Section 1
Member Information

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Member Information

My Care Family℠

My Care Family offers care and coverage through MassHealth by Greater Lawrence Family Health Center, Lawrence General Hospital, and AllWays Health Partners[EG2].

My Care Family serves patients in the Greater Lawrence area, where many residents face financial and social challenges to accessing care and to maintaining their health.

As part of the MassHealth ACO program, My Care Family members must have a My Care Family Primary Care Provider (PCP).

My Care Family members will have benefits based on their plan. A member may be enrolled on one[EG3] of the following MassHealth plans:

- Standard
- CommonHealth
- Family Assistance
- CarePlus

My Care Family members may be eligible for any service covered directly by MassHealth, such as routine dental care. Please refer to the My Care Family Member Handbook and the Covered Services list for more information.

AllWays Health Partners identifies MassHealth members by rating categories, a specific grouping of MassHealth enrollees based on, but not necessarily equivalent to, MassHealth coverage types and disability status, for which a discrete capitation rate may apply.

Member Enrollment

AllWays Health Partners' Provider Portal, allwaysprovider.org[EG4][EG5], is designed to offer network providers around the clock access to enrollment and eligibility information via timely updates and helpful reports. Member enrollment and eligibility changes are provided

daily to PCPs through the provider portal to enhance patient care, facilitate PCP outreach efforts and enable updates to their own practice management systems.

Primary Care Assignments

All My Care Family members must select a primary care site and a PCP who participates in the My Care Family network.

PCPs should make best efforts to contact newly assigned members to provide an overview of the practice (such as hours and available services). PCPs should also assess any medical needs and, when applicable, schedule an initial appointment.

Providers can update missing or discrepant PCP assignment information within the same practice, including satellite locations, through the provider portal.

During MassHealth's plan selection period, members can switch PCPs, including those that are affiliated with another ACO. In the fixed enrollment period, members are locked into My Care Family and can only switch PCPs within My Care Family.

Enrollment Activities

The Provider Portal reports provide important information on recently processed enrollment transactions, including retroactive changes. Available reports include:

- *A Provider Roster* report listing all currently enrolled clinicians
- *A Member Roster* report listing all active My Care Family members assigned to the site
- *Transaction* reports listing the latest enrollment transactions including:
    - Patients no longer enrolled with My Care Family
    - Patients who have elected to get their primary care elsewhere
    - New My Care Family members who have chosen the practice as their primary care site

  - Existing My Care Family members who have transferred from another My Care Family primary care site
  - PCP updates processed by AllWays Health Partners at the member's request
- When applicable, *Redetermination* reports provide advanced information for the site's My Care Family members at risk of losing state-subsidized coverage

To ensure proper reimbursement, providers are strongly encouraged to review available enrollment activity data regularly and notify AllWays Health Partners Provider Service (855-444-4647) of any discrepancies.

AllWays Health Partners Customer Service

AllWays Health Partners' highly skilled Customer Service Professionals are available to assist with questions on eligibility, benefits and policies, or procedures.

Contact Information:

Providers
Phone: 855-444-4647
Mon.–Fri., 8:00 am – 5:00 pm
and closed 12:00 pm-12:45 pm

My Care Family Members
Phone: 800-462-5449
TTY: 711
Email:
memberservices@allwayshealth.org
Mon.–Fri. 8:00 am – 6:00 pm
Thursday, 8:00 am – 8:00 pm

MassHealth Customer Service
Phone: 800-841-2900
TTY: 800-497-4648

Customer Service Professionals can also assist with updates member demographic and other information identified by providers. PCP information updates must be requested through allwaysprovider[EG6].org. You must attest to the patient's consent to the change.

My Care Family Member Onboarding

Once enrolled, My Care Family members have access to a variety of materials detailing benefit and other important information via the member portal. This includes the ability to access the Covered Services List and the MassHealth Member Handbook (and corresponding amendments). In addition, the member portal provides medical and pharmacy claims history, status on submitted approval requests, as well as the patient's information on file with AllWays Health Partners, should it need to be updated.

My Care Family members receive a My Care Family identification card and a member kit with information about how to use the plan. AllWays Health Partners also attempts to contact newly enrolled My Care Family members to welcome them to the plan and provide education on how to maximize their coverage.

Topics covered during the welcome call include:

- Verification of demographics and language preference
- Explanation of the role of the PCP in coordinating all care
- Overview of My Care Family benefits and covered services
- Overview of My Care Family member discounts

Member Eligibility and Identification

All My Care Family members receive a My Care Family identification card. A My Care Family card itself does not indicate that an individual is currently enrolled with My Care Family. Providers are responsible for verifying eligibility daily via the provider portal, including but not limited to while a patient is hospitalized. Eligibility information is also available on the New England Healthcare Exchange Network (NEHEN).

Except in emergencies, patient eligibility should be determined prior to rendering services. AllWays Health Partners will only reimburse for covered services rendered to a patient eligible on the date of service and when all other referral, authorization, and payment requirements are met.

The provider portal is designed to give providers around the clock access to member information and other administrative functions. Eligibility information is also available to providers with access to NEHEN.

Copayments

My Care Family members have no office visit copayment. A pharmacy copayment may apply depending on the selected medication.

Occasionally, a My Care Family member may not be able to pay the applicable pharmacy copayment at the time the prescription is filled. Under these circumstances, My Care Family members should notify the pharmacist of their inability to afford the copayment. Under federal law, and as contractually required, the pharmacy must still dispense the medication as prescribed. AllWays Health Partners is not responsible for the copayment due to the pharmacy. The patient is liable for any applicable copayment amounts and the pharmacy may exercise its legal rights to collect the amount due.

My Care Family Identification (ID) Cards

My Care Family members are issued an ID card with information as shown below. An ID card itself does not indicate an individual is currently enrolled with My Care Family.

Patient Relations

Member Rights and Responsibilities

My Care Family 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 AllWays Health Partners.

In addition, providers must treat My Care Family members with fairness, honesty, and respect, including refraining from any biases based on race, color, national origin, age, disability, sex, religion, sexual orientation, gender identity, gender expression, ancestry, marital status, veteran status, occupation, claims experience, duration of coverage, pre-existing condition, expected health status, or who pays for services.

Member Rights

My Care Family members have the right to:

- Receive information about AllWays Health Partners, our services, our providers and practitioners, their covered benefits, and their rights and responsibilities as a member of AllWays Health Partners.
- 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.
- Be 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 your 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 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 AllWays Health Partners.
- File a grievance or appeal if they have had an unsatisfactory experience with AllWays Health Partners or with any of our contracted providers, or if they disagree with certain decisions made by AllWays Health Partners.
- Make recommendations regarding AllWays Health Partners' "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 AllWays Health Partners 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.

Member Responsibilities
My Care Family 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 My Care Family member.
- Give complete and accurate health information that AllWays Health Partners or their provider needs 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 AllWays Health Partners 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/Communication

AllWays Health Partners contracted practices must provide interpreter services free of charge when necessary, including but not limited to over the phone communication, to limited English proficiency (LEP) members. 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.

AllWays Health Partners contracted providers must have the capacity to communicate with members in languages other than English, communicate with individuals with special healthcare[EG7] 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 you 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.

Privacy Rights

My Care Family believes strongly in safeguarding the personal and health information of our patients 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 AllWays Health Partners 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 a My Care Family member by our team of Care Managers or the provision of information to our providers concerning their patients' utilization of medical services.

My Care Family members are informed of their privacy rights, including how My Care Family uses their information, by distribution of our Notice of Privacy Practices.

Treatment of Minors (Privacy)

State law allows minors, under certain circumstances, to consent to medical treatment without parental consent. In such situations, the minor would be able to initiate an appeal or designate an appeal representative with respect to that medical treatment without parental consent. In such circumstances, the minor may need to consent to the release of information concerning that medical treatment, even to the parent(s).

Providers are encouraged to seek legal counsel with any questions about minors' consent to medical treatment and patient confidentiality and privacy.

Providers with questions or concerns about AllWays Health Partners' privacy practices can call the Compliance Hotline at 1-844-556-2925.

Accessing Emergency Services

My Care Family members are covered for emergency care, even when traveling outside the service area. My Care Family members have coverage for emergency services throughout the United States and its territories. Coverage includes use of an ambulance and post-stabilization care services related to an emergency. The member can go to any emergency room; the

hospital does not have to be the My Care Family network.

An emergency is a health condition a member believes will put their health in serious danger if immediate medical attention is not received.

Examples of emergencies are:

- Chest pain
- Poisoning
- Trouble breathing
- Severe bleeding
- Convulsions
- Having thoughts of hurting yourself or others

If a member believes their health problem is an emergency and needs immediate attention, the member should be instructed to call 911 at once or go to the nearest emergency room right away to be examined and stabilized before being discharged or transferred to another hospital.

If a member is experiencing a behavioral health emergency, the member should call 911, go to the nearest emergency room, or contact the emergency services program (ESP) in their area.

A list of emergency rooms in all areas of the state can be found in the AllWays Health Partners Provider Directory.

Members should contact their PCP within 48 hours of any emergency care. If applicable, the PCP will arrange follow-up care. If the member experiences a behavioral health emergency, they should be instructed to contact their behavioral health provider, if they have one.

Members are covered for emergency care 24 hours a day and seven days a week, even when traveling or outside the service area.

Emergency Service Programs
Emergency Service Programs (ESPs) can offer community-based behavioral health services when a hospital emergency department visit may not be required. Readily available services include crisis assessment, interventions, and referrals to appropriate services.

While some circumstances may necessitate a behavioral health crisis evaluation in an emergency department setting, there are many times when an individual can best be served by having a crisis evaluation conducted at the member's home, ESP office, or a community-based location, such as the PCP's office.

PCPs should consider contacting a local ESP provider for My Care Family members presenting with the following:

- Complaints of feeling depressed or having suicidal thoughts
- Deteriorating mental status brought on by recent noncompliance with psychotropic medications or reactions to changes in medical regime
- Inability to utilize usual coping strategies when in crisis

ESPs are available 24/7 and should respond within 60 minutes of being contacted. Additional information about ESPs is available from the National Alliance on Mental Illness at http://www.namimass.org/crisis/who-to-call-for-help.

For a listing of ESPs in all areas of the state, patients can refer to the Provider Directory.

Optum Partnership

My Care Family partners with Optum in managing the delivery of behavioral health services for all My Care Family members.

My Care Family delegates to Optum these behavioral health areas of responsibility:

- Claims processing and claims payment

- Patient connections and customer service
- Provider contracting and credentialing
- Quality management and improvement
- Service authorization
- Utilization management/case management

Advance Directives

My Care Family 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. My Care Family actively attempts to increase awareness of the importance of executing an advance directive among its adult patients, network providers, and staff.

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.

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 and requesting PCP referrals 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 his or her care is key to effective patient-provider relationships. It is recommended that clinicians start by creating rapport with the patient, asking for his or her goal in seeking 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 his or her 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 patient's 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. Some patients also struggle with feeling let-down by their ailing bodies or feeling spiritually betrayed.

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 also watch for overly compliant behavior, which could suggest that the patient has lost his or her identity. Providers should directly address their patient's underlying feelings, making eye contact always, and addressing the patient as "Mr." or "Miss/Ms./Mrs." in a friendly manner. When appropriate, obtaining assistance from relatives may help break any isolation and create solutions while also providing support.

Disenrolling a Patient from Your Care

AllWays Health Partners is committed to working closely with EOHHS, Providers and Members in making available appropriate resources for facilitating positive therapeutic relationships and for maintaining the enrollment of all Members/Enrollees.

AllWays Health Partners does not request the disenrollment of a Member due to:

- an adverse change in the Member's health status
- the Member's utilization of medical services, including but not limited to the Member making treatment decisions (i.e. declining treatments or tests) with which the health plan or the provider disagrees with
- appointments missed by the Member
- the Member's diminished mental capacity
- or uncooperative or disruptive behavior resulting from the Member's special needs, except when the Member's continued enrollment significantly impairs the health plan's ability to furnish services to Member and/or other members.

If a provider must request to have a Member disenroll they should contact the AllWays Health Partners Customer Services Center to submit the request.

Providers

Phone: 855-444-4647

Mon.–Fri., 8am – 5:00 pm and closed 12:00pm-12:45pm

AllWays Health Partners will process the request with EOHHS. At its sole discretion, EOHHS reserves the right to determine when and if a request to terminate a Member's enrollment will be granted.

Section 2
Covered Services

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Covered Services

Overview

It is important for providers to confirm a member's eligibility and coverage upon arrival for an appointment as coverage for certain services varies by plan.

Some benefits have limits, and it is important to note each plan's definition of "benefit period."

- Benefits with a contract or benefit period limit apply a calendar year: January 1 through December 31
- Some benefits have a rolling period (for example, a routine eye exam may be covered once every 12 months or 24 months based on the patient's age). This would require that the next appointment is booked 12 months/24 months and 1 day after the current appointment.

General Coverage Requirements

To be covered by AllWays Health Partners[EG1], all health care services and supplies must be:

- Provided by or arranged by the patient's My Care Family primary care provider (PCP) or My Care Family network provider*
- Referred by the PCP when required (most specialty care outside the My Care Family network requires a referral)
- Prior authorized when required
- Medically necessary
- Covered health care services
- Provided to eligible patients enrolled in My Care Family

*Exceptions: My Care Family members can access family planning services from any MassHealth Provider. My Care Family members can access emergency services as noted in Section 1, "Accessing Emergency Services"

Covered Services

My Care Family members have benefit coverage as outlined by their plan: MassHealth Standard and CommonHealth, Family Assistance, and CarePlus. For a complete list of ACO covered services (covered by AllWays[EG2] Health Partners) and non-ACO covered services (covered by MassHealth directly), please refer to the Covered Services booklet. The Covered Services booklet provides a table-formatted summary of benefit coverage for each plan.

It is important to note My Care Family members have coverage for services through MassHealth that are not covered by My Care Family. For example, adult day services for the disabled may be covered through MassHealth but are not covered by My Care Family. Members may confuse their "Fee for Service Medicaid "or MassHealth coverage with their My Care Family coverage. AllWays Health Partners' Customer Service team is available to further clarify coverage for members. My Care Family patients have some variation in coverage based on their particular plan; the following is a high-level outline of excluded services.

Long Term Care

My Care Family's Long Term Care (LTC) coverage for MassHealth members allows 100 LTC days a contract year/benefit period. LTC coverage depends on the member's MassHealth benefit plan as follows:

- MassHealth Standard, CommonHealth, Family Assistance, and CarePlus: AllWays Health Partners covers up to 100 days of a combination of Nursing Facility, Chronic Disease and Rehabilitation Hospital services In a Contract Year (January 1 – December 31st).
- Depending on the facility type, a Status Change for Members in a Nursing Facility or Chronic Disease and Rehabilitation Inpatient Hospital form (commonly referred to as the SC1 Form) and a MassHealth Payment of Nursing Facility Services form (commonly referred to as the Screening Form) may be required from the facility.

- Copies of the required forms must be provided to AllWays Health Partners immediately upon request. For Nursing Facility admissions (which require the additional Screening form) the requested copy must be received by AllWays Health Partners no later than by the 100th day. Non-compliance will result in payments being withheld and released only upon confirmation from the MassHealth Enrollment Center (MEC) that the form has been correctly completed and accepted in their system.

Excluded Services:

- Assisted reproduction including but not limited to in-vitro fertilization and gamete intra-fallopian tube (GIFT) procedures
- Cosmetic surgery, except as determined to be medically necessary for correction or repair of damage following an injury or illness, for other medically necessity reasons, or mammoplasty following mastectomy or as required by law
- Experimental treatment
- Non-covered laboratory services as specified in 130 CMR 401.411
- Out-of-country care (outside USA and territories) including emergency care
- Personal comfort items including, but not limited to, air conditioners, radios, telephones, and televisions
- Services and supplies not directed by My Care Family provider

Overview of Excluded *Medical Services for MassHealth Plans*

	Care Plus Plan	**CommonHealth and Standard Plans**	**Family Assistance Plan**
Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Services (members under age 21)	Excluded	Included	Excluded, however Preventive Pediatric Healthcare Screenings and Diagnostic [PPHSD] Services are covered.
Early Intensive Behavioral Intervention (EIBI)	Excluded	Included	Included
Early Intervention	Excluded	Included	Included
Fluoride Varnish	Excluded	Included	Included
Non-Emergent Transportation Out of State (outside a 50-mile radius of the MA border	Included	Included	Excluded

These services do not require referrals: referred:

- Emergency services
- Urgent Care
- Chiropractic Care
- Routine, preventive, or urgent care from a Gynecologist or Obstetrician
- Family planning services provided by a MassHealth provider
- Outpatient and diversionary behavioral health services
- Routine eye exams

Non-covered laboratory services include:

- Test performed for experimental or Clinical Investigational purposes or that are themselves experimental or clinically investigational
- Tests only for the purpose of civic, criminal, administrative, or social service agency investigation, proceedings, or monitoring activities
- Test for residential monitoring purposes
- Tests performed to establish paternity
- Tests performed by an independent clinical laboratory for services that the laboratory is not certified by Centers for Medicare & Medicaid Services (CMS) to perform
- Services provided by a provider not in the My Care Family network unless prior authorized

These services do not need to be directed by a My Care Family provider:

- Emergency services
- Family planning services provided by a MassHealth provider

Clinical Trials

AllWays Health Partners does cover care provided as part of a Qualified Clinical Trial for the treatment of cancer or other life-threatening medical condition to the extent the care would be covered if not provided as part of a Qualified Clinical Trial. Coverage is provided when services are provided by a My Care Family network provider or with prior authorization for a provider outside the My Care Family network. Covered costs exclude: the investigational item, device, or service; items and services solely for data collection and analysis; or for a service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis. Costs and limitations imposed are not greater than costs or limitations when the services are provided outside of an approved clinical trial.

The PCP (or treating provider in consultation with the PCP) must obtain prior authorization for a member's participation in a Qualified Clinical Trial or the member must provide medical and scientific information that demonstrates the member meets the conditions for participation in the qualified clinical trial. The prior authorization process must be followed.

Qualified clinical trials meet the following:

The clinical trial is intended to treat cancer or other life-threatening medical condition in a patient who has been so diagnosed.

The clinical trial has been peer reviewed and is approved by one of the following:

- United States National Institutes of Health (NIH)
- Center for Disease Control and Prevention
- Agency for Health Care Research and Quality
- Centers for Medicare and Medicaid Services
- The Department of Defense, Veterans Affairs, or the Department of Energy
- A qualified non-governmental research entity identified in NIH guidelines for grants, is a study or trial under the United States Food and Drug Administration approved investigational new drug application, or its a drug trial that is exempt from investigational new drug application requirements

- The facility and personnel conducting the clinical trial are capable of doing so by virtue of their experience and training and treat a sufficient volume of patients to maintain that expertise
- With respect to Phase I clinical trials, the facility shall be an academic medical center or an affiliated facility, and the clinicians conducting the trial shall have staff privileges at said academic medical center
- The patient meets the patient selection criteria enunciated in the study protocol for participation in the clinical trial
- The patient has provided informed consent for participation in the clinical trial in a manner that is consistent with current legal and ethical standards
- The available clinical or pre-clinical data provide a reasonable expectation that the patient's participation in the clinical trial will provide a medical benefit that is commensurate with the risks of participation in the clinical trial
- The clinical trial does not unjustifiably duplicate existing studies

The clinical trial must have a therapeutic intent and must, to some extent, assess the effect of the intervention on the patient.

Dental Care

My Care Family has limited dental benefits for its patients as outlined below.

EMERGENCY DENTAL CARE
My Care Family covers emergency dental services only when there is a traumatic injury to sound, natural, and permanent teeth caused by a source external to the mouth and the emergency dental services are provided in a hospital emergency room or operating room within 72 hours following the injury.

FLUORIDE VARNISH
My Care Family providers offering fluoride varnish application are entitled to reimbursement. Fluoride varnish is usually deemed medically necessary beginning on or around six months of age (first tooth eruption) and may be medically necessary for members up to adulthood (up to age 21).

Fluoride varnish is applied during a well-child visit to prevent early childhood dental caries in children at moderate to high risk as determined by the Caries Assessment Tool (CAT). More information on this tool is available from the American Academy of Pediatrics website at www.aap.org.

Fluoride varnish is recommended no more frequently than every 180 days from the first tooth eruption (usually at six months) to the third birthday. It is expected that this procedure will occur during a pediatric preventive care visit and will be delivered along with anticipatory guidance for oral health and/or dental referral when necessary.

While this benefit is primarily intended for children up to age three, reimbursement is allowed for children up to adulthood (see above).

To be eligible for fluoride varnish reimbursement, all of the following criteria must be met:

- The individual rendering the service may be a Physician, Nurse Practitioner, Physician Assistant, Registered Nurse, Licensed Practical Nurse, or Medical Assistant certified in the application of fluoride varnish.
- The individual rendering the service must complete the Oral Health Risk Assessment Training or equivalent.
- The provider must meet all claim submission requirements including use of valid procedure codes.
- The member is under the age of 21.
- The service is medically necessary as determined by a Caries Assessment Tool (CAT).

PCP sites that do not have providers or staff certified in the application of fluoride varnish must direct patients in need of fluoride varnish to AllWays[EG3] Health Partners' Customer Service team for help finding a certified provider.

Oral Surgery

Coverage for My Care Family members is limited to medically necessary oral surgery, including the extraction of wisdom teeth, performed in a Surgical Day Care (SDC) or as an inpatient because of an underlying medical condition. The coverage applies to the procedure, facility, and all professional fees.

When the oral surgery is performed in the surgeon's office, the provider must bill MassHealth directly.

Other Dental Care

For My Care Family members under age 21, and under special circumstances for adults, routine dental care may be covered by MassHealth. For more information on covered services, please refer to MassHealth Covered Services List.

Orthodontics (braces) for teeth and dentures are not covered by My Care Family, but may be covered by MassHealth. Full and partial dentures, and repairs to said dentures, are covered for adults age 21 and over by MassHealth.

Vision

My Care Family members have coverage for a comprehensive eye exam, however, the frequency of the eye exam may vary according to the patient's age; please check the plan materials.

All My Care Family members have coverage for medically necessary ophthalmological care, including vision training, under the specialty care coverage.

All My Care Family members have coverage for lenses that are medically necessary to treat medical conditions such as keratoconus or after cataract surgery. Other than this limited coverage, eyewear (eyeglasses and contact lenses) is not covered. Scleral lenses (bandage lenses) are covered when medically necessary; prior authorization is required.

My Care Family members have coverage for routine vision exams:

- Once per 12-month period for patients under the age of 21
- Once per 24-month period for patients age 21 and older
- For all patients, when medically necessary
- Eyeglasses are covered through MassHealth for MassHealth CarePlus, CommonHealth/Standard, and Family Assistance members.

Section 3
Provider Management

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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[EG2] 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 who's

contracted with AllWays Health Partners to provide and coordinate comprehensive healthcare 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 Andros Technologies, Inc.

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 is AllWays Health Partners' peer review body with responsibility for oversight of the credentialing and re-credentialing functions. The committee meets 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, or designee, 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 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 AllWays Health Partners Provider Service at 855-444-4647 or email PEC@AllWaysHealth.org.

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, AllWays Health Partners' Chief Medical Officer.and the Directors of Enrollment and Legal, Regulatory 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 Andros Technologies, Inc. , 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 clinicians enrolled in AllWays Health Partners, including original effective dates of the affiliation via the Provider Roster reports available from the 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**.

MassHealth Provider Enrollment Requirement

Federal regulations set forth at 42 CFR § 438.602 require that all AllWays Health Partners network providers enter into a MassHealth Non Billing MCE Network-only Provider Contract or another MassHealth provider contract. This contract should be completed within 30 days to receiving the notice.

Visit the following website to complete the contract process: https://www.mass.gov/forms/submit-the-masshealth-nonbilling-managed-care-entity-network-only-provider-contract. Note: Contracts are to be submitted to MassHealth directly per the instructions. This specific provider contract does not require AllWays Health Partners network provider to render services to MassHealth fee-for-service members.

AllWays Health Partners will then forward you the MassHealth PIDSL number and effective date that MassHealth assigns to you.

If you do not enter into a MassHealth Non Billing MCE Network-only Provider Contract or another MassHealth provider contract, AllWays Health Partners may be required to terminate you from our ACO (provider network).

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 Network Account Executive 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.

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 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.

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 Network Management 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.

Suspicions 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[EG3][EG4]
- 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 an 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 or 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 Network Account Executive.

Provider Notification and Training

AllWays Health Partners' Provider Network Management 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 Network Account Executives 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

Section 4
Provider Portal

Section 4 Provider Portal

Overview

My Care Family providers and third-party billers are required to register and actively use allwaysprovider.org, AllWays Health Partners secure provider portal. Through the provider portal, users have access to a variety of transactions in a self-service capacity. The Provider Portal allows providers access to patient information under the context of the provider site to which the user is associated. Allwaysprovider.org supports access to multiple provider sites with a single account (if required).

AllWays Health Partners strives to protect the privacy of each member's Protected Health Information (PHI) and other personally identifiable information. User actions are audited regularly. Your access to allwaysprovider.org is subject to the approval of the designated user administrator of the provider site you are associated with as well as AllWays Health Partners Provider Relations.

User access to their provider site information must be renewed every 180 days. Accounts inactive for 30 days or more are subject to automatic terminations.

The provider portal is your primary point of contact when you need to conduct the following transactions with AllWays Health Partners. Only inquiries that cannot be addressed via the provider portal should be directed to AllWays Health Partners Provider Service.

Using the Provider Portal

Member Eligibility

The provider portal is designed to give contracted providers around the clock access to member information. Eligibility information is updated three times per day to ensure the most up-to-date information is displayed.

Providers are responsible for verifying member eligibility daily through the provider portal prior to rendering services.

Claims Status

The provider portal is your primary point of contact when you need to check claim status with AllWays Health Partners. A user can verify the status of a submitted claim while in process and/or finalized by AllWays Health Partners. Only limited claim status can be obtained by calling AllWays Health Partners Provider Service.

Explanation of Payments (EOPs)

Providers have instant access to current and historical copies of AllWays Health Partners' EOPs as downloadable PDFs.

Electronic Funds Transfer and Electronic Remittance Advice

Providers are required to register for Electronic Funds Transfer (EFT) and Electronic Remittance Advice (ERA/835). Once registration is complete, providers will no longer receive paper checks or EOPs.

Referrals and Authorizations

Referrals and prior authorizations are submitted through the provider portal. Clinical documentation should be uploaded to support an authorization request.

The provider portal provides real-time access to authorization and referral status requests. Providers should refer to the provider portal for status inquiries. A report is available to verify the existence of any required prior authorization and/or referral for patients referred to the provider's office by another provider.

PCP Panel Status and Changes within Your Practice Site

Through the provider portal, AllWays Health Partners provides updated PCP assignment information daily to PCP offices. Discrepancies in a patient's PCP information can be systematically corrected by the PCP

office through allwaysprovider.org or initiated by the patient by calling AllWays Health Partners Member Service.

The primary way to notify AllWays Health Partners of enrollment changes is through the provider portal. Requests that can be submitted through the provider portal include:

- Enroll a new clinician into your group
- Terminate an existing clinician from your group
- Open and close your panels
- Provider demographic changes

Through the provider portal, you can also view real time status information on your enrollment request as well as receive email notification when your request has been completed.

Reports

The Enrollment Reports function is divided into four sections:

- Member Roster Report—Allows you to download a complete listing of patients by provider.
- Member Transaction Report—Displays member enrollment changes for your site.
- Redetermination Report —This report will display all members for the currently selected site with recent Medicaid and Connector redetermination dates.
- Site Provider Roster Report—Displays a current listing of enrolled practitioners for your site. Providers are required to regularly review this report and notify AllWays Health Partners of any changes to their roster.

Clinical Reports

Provider can access site-based member utilization data on ER utilization, immunization rates, and other disease management (e.g., asthma, diabetes).

Site Documents

Providers have access to securely retrieve sensitive reports and other data requested of AllWays Health Partners.

User Administrator Functions

All sites must have at least one designated User Administrator to manage user accounts and permissions for your practice. The User Administrator has access to view all allwaysprovider.org users registered for the site and change permissions as needed. Request for new access within your site must be approved by your User Administrator.

To enroll, please visit allwaysprovider.org and follow the easy registration instructions or consult with your site's appointed User Administrator.

For detailed step-by-step instructions on the provider portal functionality please refer to the provider portal user guide.

Providers needing more help can email* prweb@allwayshealth.org.

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

Section 5
Quality Management Program

Section 5
Quality Management Program

Overview

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

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

Quality monitoring and improvement activities are oriented around: routine reporting, management, and analysis of complaints and grievances; specific quality improvement projects; peer review; and the implementation and evaluation of the quality improvement plan.

Quality management and improvement activities are aimed at creating highly integrated collaborative partnerships, both internally and externally, to ensure excellence in care and service—as well as to establish and share best practices.

The Advisory Commission on Consumer Protection and Quality in the healthcare Industry recommends that all healthcare organizations make it their explicit purpose to continually reduce the burden of illness, injury, and disability, and to improve the health and functioning of the people of the United States. In Crossing the Quality Chasm: A New Health System for the 21 Century (Committee on Quality Health Care in America, Institute in America, Institute of Medicine, 2001), the Institute of Medicine called upon all healthcare organizations to pursue six major aims and that, specifically, healthcare should possess the following qualities:

- *Safety*—Avoiding injuries to patients from the care that is intended to help them.
- *Effectiveness*—Providing services based on scientific knowledge to all who could benefit and refraining from providing services to those not likely to benefit (avoiding underuse and overuse).
- *Patient-centeredness*—Providing care that is respectful of and responsive to individual patient preferences, needs, and values and ensuring that patient values guide all clinical decisions.
- *Timeliness*—Reducing waits and sometimes harmful delays for both those who receive and those who give care.
- *Efficiency*—Avoiding waste, in particular waste of equipment, supplies, ideas, and energy.
- *Equity*—Providing care that does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location, and socioeconomic status.

My Care Family is committed to achieving each of these quality aims and the Quality Management Program provides the specifications for that effort. Clinicians are expected to collaborate with AllWays Health Partners in all quality management efforts

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

Scope

The scope of the Quality Management Program, which speaks to each of the major 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 My Care Family's commitment to continuous performance improvement in all aspects of care and services provided to its members.

The program is continuous, broad-based and collaborative, involving all departments, programs and staff. The components of the program are implemented by the actions of the leadership, directors, clinicians and support staff that design, measure, assess and improve their work processes. Other sources of guidance include input from patients, external benchmarks and aggregate data.

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

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

The Quality Management Program maintains a strong linkage with the 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.

The care management programs strive to:

- Support the relationship between practitioners and their patients with a plan of care
- Emphasize prevention of exacerbations and complications use evidence-based guidelines

- Promote patient empowerment strategies such as motivational coaching and self-management, and continuous evaluation of the 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 healthcare 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

MassHealth ACO Quality Measures

ACOs are accountable for providing high-value, cross-continuum care, across a range of measures that improves member experience, quality, and outcomes. MassHealth will regularly evaluate measures and determine whether measures should be added, modified, or removed.

MassHealth's ACO quality measures cover the following domains:

- Prevention and primary care
- Chronic disease management
- Substance use disorder
- Member experience surveys
- Mental and behavioral health
- Care transitions
- SDOH care integration
- BH and LTSS care integration

AllWays Health Partners Board of Directors

The AllWays Health Partners Board of Directors is responsible for the Quality Improvement Program. The Board delegates oversight responsibility for quality of care and services to the Quality Program Committee. This committee reports directly to the Board. Day-to-day oversight of the Quality Improvement Program is the responsibility of the Chief Medical Officer and the Vice President of Quality Management.

Quality Program Committee (QPC)

This committee is responsible for the development, implementation and oversight of the Quality Improvement program, including oversight of other organizational committees involved in Quality Improvement initiatives.

QPC members include: decision makers who represent stakeholders within the Quality Department as well as representatives from other departments including Clinical Operations, Pharmacy Operations, Commercial Sales, Regulatory Affairs/Compliance, the Medicaid Office and Behavioral Health. Each member is responsible for contributing subject matter

expertise to ensure a balanced discussion of Quality Improvement programs and improvement initiatives. In addition to internal participants, QPC includes members from external organizations including Optum and participating network providers.

Clinical Care Committee (CCC)

This committee develops, implements, and monitors the Quality Improvement (QI) program and functions by ensuring that performance improvement activities meet the needs of its members to support population health, and external regulatory requirements.

CCC 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.

Performance Reporting and Improvement

Provider Profiling System

AllWays Health Partners shall establish and maintain a profiling system for all providers rendering care for AllWays Health Partners for the purpose of obtaining and providing detailed information which includes, but is not limited to:

- Patient satisfaction
- Outcomes
- Access and utilization data for a provider

The provider agrees to cooperate and participate in such systems in a manner that is conducive to quality improvement activities.

Reporting

On a regularly scheduled basis, selected primary care sites are provided with reports outlining their performance in areas including but not limited to:

- Emergency room utilization
- Asthma
- Diabetes (hemoglobin A1c testing, retinal screening exam rates)
- Patient satisfaction*
- Cost and utilization

*Annually, AllWays Health Partners conducts a survey of patients' satisfaction with their primary care site. The survey focuses on patients' satisfaction with access to routine and urgent care, the effectiveness of communication with the practice staff, and the perceived level of courtesy and respect demonstrated by reception staff. Practice specific results are subsequently shared with practice sites.

Clinical Practice Guidelines

AllWays Health Partners participates in local and statewide forums to establish uniform guidelines that all state purchasers, payers and providers endorse.

AllWays Health Partners adopts regional and national clinical practice guidelines from recognized sources that are:

- Significance to our membership (prevalence of disease in our population)
- Based on sound scientific evidence or expert consensus
- Developed with practicing clinicians (local or national) in the applicable specialty
- Address documented variation in important care processes and outcomes

Annually, AllWays Health Partners establishes external benchmarks for important quality measures addressed by clinical practice guidelines and compares its performance relative to these benchmarks. AllWays Health Partners also uses Clinical Practice Guidelines for its Disease Management Programs. AllWays Health Partners selects at least two important aspects of care from the clinical practice guidelines that relate to its Disease Management Programs for quality

performance measurement and improvement activities.

Clinical Practice Guidelines are reviewed by AllWays Health Partners' clinical leadership at least every two years and/or as regional and national guidelines change.

Updates to the guidelines are posted on AllWays Health Partners' website, and written notification of update guidelines are provided in the next scheduled Provider Newsletter following Internet posting.

For a list of clinical practice guidelines currently endorsed by AllWays Health Partners, please visit allwaysprovider.org. If you do not have access to the Internet, please contact Provider Service to request a copy.

Health Care Access Standards

As part of its ongoing quality of care efforts and to meet regulatory and contractual requirement, AllWays Health Partners monitors and reports on member access to primary care and specialty services. This is done by the following methods:

Office-based access and availability surveys administered by AllWays Health Partners Provider Network Account Executive.

- to provider office staff
- Member satisfaction surveys
- Site-based surveys
- Consumer Assessment of Health Care Providers and Systems (CAHPS) surveys
- Geographic and numerical assessment:
  - » Mileage from member's residence to provider location
  - » Ratio of provider to members

The survey seeks responses to verify a provider's compliance with the availability or wait time access for the following services:

- Emergency services (including all necessary care coordination with home health, case management, behavioral health or other providers involved in the care of member) must be provided immediately and be available 24 hours a day, seven days a week
- Primary care
  - » *Urgent*—within 48 hours of the member's request
  - » *Non-urgent, symptomatic*—within 10 calendar days of the request
  - » *Non-symptomatic*—within 45 calendar days of the request, unless an appointment is required sooner in order to ensure the provision of screenings in accordance with the MassHealth Early and Periodic Screening, Diagnosis and Treatment and Preventive Pediatric Healthcare Screening and Diagnosis Periodicity Schedules.
- Specialty care
  - » *Urgent*—within 48 hours of request
  - » *Non-urgent, symptomatic*—within 30 calendar days of request
  - » *Non-symptomatic*—within 60 calendar days of the request
- Behavioral health
  - » Emergency and ESP services (including all necessary care coordination with home health, case management, mental health or other providers involved in the care of member) must be provided immediately and be available 24 hours a day, seven days a week.
  - » For services described in an inpatient of 24-hour diversionary services discharge plan:
    - *Non–24-hour diversionary services*—within two calendar days of discharge
    - *Medication management*—Within 14 calendar days of discharge
    - *Other outpatient services*—within seven calendar days of discharge
    - *Intensive care coordination services*—within the time frame directed by the Executive Office of Health and Human Services.
  - » *Urgent*—within 48 hours of request

  - » *All other behavioral healthcare*—within 14 calendar days
- Children newly placed in the Department of Children and Family (DCF) custody— For enrollees newly placed in the care or custody of DCF—providers must make best efforts to provide a DCF Health Care Screening within seven calendar days of receiving a request, and provide an initial Comprehensive Medical Examination within 30 calendar days of receiving a request unless otherwise mandated by the MassHealth Early and Periodic Screening, Diagnosis and Treatment and Preventive Pediatric Healthcare Screening and Diagnosis Periodicity Schedules. Providers must make best efforts to communicate with the child's assigned DSS caseworker(s) and when appropriate, inform them of rendered AllWays Health Partners covered services that support the child's needs.

Waiting Room Wait Time

In addition to these access standards, patients should be seen within a reasonable time after timely arrival. A reasonable time is defined as within 30 minutes from the appointment time.

For more details, call AllWays Health Partners Provider Service at 855- 444-4647.

Medical Records and Office Site Audits

As part of the contracting and quality oversight processes, AllWays Health Partners conducts a pre-contracting site visit and medical records review of all primary care office provider offices (including those staffed by nurse practitioners practicing in an expanded role as PCPs), in addition to high volume behavioral health provider practices. When applicable, a facility review is also conducted for newly contracted facilities prior to enrollment with AllWays Health Partners.

Site visits are performed by the Provider Relations staff or outside consultants and provide a mechanism for practitioner education and facilitation of continuous improvement in the provision of patient care and service. During site visits, specific established standards are applied which are reviewed and approved by AllWays Health Partners' Operations and Clinical Policy and Quality Committees. Site visits for potentially high-volume behavioral health practitioners are conducted by AllWays Health Partners' delegate, Optum, a fully accredited NCQA managed behavioral healthcare organization.

- Practice sites are assessed against the following standards:
- Physical accessibility
- Physical appearance
- Adequacy of waiting and examining rooms
- Appointment availability.

At a minimum, the medical record keeping practices of each site are assessed against the following standards:

- Secure/confidential filing and storing system
- Legible file markers
- Records easily located

When a practice site passes AllWays Health Partners' threshold, the provider moves forward in the contracting process.

If a practice site fails to achieve a score of 80 percent on all three components of the office site visit (including the overall score), the practice is notified of the score, the need for a corrective action plan and that the site will be re-evaluated within six months. At the time the practice site achieves at least 80 percent on all components of the review, AllWays Health Partners moves forward with the contracting process. When full compliance is not achieved during a corrective visit following the initial site visit, an additional visit is scheduled within 30 days. If full compliance is not achieved during this visit, it may result in a decision by AllWays Health Partners to terminate the practice and affiliated practitioners.

Site visit outcomes apply to all clinicians practicing within the same office site. Provider practices are notified in writing of their score.

AllWays Health Partners reserves the right to conduct a site visit for other provider types when an identified quality of care issue arises or when member complaints about the provider or practice site reach a specified threshold. Site visits are conducted when three or more- member complaints/grievances are received or when AllWays Health Partners becomes aware of quality of care concerns deemed serious based on a severity rating and/or review by the AllWays Health Partners Credentialing Committee.

Such complaints include but are not limited to:

- Reported cases of a patient's concern when the time spent with the clinician is perceived as inadequate to have fully addressed the purpose for the specific visit
- Failure of clinicians to adhere to patient safety measures (e.g., washing of hands, wearing of protective gloves, etc.)
- Failure of the practice to ensure a patient's safety and confidentiality (e.g., exam rooms not adequately locked, etc.).
- Sharp containers located within a child's reach
- Inappropriate disposal of hazardous waste
- Changes in procedures or policies post passing of the initial site visit (e.g., medical records no longer adequately secured)

A site visit is scheduled within 60 days of the registered concern, and providers may be asked for a corrective action plan with continuing follow-up site visits until all deficiencies have been addressed.

Medical Records Documentation Standards

To streamline utilization and quality review, medical records must adhere to nationally accepted standards for paper and systematic documentation pertaining to the appropriateness, course and result of treatments/services and corresponding outcomes. As part of ongoing monitoring of network practitioners, AllWays Health Partners conducts an annual review of medical records in a random sample of the network of PCPs and inpatient hospital sites. These medical record audit results are analyzed, and providers are notified of their results.

Documentation of the provision of effective patient care should contain all relevant information regarding the patient's diagnoses and overall health status, up to and including:

- Patient's primary language spoken
- Encounter date
- Clinical information/assessments
- Treatment/services provided
- Treatment plans
- Treatment goals and outcomes
- Contacts with the patient's family, guardians, and/or significant others

In monitoring adherence to medical records documentation standards, AllWays Health Partners staff conduct medical record audits at randomly selected primary care sites to review a sample of medical records.

Medical records are examined for evidence of compliance with each of the following essential medical record standards:

- Name, DOB, MR#, PCP identified on record
- History and physicals recorded on record
- Allergies and adverse reactions documented
- Problem list is present and updated
- Medications list is present and updated
- Visit notes contain clinical findings and evaluation
- Preventive services and risk screenings are recorded
- Lab, radiology and hospital reports are filed
- Advanced directives are discussed with patients 18 years and older

- Behavioral health screening completed at well child visit

The AllWays Health Partners reviewer must be given full access to the randomly selected medical charts or direct access to an EMR system. Compliance for each element requires that the element be present and easily found. The percentage of compliance is calculated based on the number of elements passed divided by the total number of elements.

The following elements also must be updated regularly. This is verified by checking recent office visit notes:

- Allergies and adverse reactions, or their absence, documented
- Problem list is present and updated
- Medications list is present and updated
- Preventive services and risk screenings are recorded

When recording compliance, the AllWays Health Partners reviewers use the Documentation Standards Review tool. Upon the completion of the audit, Quality Management staff analyze the results and develop site-specific reports. These reports are then delivered to the previously identified "key contacts" at each PCP or inpatient hospital site.

Medical Records Documentation Guidelines

In addition to the items referenced above, AllWays Health Partners reserves the right to audit member charts for compliance with all elements of medical records documentation requirements. The following guidelines are provided to assist network providers with ensuring and maintaining compliance with appropriate medical records documentation.

Advance Directives

All members 18 years of age and older are notified in writing of their right to execute advance directives. Members are provided information about their rights to:

- Make decisions concerning medical care
- Accept or refuse medical or surgical treatment
- Formulate advance directives (e.g., living wills, durable powers of attorney for health care, or health care proxy designations)

Participating PCPs are encouraged to discuss Advance Directives with adult patients and also required to document results of the discussion in the medical record. AllWays Health Partners audits practitioners' medical records for documentation of education and information about Advance Directives.

AllWays Health Partners refers members and providers to the Massachusetts Medical Society's website, www.massmed.org, to the "Patients," "Patient Education Materials," and "Health Care Proxy Information and Forms" sections to obtain information and forms.

Personal/Biographical Data

Must include, at a minimum and if applicable, full name, date of birth, sex, marital status, race, primary language, address, telephone number (home, mobile, work), employer name, insurance name, insurance ID number and any disabilities, such as visually and/or hearing impaired, uses a wheelchair, and other information.

Two Unique Identifiers

Must be found on each and every page of the medical record. Examples of identifiers are patient name, medical record number, AllWays Health Partners ID number, and date of birth.

Medical Record Entries

All medical record entries, whether related to a visit or for other purposes, must be dated and author-identified (signed). Author identification signature may be handwritten stamped, unique electronic identifier or initials. Professional designation (credentials) should accompany the signature.

Legibility

The medical record must be legible enough for someone other than the author to

understand the content of each entry.

Allergies/Adverse Reactions
Medication allergies and adverse reactions, or lack thereof, must be noted in a prominent location in the chart. Other allergies significant to the member's health status should be documented as well. If the patient has no known allergies and/or history of adverse reaction, the record should reflect this.

Drugs, Alcohol and Tobacco
Documentation of an assessment for alcohol, tobacco and illicit drug use must be present for all members age 12 and older, including seniors. Members age 12−21 must, at a minimum, be assessed at each well child care visit.

Patient Medical History
A comprehensive medical history including serious illnesses, accidents, surgeries/procedures and relevant family and social history. An appropriate entry with regards to immunization records should be noted in the chart. For children and adolescents, past medical history relates to prenatal care, birth, surgeries and childhood illnesses.

Problem List
Significant illnesses and medical conditions (acute, chronic, active, resolved, physical and mental), surgeries and relevant family and social history must be documented on the problem list. Short-term illnesses (e.g., flu) and "rule out" conditions may be excluded. This form must be updated at the time a new significant problem is identified and confirmed.

Immunizations
An immunization record (for children) is up to date and (for adult) an appropriate history has been made in the medical record.

Medication List
A medication list must be present in the record that includes, at a minimum, the name of the prescription medication, dosage, frequency, and the date prescribed. Short-term, illness-specific medications (e.g., antibiotics) need not be included on this list but should be documented in the notes of any visits that occur for the duration of the medication therapy. When a medication is discontinued, this should be noted on the medication list with the date that the medication was discontinued. In the absence of a structured medication list, all medications must be relisted in each visit note.

Under- or Over Utilization
There is appropriate notation for under- or over-utilization of specialty services or pharmaceuticals.

Visit Note
All visit note entries must contain the following elements, except where not applicable based on the nature of the visit: date of visit, purpose of visit, pertinent history, physical exam, diagnosis or clinical impression including under/over utilization of specialty services or pharmaceuticals, description of treatment provided including any medical goods or supplies dispensed or prescribed, plan of care and author identification. Author identification signature may be handwritten, stamped, a unique electronic identifier or initials. Professional designation (credentials) should accompany the signature. If the service is performed by someone other than the provider claiming payment for the service, the identity, by name and title, of the person who performed the service must be documented.

Some visits may not require all of the elements of a visit note. Examples of such visits include, PPD planting/reading, blood pressure check, flu shot, and medication counseling.

Standards for each clinical element of the visit, with examples, are as follows:

- Purpose of visit—Chief complaint; consists of the patient's reason for the visit. May quote the patient directly (e.g., "I have an itchy rash on my arm," or "in for a blood pressure check").
- Pertinent history—History of the condition

identifying subjective and objective information pertinent to the reason the patient presents (e.g., “Pt. complains of a stuffy nose and dry cough for three days. Cough is worse at night. Has been taking OTC cough medicine q 6 hours with no relief. No fever or sore throat. . .”).

- Physical exam—Objective and subjective information, whether positive or negative, pertinent to the chief complaint (e.g., “Chest clear to auscultation. Normal breath sounds”).
- Diagnosis/clinical impression—Working diagnosis/assessment must be consistent with findings from history and physical (e.g., “otitis media,” “well-controlled hypertension,” “well child”).
- Plan of care—Plans for treatment of condition and/or follow-up care must be consistent with the diagnosis. Plans should include instructions to member as appropriate, and notation of when member is expected to return for next visit. (e.g., “amoxicillin t.i.d. x 10 days,”“Hct, Pb, dental referral. RTC 1 yr. or prn.”). Notes and/or encounter forms should reflect follow-up care, calls, or visits, when indicated, including the specific time of return recorded as weeks, months or as needed.
- Laboratory/radiology/other—Laboratory and other studies are ordered, as appropriate. Results/reports of laboratory tests, x-rays and other studies ordered must be filed in the medical record initialed by the ordering practitioner signifying review. The review and signature cannot be done by someone other than the ordering practitioner. When the information is available electronically, there must be evidence of review by the ordering practitioner. If a test or study ordered at the primary care site is performed at another location, these results must also be filed in the primary care site’s medical record. Abnormal reports must be accompanied by a documented follow-up plan.
- Consultation referrals—Referrals to consultants must be appropriate and clearly documented. Clinical documentation must be present in the chart, which supports the decision to refer to a consultant. Documentation of the referral should include the name, location and specialty of the consultant, the reason for the referral, the date of the referral and, whenever possible, the date of the scheduled appointment.
- Consultation reports—For each referral, there must be a corresponding report in the chart for the consultant, as well as documented acknowledgement of the report by the provider. Results/reports of all consultations must be initialed by the ordering practitioner signifying review. The review and signature cannot be done by someone other than the ordering practitioner. If the consultant’s findings are abnormal, there must be documentation in the chart of the follow-up plan. There must be no evidence of inappropriate risk to a patient as a result of diagnostic or therapeutic procedures from consultations or the provider’s procedures.
- Consultation, laboratory, and imaging reports filed in the chart are initialed by the practitioner who ordered them, to signify review (review and signature by professionals other than the ordering practitioner do not meet this requirement.) If the reports are presented electronically or by some other method, there is also representation of review by the ordering practitioner. Consultation and abnormal laboratory and imaging study results have an explicit notation in the record of follow-up plans.
- Unresolved problems—Any problems identified at a visit that are not resolved during that visit must be addressed and documented in subsequent visits.
- Preventive Screenings—Evidence that preventive screenings and services were offered in accordance with the early periodic screening diagnosis and treatment EPSDT periodicity schedule for children and adolescents or, for individuals over the age of 21, in accordance with the provider’s own guidelines, including the administration of behavioral health screenings, is present.
- Advance Directives—Evidence that the provider attempted to discuss advance directives with all adult patients is in the patient’s medical record.

Additional Pediatric Documentation Standards

The medical records of all AllWays Health Partners members under age 21 must reflect periodic health maintenance visits as defined by the Massachusetts Quality Health Partners (MHQP) Pediatric Preventive Health Guidelines in effect at the time of the visit. Some health maintenance standards below apply to pediatric members of all ages while others apply only to certain ages or are required once over a specified time frame.

AllWays Health Partners documentation requirements include, but are not limited to, the following (the ages at which each standard applies will be noted below the definition of each standard, and will be followed by the documentation expectation):

Initial/Interval Medical History

For children and adolescents, past medical history relates to prenatal care, birth, surgeries and childhood illnesses. The initial medical history must contain information about past illnesses, accidents and surgeries, family medical history, growth and development history, assessment of immunization status, assessment of medications and herbal remedies, psychosocial history and documentation of the use of cigarette, alcohol and/or other substances.

The interval history must contain a review of systems and an assessment of the member's physical and emotional history since the last visit.

Comprehensive Physical Exam

Documentation of a complete, unclothed physical exam, including measurement of height and weight, must be present. Head circumference should be measured until age two and documentation of blood pressure should begin by age three.

Developmental Assessment

The member's current level of functioning must be assessed as concisely and objectively as possible in all of the following areas. Documentation such as "development on target" or "development WNL" is acceptable.

PHYSICAL
Gross motor, fine motor and sexual development

COGNITIVE
Self-help and self-care skills and ability to reason and solve problems

LANGUAGE
Expression, comprehension and articulation

PSYCHOSOCIAL
Social integration, peer relationships, psychological problems, risk-taking behavior, school performance and family issues. Ask about daycare arrangements for infants, toddlers and preschoolers. Follow- up should be documented, as appropriate, for developmental delays or problems.

SENSORY SCREENING

Hearing

- *Infancy*—The results of a formal newborn hearing screening, administered prior to a newborn's discharge from the birthing center or hospital should be documented in the chart. A gross hearing screening (e.g., "turns to sound," "hearing OK") must be documented for all members under age three. Newborns should be assessed before discharge or at least by 1 month of age. A subjective assessment should be conducted at all other routine check-ups.
- *1–17 (Early childhood–adolescence)*—Conduct objective hearing screening at ages 4, 5, 6, 8, and 10. A subjective assessment should be conducted at all other routine check-ups.

If testing is performed elsewhere (e.g., school), it does not need to be repeated by the provider, but findings, including the date of

testing, must be documented in the medical record. Follow- up should be documented, as appropriate, for abnormal findings.

Vision

- *0–1 (Infancy)*—A gross vision screening (e.g.,"follows to midline," "vision OK") must be documented for all members under three. Newborns should be assessed using corneal light reflex and red reflex before discharge or at least by 2 weeks of age. Evaluation of fixation preference, alignment and eye disease should be conducted by age six months.
- *1–17 (Early Childhood–Adolescence)*— Visual acuity testing should be performed at ages 3, 4, 5, 6, 8, 10, 12, and 15 years.
- *Screen for strabismus between ages 3 and 5*—A child must be screened at entry to kindergarten if not screened during the prior year per Massachusetts Preschool Vision Screening Protocol.

Dental Assessment/Referral

Documentation of an assessment of dental care must be present in the chart. For members under age three, a discussion of fluoride and bottle caries must be present and for members age three and older, teeth must be checked for obvious dental problems and an assessment must be documented as to whether the member is receiving regular dental care. Referral to a dentist must be provided to those members with abnormal findings.

The documentation should include the following:

Standard: 0-1 Age Range:

- Counsel against bottle-propping when feeding infants and babies.
- Counsel against bottles to bed.
- Assess oral health at each visit and need for fluoride supplementation at 6 months based upon availability in water supply and dietary source of fluoride.
- Encourage brushing with a soft toothbrush/cloth and water at age 6 months.
- Encourage weaning from bottle and drinking from a cup by the first birthday.
- Apply fluoride varnish to primary teeth of all infants and children every 6 months if not applied at dental home and every 3 months if at high risk for caries.

Standard 1-21 Age Range:

- Apply fluoride varnish to primary teeth for all children aged 1-5 every 6 months if not applied at dental home and every 3 months if at high risk for caries.
- Assess oral health at each visit and need for fluoride supplementation up to age 14 based on availability in water supply and dietary source of fluoride.
- Counsel on good dental hygiene habits, including brushing twice daily.
- Counsel on the establishment of a dental home beginning at 12 months or after eruption of first tooth.
- Counsel on use of mouth guards when playing sports.

Health Education/Anticipatory Guidance

Age-appropriate assessment, discussion and education relating to physical, developmental, psychosocial, safety and other issues must be documented at each well child care visit.

Immunization Assessment/Administration

Updated documentation of assessment of immunization status, and administration of immunizations according to most current Department of Public Health (DPH) guidelines, must be present in the chart on an immunization flow sheet. For immunizations administered, the documentation must include, at a minimum, the name of the immunization, the initials of the person who administered the vaccine and the date administered. It is recommended that lot number also be documented. For immunization records received from prior providers, including the hepatitis B #1 received in the hospital at birth, review by the provider must be explicitly documented. "Immunizations up-to-date" is not adequate documentation to indicate review. For

hepatitis B immunizations received at birth, the name of the hospital and the date administered must also be documented.

Exposure to Lead Risk Assessment

0–10 (INFANCY–MID-CHILDHOOD)
There must be documented evidence that the provider assessed the member for exposure to lead according to the following schedule:

- Initial screening between 9–12 months of age
- Annually at 2 and 3 years of age
- At age 4 if the child lives in a city/town with high risk for childhood lead poisoning
- At entry to kindergarten if not screened before

Documentation that the member is either "high" or "low" risk is acceptable. For members documented as "high risk," results of a blood lead test must be present in the chart.

Tuberculin Test

0–21 (infancy–young adult)
Tuberculin skin testing for all patients at high risk. Risk factors include having spent time with someone with known or suspected TB; coming from a country where TB is very common; having HIV infection; having injected illicit drugs; living in the U.S. where TB is more common (e.g., shelters, migrant farm camps, prisons); or spending time with others with these risk factors. Documentation of a reading of the results by a clinician must be present and dated 48−72 hours after testing. Determine the need for repeat skin testing by the likelihood of continued exposure to infectious TB.

Early and Periodic Screening and Diagnostic Testing (EPSDT)

Primary care providers (PCPs) caring for AllWays Health Partners MassHealth members under age 21 must offer to conduct periodic and medically necessary inter-periodic screens as defined by Appendix W of MassHealth's Early and Periodic Screening, Diagnosis and Treatment (EPSDT) and Preventive Pediatric Healthcare Screening and Diagnosis (PPHSD) Periodicity Schedules. For more information, please see the Behavioral Health Provider Manual.

Other Testing

There should be documentation for other screening tests, such as sickle cell, cholesterol, urinalysis/ culture and for sexually transmitted diseases, as appropriate to the member's risk and the provider's judgment. At a minimum, the date and results of the test must be documented.

Additional Inpatient Hospital Documentation Standards

- Member identification
- Admission date
- Dates of application for and authorization of Mass Health benefits, if applicable
- Emergency admission justification, if applicable
- Dates of operating room use, if applicable
- Dates of initial and continued stay review
- Physician Name
- Plan of care
- Reason and plan for continued stay

In accordance with AllWays Health Partners Member Rights and Responsibilities, members have the right to ask for and receive a copy of their medical record and request that it be changed or corrected.

Serious Reportable Events/Occurrences

A serious reportable event (SRE) is an event that occurs on the premises of a provider's site that results in an adverse patient outcome, is identifiable and measurable, has been identified to be in a class of events that are usually or reasonably preventable, and is of a nature such that the risk of occurrence is significantly influenced by the policies and procedures of the provider.

Potential SREs or quality of care (QOC) occurrences may be identified by members, providers, or AllWays Health Partners staff and may come into AllWays Health Partners

through AllWays Health Partners Customer Service or any other department. The duty to report a SRE is the responsibility of the individual facility or provider. The facility or provider must document their findings, and provide a copy of the report to both DPH and the AllWays Health Partners Manager of Quality Improvement within the required time frame.

Issues of concern may also be found through claims data or when medical record audits are performed by AllWays Health Partners. Claims data are reviewed on a monthly basis to identify possible SREs. Any problems identified include both acts of commission and omission, deficiencies in the clinical quality of care, inappropriate behavior during the utilization management process, and any instances of provider impairment documented to be a result of substance abuse or behavioral health issues. All contracted providers must participate in and comply with programs implemented by the Commonwealth of Massachusetts through its agencies, such as, but not limited to the Executive Office of Health and Human Services (EOHHS), to identify, report, analyze and prevent SREs, and to notify AllWays Health Partners of any SRE.

AllWays Health Partners promptly reviews and responds within 30 days to actual or potential QOC occurrences. The provider will have within seven days to report SREs. AllWays Health Partners uses the National Quality Forum's (NQF) definition of SREs and the NQF's current listing of "never events."

AllWays Health Partners does not reimburse services associated with SREs that are determined to be preventable after a root cause analysis (RCA) has been completed. To administer this policy, AllWays Health Partners recognizes but is not limited to the SREs identified by the National Quality Forum, HealthyMass, and the CMS Medicare Hospital Acquired Conditions and Present on Admission indicator reporting.

This policy applies to all hospitals and sites covered by their hospital license, ambulatory surgery centers, and providers performing the billable procedure(s) during which an "event" occurred.

AllWays Health Partners will reimburse eligible providers who accept transferred patients previously injured by an SRE at another institution (facility) or under the care of another provider.

Section 6
Clinical Programs and Utilization Management

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My Care Family Care Management Program

My Care Family is dedicated to providing well-managed patient-centered care to My Care Family patients. For optimal coordinated care, My Care Family patients should always be referred within the My Care Family network.

The My Care Family care management program primarily serves patients identified as high-risk and rising-risk. Interventions are tailored to meet patients where they are with increased services being made available to those with complex, costly, and/or chronic needs.

The care management program combines local, in-person care management at the points of care and in the community with remote, health-plan-based, telephonic Care Management. As appropriate, services may be delivered in the patient's home.

With this well-coordinated and patient-centered model, the care management program promotes high-quality and efficient care delivery. The program is intended to help reduce avoidable readmission and ED utilization, while improving member health outcomes and satisfaction.

My Care Family Care Teams

Integrated and multidisciplinary care teams are available to patients across all My Care Family practices. These collaborative teams will include cross-organizational clinical staff and primarily serve those that are identified as high risk or rising risk patients. With this collaborative model, this program expects to:

- Deliver stronger care coordination
- Improve communication with patient and within care team
- Improve patient outcomes
- Reduce duplicative spending and services
- Develop and strengthen community physician relations
- Improve quality of care
- Improve patient satisfaction and engagement
- Ensure that the patient has access to the right care at the right time

My Care Family Care Management Services

High-risk and rising-risk patients enrolled in My Care Family's Care Management Program are eligible to receive the following services as appropriate based on individual patient needs and goals:

- Comprehensive Assessments (if Care Needs Screening indicates the member has a Special Health Care Need)
- Development of patient-centered Care Plans
- Referrals to specialty and disease management programs as appropriate (HIV, High Risk OB, Diabetes, Hepatitis C, etc.)
- Referrals to LTSS and BH CPs as needed and appropriate
- Home visits
- Face-to-face and/or telephonic Care Management
- Care Management focused on improving health outcomes, reducing inappropriate utilization of resources, and ensuring communication and collaboration across the care continuum.
- Assistance when appropriate with improving Social Determinants of Health (SDOH) as they relate to and affect the members' health status
- Disease management
- Wellness programs
- Transitions of care management
- Medication reconciliation and medication education

Additional Care Management Services

In addition to services through the My Care Family Care Management program, My Care Family patients have access, when appropriate, to existing care management

programs at Greater Lawrence Family Health Center, Lawrence General Hospital, and AllWays Health Partners.

My Care Family Utilization Management

The Utilization Management (UM) program is designed to ensure the provision of the highest quality of health care to My Care Family patients 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 policies to ensure that utilization management criteria are objective and based on medical evidence and that My Care Family patients have appropriate access to new and emerging efficacious technologies.

Referrals, prior authorization, notification, concurrent review, retrospective 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, My Care Family promotes appropriate utilization of services. Utilization management decisions are based on appropriateness of care and service and the existence of coverage. My Care Family does not specifically reward practitioners or other individuals conducting utilization review for issuing denials of coverage or service, nor does My Care Family provide financial incentives to UM decision makers to encourage decisions that result in underutilization.

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. My Care Family clinicians are responsible for making all utilization decisions in accordance with the patient's plan of covered benefits and established medical necessity criteria.

My Care Family network providers are contractually prohibited from holding any My Care Family member financially liable for any service administratively denied by AllWays Health Partners for the failure of the provider to obtain the required prior authorization or notification for the service, or for services denied because the provider failed to submit supporting clinical documentation with their request.

My Care Family periodically reviews the services for which prior authorization is required as practice patterns in the network warrant. Providers are notified of changes via the eNewsletter, the provider portal, and/or written communications.

Requesting and Obtaining an Authorization or Referral

Prior authorization, referral and notification requirements for general services are available on allwaysprovider.org.

Most Surgical Day Care (SDC) services do not require authorization. A consolidated list of SDC procedures requiring authorization can be found on allwaysprovider.org.

Not all DME and orthotics require authorization. See the Prior Authorization Exemptions for DME, Orthotic and Prosthetics list on allwaysprovider.org.

Submission through the Provider Portal

Required referrals, authorizations and notifications must be submitted through

AllWays Health Partners online authorization tool, accessed through the provider portal, allwaysprovider.org. Clinical documentation to support authorization requests can also be submitted through allwaysprovider.org. To expedite decision making, complete clinical information supporting medical necessity should be uploaded with the request on allwaysprovider.org.

Authorization or referral requests to a non-My Care Family 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 My Care Family at the time of the service.
- The appropriate authorization template is completed for those service requests that require submission through allwaysprovider.org.
- 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

My Care Family providers obtain confirmation of received authorization requests and UM decision-making from allwaysprovider.org 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.

Utilization Management Methods

Referrals

My Care Family promotes a health care delivery model that supports PCP coordination and oversight of care. My Care Family recognizes that its members are best served when there is coordination between specialty and primary care clinicians. Referrals are not required to specialists within the My Care Family network.

To ensure reimbursement, care provided by a non-My Care Family specialist may require a referral from the PCP. The My Care Family PCP is the only provider authorized to make referrals to specialists. The PCP should submit the referral before the initial recommended specialty visit and no later than 90 days after the initial specialty visit. Without the required referrals, payment is subject to denial.

Some services such as family planning, gynecologist or obstetrician for routine, preventive, or urgent care, behavioral health services, and emergency services do not require a referral.

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.

My Care Family 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.

For elective services, such as admissions and surgical day, My Care Family requires at a minimum, submission five business days prior to the admission. Authorization determinations for elective services can take up to 14 calendar days to ensure adequate time for review and processing (See “UM Time Frame for Decision-making and Notification”).

Prior authorization is not required for:

- Emergency room care
- Observation
- Emergent acute inpatient admissions.

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 My Care Family Utilization Management Care Managers based on medical necessity criteria. Prior authorization denials (adverse determination) for medical necessity are made only by the Chief Medical Officer, an AllWays Health Partners Medical Director, or a designated physician reviewer, based upon medical necessity criteria, the specific needs of the individual patient and the availability of local resources.

Durable Medical Equipment (DME)

DME purchases and rentals must be requested by the patient’s PCP, treating provider, or an approved vendor.

Some DME items are not subject to authorization requirements. For a list of services that require prior authorization, please review the DME Prior Authorization list on the provider portal. This list also includes medical supplies, oxygen related equipment, orthotics and prosthetics that require prior authorization.

DME prior authorization requests are submitted through allwaysprovider.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.

Providers need to submit requests including supporting information and a prescription directly to the participating vendor. My Care Family staff works directly with the vendors to insure efficient and timely filling of requests.

Enteral Products

Authorization requests for enteral products are submitted through allwaysprovider.org. A valid authorization request and completed Combined MassHealth Managed Care Organization (MCO) Medical Necessity Review Form for Enteral Nutrition Products (special formula) form indicating the specific product and quantity are required before a determination can be made to approve a requested service.

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

The medical services that may be reviewed include inpatient services, select inpatient and outpatient surgical procedures and select imaging and ancillary services.

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 www.evicore.com. 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 an administrative denial of services to the provider.

Sleep Studies and Therapy Management

My Care Family partners with SMS (Sleep Management Solutions) and their parent company, CareCentrix (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 using a polysomnogram.

Submit requests directly to SMS by:

- Visiting the SMS website http://www.sleepmanagementsolutions.com and accessing the secure Sleep Portal to submit the request.
- Phoning SMS/CCX Monday through Friday, 8AM to 5:00 PM, EST, at: (886)-827-5861

For information on billable codes, access AllWays Health Partners' Provider Payment Guideline for Sleep Studies and Therapy Management. Criteria for medical necessity decision making is available on allwaysprovider.org.

Behavioral Health Services

My Care Family partners with Optum to manage the delivery of behavioral health services for all My Care Family patients. For more information, contact Optum at 844-451-3519.

Concurrent Review

Concurrent review is required for subsequent days of care or visits or services beyond the initial authorization or required notification. Concurrent review must be conducted via allwaysprovider.org where indicated. For services that cannot be conducted via allwaysprovider.org, you may fax, mail, or work with an on-site utilization management care manager at designated facilities.

Most requests for concurrent services are submitted through the provider portal. Follow the provider portal User Guide for revising authorizations. Those service requests that are not accepted through the provider portal must be faxed or mailed to AllWays Health Partners. 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 an administrative 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, and continuous DME supplies/equipment).

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 his or her 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 My Care Family'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.

Retrospective Review

As part of My Care Family's UM program in assessing overutilization and underutilization of services, focused retrospective review activity may be performed as cost drivers, HEDIS scores, changes in medical and pharmacy utilization trends, provider profiling and financial audits suggest.

Retrospective review is also performed on a case- by-case basis and is routinely applied to hi-tech radiology cases.

In the event that the Utilization Management Care Manager is unable to perform concurrent review, cases may be reviewed retrospectively. For facilities in which on-site Care Management review is performed, the medical record may be reviewed in the Medical Records department. In all other cases, a copy of the medical record will be requested in accordance with applicable confidentiality requirements

UM Time Frame for Decision-Making and Notification

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

MassHealth members do not receive written notification of prior authorization or concurrent authorization approvals.

UM Time Frame for Decision-Making and Notification

UM Subset	Decision Time Frame	Verbal Notification Provider	Written/Electronic Provider Approval Notification	Written Denial Notification
Pre-service/Initial Determination *Non-urgent Standard*	Within 14 *calendar* days after receipt of the request the member or authorized representative may request an extension for up to 14 additional *calendar* days	**Denial** Within 14 *calendar* days after receipt of the request	Electronic notification is available on the next *business* day after the decision determination and within 14 *calendar* days after receipt of the request	Within 14 *calendar* days after receipt of the request
Pre-service/Initial Determination *Urgent/Expedited*	Up to 72 hours/three *calendar* days of receipt of the request the member or authorized representative may request an extension for up to 14 additional *calendar* days	**Denial** Within 72 hours/three *calendar* day of receipt of request	Electronic notification is available on the next business day after the decision determination and within three business days after receipt of the request	Within 72 hours/three calendar days of verbal notification and not to exceed three business days from receipt of receipt of the request
Concurrent Review *Urgent/Expedited* Inpatient stays are always considered Urgent/Expedited	Within 24 hours/one *calendar* day of receipt of the request. The member or authorized representative may request an extension for up to 14 additional calendar days	**Denial** Within 24 hours/one *calendar* day of receipt of request **Approval** Within 24 hours/1 *calendar* day of receipt of request	Electronic notification is available on the next business after the decision determination and within three business days after receipt of the request	Within 72 hours/three *calendar* days of verbal notification and not to exceed 3 business days from receipt of request exceed three business days from receipt of request Service is continued Service is continued without liability to member until notification

UM Subset	Decision Time Frame	Verbal Notification Provider	Written/Electronic Provider Approval Notification	Written Denial Notification
Concurrent *Non-urgent/ Standard*	Within 14 *calendar* days after receipt of the request. The member or authorized representative may request an extension for up to 14 additional *calendar* days	**Denial** Within 14 *calendar* days after receipt of the request **Approval** Within 14 *calendar* days of receipt of the request	Electronic notification is available on the next *business* day after the decision determination and within 14 *calendar* days after receipt of the request	Within 1 business day following verbal notification, but no later than 14 calendar days after receipt of the request
Reconsideration of Adverse Determination (Initial and concurrent medical necessity review determination)	Within one *business* day of receipt of request for reconsideration	Within one *business* day of receipt of request for reconsideration	According to type of request as described above	According to type of request as described above
For termination, suspension, or reduction of a previous authorization	N/A	N/A	N/A	At least 10 *calendar* days prior to date of action

Notification of Birth Process

• Babies will no longer be automatically assigned to their mother's plan. Plan assignments for newborns are now prospective. MassHealth no longer assigns plans retroactively to date of birth. There are two new fields on the NOB so the family can select the baby's PCP and plan when the NOB is completed in the hospital

• Hospitals will be required to notify MassHealth within 10 days of a baby's birth whenever possible. However, you will no longer be required to notify AllWays Health Partners.

• The family can also enroll the newborn in a health plan by visiting MassHealthchoices.com or calling MassHealth customer service at 800-841-2900, Monday-Friday 8 am – 5 pm.

• Babies will be enrolled in MassHealth fee-for-service until MassHealth receives the NOB and assigns a plan. If the family does not enroll the newborn in a plan either on the NOB or within 14 days of NOB submission, MassHealth will automatically assign the newborn into a managed care plan.

• To determine eligibility and plan information, hospitals should check the MassHealth electronic verification system daily.

For further details please refer to the MassHealth Bulletin https://www.mass.gov/doc/all-provider-bulletin-305-policies-and-procedure-for-newborn-members-eligibility-enrollment-0/download?_ga=2.94717855.2084645410.1653506649-1970858986.1653506649

Changes for Sick Newborns

For sick newborns, submit authorizations under the baby's ID once the baby is enrolled in AllWays Health Partners. When eligibility has been established, you must submit a prior approval to AllWays Health Partners within 24 hours. Notification of the admission should be submitted by the hospital.

Out-of-Network Requests

My Care Family PCPs should always refer members within the My Care Family network. Should the PCP refer a member outside the My Care Family network, the PCP must obtain the applicable referral and prior authorizations to confirm coverage.

Authorization is required for all non-emergent out-of-network service requests except for early intervention services, and family planning services provided to My Care Family patient. My Care Family patient may obtain family planning services at any MassHealth family service planning provider, even if the provider is out of the My Care Family network.

My Care Family providers can be found in the Provider Directory.

My Care Family works with patients and clinicians to provide continuity of care and to ensure uninterrupted access to medically necessary covered services, whether current patients or newly enrolled.

In most cases, a pre-existing relationship with an out-of-network provider is not reason alone to justify the need for an out- of-network provider.

Authorization requests for out-of-network specialists are submitted by fax or mail and are subject to medical necessity review.

Discharge Planning

Discharge planning occurs through the entire continuum of care for members engaged in medical as well as behavioral health treatments since members are discharged from home care and outpatient service, as well as inpatient stays more commonly associated with discharge planning.

Discharge planning for My Care Family members is initiated as expeditiously as possible on admission to the inpatient facility and with the initiation of home and outpatient services, and is addressed through- out the continuum of care to facilitate timely and appropriate discharge and post-discharge services.

Utilization Management Care Managers ensure that treating providers have up-to-date benefit information, understand the member's benefit plan, possible barriers with authorizing transition services, and know how to access covered. Discharge planning transcends the care setting, and therefore, all Utilization Management Care Managers are required to be proficient in all operations that encompass discharge planning, including a full understand of community resources available to the member.

Utilization Management Care Managers arrange for in-network services and out-of-network authorizations when the network of providers cannot meet the member's after care needs. In addition to assisting the provider with traditional authorization/benefit information, the Utilization Management Care Manager collaborates and coordinates services with the provider and works with other appropriate members of the health care team, including but limited to, My Care Family care management programs, behavioral health care management programs, community and agency resources and the patient's designee on their unique discharge planning needs in order to coordinate services and facilitate a smooth transfer of the patient to the appropriate level of care and/ or into clinical care management programs that will continue to support the patient's recovery.

Discharge Planning to Support Members Experiencing or at Risk of Homelessness

MassHealth has established specific discharge planning requirements for Acute Inpatient Hospitals, Freestanding Psychiatric Hospitals and Accountable Partnership Plans. These requirements were put in place to create more effective discharge planning efforts in order to decrease the number of people who are discharged from healthcare facilities directly to homeless shelters. For additional information on MassHealth requirements can be found on the mass.gov website, MassHealth Bulletins, July 2021, #27 and #64.

As required, please notify us to initiate a member's discharge planning process at: massbhcca@ optun.com (behavorial health), or
massheakthcm@allwayshealth.org
(medical)
Please provide the following member information in your email: patient's full name, date of birth, referring facility name, facility discharge specialist name, phone number and email.

Medical Necessity Decision-Making

Underutilization of medically appropriate services has the potential to adversely affect our members' health and wellness. For this reason, My Care Family promotes appropriate utilization of services. My Care Family utilization management decisions are based only on appropriateness of care and service and existence of coverage. My Care Family does not arbitrarily deny or reduce the amount, duration, or scope of a covered service solely

because of the diagnosis, type of illness, or condition of the patient or make authorization determinations solely on diagnosis, type of illness or the condition of the patient.

All medical necessity decisions are made only after careful consideration of the applicable written medical criteria, interpreted in light of the individual needs of the member and the unique characteristics of the situation.

My Care Family does not specifically reward practitioners or other individuals conducting utilization review for issuing denials of coverage or service, nor does My Care Family provide financial incentives to UM decision-makers to encourage decisions that result in underutilization.

In all instances of medical necessity denials, it is My Care Family's policy to provide the treating/referring practitioner with an opportunity to discuss a potential denial decision with the appropriate practitioner.

Collection of Clinical Information for UM Decision-making

The clinical operations staff requests only that clinical information which is relevant and necessary for decision-making. My Care Family uses relevant clinical information and consults with appropriate health care providers when making a medical necessity decision.

When the provided clinical information does not support an authorization for medical necessity coverage, the care manager and/or physician reviewer outreaches to the treating provider for case discussion. A decision will be made based on the available information if the treating provider does not respond within the time frame specified.

All clinical information is collected in accordance with applicable federal and state regulations regarding the confidentiality of medical information.

Utilization Management Care Managers conducting utilization review at a facility are required to become familiar with the facility's rules and policies and procedures governing on-site review activity prior to initiating review and follow such rules and policies and procedures as required and agreed upon by the facility.

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), My Care Family is entitled to request and receive protected health information for purposes of treatment, payment, and health care operations without the authorization of the patient.

Clinical Criteria

My Care Family internally develops and uses medical necessity guidelines and criteria to review medical appropriateness of targeted services based on its member population and service utilization. Utilization management criteria and procedures for their application are reviewed at least annually and guidelines and criteria are updated when appropriate.

My Care Family has adopted McKesson's InterQual Level of Care Criteria for Acute Care Adult, Acute Care Pediatric, Rehabilitation Adult and Pediatric, Sub Acute and Skilled Nursing Facilities Adult. InterQual criteria represent the gold standard in evidence−based clinical decision support, used by CMS and thousands of hospitals and health plans across the country to assess appropriateness of care.

Guidelines and criteria are developed and amended by My Care Family clinicians under the direction of the Chief Medical Officer and Medical Directors and are approved, as appropriate, by the Utilization Management Committee, the Pharmaceutical and Therapeutics Committee, and the Clinical Policy and Quality Committee.

Medical necessity guidelines and criteria are based on sound clinical evidence of safety and efficacy, and developed and amended using various professional and government agencies and local health care delivery plans.

The Utilization Management Care Manager and/or physician reviewer evaluates all relevant information before making a determination of

medical necessity. Clinical guidelines and criteria are used to facilitate fair and consistent medical necessity decisions. At a minimum, the Care Manager considers the following factors when applying criteria to a given member: age, co- morbidities, complications, progress of treatment, psychosocial situation, home and family environment, when applicable. Medical necessity criteria are applied in context with individual member's unique circumstances and the capacity of the local provider delivery system. When criteria do not appropriately address the individual member's needs or unique circumstances, the Care Manager and/or physician reviewer may override the criteria for an approval of services.

Providers can obtain a copy of internally developed criteria used for a specific determination of medical necessity by accessing allwaysprovider.org. Proprietary criteria are made available to providers and members on request and only to the extent it is relevant to the particular treatment or service.

MassHealth's Definition of Medical Necessity

Medically necessary services for My Care Family members are those health care services:

- Reasonably calculated to prevent, diagnose, prevent the worsening of, alleviate, correct or cure conditions in the member that endanger life, cause suffering or pain, cause physical deformity or malfunction, threaten to cause or to aggravate a disability, or result in illness or infirmity
- For which there is no comparable medical service or site of service available or suitable for the member requesting the service that is more conservative or less costly of a quality that meets professionally recognized standards of health care, and must be substantiated by records including evidence of such medical necessity and quality

Information Request

PROVIDER SERVICE
Phone 855-444-4647
Mon.-Fri. 8:00 a.m.-5:00 p.m and closed 12:00pm – 12:45pm.

MEMBER SERVICE
Phone 800-462-5449
TTY 711
Mon.-Fri. 8:00 a.m.-6:00 p.m.
Thursday, 8:00 a.m.-8:00 p.m.

For after-hour requests and utilization management issues, these lines are available 24 hours a day, seven days a week. All requests and messages will be retrieved on the next business day. Language assistance is available to all members.

Medical Necessity Denials

A medical necessity denial is a decision made to deny, terminate, modify or suspend a requested health care benefit based on failure to meet medical necessity, appropriateness of health care setting, or criteria for level of care or effectiveness of care.

Only a My Care Family physician reviewer or physician designee may make medical necessity determinations for denial of service. Appropriate My Care Family network specialists and external review specialists are used for complex specialty reviews and to review new procedures or technology. Reconsideration (clinical peer review) may be requested for services that are denied prospectively or concurrently on the basis of medical necessity. Reconsideration is an informal process offered to providers. It is not an appeal nor is it a precondition for filing a formal appeal. A physician reviewer conducts the reconsideration within one business day of the request.

Written notifications of medical necessity denials contain the following information:

- The specific information upon which the denial was made

- The member's presenting symptoms or condition, diagnosis and treatment interventions and the specific reasons such medical evidence fails to meet the relevant medical necessity review criteria
- Specification of any alternative treatment option that is available through My Care Family or the community, if any
- A summary of the applicable medical necessity review criteria and applicable clinical practice guidelines
- How the provider may contact a physician reviewer to discuss the denial
- A description of the formal appeals process, the mechanism for instituting the appeals process, and the procedures for obtaining an external review of the decision

Administrative Denials

Administrative denials for authorization of requested services or payment for services rendered may be made when:

Member issued

- A service is explicitly excluded as a covered benefit under the member's benefit plan.
- The requested benefit has been exhausted.

Provider only issued

- A service was provided without obtaining the required prior authorization.
- Required notification was not made in a timely manner.
- Failure to submit clinical documentation necessary to make a medical necessity determination with the requested service.

My Care Family network providers are contractually prohibited from holding any My Care Family patient financially liable for any service administratively denied by AllWays Health Partners for failure of the provider to adhere to established utilization processes.

Delegation of Utilization Management

My Care Family delegates some utilization management activities to external entities and provides oversight of those entities. UM delegation arrangements are made in accordance with the requirements of the National Committee on Quality Assurance (NCQA), the Massachusetts Division of Insurance, the Executive Office of Health and Human Services (EOHHS), and other regulatory requirements.

- Optum for the utilization and care management of behavioral health services on behalf of My Care Family patients. Optum is a fully NCQA accredited Managed Behavioral Health Organization.
- CVS Caremark has been delegated certain utilization management functions for a select group of pharmaceuticals. AllWays Health Partners' Pharmacy and Therapeutics Committee approves all pharmaceuticals to be included in CVS Caremark's prior authorization process. The responsibility for making denials based on medical necessity remains with AllWays Health Partners.
- eviCore Healthcare

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

  The medical services that may be reviewed include inpatient services, select inpatient and outpatient surgical procedures and select imaging and ancillary services.

  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.
- Focus Health provides consultative reviews of prior authorization requests for spinal surgery. Focus Health is a medical management services organization specializing in the evaluation of pain management services, including spinal surgery.

- Sleep Management Solutions has been delegated sleep diagnostic and therapy management services.
- Medical Review Institute of America (MRIoA) has been delegated to supplement the prior authorization review process. MRIoA is an external review organization that is staffed with board-certified physicians with a wide variety of specialties. In the rare instance when My Care Family physician reviewers are unavailable, MRIoA will provide support for the UM reviews. In these instances, MRIoA representatives may reach out to the requesting provider to obtain additional clinical information or conduct a physician-to-physician review.

My Care Family maintains close communications with its delegated partners to ensure seamless operations and positive member and provider experiences.

Online Clinical Reports on the Provider Portal

Clinical reports to help effectively manage patients are available via the provider portal. This provision of timely, actionable site and patient-level data allows PCPs to download electronic versions of a variety of reports and analyze the data based on the specific needs of their practice.

Available reports include both quality and utilization information. This includes both quality measures and utilization for members with asthma and diabetes as well as ER utilization.

Access to the data is entirely at the discretion of the provider office. To protect the confidentiality of our members and due to the sensitive contents of these reports, providers are strongly encouraged to grant role-based access only and review user permissions regularly.

Nurse Advice Line

My Care Family members have access to a toll free 24/7 Nurse Advice Line. Patients can speak directly with a registered nurse at any time of the day, seven days a week. Members may also listen to automated information on a wide range of health-related topics, ranging from aging and women's health to nutrition and surgery. The Nurse Advice Line doesn't take the place of a primary care visit. It is intended to help our members decide if they should make an appointment with their PCP or go to the emergency room. The nurse also provides helpful suggestions for how your patients might care for themselves at home.

Your patients may access the My Care Family Nurse Advice Line at 1-833-372-5644

Section 7
Billing Guidelines

Section 7
Billing Guidelines

Billing, Reimbursement, and Claims Submission

Submitting a Claim

AllWays Health Partners manages the claims processing for My Care Family. AllWays Health Partners is committed to processing clean claims within at least 45 days of receipt. The claim receipt's Julian date is embedded in the AllWays Health Partners claim number as shown on the Explanation of Payment (EOP).

A clean claim is defined as one that includes at least the following information:

- Full member name
- Member's date of birth
- Full AllWays Health Partners 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, when applicable
- Vendor name and address
- Provider's federal tax identification number

Claim Submission Guidelines

When using a billing agent or clearinghouse, providers are responsible for meeting all AllWays Health Partners claim submission requirements.

AllWays Health Partners requires the submission of all paper and electronic claims within 90 days of the date of service unless otherwise contractually agreed.

AllWays Health Partners will not accept handwritten claims or handwritten corrected claims.

AllWays Health Partners will only accept claims for services that you, your organization or your staff perform. Pass-through billing is not permitted and may not be billed to our members.

AllWays Health Partners' claim submission guidelines are as follows:

Claim Type	Submission Format
Professional Charges	CMS-1500
Durable Medical Equipment (DME)	CMS-1500
DME Supplies, Home Infusion Services, etc.	CMS-1500
Institutional/Facility Charges	UB-04

EDI (Electronic) Claims

Claims submitted electronically are subject to the claim edits established by AllWays Health Partners. AllWays Health Partners' payer ID number is 04293. Companion Guides are available to assist providers interested in electronic claim submissions.

For questions regarding electronic claims submissions, please contact AllWays Health Partners Provider Service at 855-444-4647.

Paper Claims

Paper claims must be submitted on the proper forms within the aforementioned time frames or per specific contract arrangements. Claim forms other than those noted above cannot be accepted. AllWays Health Partners' front edits apply to both EDI and paper claim submissions.

NEW CLAIMS ONLY

Mail: AllWays Health Partners
P. O. Box 853908
Richardson, TX 75085-3908

This address is for submission of brand new paper claims only. To avoid processing delays, please do not send claims adjustment requests or any other correspondence to this address.
Address all other correspondence as shown below.

CLAIM ADJUSTMENT REQUESTS

Mail: AllWays Health Partners
Attn: Correspondence Department
399 Revolution Drive, Suite 810
Somerville, MA 02145

CLAIMS APPEAL REQUESTS

Mail: AllWays Health Partners
Attn: Appeals Department
399 Revolution Drive, Suite 810
Somerville, MA 02145

Corrected Claims

AllWays Health Partners accepts both electronic and paper corrected claims, in accordance with guidelines of the National Uniform Claim Committee (NUCC) and HIPAA EDI standards. Corrected claims must be submitted with the most recent version of the claim to be adjusted. For example: a corrected claim to the original claim (00000E00000) should include the original claim number. A second corrected claim request should include the latest version (00000E00000A1).

Electronic Submissions

To submit a corrected facility or professional claim electronically:

- Enter the frequency code (third digit of the bill type for institutional claims; separate code for professional claims) in Loop 2300, CLM05-3 as either "7" (corrected claim), "5" (late charges), or "8" (void or cancel a prior claim).
- Enter the original claim number in Loop 2300, REF segment with an F8 qualifier. For example, for claim #12234E01234, enter REF*F8*12234E01234.

Provider payment disputes that require additional documentation must be submitted on paper, using the Request for Review Form.

Late Charge Billing

AllWays Health Partners accepts corrected claims to report services rendered in addition to the services described on an original claim. AllWays Health Partners will not accept separate claims containing only late charges.

AllWays Health Partners 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.

Claim Adjustments/Requests for Review

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

Filing Limit Adjustments

To be considered for review, requests for review and adjustment for a claim received over the filing limit must be submitted within 90 days of the EOP date on which the claim originally denied. Disputes received beyond 90 days will not be considered

If the initial claim submission is after the timely filing limit and the circumstances for the late submission are beyond the provider's control, the provider may submit a request for review by sending a letter documenting the reason(s) why the claim could not be submitted within the contracted filing limit along with any supporting documentation. Documented proof of timely submission must be submitted with any request

for review and payment of a claim previously denied due to the filing limit. A completed Request for Review Form must also be sent with the request.

For paper claim submissions, the following are considered acceptable proof of timely submission:

- A copy of the computerized printout of the Patient Account Ledger indicating the claim was billed to AllWays Health Partners, with the submission date circled in black or blue ink.
- Copy of Explanation of Benefits (EOB) from the primary insurer that shows timely submission (90 days) from the date carrier processed the claim.
- Proof of follow-up with the member for lack of insurance information, such as proof that the member or another carrier had been billed, if the member did not identify him/herself as a My Care Family member at the time of service.

For EDI claim submissions, the following are considered acceptable proof of timely submission:

- For claims submitted though a clearinghouse: A copy of the transmission report and rejection report showing the claim did not reject at the clearinghouse, and the claim was accepted for processing by AllWays Health Partners within the time limit.
- For claims submitted directly to AllWays Health Partners: The corresponding report showing the claim did not reject at AllWays Health Partners and was accepted for processing by AllWays Health Partners within the time limit.
- Copy of EOB from the primary insurer that shows timely submission from the date that carrier processed the claim.

A copy of the Patient Account Ledger is not acceptable documentation for EDI claims except when the patient did not identify him/herself as a My Care Family patient at the time of service.

The following are not considered to be valid proof of timely submission:

- Copy of original claim form
- Copy of transmission report without matching rejection/error reports (EDI)
- An AllWays Health Partners rejection report or a report from the provider's clearinghouse without patient detail.
- A computerized printout of the Patient Account ledger stating "billed carrier"
- A computerized printout of the Patient Account ledger stating another carrier was billed in error, where AllWays Health Partners is the primary carrier via the New England Healthcare Exchange Network
- Hand-written Patient Account Ledger
- Verbal requests

Behavioral Health Services Claims

My Care Family's Behavioral Health benefit is administered through Optum. Claims, appeals, and adjustment requests for behavioral health specific services must be submitted to Optum directly.

Billing for Professional Services, Durable Medical Equipment, and Supplies

Professional charges, as well as DME and supplies must be billed on a CMS-1500 claim form and include all pertinent and/or required information. Missing, incomplete, or invalid information can result in claim denials.

In addition, the group and the rendering clinician's NPI numbers are required on most professional claim submissions. Claims submitted without a valid number are subject to rejection by My Care Family.

Billing for Inpatient and Outpatient Facility Services

Institutional charges must be billed on a UB-04 claim form and include all pertinent and/or required information. Where appropriate, valid ICD-10, revenue (REV), CPT-4 and/or HCPCS, and standard three-digit type of bill codes are required on institutional claims.

AllWays Health Partners requires the facility's NPI on all institutional claim submissions. Claims submitted without valid numbers are subject to rejection by AllWays Health Partners.

Room Charges

AllWays Health Partners covers only the semi-private room rate unless a private room is pre-authorized. When not pre-authorized, the semi-private room rate will be applied to all private room charges during claim adjudication.

Itemization

Itemization of inpatient charges is required upon request with each day of service separately reported.

Please refer to AllWays Health Partners' UB-04 Claim Form Completion Guidelines for more information on required fields.

Coordination of Benefits (COB) Guidelines

COB is the process to determine how medical, dental, and other health care services will be paid when a person is covered under more than one insurer. Providers are required to notify AllWays Health Partners 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 patient enrolls with My Care Family, AllWays Health Partners is *always* the payer of last resort. All payments for covered My Care Family services rendered are considered as payment in full.

Services and charges must be billed on an appropriate claim form and submitted to AllWays Health Partners within 90 days of receipt of the Explanation of Payment (EOP) or remittance advice from the primary insurance carrier.

Third-Party Liability Claims

When a My Care Family member is involved in an automobile accident, providers should notify AllWays Health Partners directly by calling the Third-Party Liability Department at 617-772-5729 and making the proper notation on submitted claims. An AllWays Health Partners representative can assist with the process of determining which carrier should be billed for services. Providers should use a TPL Indicator Form for reporting other insurance information discovered during patient encounters for all My Care Family members. These forms are available to providers by calling Provider Service.

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

Workers Compensation (WC) Claims

When a My Care Family 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 AllWays Health Partners consider additional claims.

Reconciling AllWays Health Partners' Explanation of Payment (EOP)

Each EOP claim line reflects the specific service codes billed to AllWays Health Partners. Denied claim lines will have corresponding "Remarks" explaining the reason for the denial.

A claim line can be denied for many reasons, including but not limited to:

- The payment submitted is included in the allowance for another service/procedure.
- The service code submitted is not within the AllWays Health Partners contract.
- The member was not effective for some or all dates of service (i.e., AllWays Health Partners was billed for five days but the member was effective for only three of those days).
- The time limit for filing the claim has expired.
- A required authorization is required and not on file.

Providers with questions or concerns on the disposition of a denied claim should first validate that all reasons for the claim denial have been considered before re-submitting to AllWays Health Partners.

Providers are strongly encouraged to reconcile the EOP timely or at least within 90 days of receipt. Requests for adjustments or corrections received beyond the 90-day adjustment request filing limit cannot be considered for reprocessing.

To assist in reconciling, AllWays Health Partners offers instant access to PDF versions of current and historical EOP copies on our secure provider portal, allwaysprovider.org. To enroll in the provider portal, simply follow the easy registration instructions, or consult with your site's appointed user administrator.

Provider Reimbursement

Reimbursement for services rendered must be treated as payment in full. Providers may not seek or accept payment from a My Care Family patient for any covered service rendered. In addition, providers may not have any claim against or seek payment from MassHealth for any My Care Family covered service rendered to a My Care Family patient. Providers should look solely to AllWays Health Partners for payment with respect to My Care Family covered services rendered.

Furthermore, a provider may not maintain any action at law or in equity against any member or MassHealth to collect any sums that are owed to the provider by AllWays Health Partners for any reason, up to and including AllWays Health Partners' failure to pay, insolvency, or otherwise breach of the terms and conditions of the AllWays Health Partners Provider Agreement.

In the event that a non-medically necessary or non-My Care Family covered service is provided in place of a covered service, the provider may not seek reimbursement from the member unless documentation is provided indicating the provider explained the liability of payment for the non-medically necessary or non-My Care Family covered service to the member prior to services being rendered. Documentation must indicate that the member both understood and agreed to accept liability for payment at the time of service.

Serious Reportable Events/Occurrences

A serious reportable event (SRE) is an event that occurs on the premises of a provider's site that results in an adverse patient outcome, is identifiable and measurable, has been identified to be in a class of events that are usually or reasonably preventable, and is of a nature such that the risk of occurrence is significantly influenced by the policies and procedures of the provider.

Potential SREs or quality of care (QOC) occurrences may be identified by members, providers, or My Care Family staff and may come into AllWays Health Partners through Customer Service or any other department. The duty to report a SRE is the responsibility of the individual facility or provider. The facility or provider must document their findings; and provide a copy of the report to both the MA Department of Public Health (DPH) and to the AllWays Health Partners Director of Quality Management and Improvement within the required time frame.

Issues of concern may also be found through claims data or when medical record audits are performed by AllWays Health Partners. Claims data are reviewed on a quarterly basis to identify possible SREs. Any problems identified include both acts of commission and omission, deficiencies in the clinical quality of care, inappropriate behavior during the utilization management process, and any instances of provider impairment documented to be a result of substance abuse or behavioral health issues. All contracted providers must participate in and comply with programs implemented by the Commonwealth of Massachusetts through its agencies, such as, but not limited to the Executive Office of Health and Human Services (EOHHS), to identify, report, analyze and prevent SREs, and to notify AllWays Health Partners of any SRE.

AllWays Health Partners reviews and promptly responds within 30 days to actual or potential QOC occurrences. The provider will have within seven days to report SREs. AllWays Health Partners uses the National Quality Forum's (NQF) definition of SREs (referred to as "never events") and the NQF's current listing of "never events."

AllWays Health Partners does not reimburse services associated with SREs, "never events," and/or provider preventable conditions.

To administer this policy, AllWays Health Partners recognizes but is not limited to the SREs identified by the National Quality Forum, HealthyMass, and the CMS Medicare Hospital-Acquired Conditions (Present on Admission Indicator) reporting.

This policy applies to all hospitals and sites covered by their hospital license, ambulatory surgery centers, and providers performing the billable procedure(s) during which an "event" occurred.

AllWays Health Partners will reimburse eligible providers who accept transferred patients previously injured by an SRE at another institution (facility) or under the care of another provider.

Prov Name Patient Account#			Member Number / Name		Prov NPI#			Prov NHP# Claim Number		DRG	
1	12/16/2016 12/16/2016 0250	1	$0.37	$0.00	$0.00	$0.00	$0.00	$0.00	**$0.00**	$0.00	DENIED
2	12/16/2016 12/16/2016 73590 0320	1	$240.00	$0.00	$0.00	$0.00	$0.00	$0.00	**$0.00**	$0.00	DENIED
3	12/16/2016 12/16/2016 99284 0450	1	$1,321.00	$0.00	$0.00	$0.00	$0.00	$0.00	**$0.00**	$0.00	DENIED
Totals:			**$1,561.37**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	

Remarks: Claim denied as patient cannot be identified as our insured.

On this example of an EOP section above, all claim lines were denied, with corresponding explanations below.

Billing for Missed Appointments

My Care Family considers a missed appointment as factored into the overhead cost of providing services and not a distinct reimbursable service. In recognition of this, provider fee schedules are designed to cover this cost, keeping the member from incurring additional costs.

My Care Family expects that the practice and its providers will cooperate and participate with My Care Family in programs focused on improving member appointment attendance.

Providers must not:

- Bill members for missed appointments.
- Refuse to provide services to members due to missed appointments.
- Refuse to provide services to members because the member has an outstanding balance owed to the practice from a time prior to the patient becoming a My Care Family member.

Audits

AllWays Health Partners' audit process ensures accuracy of charges and consistency with plan policies, provider agreements, and applicable nationally recognized medical claims reimbursement and administration policies. AllWays Health Partners auditing specialists, possessing thorough knowledge of medical procedures, terminology, and procedural coding, will perform the audits, review findings, and respond to provider questions or concerns.

Audits may be conducted on claims paid during the current year or two prior AllWays Health Partners fiscal (calendar) years and up to six years when investigating possible cases of fraud or abuse. AllWays Health Partners policies, including but not limited to medical policies, claims administration policies, and provider payment guidelines, will apply to all reimbursement and claims matters. In any matter where AllWays Health Partners does not maintain a specific policy or guideline, AllWays Health Partners adopts and follows the national standards and policies relating to procedural coding, medical claims administration, and reimbursement, which are recognized by government payers such as the Centers for Medicare and Medicaid Services (CMS), national health insurance carrier organizations, local coverage determinations (LCDs), and the American Medical Association (AMA).

Pursuant to the AllWays Health Partners Provider Agreement, AllWays Health Partners has the right to inspect, review, and make copies of medical records. All requests for medical record review are made in writing. The inspection of medical records is conducted in compliance with the provider's standard policies governing such processes and that are applied uniformly to all payers.

Provider notification includes the audit parameters and corresponding medical records. The number of selected medical records is determined based on generally accepted statistical sampling methodology, rules, and techniques recognized in the field of statistical probability. Should additional areas of questions be identified, AllWays Health Partners reserves the right, at its election, to expand the scope of any audit, and perform extrapolation of audit results to the defined audit population. If extrapolation methodology is selected, the process shall be performed in accordance with generally accepted sampling principles as outlined above. AllWays Health Partners strictly adheres to state and federal requirements regarding confidentiality of patient medical records. A separate consent form will be provided when required by law.

When an initial review of a provider's medical records is required, AllWays Health Partners' provider audit process includes written 30-days' prior notification. For on-site audits, the provider must arrange a suitable work area, and make available to the auditor the medical records, including but not limited to pharmacy profile and corresponding fee book when applicable. The fee

book should be an electronic file (Excel or similar program) unless another format has been agreed upon.

When additional records or documentation are necessary to complete the audit, the auditor will submit a written request for information to the provider's representative identifying the necessary documents to complete the audit, specifying a reasonable time period within which the provider will supply the requested documents.

Unless otherwise contractually agreed upon, AllWays Health Partners does not reimburse for audit-related administrative fees incurred by a provider.

General Claims Audits

General post payment claims audits are conducted to identify the accuracy of charges and the consistency of claims reimbursement with My Care Family's 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. 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 based on My Care Family and/or CMS guidelines as applicable to the member benefit plan

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

AllWays Health Partners will review the appeal and, when appropriate, consult with clinicians or subject matter experts in the areas under consideration. The appeal determination will be final and if the determination is favorable to the provider, the claims in question will be adjusted accordingly within 10 calendar days of the final determination notification.

External Hospital Audits

Audits are conducted at a mutually convenient time and cancellations by either party require written 15 days advance notice. In the event that an audit is cancelled, the audit must be rescheduled within 45 days of the originally

scheduled date. AllWays Health Partners' audits involving inpatient and outpatient claims also include an exit interview to review and discuss the findings.

Documented unbilled services are charges for documented services that were detailed and billed for on the original audited claim but not billed to the full extent of the actual services provided. These charges will be considered for payment only when an accounting of the services is presented at the time of the on-site audit review for verification and acceptance during the on-site audit review. In addition, the charges must be submitted on an AllWays Health Partners accepted claim form. The accepted charges will be adjusted (netted out) against the unsupported charges at the conclusion of the audit.

If there is a question of medical necessity or level of care, the hospital designee will coordinate dissemination and review of the findings with hospital staff and present a rebuttal position prior to the exit interview or within the 30-day appeal period.

At the conclusion of the audit, if the hospital designee agrees with the findings, the auditor will provide a dated copy of the signed and final Discrepancy Report. Adjustments will be made 30 calendar days after the date indicated on the Discrepancy Report and will reflect accordingly in subsequent EOPs. Alternative arrangements for payment to AllWays Health Partners must be made in writing and signed by all parties.

Physician and Ancillary Audits

Physician and ancillary provider audits may consist of both off-site and on-site audits, with the audit of designated medical records conducted at either AllWays Health Partners or the vendor's office, when applicable. The determination of an off-site and/or on-site audit will be made by AllWays Health Partners.

Adjustments will be made 30 calendar days after the date indicated on the Discrepancy Report and will reflect accordingly in subsequent EOPs. Alternative arrangements for payment to AllWays Health Partners must be made in writing and signed by all parties.

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 member 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 My Care Family 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.

Payment Guidelines

AllWays Health Partners' payment guidelines are designed to help with claim submissions by promoting accurate coding and by clarifying coverage. AllWays Health Partners' payment guidelines are found at allwaysprovider.org.

Section 8
Pharmacy

Section 8 Pharmacy

CVS Caremark

My Care Family has partnered with CVS Caremark for pharmacy benefit management services. CVS Caremark provides members with access to a comprehensive retail pharmacy network, as well as administers a variety of services including pharmacy claims processing, mail order, and specialty and formulary management.

Formulary Drug Lookup Tool

The Searchable Formulary Drug Lookup Tool for clinicians is designed to provide information about My Care Family drug coverage. It provides a searchable formulary by information such as drug name, member cost share, and prior authorization limitations.

You may also obtain patient-friendly medication information from Healthwise Knowledgebase and the Healthwise Knowledgebase Drug Interaction Checker.

My Care Family encourages providers to use the Formulary Drug Lookup Tool to become familiar with the drug selection. Our formulary is regularly reviewed, evaluated and revised by the AllWays Health Partners Pharmacy and Therapeutics Committee. This committee is comprised of representatives from various practices and specialties.

Pharmacy Copayment

If a My Care Family patient is unable to pay a copayment at the time of service, the pharmacy must fill the prescription. However, the pharmacy can bill the patient later for the copayment.

Copayment Exemptions

A My Care Family patient is exempt from prescription co-pays if he or she:

- Is under 21 years old
- Is pregnant or pregnancy ended within 60 days of the service
- Is receiving inpatient care at an acute hospital, nursing facility, chronic disease or rehabilitation hospital, or intermediate-care facility for the developmentally delayed, or is admitted to a hospital from such a facility
- Is receiving hospice care
- Is enrolled in MassHealth because they were in the care and custody of the Department of Children and Families (DCF) when they turned 18, and their MassHealth coverage was continued
- Is Native American or Alaska Native from a federally recognized tribe
- Has reached the pharmacy copayment cap for the calendar year

E-prescribing

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

My Care Family understands and embraces the value that e-prescribing brings to the effective care of its members and continues its commitment, along with its contracted pharmacy benefits management partner, CVS Caremark, in bringing these capabilities to the provider community. Specifically, My Care Family provides patient eligibility/coverage status, medication history, and formulary information to physicians who use e-prescribing tools.

Pharmacy Coverage

Over-the-Counter Benefit

My Care Family covers many over-the-counter products, including smoking deterrents. To ensure safe and appropriate use, covered over-the-counter items do require a prescription and must be obtained from a participating pharmacy. My Care Family's

pharmacy network includes most Massachusetts pharmacies. (Refer to CVS Caremark's Pharmacy Directory for a complete listing of participating pharmacies). Visit allwaysprovider.org for listing of some of the covered over-the-counter medications available to My Care Family patients.

Generic Interchange Policy

My Care Family has a mandatory generic substitution policy. The generic equivalent must be dispensed when available. Multi-source brand name drugs are not covered when a clinically equivalent lower cost generic is available. Brand name medications may be covered only when a generic is not available.

Exception Requests

There may be cases where a medication, a quantity of medication or a brand name medication is not normally covered by My Care Family but the prescribing physician feels that it is medically necessary for the patient. In these instances, the physician can submit a fax form to CVS Caremark, available on allwaysprovider.org.

The medication prior authorization and step-therapy criteria can be found on allwaysprovider.org.

Exception requests are reviewed by CVS Caremark. Because we are committed to providing our patients with prompt access to care, decisions regarding override requests are generally communicated within 24 hours to two business days from the time complete medical documentation is received.

Quantity Limitations

Quantity limitations have been implemented on certain medications to ensure the safe and appropriate use of the medications. Quantity limitations are approved by AllWays Health Partners' Pharmacy and Therapeutics Committee. See the Formulary Drug Lookup Tool to determine if a medication has a quantity limitation.

Prior Authorization Drug Policy

To ensure appropriate utilization, My Care Family delegates to CVS Caremark prior authorization of some drugs. Prescribers can request clinical reviews by calling the Prior Authorization (PA) department at CVS Caremark. CVS Caremark staff will ask several questions to determine if the patient meets the established clinical criteria for the drug. After the clinical review, if the medication is approved for the patient, the Prior Authorization department at CVS Caremark will process the authorization and the pharmacy will be systematically notified of the decision and can then dispense the prescription. Please refer to the Formulary Drug Lookup Tool for medications requiring prior authorization. The clinical criteria for prior authorizations are reviewed annually by our Pharmacy and Therapeutics Committee and are available in the pharmacy section of our website.

Step-Therapy Programs

Step therapy programs require use of specific, lower cost, therapeutically equivalent medications within a therapeutic class before higher cost alternatives are approved. Prescriptions for "first-line" medication(s) are covered; prescriptions for "second-line" medications process automatically if the member has previously received a first-line medication(s) in the past 6–12 months of My Care Family enrollment. The look-back period depends upon the particular program. Physicians may submit an override request to prescribe a second-line medication prior to using a first-line medication or if the member has previously failed a first-line medication outside of the drug look-back period. The request can be submitted by calling the Prior Authorization (PA) department at CVS Caremark, or by faxing a request form. Step therapy programs are approved by AllWays Health Partners' Pharmacy and Therapeutics Committee.

Specialty Medications Programs

Certain injectables or specialty medications (such as oral oncology) are covered only

when obtained from any My Care Family contracted specialty pharmacy including CVS Caremark Specialty Pharmacy.

The Specialty Medications Program offers a less costly method for purchasing expensive injectable drugs. Providers may still choose to administer the medications providing oversight to patients' health status. Under the program, medication and supplies will be shipped out and labeled specifically for each patient and delivered to the provider's office within 24 to 48 hours after ordering. Providers will then bill AllWays Health Partners only for the administration of the injectable drug.

In addition, for those injectable medications that are self-administered or for patients with transportation restrictions, the specialty pharmacy can ship injectable medications and necessary administration supplies, if applicable, directly to the patient's homes.

Please visit allwaysprovider.org for copies of the specialty pharmacy prior authorization fax forms, the list of specialty drugs, and medications supplied.

Maintenance 90 Program

My Care Family patients are automatically enrolled in the Maintenance 90-day program for ongoing prescription refills. Patients who have filled a maintenance medication (such as drugs used for asthma, hypertension, high cholesterol, or arthritis) at least twice in the past four months will need to fill a 90-day supply on their next fill. The copayment for a 90-day supply is reduced for most medications.

Please provide your patients with a 90-day script when appropriate. For the most up-to-date list of maintenance medications, use the Drug Lookup Tool.

If you feel it is medically necessary for your patient to remain on a 30-day supply, please call AllWays Health Partners Provider Service at 855-444-4647 to request an opt-out for your patient. Please indicate the medication(s) that should be opted-out, the proposed time frame for exclusion, and the reason for the 30-day supply.

A member can request to stay with 30-day refills by calling AllWays Health Partners Customer Service at the phone number on the back of their My Care Family ID card.

Access90 Program

Access90 provides My Care Family members with a 90-day supply of certain maintenance medications when purchased through participating pharmacies. This program allows My Care Family patients to obtain a 90-day supply of certain medicines at a reduced cost.

Medicare Part D

Certain My Care Family patients with Medicare coverage and enrolled in MassHealth have their prescriptions drug benefit covered by Medicare. My Care Family patients received ID cards for their Medicare prescription drug coverage.

Most prescription drugs are covered under their Medicare benefit. My Care Family does provide coverage for some drugs that are excluded by the federal Medicare mandate. Examples include certain over-the-counter drugs and vitamins. For more information, please call AllWays Health Partners Customer Service.

To find out more about Medicare's prescription drug coverage:

- Contact Medicare at 800-633-4227.
- Visit the Medicare website at www.medicare.gov.
- Go to www.cms.gov.

More Information

Updates to the formulary are communicated through the provider newsletters and the provider portal.

CVS Caremark Contact Information:

Non-Specialty Drug Requests
Main Phone: 844-294-0395

My Care Family MassHealth
Phone: 877-433-7643
Fax: 866-255-7569

Specialty Drug Requests
Phone: 866-814-5506
Fax: 866-249-6155

Section 9
Appeals and Grievances

Section 9
Appeals and Grievances

Provider Grievances and Administrative Appeals

AllWays Health Partners has a comprehensive process for resolving appeals and grievances.

An appeal is a request that AllWays Health Partners or Optum review an adverse action or denied claim, having provided documentation supporting the request for reconsideration. Appeal requests must be submitted in writing.

A grievance is any expression of dissatisfaction about any action or inaction by AllWays Health Partners other than an Adverse Action. Possible subjects for grievances include, but are not limited to, quality of care or services provided, aspects of interpersonal relationships such as rudeness of a provider or employee of AllWays Health Partners, or failure to respect the member's rights. Grievances should be reported to AllWays Health Partners' Provider Service.

Requesting an Administrative Appeal

As described in the Billing Guidelines section or as contractually agreed, providers can request a review and possible adjustment of a previously processed claim within 90 days of the Explanation of Payment (EOP) date on which the original claim was processed. If the provider is not satisfied with the decision, an appeal can be submitted to AllWays Health Partners' Provider Appeals Department.

Appeal requests must be submitted in writing within one of the following timeframes:

- 90 days from receipt of the EOP
- 90 days from receipt of EOP from other insurance
- 90 days from the date of the claims adjustment letter

The appeal must include additional relevant information and documentation to support the request. Requests received beyond the 90-day appeal request filing limit will not be considered.

When submitting a provider appeal, please use the Request for Claim Review Form.

Appeals may be sent to:

Mail: AllWays Health Partners
Appeals & Grievances Dept.
399 Revolution Drive
Suite 820
Somerville, MA 02145

Fax: 617-526-1902

Administrative Appeals Process

AllWays Health Partners' administrative appeals option applies only for services already rendered.
Administrative denial letters issued by AllWays Health Partners' Clinical Department informing the provider that AllWays Health Partners received insufficient documentation to make a medical necessity decision require the submission of a new approval request through AllWays Health Partners' Provider Portal, allwaysprovider.org. Providers should not appeal these denials. Instead, submit the additional information requested through allwaysprovider.org.

For denials on services already rendered, the AllWays Health Partners administrative appeals process includes two appeal levels:

- A Level I appeal is the initial request to AllWays Health Partners for reconsideration of a denied claim. Level I appeal submissions are reviewed and completed within 30 calendar days from the date AllWays Health Partners receives the request with all supporting documentation. If additional information is needed to finalize the appeal request, the provider will be notified in writing. The requested documentation must be submitted within 60 days from the date of AllWays Health Partners' Level I appeal letter.

- If approved, AllWays Health Partners will adjust the claim. The provider will be notified of the outcome via the AllWays Health Partners Explanation of Payment which should reflect the reprocessed claim(s) within two weeks once reprocessed.
- If denied, the provider will be notified in writing of the reason and when applicable, provided with instructions for filing a Level II appeal. A Level II appeal provides the option to request a reconsideration of the Level I appeal when the provider has new and/or additional information that supports the request for a second review. The request for a Level II appeal needs to be received by AllWays Health Partners within 60 days of the Level I appeal denial letter. Level II appeal decisions are considered final.

Appealing a Behavioral Health Service Denial

Provider appeals and grievances for behavioral health services are handled by Optum, AllWays Health Partners' Behavioral Health Partner. All behavioral health appeals should be submitted directly to Optum.

For more information, please refer to the Behavioral Health Provider Manual or contact Optum at 844-451-3519.

Post-Payment Claim Adjustments

AllWays Health Partners regularly reviews claims post payment and adjust as needed. Depending on the total dollars adjusted, AllWays Health Partners proactively notifies the provider of the scheduled adjustments. Providers who disagree with these adjustments can submit a letter of appeal or a completed AllWays Health Partners Provider Audit Appeal Form to AllWays Health Partners' Appeals department within 90 days of the Explanation of Payment (EOP) along with comprehensive documentation to support the dispute of relevant charges.

Appeals are reviewed within 30 calendar days from AllWays Health Partners' receipt of all required documentation. When appropriate, AllWays Health Partners will consult with clinicians or subject matter experts in the areas under consideration before finalizing the appeal request.

To the extent that the provider fails to submit evidence of why the adjustment is being disputed, the provider will be notified of AllWays Health Partners' inability to thoroughly review the request. The provider can resubmit the appeal within the 90 days of the EOP. The appeal's receipt date will be consistent with the date AllWays Health Partners received the additional documentation.

The appeal determination will be final. If the appeal request is upheld, AllWays Health Partners will adjust the claims in question within 10 calendar days of the final determination notification. Providers are notified of the claim's reprocessing via the EOP.

Member Grievances and Inquiries

AllWays Health Partners is committed to ensuring member satisfaction and to the timely resolution of reports of dissatisfaction by a member (or the member's representative on file) about any action or inaction by AllWays Health Partners or a health care provider. AllWays Health Partners provides processes that allow for the adequate and timely resolution of member complaints/grievances.

Inquiries

AllWays Health Partners is also committed to timely responding to all member inquiries.

An inquiry is any oral or written question made to AllWays Health Partners' Customer Service regarding an aspect of AllWays Health Partners' operations that does not express dissatisfaction about AllWays Health Partners.

Upon receipt of an inquiry, AllWays Health Partners Customer Service Representative will document the matter and, to the extent possible, attempt to resolve it at the time of the inquiry.

Grievances

AllWays Health Partners investigates all reported incidents of dissatisfaction on the part of AllWays Health Partners and/or a provider. Possible subjects of grievances include, but are not limited to:

- *Quality of Care*— Concerns with the quality of the care and/or treatment provided by medical staff;
- *Access*— Reports of barriers to needed care in accordance with wait-time access standards or in a manner that met the member's perceived needs. Access is defined as the extent to which a member can obtain services (telephone access and scheduling an appointment) at the time they are needed. It can also include wait time to be seen upon arrival, and geographic distance to a network provider;
- *Service/Administration*— Reports of poor member experiences, including rudeness by AllWays Health Partners and/or provider staff;
- *Billing and Financial*— A dispute of financial responsibility for rendered services and/or rendered as billed;
- *Provider's Facility*— Reports that a provider's facility is deemed inadequate, including but not limited to cleanliness of waiting room, restrooms, and overall physical access to the premises;
- *Privacy Violation*— Member reports that a provider and/or AllWays Health Partners violated or compromised protected health information (PHI);
- *Member Rights*— Reports of violation of a member's rights by a provider and/or AllWays Health Partners, including but not limited to Mental Health Parity Laws violations.

When a member designates an authorized representative to act on their behalf, such representative is granted all the rights of a member with respect to the grievance process, unless limited in writing by the member, law, or judicial order.

The member must complete and return a signed and dated Designation of Appeal or Grievance Representative Form prior to the deadline for resolving the grievance. If the signed form is not returned, communication will only take place with the member.

AllWays Health Partners ensures that any parties involved in the resolution of grievances and any subsequent corrective actions have the necessary skills, training, and subject matter expertise to make and implement sound decisions and that they have not been involved in any previous level of review or decision-making. Members or their representatives are provided with a reasonable opportunity to present evidence and allegations of fact or law, in person as well as in writing.

A member may file a complaint or grievance by telephone, fax, letter, or in person. AllWays Health Partners Customer Service Professionals provide assistance to members, including interpreter services, TTY, and other options when explaining the grievance or appeal process and assisting with the completion of any forms.

Upon notification of a grievance, a Customer Service Professional logs the details of the grievance and refers the matter to the Appeals and Grievances Department. An acknowledgement letter follows within one business day requesting the member's review that AllWays Health Partners Customer Service accurately captured the details and to sign and return a copy to AllWays Health Partners prior to the deadline for resolving the grievance. However, the investigation of a member's grievance is not postponed pending return of this signed letter. The member's signature merely acknowledges that AllWays Health Partners has documented the details of the grievance correctly.

A health care professional with the appropriate clinical expertise in treating the medical condition, performing the procedure, or providing treatment that is the subject of a grievance will make an initial assessment as to the clinical urgency of the situation and establish a resolution time frame accordingly if the grievance involves:

- The denial of a request that an internal appeal be expedited
- Any clinical issue

The AllWays Health Partners Appeals Committee will resolve a grievance when the subject of the grievance involves:

- The denial of payment for services received because of failure to follow prior authorization/referral procedures
- The denial of a request for an internal appeal because the request was not made in a timely fashion
- The denial of coverage for non-covered services
- The denial of coverage for services where benefit limitations apply

When the subject matter involves the act or omission on the part of an AllWays Health Partners employee, resolution is made by the employee's department, when appropriate.

For grievances involving non-clinically related actions or omissions of a provider, assistance from the provider is requesting in investigating the grievance. Network providers' adherence to the grievance process is monitored regularly to identify training and other interventions.

For grievances specific to a provider, the nature of the grievance will determine whether the matter is addressed directly with the clinician or with the site's administrator. In either case, the provider is contacted to discuss the matter and asked for a written response addressing all identified concerns, corrective actions taken and supporting documentation when applicable. To allow timely completion of the review of all relevant information within the specified time frame, a response from the provider is expected within five business days unless otherwise agreed upon.

Upon receipt and review of the provider's response, a written response is sent to the member containing the substance of the complaint, the findings and actions taken, while ensuring the appropriate confidentiality rights of all parties. At a minimum, the resolution will acknowledge receipt of the grievance and that it has been investigated.

Grievances are researched and resolved as expeditiously as warranted, but no later than 30 calendar days from the verbal or written notice of the grievance. If the grievance resolution results in an adverse action, the response letter will advise the member of his or her right to appeal the decision.

Behavioral Health Inquiries and Grievances

Management for all behavioral health–related inquiries and grievances is delegated to AllWays Health Partners' Behavioral Health Partner, Optum.

For more information, please see the Behavioral Health Provider Manual or contact Optum.

Member Clinical Appeals

Expedited Clinical Appeals

Level I Expedited Appeal (Level II = n/a)
A member, member representative, or provider may request an expedited internal appeal when the member's life, health, or ability to attain, maintain, or regain maximum function would be seriously jeopardized by waiting 30 calendar days for a standard appeal resolution. Punitive action will not be taken against a provider who requests an expedited appeal on behalf of a member. An expedited appeal must be filed within 30 calendar days of AllWays Health Partners' decision to deny, terminate, modify, or suspend a requested health care service. AllWays Health Partners will continue to authorize disputed services during the formal appeal process if those services had initially been authorized by AllWays Health Partners, unless the member indicates that they do not want to continue receiving services, as long as the appeal request is submitted within 10 days of the adverse action. Provider expedited appeal requests will be granted unless AllWays Health Partners determines that the provider's request is unrelated to the member's health condition. To file an appeal on behalf of a member, the provider must submit to AllWays Health Partners a written authorization from the member, designating the provider as their appeal representative. The AllWays Health Partners Designation of Appeal Representative Form should be used for this purpose. While AllWays Health Partners will not postpone the appeal pending receipt of the form, it must be provided within a reasonable time period. If an expedited appeal request is not granted, the provider will receive timely notification of the decision verbally, as well as written notification of the dismissal of the expedited appeal request within two calendar days. The expedited appeal request will be processed in accordance with standard appeal time frames, with the member (or authorized representative) notified accordingly. If the request is denied, the member will be notified of their right to file a grievance. If approved, a decision will be communicated within 72 hours of receipt. Providers are notified verbally and in writing on approved and denied requests. The time frame for making expedited internal appeal resolutions may be extended for up to 14 calendar days if AllWays Health Partners receives a request for an extension. For extension requests not initiated by the member, AllWays Health Partners will notify the member in writing of their right to file a grievance

Expedited External Review
The expedited internal appeal process is limited to one appeal level. Otherwise, the decision may be appealed via the Office of Medicaid Board of Hearings (BOH). The appeal must be submitted within 20 days of an expedited appeal decision. An appeal submitted to the BOH within 21 to 30 days will be treated as a standard appeal. To continue receiving ongoing services during a BOH expedited appeal, the Appeal must be requested within 10 calendar days of AllWays Health Partners' initial appeal decision to uphold the decision to deny, terminate, modify, or suspend a requested health care service. If the BOH determines that the member submitted the request for a BOH appeal in a timely manner, and the appeal involves the reduction, suspension, or terminations of a previously authorized service, AllWays Health Partners will authorize continuing services until one of the following occurs: - The member withdraws the BOH appeal; or - The BOH issues an adverse decision to the member's appeal request.

Standard Clinical Appeals

Level I Standard Appeals

A treating provider may file a clinical appeal on behalf of a member for any decision made by AllWays Health Partners to deny, terminate, modify, or suspend a requested health care benefit based on failure to meet medical necessity, appropriateness of health care setting, or criteria for level of care or effectiveness of care. Punitive action will not be taken against a provider who requests an appeal on behalf of a member.

A member appeal must be filed within 30 calendar days of AllWays Health Partners' decision. However, a member can continue receiving ongoing services during an appeal, as long as the appeal is requested within 10 calendar days of AllWays Health Partners' decision.

In order to consider an appeal filed by a third-party, AllWays Health Partners must receive written authorization from the member designating the individual as their appeal representative. The AllWays Health Partners Designation of Appeal Representative Form should be used for this purpose. The appeal process will not be held up pending receipt of the form.

The completed, signed, and dated form must be received prior to the deadline for resolving the appeal. Otherwise, all communication will take place with the member.

When filing an appeal on behalf of a member, the provider must identify the specific benefit that AllWays Health Partners denied, terminated, modified, or suspended, the original date of AllWays Health Partners' decision and the reason(s) the decision should be overturned. The provider may request a peer-to-peer discussion with the AllWays Health Partners medical director involved in the Internal Appeal regarding these matters.

Appeals may be filed by telephone, mail, fax, or in person. AllWays Health Partners will send a written acknowledgment of the appeal on behalf of a member, along with a detailed notice of the appeal process within one business day of receiving the request.

An appeal will be conducted by a health care professional that has the appropriate clinical expertise in treating the medical condition, performing the procedure, or providing the treatment that is the subject of the Adverse Action, and who was not involved in the original Adverse Action.

For a standard appeal, AllWays Health Partners will complete the appeal and contact the provider with the outcome of the review within 30 calendar days.

The time frame for a standard appeal may be extended for up to five calendar days if the member requests an extension, or if AllWays Health Partners requests the extension having determined that it will be in the member's best interest and there is reasonable likelihood that receipt of more information within five calendar days would lead to an approval.

AllWays Health Partners' Appeals and Grievances Department will make reasonable efforts to provide verbal notification of the decision within one business day, with written notification to follow within 30 days of receipt of the appeal.

A clear description of the procedures for requesting a BOH external appeal, including enclosures of AllWays Health Partners' Appeals Process and Rights for MassHealth members and a Request for a Fair Hearing Form are included with any denial of appeal notice to the member.

Providers, if acting in the capacity of an authorized representative, may request that AllWays Health Partners reconsider an appeal decision if the provider has or will soon have additional clinical information that was not available at the time the decision was made. Upon a reconsideration request, AllWays Health Partners will agree in writing to a new time period for review. To initiate reconsideration, contact the Appeal Coordinator:

Contact Information
Appeals and Grievances Department
AllWays Health Partners
399 Revolution Drive, Suite 820
Somerville, MA 02145

Standard Clinical Appeals *(continued)*

Standard External Reviews

Once the AllWays Health Partners' appeal options have been exhausted, members may file an appeal with the Board of Hearings (BOH). The exhaustion requirement is satisfied if AllWays Health Partners has issued a decision following the Level I appeal.

BOH appeals of a standard internal appeal must be filed within 30 calendar days after the notification of decision on the final internal appeal.

Any services that are subject of a BOH appeal will continue, pending resolution of the appeal, unless the member specifically indicates that they do not want to receive continuing services, and the BOH receives a written request from the member within 10 calendar days from the notification of decision on the final internal appeal. If the BOH upholds an adverse action to deny, limit, or delay services and the member received continuing services while the BOH Appeal was pending, the member may be financially responsible for the cost of any requested services received during this time period.

Members must complete the Request for Fair Hearing form (included with the appeal decision notification) and submit it to the BOH. AllWays Health Partners can assist Members in completing this form.

Contact Information

Appeals and Grievances Department
AllWays Health Partners
399 Revolution Drive, Suite 820
Somerville, MA 02145

Phone: 800-462-5449
Fax: 617-526-1980

To initiate an external review, contact:
Board of Hearing (BOH)
Office of Medicaid
100 Hancock Street, 6th Floor
Quincy, MA 02171

Fax: 617-847-1204.

Access to Appeal File by Member or Member Representative

Members or their representative have the right to receive a copy of all documentation used in the processing of their appeal, free of charge. The request must be submitted in writing to AllWays Health Partners.

Limitations may be imposed, only if, in the judgment of a licensed health care professional, the access requested is reasonably likely to endanger the life or physical safety of the individual or another person.

Requests for access to appeal files will be processed as quickly as possible, taking into consideration the member's condition, the subject of the appeal, and the time frames for further appeals.

Continuation of Ongoing Services During Appeal

If the appeal concerns the denial, modification, or termination of covered service that the member is receiving at the time of the adverse action, the member has the right to continue their benefits through the conclusion of the appeals process. There are timeframes for requesting continuation of coverage, as explained in the table above. Continued authorization will not, however, be granted for services that were terminated pursuant to the expiration of a defined benefit limit.

If the appeal concerns the denial, modification, or termination of a non-covered service that the member is receiving, and AllWays Health Partners does not reverse the adverse action, the member may be liable for payment of the service.

Notification of Decision

If AllWays Health Partners does not act upon an appeal within the required timeframe, or an otherwise agreed upon extension, the appeal will be decided in the member's favor. Any extension deemed necessary to complete review of an appeal must be authorized by mutual written agreement between the member (or an authorized representative) and AllWays Health Partners.

Reconsideration of Appeal Decision

Providers acting in the capacity of an authorized representative may request that AllWays Health Partners reconsider an appeal decision if the provider has or will soon have additional clinical information that was not available at the time the decision was made. Upon a reconsideration request, AllWays Health Partners will confirm in writing the agreement to a new time period for review. A reconsideration request can be initiated by contacting the individual identified in the AllWays Health Partners letter.

Consumer Protection from Collections and Credit Reporting During Appeals

Massachusetts Law requires health care providers (and their agents) to abstain from reporting a member's medical debt to a consumer credit reporting agency or sending members to collection agencies or debt collectors while an internal or external appeal is going on. This consumer protection also extends for 30 days following the resolution of the internal or external appeal.

Behavioral Health Appeals

Management for all behavioral health related appeals is delegated to AllWays Health Partners' Behavioral Health Partner, Optum.

For more information, please see the Behavioral Health Provider Manual or contact Optum at 844-451-3519.