-895-2611
Phone: 888-656-6671

Members will be notified of organization determinations as required. The medications that are covered under the Part B medical benefit that require prior authorization through Prime Therapeutics are posted on the website.

Prior Authorization Requirements

Certain prescription drugs on the Mass General Brigham Health Plan Drug Formulary have additional requirements or limits on coverage. These requirements and limits ensure that members can use these drugs in the most effective way and help to control drug costs. Mass General Brigham Health Plan uses prior authorization (PA) criteria and requirements, quantity limits (QL), and step therapy (ST) to ensure members receive safe, cost-effective, and efficacious medicines.

For SCO and One Care members, if the benefit is not a Medicare benefit or a Medicare-approved supplemental benefit, MassHealth Guidelines for Medical Necessity Determinations will be followed when applicable.

Requests for Part D drugs that require prior authorization should be submitted directly to Mass General Brigham Health Plan's Pharmacy Benefit Manager (PBM), Optum Rx. Providers may use the Request for Medicare Prescription Drug Coverage Determination form to submit these requests.

Requests for Part D drug authorizations may be submitted to Optum Rx via the following methods:

Fax: 844-403-1028
Mail: Optum Prior Authorization Department
P.O. Box 2975
Mission, KS 66201

Pharmacy Covered Services

Medicare Part B Prescription Drug Coverage

Medications Covered under Medicare Part B include:

- Monoclonal antibodies for the treatment of early Alzheimer's Disease
- Drugs used with some types of durable medical equipment (DME): If the drug used is medically necessary, Medicare covers drugs infused through DME (like an infusion pump or nebulizer).
- Some antigen allergy tests and treatments: Medicare covers antigen tests to check for allergies and their treatment if a doctor or other health care provider prepares them, and they're given by a properly instructed person (who could be the Member) under appropriate supervision.
- HIV prevention drugs.
- Injectable osteoporosis drugs.
- Erythropoiesis-stimulating agents: Medicare covers erythropoietin by injection if a Member has End-Stage Renal Disease (ESRD) or needs this drug to treat anemia related to certain other conditions.

- Blood clotting factors: If a Member has hemophilia (a genetic bleeding disorder that keeps blood from clotting properly), Medicare covers injectable clotting factors Members give themselves or get in a doctor's office.
- Injectable and infused drugs: Medicare covers most injectable and infused drugs when a licensed medical provider gives them.
- Oral End-Stage Renal Disease (ESRD) drugs: Medicare covers all oral ESRD drugs.

Formulary Overview

Mass General Brigham Health Plan provides coverage for drugs and items covered by Original Medicare for Medicare Part D members, while additional coverage for drugs and items covered by MassHealth is provided to Mass General Brigham Health Plan SCO and One Care members.

The Part D pharmacy benefit does not cover all medications. Some medications require prior authorization or have limitations (e.g. quantity limits).

Mass General Brigham Health Plan's SCO and One Care Drug Formularies have one tier. The formularies are organized into categories by medical condition and divided by therapeutic drug class. Depending on formulary coverage, products may be listed either by the generic or the brand name. Only the specific strengths and formulations (e.g. tablet, capsule, solution, etc.) of the drug listed in the Drug Formulary are covered. If a specific strength or formulation is not listed in the Drug Formulary, the specific drug in that strength and formulation is not covered.

Mass General Brigham Health Plan's pharmacy and therapeutics committee (P&T) reviews all medications selected for inclusion in the Mass General Brigham Health Plan Formulary. The P&T committee meets regularly to ensure that the formulary remains current, and that it provides members with optimal access to effective and cost-effective pharmacotherapies.

Formulary documents, including a comprehensive list of medications included on the Mass General Brigham Health Plan SCO and One Care Formulary, can be found on Mass General Brigham Health Plan's website at https://mgbadvantage.org/SCO (for SCO) and https://mgbadvantage.org/onecare (for One Care).

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 100-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 100 days, with refills for up to one year, and can

be filled through the Optum Rx Mail Order Pharmacy. 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.

Medicare Part D Transition

Mass General Brigham Health Plan may offer a temporary 30-day supply of Part D prescription drugs that were either not on the previous year's formulary or that may have been restricted in some way. Members may receive this "transition fill" during the first 90 calendar days of new membership or the first 90 calendar days of the calendar year for existing members. If the member receives a transition fill, Mass General Brigham Health Plan will send a letter to the practitioner and the member detailing the nature of the temporary supply.

For SCO and One Care members, the pharmacy may provide a 72-hour **emergency supply** to the member at usual cost-sharing.

Medication Therapy Management (MTM) Program

Mass General Brigham Health Plan SCO and One Care members may be eligible for the Medication Therapy Management (MTM) Program. Eligible members are automatically enrolled in the program and are offered a one-to-one telephone consultation with a clinical pharmacist. Information gathered during this process, along with pharmacy claims, is used to develop clinical recommendations where appropriate. More information may be found at https://mgbadvantage.org/SCO (for SCO) and https://mgbadvantage.org/onecare (for One Care).

Pharmacist recommendations are faxed to the provider for consideration. Members will receive an individualized written summary of the consultation and comprehensive medication review (CMR) by mail. CMRs are offered at least once a year.

In addition, targeted medication reviews (TMRs) are done to assess medication use, monitor unresolved issues, and identify new drug therapy problems. These TMRs are performed on a quarterly basis with any recommendations sent to the provider via fax.

The MTM Program is free to members. Participation in the program is voluntary, and a member can disenroll at any time. If your patients are eligible for the MTM program, they will receive a welcome letter and a phone call from our MTM vendor, OptumRx. Please recommend that your patients participate in this valuable, free opportunity.

Who is eligible for the MTM Program?
Members who are enrolled in a Medicare Part D plan AND meet the characteristics of at least one of the following groups:

1. Group 1: Taking at least eight Part D maintenance drugs, AND have three or more chronic conditions,* AND are spending an annual amount as determined by CMS on Part D prescriptions.
2. Group 2: Are at-risk beneficiaries (ARBs) - that is, members with an active coverage limitation under a Drug Management Program (DMP)

** Qualifying chronic conditions include: Alzheimer's disease, Bone disease-arthritis (including osteoporosis, osteoarthritis, and rheumatoid arthritis), Chronic congestive heart failure (CHF), Diabetes, Dyslipidemia, End-stage renal disease (ESRD), Human immunodeficiency virus/acquired immunodeficiency syndrome (HIV/AIDS), Hypertension, Mental health (including depression, schizophrenia, bipolar disorder, and other chronic/disabling mental health conditions), Respiratory disease (including asthma, chronic obstructive pulmonary disease (COPD), and other chronic lung disorders).*

What does the member receive as an MTM Program participant?
Enrolled members will receive at least one comprehensive, interactive phone consultation with a clinical team member and one or more quarterly medication reviews. The purpose of the phone consultation is to gather information to conduct a comprehensive medication review. The medication review is not intended to interfere with the care already provided by doctors.

The medication review may include:

1. Checking for drug-to-drug interactions, including interactions with over-the-counter medications
2. Offering solutions that may reduce any side effects from medications
3. Identifying less expensive medication alternatives
4. Presenting ways to simplify medication regimens
5. Monitoring medications and medical conditions (such as high blood pressure, high cholesterol or diabetes) to be sure members are getting the most out of their medications.

We'll give members and their providers a written summary of the review, a list of their medications, and a list of any recommendations made by the pharmacists. We encourage the member to complete the MTM review prior to their yearly check-up. They can use the summary to discuss their drug therapy with their provider.

Part D Vaccines when Administered in a Providers Office
If a member receives a Part D vaccine in a provider's office, rather than at the pharmacy, you may now access the **TransactRx** application to submit Part D Vaccine claims electronically to the PBM.
After completing a one-time, online enrollment process, on the TransactRx portal you can:

- Verify a member's eligibility and benefits in real-time
- Advise members of their appropriate out-of-pocket cost share
- Submit Part D vaccine claims electronically
- Receive reimbursement information in real-time

To Get Started
To learn more, and enroll, please visit TransactRx at https://www.transactrx.com/enrollment

Confidentiality and 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
https://resources.massgeneralbrighamhealthplan.org/members/privacy-practices.pdf