

Section 3

Provider Management

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Section 3

Provider Management

Joining the My Care Family Network

Providers can join the My Care Family network by submitting the request in writing to AllWays Health Partners Provider Network Operations.

Participation in the My Care Family provider network requires the execution of a provider agreement. This agreement contains the provisions that govern the relationship between AllWays Health Partners and the provider.

A clinician or group will be considered a participating provider only upon successful execution of a provider agreement. The provider must notify AllWays Health Partners of any changes to the information submitted in the initial application request to contract. Material omissions and/or misstatements in the application request to contract will deem the contract voidable.

The contract will be effective as of a date determined by AllWays Health Partners, and the provider will be notified accordingly. AllWays Health Partners will not reimburse for any services provided prior to the effective date of the contract.

When applicable, credentialing requirements must be met before becoming a contracted provider.

Some changes in a provider's practice may require reconsideration by AllWays Health Partners, up to and including re-application for continued participation as a network provider. These changes include but are not limited to:

- Change in practice location to a different state
- Change in practice specialty
- Change in ownership

- Entering into or exiting from a group practice
- Changes in hospital privileges
- Change in insurance coverage
- Disciplinary and/or corrective action by a licensing or federal agency
- Material changes in the information submitted at the time of contracting.

When in doubt, please send an email* to pec@allwayshealth.org.

*Please do not send Protected Health Information (PHI) through unsecured email.

Board Certification Requirement

Board certification for PCPs and specialty physicians is required to ensure that the percentage of board-certified PCPs and specialty physicians participating in the My Care Family network, at a minimum, is approximately equivalent to the community average for PCPs and specialty physicians. Participating physicians are required to be either board-certified or board-eligible and to be actively pursuing board certification in order to participate in the network.

During the initial credentialing process and then every two years, AllWays Health Partners will validate a participating physician's board certification status. If the participating physician is not board-certified, he/she must provide written documentation that they are board-eligible and are actively pursuing board certification within the required time period as defined by the American Board of Medical Specialties (ABMS) or American Osteopathic Association (AOA). Any provider that is not board-certified and not appropriately board-eligible must receive approval to be added to the My Care Family network.

Primary Care Provider Group (PCPG)

A primary care provider group (PCPG) is an entity whose practice is in general/internal medicine, pediatrics, family practice, or OB/GYN and is

contracted with AllWays Health Partners to provide and coordinate comprehensive health care services to all assigned members. A PCPG may be a health center, hospital ambulatory care clinic, or other physician practice and can consist of one or more clinicians and/or locations.

Role of the Primary Care Provider

The primary care provider (PCP) provides or manages first-contact, continuous, and comprehensive health care services for a defined group of assigned patients at his/her primary care site. The PCP is responsible for providing, arranging for, and coordinating the provision of covered services to his or her patients. For optimal coordination of care, My Care Family PCPs should only refer to specialists within the My Care Family network whenever possible.

A PCP can be an individual physician, a registered nurse practitioner, or a physician assistant eligible to practice one of the following specialties:

- Family practice
- Internal medicine
- OB/GYN
- Pediatrics

Role of the Specialty Provider

A specialty provider is responsible for the provision of covered specialty care services working in collaboration with the member's PCP.

Specialty providers should communicate their findings in a timely manner to the PCP and when applicable, other referring providers. A consultation is not considered complete until the specialist's provision of a written report to be incorporated by the PCP's office into the patient's medical record.

Credentialing

AllWays Health Partners has a full credentialing delegation agreement with Harvard Pilgrim Healthcare.

Credentialing is a process used to ensure that providers who intend to participate and practice in an AllWays Health Partners network meet a level of quality compared to established standards. AllWays Health Partners uses the National Committee on Quality Assurance (NCQA) guidelines in the credentialing process. AllWays Health Partners continuously strives to expand the capacity of its provider networks through the credentialing process in order to have multilingual practitioners available to members who are responsive to linguistic, cultural, ethnic, and other unique needs of minority groups or special populations and who do not unlawfully discriminate based upon state or federal laws and regulations. The credentialing application collects information on a practitioner's languages spoken.

AllWays Health Partners expects that all credentialed practitioners obtain the required Continuing Education Units in their practice areas as recommended by their applicable licensing board. Unless based on access requirements where exceptions are granted, all credentialed physicians must be board-certified in their medical specialty or be in the process of achieving initial certification in a time frame relevant to guidelines established by their respective medical specialty board. In some cases, AllWays Health Partners retains the right to contract and enroll providers who are not board certified if there is a shortage of providers in that specialty. Upon receipt of a physician's new certification status, the physician is required to notify AllWays Health Partners of his or her new certification status. AllWays Health Partners monitors all non-board certified physicians' board certification at least every two years or at the time of the physician's re-credentialing cycle.

At a minimum, all medical doctors (MDs), doctors of osteopathy (DOs), doctors of optometry (ODs),

doctors of chiropractic medicine (DCs), doctors of podiatric medicine (DPMs) and any independently licensed and practicing practitioner must be credentialed by AllWays Health Partners. Doctors of dental medicine (DMDs) and doctors of dental surgery (DDSs) must be credentialed in order to be participants in My Care Family's network. Allied professionals such as physical therapists (PTs), occupational therapists (OTs), and speech and language therapists (SLTs) are also subject to credentialing requirements at a group level. Nurse practitioners (NPs) and physician assistants (PAs) (acting in the role of a PCP), and certified nurse midwives (CNMs) are also eligible for credentialing and billing under their corresponding National Provider Identifier (NPI) number.

A nurse practitioner or a physician assistant, practicing within the scope of his or her license, including all regulations requiring collaboration with a physician, may choose to enroll as a PCP subject to member assignments.

Re-credentialing occurs in a two-year cycle consistent with the practitioner's birth month and year.

Hospital-based physicians with specialties in pathology, emergency room, anesthesiology and radiology (also known as HERAP providers) practicing exclusively in a facility setting or facility-based emergency room are not credentialed by AllWays Health Partners. That list would also include NPs (specialists), covering providers, locum tenens, urgent care providers, and critical care medicine specialists. However, they are reviewed and privileged through their respective licensed institutions, which includes review of their credentials.

Behavioral health practitioners are credentialed by AllWays Health Partners' behavioral health benefits manager, Optum.

The Credentialing Committee

The Credentialing Committee, a subcommittee of the Patient Care Assessment Committee, is AllWays Health Partners' peer review body with responsibility for oversight of the credentialing and re-credentialing functions. The committee also meets quarterly or on an as-needed basis to review other applications and includes consultants actively practicing in some of the same specialties as those practitioners credentialed by AllWays Health Partners.

AllWays Health Partners' Chief Medical Officer is responsible for oversight of the credentialing program. Portions of the credentialing process may be delegated. However, AllWays Health Partners retains the right to approve new clinicians and to terminate or suspend existing clinicians.

At each meeting the Credentialing Committee makes one of the following credentialing decisions about inclusion in or exclusion from AllWays Health Partners' provider networks:

- Approve
- Conditionally approve (with a corrective action plan and follow-up)
- Table for more information and further review
- Decline/deny

Practitioner Rights

AllWays Health Partners 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, type of procedure, or patient served. AllWays Health Partners' credentialing policies do not discriminate against particular clinicians who service "high-risk" populations or who specialize in conditions or procedures requiring costly treatment.

Practitioner rights in the credentialing and re-credentialing 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 AllWays Health Partners Provider Service at 855-444-4647.

Sanctioned Providers

To ensure a quality network and the safety of enrolled members, AllWays Health Partners reserves the right to alter a contractual relationship when a practitioner fails to meet AllWays Health Partners' quality standards.

AllWays Health Partners monitors the following activities on an ongoing basis as a part of the re-credentialing and re-licensure process:

- Sanctioned providers
- Adverse events
- Complaints

Decisions about altering a practitioner's relationship with AllWays Health Partners are guided by patient care considerations and based on information submitted by the practitioner as well as other objective evidence.

An appeal process is available for practitioners who are not offered network participation after initial credentialing or re-credentialing. Notification of their right to appeal a credentialing decision and a description of the appeal process is included in AllWays Health Partners' letter to the practitioner at the time they are notified of the adverse credentialing or re-credentialing decision. Practitioners have the right to review information submitted to support their credentialing and re-credentialing application (excluding NPDB information) at any time. The practitioner may request to review his or her credentialing or re-credentialing file in writing, verbally or electronically, and a member

of AllWays Health Partners' Credentialing staff will contact him or her to schedule a mutually agreed upon time to review the file. If desired by the practitioner, copies of the file can be forwarded to the practitioner by certified, returned receipt mail.

Practitioners have the right to correct erroneous information submitted to AllWays Health Partners in support of their credentialing or re-credentialing application.

AllWays Health Partners reports all terminations of network practitioners for quality of care reasons to the appropriate authorities, including the NPDB and the state licensing board. Reporting of practitioners terminated for quality reasons occurs within 15 calendar days of the practitioner's final appeal outcome in accordance with the regulations governing the NPDB and the procedures set forth below. The provider can appeal any negative credentialing decision.

If there is a negative report, disciplinary action, sanction, or other evidence of serious quality deficiencies regarding a practitioner, an objective assessment of the practitioner's practice is undertaken by the AllWays Health Partners Credentialing Committee to determine whether the practitioner's status or contract should be reduced, suspended, or terminated. Events leading to a change in the practitioner's participation status with AllWays Health Partners include but are not limited to:

- Sanctions rendered by a state or federal agency
- Refusal to comply with AllWays Health Partners, local, state, or federal requirements or regulations on clinical or administrative practices
- A pattern of practice that falls below applicable standards and expectations
- Failure to maintain full and unrestricted licensure in the Commonwealth of Massachusetts
- Failure to comply with accepted ethical and professional standards of behavior

When any of the following situations comes to the attention of AllWays Health Partners staff, the information regarding the practitioner, as well as all available historical credentialing and performance information, is presented for review by the chairperson of the Credentialing Committee, or his or her designee:

- The practitioner's application for staff privileges or membership with any group/facility is denied or rejected for disciplinary cause or reason
- The practitioner's staff privileges, membership, or employment with any group/facility is terminated or revoked for disciplinary cause or reason
- The practitioner voluntarily accepts, or restrictions are imposed on, staff privileges, membership, or employment with any group/facility for disciplinary cause or reason
- Malpractice complaints
- Any sanction imposed by the Massachusetts Board of Registration in Medicine
- A pattern of practice that falls below applicable standards and expectations
- Failure to maintain full and unrestricted licensure in the Commonwealth of Massachusetts
- Failure to comply with accepted ethical and professional standards of behavior
- Refusal to comply with AllWays Health Partners, local, state, or federal requirements or regulations on clinical or administrative practices

The chairperson, or his or her designee, will make an immediate and temporary decision on whether to suspend or reduce the practitioner's participation status with AllWays Health Partners. A decision to immediately suspend or curtail a practitioner's participation status is made when the event indicates that a practitioner may be a threat to the health and/or safety of his or her patients and/or is in a situation where the practitioner cannot serve the health needs of his or her patients appropriately.

Where a determination that the seriousness of the deficiency warrants an immediate alteration of a practitioner's participation status, the practitioner is notified in writing that a professional review action has been brought against him or her, including the reasons for the action and a summary of the consideration process and appeal rights.

The practitioner is invited to attend a meeting within 30 calendar days to have his or her case heard and provided with the corresponding date, time, location and other relevant information.

The practitioner may present appropriate materials supporting his/her case. After full consideration of the facts, the committee will decide as follows:

- Continued full participation
- Continued participation with supervision
- Continued participation with mandatory education, counseling, and/or training
- Continued participation with limits
- Reduction or restriction of participation privileges
- Suspension from the network for a given period or until conditions for full participation are met
- Termination from an AllWays Health Partners provider network

The practitioner is notified by registered mail within 10 business days of the Credentialing Committee's determination. When applicable and depending on the decision, the notification may include the following information:

- That a professional review action has been brought against the practitioner, reasons for the action, and a summary of the appeal rights and process
- That the practitioner can request an appeal hearing no later than 30 calendar days from the date of the letter
- That the practitioner may be represented by an attorney or another person of his or her choice during the appeal proceedings

- That if an appeal is requested by the practitioner, AllWays Health Partners will appoint a panel of individuals to review the appeal and notify the practitioner in writing of the appeal decision and reasons.

AllWays Health Partners Provider Service and other relevant staff are notified of any change in the practitioner's relationship with AllWays Health Partners, along with notification to the Executive Office of Health and Human Services (EOHHS), applicable state licensing boards, the NPDB, and other applicable entities of any reportable incidents. Updates to AllWays Health Partners' online Provider Directory are made immediately.

If the practitioner is a PCP, the practitioner's member panel will be closed and arrangements will be made for the transfer of the membership to another credentialed primary care network provider.

Appeals Process

If a practitioner chooses to appeal a network participation decision made by AllWays Health Partners, the request must be made in writing within 30 calendar days from AllWays Health Partners' notification. The notification should include whether the practitioner will bring an attorney or another person of his or her choice.

Pending the completion of the appeal process, and unless specified otherwise, the initial decision of the Credentialing Committee remains in full force and effect.

Upon timely receipt of the request, a meeting is scheduled with AllWays Health Partners' Appeals Panel to review the appeal. The Appeals Panel consists of: AllWays Health Partners' Vice President of Provider Network Management, the Chair of the Credentialing Committee (AllWays Health Partners' Chief Medical Officer), and the Vice President of Quality and Compliance. Each panel member can appoint a designee of his or her choice and AllWays Health Partners' legal

counsel will be present when deemed appropriate.

The practitioner is notified of the Appeals Panel decision in writing, including the specific reasons for the decision.

Reporting to Appropriate Authorities

After a final determination has been made resulting in a practitioner's termination, a letter is issued to the practitioner advising him or her of AllWays Health Partners' determination, including its responsibility to report such termination to the NPDB, EOHHS, and appropriate state board licensing entities. The practitioner may dispute the language of the NPDB or state reports. A dispute can be based upon any one of the following reasons:

- The factual accuracy of the report
- Whether the report was submitted in accordance with the NPDB or other state guidelines
- AllWays Health Partners' eligibility as an NPDB reporting entity

Upon receipt, AllWays Health Partners will review the applicable reason(s) and make a determination as to whether any changes should be made. When applicable, necessary changes are processed.

Subsequent notification to the practitioner, the NPDB, applicable state board licensing entities, and EOHHS is made indicating one of the following actions:

- Void of the initial report
- No action
- Correction to the language reported

When no appeal is initiated by the practitioner within 30 calendar days following notice of the AllWays Health Partners decision, or when an appeal is upheld, the practitioner's name remains removed from AllWays Health Partners' Provider Directory. When applicable, arrangements are made by AllWays Health

Partners staff to have affected members assigned to another contracted provider.

Credentialing Requirements

To participate in the My Care Family provider network and, where applicable, be listed in AllWays Health Partners' provider directory, practitioners must be credentialed by AllWays Health Partners. Providers listed in the Provider Directory are those who a member can choose when accessing care.

AllWays Health Partners does not recognize interim/provisional credentialing or providers still in training. Providers must be fully credentialed before they can be compensated for care rendered to AllWays Health Partners members.

Practitioners seeking enrollment with AllWays Health Partners, and who work for an AllWays Health Partners-contracted group, must first submit a request through AllWays Health Partners' Provider Enrollment Portal.

Alternatively, the group can also submit a completed [HCAS Enrollment Form](#) to AllWays Health Partners with preliminary information about the practitioner and his or her practice.

The form may be sent to:

Address: AllWays Health Partners
Credentialing Department
399 Revolution Drive, Suite 810
Somerville, MA 02145
Fax: 617-526-1982
Email: pec@allwayshealth.org

Shortly after receipt and processing of the enrollment request, the practitioner or his or her credentialing administrator will receive a welcome packet with instructions for completing the initial credentialing submission process by registering with Council for Affordable Quality Healthcare (CAQH) that contains a replica of the Integrated Massachusetts Application (IMA). Those practitioners submitting an enrollment request who already registered with CAQH (and have authorized release of their CAQH

information to AllWays Health Partners) will not receive a welcome packet, but they may receive an email requesting that they re-attest to their data. If the attestation is current, AllWays Health Partners will then initiate the credentialing process.

AllWays Health Partners' credentialing process involves accumulating and verifying many elements of a practitioner's professional history including licensure, training, hospital privileges, and malpractice history. At a minimum, AllWays Health Partners is required to:

- Check each applicant with the NPDB
- Verify licensure to practice, including with the Drug Enforcement Administration (as applicable), and carry malpractice insurance coverage of \$1,000,000 per occurrence and \$3,000,000 aggregate
- Determine if an applicant has any pending Medicare or Medicaid sanctions
- Where applicable, verify that an applicant has clinical privileges in good standing at a licensed facility designated by the applicant as the primary admitting facility. If an applicant does not have admitting privileges, the applicant must have a coverage relationship with an AllWays Health Partners credentialed provider.

AllWays Health Partners has a process in place to provide ongoing performance monitoring of practitioners between credentialing and re-credentialing cycles. In addition to monitoring practitioner performance through member complaints and grievances, at least twice a month AllWays Health Partners' 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. Complaints received by AllWays Health Partners and sentinel events regarding practitioners are also compiled periodically for review.

If a credentialed, contracted practitioner has been disciplined, excluded, or is shown to have other performance issues after his or her initial credentialing, AllWays Health Partners will immediately take appropriate actions to address the issue, in accordance with its policies and procedures. Possible actions taken may range from establishing corrective action plans with close monitoring for compliance until the issues are resolved to reconsideration of the credentialing decision, up to and including termination from the network. AllWays Health Partners also has a process in place to notify applicable state licensing boards and the NPDB of any reportable incidents.

The Credentialing Process

AllWays Health Partners is a member of [HealthCare Administrative Solutions, Inc.](#) (HCAS). This non-profit entity was founded in 2007 with collaboration from several Massachusetts health plans to streamline the credentialing and re-credentialing processes.

Submission of those elements of the credentialing and re-credentialing transactions that are common to participating HCAS health plans can occur through a centralized database. The CAQH allows providers to submit credentialing information into its Universal Credentialing DataSource to be used by all HCAS health plans in which the practitioner participates or is in the process of contracting.

As part of the full delegation agreement with Harvard Pilgrim Health Care, AllWays Health Partners is committed to the turn-around of completed credentialing applications submitted by MDs, DOs, and other PCPs within 30 days of receipt of a completed application. Upon completion of the credentialing process, providers are notified within four business days of the Credentialing Committee decision and are included in the AllWays Health Partners Provider Directory. Providers who do not meet the credentialing standards are given an opportunity to appeal the decision.

The Re-credentialing Process

Re-credentialing occurs in a two-year cycle consistent with the practitioner's birth month and year.

A practitioner who has been successfully credentialed by AllWays Health Partners, and either leaves the practitioner network voluntarily or has been terminated by AllWays Health Partners for any reason with a break in service greater than 30 calendar days, must go through AllWays Health Partners' initial credentialing process again prior to reinstatement in the network.

Locum Tenens

AllWays Health Partners defines locum tenens as a physician covering for another physician temporarily for six months or less and not subject to full credentialing. Providers must specifically indicate that the physician is being enrolled in a locum tenens capacity. Enrollment for these clinicians require completion of request in the AllWays Health Partners' Provider Enrollment Portal or an [HCAS Enrollment Form](#), malpractice information, as well as hospital privileges or covering arrangements otherwise.

Locum tenens providers are not eligible to render and bill for services until written confirmation from AllWays Health Partners of their successful enrollment and are held to the same expectations of all other AllWays Health Partners providers.

If the locum tenens physician will be in place beyond six months, AllWays Health Partners must be notified at least 45 days ahead of time such that AllWays Health Partners can initiate the abbreviated credentialing process. Failure to timely notify AllWays Health Partners will result in claim denials and the retroactive processing of any denied claim cannot be considered.

Provider Enrollment

AllWays Health Partners requires that, when applicable, all providers be credentialed or

enrolled prior to rendering care. AllWays Health Partners does not recognize interim or provisional credentialing of practitioners still in training. Services rendered prior to a practitioner's enrollment by AllWays Health Partners cannot be honored. Practitioners seeking enrollment with AllWays Health Partners, and employed by an AllWays Health Partners contracted group, must submit a request through AllWays Health Partners' Provider Enrollment Portal or a completed [HCAS Enrollment Form](#) to AllWays Health Partners with preliminary information about the practitioner and his/her practice.

Provider sites can review a list of all AllWays Health Partners enrolled clinicians, including original effective dates of the affiliation via the Provider Roster reports available from AllWays Health Partners' provider portal, allwaysprovider.org.

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

For questions on a clinician's enrollment status, email AllWays Health Partners at pec@allwayshealth.org or contact AllWays Health Partners Provider Service at 855-444-4647.

Provider Enrollment Changes

To keep accurate network provider information, AllWays Health Partners must be promptly notified in writing of relevant changes pertaining to a provider's practice. The primary way to notify AllWays Health Partners of enrollment changes is through the Provider Enrollment Portal within allwaysprovider.org. The Provider Enrollment Portal gives you easy access to submit requests such as the following:

- Enroll a new provider into your group
- Terminate an existing provider from your group
- Open and close your panels

- Submit demographic changes
- Generate a complete HCAS form

The Provider Enrollment Portal gives you real time status information of your enrollment request as well as send you an email notification when your request has been completed.

Providers can also submit provider enrollment changes on the [Standardized Information Change Form](#) or with a signed document on the provider's stationery. Completed forms should be emailed to pec@allwayshealth.org. Verbal requests and/or those submitted by third-parties or billing agents not on record as authorized to act on a provider's behalf cannot be accepted.

Provider Terminations

For providers terminating from a practice, AllWays Health Partners 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 allwaysprovider.org, 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, AllWays Health Partners' 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 AllWays Health Partners) 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, AllWays Health Partners 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 AllWays Health Partners' quality assurance programs and other AllWays Health Partners policies and procedures including, but not limited to, procedures regarding prior authorization and notification.

For members who will continue receiving care from the provider, AllWays Health Partners 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 AllWays Health Partners' knowledge will be automatically denied. Disputes in these cases can be addressed through AllWays Health Partners' administrative appeals process and, depending on the outcome, the

provider will be reimbursed for services rendered at the applicable fee schedule.

Panel Changes

Panel closure notification does not apply to specialty providers. AllWays Health Partners requires that a practice maintain at least 50 percent of PCP panels open at all times. A PCP panel may not be closed to an existing patient who has transferred to AllWays Health Partners from another health plan.

PCPs may not close their panels to a specific AllWays Health Partners product. When a PCP's panel reaches 1,500 members, the provider must request to close his or her panel by providing AllWays Health Partners with 30 days advance written notice. The PCP may decline new or additional AllWays Health Partners members only if his or her panel is also closed to all other health plans.

Members who had selected the PCP prior to AllWays Health Partners' notification must be allowed assignment to his/her panel. Other exception requests for PCPs with closed panels will be discussed with the PCP's office and processed only upon obtaining verbal approval.

PCPs are required to notify AllWays Health Partners through the Provider Enrollment Portal of any changes in their panels. The PCP can also submit a notification letter that must include the effective date of the panel closure and whenever possible, the anticipated duration of such closure. The PCP's panel status will be reflected accordingly in the AllWays Health Partners Provider Directory. An AllWays Health Partners Provider Relations Manager reviews rosters at each provider visit as additional confirmation of panel status, to monitor the duration of closed panels, and to ensure accuracy of provider enrollment information and adequate access.

Through allwaysprovider.org, AllWays Health Partners provides updated PCP assignment information daily to PCP offices. Discrepancies in

a member's PCP information can be systematically corrected by the PCP office without assistance from AllWays Health Partners.

- This option is limited to PCP changes within the same site, to a PCP with an open panel.
- Changes to a member's PCP and Primary Care Site must be initiated by the member calling AllWays Health Partners Member Service or by submitting the request through allwaysprovider.org and attesting to obtaining the member's consent.

Behavioral Health Care Integration

AllWays Health Partners and its designated behavioral health contractor, Optum, are committed to fully integrating My Care Family patients' medical and behavioral health care. My Care Family recognizes the importance of working collaboratively to create a coordinated treatment system where all providers work together to support the member in a seamless system of care. To this end, My Care Family has worked closely with Optum to develop specific programs and provider procedures that standardize communication and linkage between My Care Family members' primary care and behavioral health providers. Linkage between all providers (primary care, mental health and substance abuse providers, as well as state agencies) supports member access to medical and behavioral health services, reduces the occurrence of over-and-underutilization, and provides coordination within the treatment delivery system.

Communication among providers also improves the overall quality of both primary care and behavioral health services by increasing the early detection of medical and behavioral health problems, facilitating referrals for appropriate services, and maintaining continuity of care.

Provider Rights and Responsibilities

AllWays Health Partners does not prohibit or restrict network providers acting within the lawful scope of practice from advising or giving treatment options, including any alternative treatment.

To ensure effective relationships, and to be consistent with our joint commitment to enhance the quality of life for all My Care Family members, we require network providers to:

- Accept My Care Family members as patients to the extent other health plan members are accepted.
- Make My Care Family patients aware of all available care options, including clinical care management
- Treat My Care Family patients as equals to all other patients.
- Be active participants in discharge planning and/or other coordination of care activities.
- Comply with medical records requirements relative to proper documentation and storage, allowing access for review by individuals acting on AllWays Health Partners' behalf and supporting appropriate medical record information exchange at a provider and/or patient's request.
- Comply with patient access standards as defined within this manual.
- Remain in good standing with local and/or federal agencies.
- Be responsive to the cultural, linguistic, and other needs of AllWays Health Partners members.
- When applicable, inform My Care Family patients of advanced directive concurrent with appropriate medical records documentation.
- Coordinate care with other clinicians through notification of findings, transfer of medical records, etc., to enhance continuity of care and optimal health.
- Report findings to local agencies as mandated

and to AllWays Health Partners when appropriate.

- Promptly notify AllWays Health Partners of changes in their contact information, panel status, and other relevant information.
- Respect and support AllWays Health Partners Members Rights and Responsibilities.

Of equal importance, My Care Family providers have the right to:

- Receive written notice of network participation decisions.
- Exercise their reimbursement and other options as defined within this manual and/or the AllWays Health Partners Provider Agreement.
- Communicate openly with patients about diagnostic and treatment options.
- Expect AllWays Health Partners' adherence to credentialing decisions as defined herein.

availability of high-volume specialty care practitioners is evaluated at least annually. High-volume specialties are defined as the top five specialties based on claim volume.

AllWays Health Partners strives to ensure the availability of practitioners who are multilingual, understand and comply with state and federal laws requiring that practitioners assist members with skilled medical interpreters and resources, and are responsive to the linguistic, cultural, ethnic, and/or other unique needs of minority groups and special populations.

At least annually, AllWays Health Partners reviews data on My Care Family patients' cultural, ethnic, racial, and linguistic needs to define quality initiatives, inform interventions, and assess availability of practitioners within defined geographical areas to meet the needs and preferences of our membership.

Member Complaints and Grievances

AllWays Health Partners is strongly committed to ensuring member satisfaction and the timely resolution of reported concerns regarding a member's experience with a health care provider. For more information on AllWays Health Partners' processes for inquiries, complaints, and grievances, please see the "Appeals & Grievances" section of this manual.

Access and Availability Requirements

AllWays Health Partners' Provider Network Management staff regularly evaluates access and availability and the comprehensiveness of AllWays Health Partners' provider networks.

Access and availability of acute care facilities, PCPs and obstetricians/gynecologists are evaluated at least quarterly. Access and

Availability and access standards are defined as follows:

Provider	Access Ratio to Members	Availability by Geographic Standards
Primary Care	1:200	Two primary care providers within 15 miles or 30 minutes travel time from member's residence
OB/GYN Specialists	1:500	One provider within 15 miles or 30 minutes travel time from member's residence
High Volume Specialists	1:1500	One provider within 15 miles or 30 minutes travel time from member's residence
Acute Care Facilities	N/A	One facility within 20 miles or 40 minutes travel time from member's residence
Rehabilitation Facility	N/A	One facility within 30 miles or 60 minutes travel time from member's residence
Urgent Care Services	N/A	One facility within 15 miles or 30 minutes travel time from member's residence

AllWays Health Partners reserves the right to either expand or limit its provider networks according to AllWays Health Partners' business objectives. In determining network expansion needs, AllWays Health Partners evaluates these availability and access standards along with other criteria.

Cultural Competency

My Care Family has a diverse patient population in terms of linguistic abilities and cultural and ethnic backgrounds. To promote access to clinicians who have the ability to communicate with the member in a linguistically appropriate and culturally sensitive manner, AllWays Health Partners uses a number of strategies to capture robust and detailed linguistic, ethnic, and cultural data on our members, including the use of health needs assessment tools and querying members upon contact with AllWays Health Partners Member Service. AllWays Health Partners captures linguistic capabilities of providers as part of the credentialing process for individual clinicians.

For access and availability assessment, the member's self-reported primary language serves as a measure of their linguistic needs and preferences as well as a proxy for cultural and ethnic identity. The providers' self-report of languages spoken serves as the measure of their linguistic ability and a proxy for cultural and ethnic backgrounds. AllWays Health Partners also employs US Census Data on prevalent non-English languages spoken in Massachusetts and identifies those languages spoken by 10,000 or more individuals, five years and older, within each Massachusetts county.

Wait Time Access Standards

My Care Family providers must ensure the availability of prompt provider consultation, including arrangements to assure coverage for patients after hours. AllWays Health Partners requires the hours of operation offered for all members to be the same regardless of their coverage.

In addition to after-hours access standards, patients should be seen within a reasonable time after their arrival. A reasonable time is defined as within 30 minutes of the appointment time.

Patient calls regarding active clinical problems and received during routine office hours should be

returned within the hour when clinically appropriate, or on a same day basis otherwise. Telephone calls regarding routine administrative requests should be returned within two business days.

AllWays Health Partners is required to monitor and report on member access to specific primary care and specialty services. This is done with an access and availability survey administered by AllWays Health Partners Provider Relations Department.

The survey seeks responses as to the availability or wait time access for services such as:

- Emergency care
- Urgent care
- Routine symptomatic care
- Routine non-symptomatic care
- After-hours care
- Department of Social Service (DSS) custody initial exam
- DSS custody comprehensive exam

Fraud, Waste and Abuse

Fraud Prevention

AllWays Health Partners 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.

Suspicious or concerns involving a My Care Family patient or clinician can be reported to AllWays Health Partners' Quality and Compliance Office in writing or by email. These concerns can also be reported anonymously to the AllWays Health Partners Compliance Hotline 24 hours a day, seven days a week. The Hotline is operated by an independent company and is not staffed by AllWays Health Partners employees.

Fraudulent acts or suspicions may be reported as follows:

- | | |
|--------|--|
| Mail: | AllWays Health Partners
Quality and Compliance
399 Revolution Drive
Suite 810
Boston, MA 02210 |
| Phone: | AllWays Health Partners
Quality & Compliance Office
800-433-5556 (then dial 0 to
have your call directed) |
| | AllWays Health Partners
Compliance Hotline
(anonymous) 844-556-2925 |

False Claims Act

In complying with our obligations under the Deficit Reduction Act of 2005, AllWays Health Partners provides detailed information to our employees, contractors, and agents regarding the False Claims Act and comparable state anti-fraud statutes, including whistleblower protections. To that end, AllWays Health Partners 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

Waste Identification, Reimbursement Validation and Recoveries

AllWays Health Partners' 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.

AllWays Health Partners 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 AllWays Health Partners Provider Agreements, AllWays Health Partners' policies and procedures, and applicable nationally

recognized medical, claims administration, and claims reimbursement policies. AllWays Health Partners' 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 AllWays Health Partners does not maintain an applicable policy, AllWays Health Partners 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 & Medicaid Services (CMS), national health insurance carrier organizations, and the American Medical Association (AMA).

AllWays Health Partners may conduct reimbursement validation audits on claims that AllWays Health Partners has paid during the current fiscal year or has paid during the two (2) prior fiscal years. AllWays Health Partners 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. AllWays Health Partners determines the venue, or combination of venues, that its Audit Specialists shall employ in an audit.

General Claims Audits

General post-payment claims audits are conducted to identify the accuracy of charges and the consistency of claims reimbursement with AllWays Health Partners' policies, Provider Agreements, Payment Guidelines, and applicable nationally recognized medical claims reimbursement and administration policies, including but not limited to: CPT, MassHealth, and CMS guidelines. Audit topics can include, but are not limited to:

- Overpayments due to incorrect setup or update of contract/fee schedules in the system

- Overpayments due to claims paid based upon conflicting authorizations or duplicate payments
- Overpayments resulting from incorrect revenue/procedure codes
- Provider billing for services at a higher level than provided;
- Provider billing for services not documented and not provided;
- Incorrect coding, including unbundling component service codes, modifier usage, units of service, and/or duplicate payments;
- Historical claim audits to include the global surgical period for codes submitted on the current claim;
- Medical necessity based on AllWays Health Partners, MassHealth, and/or CMS guidelines as applicable to the member benefit plan

When an overpayment event is identified, AllWays Health Partners 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 AllWays Health Partners 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, AllWays Health Partners reserves the right to seek

additional legal recourse such as referral to a collection service.

On-Site Audit

In the on-site audit, an AllWays Health Partners Audit Specialist or designated party conducts the audit of designated medical records at the provider's site. For on-site audits, AllWays Health Partners 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. AllWays Health Partners requires that a provider schedule an audit at a mutually convenient time for AllWays Health Partners' Audit Specialist, medical records department, and the patient account representative. The provider and AllWays Health Partners 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 AllWays Health Partners' Manager of Provider Audit and the designated facility representative.

The inspection and copying of medical records is 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 AllWays Health Partners Manager of Provider Audit. All designated records must be produced within twenty-one (21) days of the request by AllWays Health Partners. 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 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.

AllWays Health Partners' 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, AllWays Health Partners' Claims department retracts all audit discrepancies.

Off-Site Audit

The second reimbursement validation audit venue is the off-site audit in which the AllWays Health Partners Audit Specialist or designated party requests specific medical record information from the provider be sent to AllWays Health Partners for review.

Pursuant to AllWays Health Partners' provider agreements, AllWays Health Partners 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. AllWays Health Partners specifies whether the provider must make the original medical records or copies of the requested records available for inspection.

Provider Appeals

If a provider disagrees with AllWays Health Partners' audit findings, the provider may appeal the audit findings by submitting a request for an appeal to the AllWays Health Partners Provider Appeals department or designated party. Please refer to Section 10, "Provider Audit Appeals" for more information.

In accordance with the AllWays Health Partners agreement in effect with the provider, Members cannot be billed for audit discrepancies.

AllWays Health Partners strictly adheres to state and federal requirements regarding confidentiality of patient medical records. A separate patient authorization is provided when

required by law. In accordance with the AllWays Health Partners agreement in effect, patients are not billed for audit discrepancies.

Fraud, Abuse, and the Special Investigations Unit

AllWays Health Partners receives state and federal funding for payment of services provided to our members. In accepting claims payment from AllWays Health Partners, 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.

AllWays Health Partners 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 AllWays Health Partners' 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
- AllWays Health Partners, 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. AllWays Health Partners 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, AllWays Health Partners reserves the right to impose sanctions, including and up to terminating the provider from AllWays Health Partners' network. As stated above, AllWays Health Partners seeks recovery of all excess payments discovered as a result of its fraud and abuse operational efforts.
- When overpayment event is identified, AllWays Health Partners 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 AllWays Health Partners 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, AllWays Health Partners 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 AllWays Health Partners shall each preserve all books, records, and data that are required to be maintained under the provisions of the agreement 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 AllWays Health Partners offices in Massachusetts at reasonable times. The facility and AllWays Health Partners 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 AllWays Health Partners 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.

Code of Ethics

Concerns regarding AllWays Health Partners' adherence to our Code of Ethics should be reported to AllWays Health Partners' Quality and Compliance Office as directed above.

Provider Marketing Activities

Any activities occurring at or originating from a provider site whereby My Care Family staff or designees, including physicians and office staff, personally present My Care Family marketing materials or other marketing materials produced by the provider site to members that EOHHS can reasonably determine influence the patient to enroll in My Care Family or to disenroll from My Care Family into another MassHealth plan. This includes direct mail campaigns sent by the provider site to its patients who are members. With the exception of posting written materials that have been pre-approved by EOHHS at provider sites and posting written promotional marketing materials at network provider sites throughout My Care Family service area, provider site marketing is prohibited.

“Hold Harmless” Provision

Providers contractually agree that in no event, including, but not limited to, non-payment by AllWays Health Partners, AllWays Health Partners' 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 My Care Family patient or person, other than AllWays Health Partners, 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 AllWays Health Partners for payment with respect to covered services rendered to all AllWays Health Partners members.

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

If you have questions about this contract provision, please contact your AllWays Health Partners Provider Relations Manager.

Provider Notification and Training

AllWays Health Partners' Provider Relations department works in partnership with provider offices to build and maintain positive working relationships and respond to the needs of both providers and members.

AllWays Health Partners believes in keeping providers informed and uses direct mail, newsletters, and other vehicles for communicating policy, procedural changes, and/or pertinent updates and information. The provider network's implementation and adherence to communicated procedural changes is monitored with internal reports, provider site visits, reported member grievances, and other resources.

Providers receive a minimum of 30 days advanced notice on any changes that may affect how they do business with AllWays Health Partners. Where a policy or procedure change results in modification in payments or covered services or otherwise substantially impacts network providers, notification will be made at least 60 days prior to the effective date unless mandated sooner by state or federal agencies.

AllWays Health Partners "Provider News" is our monthly e-newsletter for notifying our network of important changes and updates, including revisions to the AllWays Health Partners Provider Payment Guidelines and the Provider Manual.

Providers are strongly encouraged to sign up to receive AllWays Health Partners' updates by visiting allwaysprovider.org.

Provider Relations Managers incorporate provider notifications into their agenda for provider visits to reiterate AllWays Health Partners provider notifications and to address any need for clarification.

AllWays Health Partners also hosts periodic forums for network providers, focusing on administrative and clinical topics, as well as policy and procedural changes. These forums may be offered in person or with a "webinar" option.

Role of the AllWays Health Partners Provider Network Account Executive

Every contracted provider is assigned a dedicated Provider Network Account Executive early in the contracting process, often before the provider sees his/her first My Care Family patient. The Provider Network Account Executive serves as the primary liaison between AllWays Health Partners and our provider network. Provider Network Account Executives work in partnership with AllWays Health Partners' Contracting Department and other staff in administering contractual provisions of the Provider Agreement and/or to ensure contract compliance.

Provider Network Account Executives meet regularly with designated staff within their provider territories to:

- Coordinate and conduct on-site training and educational programs
- Respond to inquiries related to policies, procedures and operational issues
- Facilitate problem resolution
- Manage the flow of information to and from provider offices
- Ensure contract compliance
- Monitor performance patterns