Provider Manual | 2026

CCA Senior Care Options (FIDE-SNP) and CCA One Care (FIDE-SNP)

commonwealth care alliance®

TABLE OF CONTENTS

Dear Provider,

Welcome to the 2026 Commonwealth Care Alliance, Inc. (CCA) Provider Manual. This manual serves as a guide and resource for you as we work together on behalf of the members and patients we mutually serve.

This year has been one of great change both within CCA and across the entire healthcare landscape. Our most significant development has been CCA's affiliation with CareSource, a nationally recognized, nonprofit managed care organization.

As part of the CareSource family of companies, CCA's members and patients continue to receive best-in-class, disability-competent care and coordination from their same care teams – enhanced and strengthened through shared resources and expertise to address the critical needs of members and the broader community. The linchpin in all of this is our robust network of providers – our valued partners who share our deep understanding of the complex needs of those we serve across the Commonwealth.

As we look ahead to continued developments to better meet the needs of those we serve, I'd like to thank you for your ongoing commitment to the populations in our CCA Senior Care Options and CCA One Care plans – all of whom are dual-eligible and often have multiple co-occurring conditions. Your partnership and collaboration are essential to achieving our mission of improving the health and well-being of those with the most significant needs.

Our provider manual is an administrative resource that provides comprehensive information about our programs and plans. It serves as a centralized location for much of the information CCA shares with you throughout the year in letters, email blasts, faxes and newsletters. Along with detailed CCA program information, you will find our policies and procedures, referral and claim information, as well as other useful reference materials. This year's manual includes key updates such as the transition of the One Care plan to a FIDE-SNP; changes to the State's eligibility process and deeming periods; and information on important quality initiatives.

We hope this manual lends itself to a more seamless experience in your work with CCA staff and members. If you have any questions about the contents of this provider manual, please contact CCA's Provider Services team at 866-420-9332 on Monday, Tuesday, Wednesday, and Friday from 8 a.m. to 5 p.m. EST; and on Thursday from 8:30 a.m. to 5 p.m. EST.

And as always, please feel free to contact your dedicated Provider Relations liaison, or reach out to our team by sending an email to providerrelations@commonwealthcare.org.

Thank you for choosing to be a part of our network. Your continued partnership is the key to meeting the needs of those we mutually serve.

Sincerely,

Kevin McKay
Vice President, Network Strategy and Contracting

SECTION 1: KEY CONTACT INFORMATION

Contact	Telephone	Fax	Email	Website/ Portal
Provider Network				
Provider Services • Member eligibility • Claims status, questions • Connect with CCA Care Partner • Behavioral health services • Inpatient facility admission • DME • Pharmacy • Authorizations	866-420-9332 From 8 am to 5 pm ET, Monday, Tuesday, Wednesday, Friday From 8:30 am to 5 pm ET, Thursday		providerservices@commonwealthcare.org	CCA Secure Provider Portal
Provider Relations • Training, orientation, general questions		857-465-7465	providerrelations@commonwealthcare.org	
Provider Data Management • Provider enrollment • Provider demographic updates • Provider enrollment status		617-517-7738	pnmdepartment@commonwealthcare.org	
Credentialing • Credentialing status • Submission of updated licensure		857-465-7465	credentialing@commonwealthcare.org	
Provider Contracting • Requests to become a network CCA provider, medical or behavioral health			ccacontracting@commonwealthcare.org	

Contact	Telephone	Fax	Email	Website/ Portal
Member Services				
Member information	866-610-2273	617-426-1311	memberservices@commonwealthcare.org	CCA Member Web Page
Member Appeals and Grievances				
Member appeals and grievances	866-610-2273		agdepartment@commonwealthcare.org	
Member Enrollment				
Outreach and marketing • Referrals for potential members	866-610-2273	617-830-0534	marketdevelopment@commonwealthcare.org	CCA Member Resources
Clinical Operations				
Prior authorization • Benefit and service authorizations	866-420-9332	855-341-0720		
Transitions of Care team and facility inpatient authorization	857-246-8822	855-811-3467		
Dental Benefit Administrator: SKYGEN				
• Claims processing • Member eligibility • Prior authorization submission • Provider Relations	855-434-9243		providerservices@skygenusa.com	pwp.sciondental.com
			providerservices@skygenusa.com	Dental provider manual located in the Dental provider portal

Contact	Telephone	Fax	Email	Website/ Portal
Hearing (Routine) Benefit Administrator: NationsHearing				
• Claims processing • Member eligibility • Provider Relations • Hearing provider manual	800-921-4559			providers.nationshearing.com
Pharmacy Administrator: CVS				
• General pharmacy questions • Pharmacy coverage • Determinations (e.g., prior authorization) • Pharmacy redeterminations (appeals)	855-344-0930	855-633-7673		Coverage determination: https://cdrd.cvscaremarkmyd.com/CoverageDetermination.aspx?ClientID=64
Vision (Routine) Benefit Administrator: EyeMed				
• Claims processing • Member eligibility • Covered services • Provider Services • Appeals and grievances • Vision provider manual	CCA Senior Care Options: 877-493-4586 CCA One Care: 877-493-4588	866-293-7373	Members & Providers	https://claims.eyemedvisioncare.com/claims/loginForm.emvc
EyeMed Vision Care/First American Administrators P.O. Box 8504 Mason, OH 45040-7111				

Contact	Telephone	Fax	Email	Website/ Portal
Fitness Benefit: Silver&Fit				
CCA Senior Care Options only • Claims processing • Member eligibility • Provider Relations • Gym assignment **American Specialty Health Fitness, Inc.** PO Box 509117 San Diego, CA 92150-9117	877-427-4788		FitnessService@ashn.com877-	Homepage | Silver&Fit
Compliance				
Concerns and reporting • Compliance • Fraud, waste, and abuse and compliance concerns	866-457-4953		CareSourceComplianceOfficer@caresource.com	CCA electronic submission form
	844-415-1272	800-418-0248	fraud@caresource.com	
Third-Party Liability				
Third-party liability	617-426-0600 x51221		tplcoordinator@commonwealthcare.org	

Contact	Telephone	Fax	Email	Website/ Portal
Interpreter Services				
In accordance with Title VI of the Civil Rights Act of 1964, providers are required to provide interpreter services for members with limited English proficiency, **at the provider's expense**. Providers are also required to provide communications in an accessible format for members with a disability, such as signers or TTD/TTY services, at the provider's expense. Providers may not charge members for these services. CCA is available to help providers locate interpreter and/or accessibility services upon request. Please refer to the **Interpreter Services** subsection for additional information.	866-420-9332		memberservices@commonwealthcare.org	

SECTION 2: INTRODUCTION TO COMMONWEALTH CARE ALLIANCE

Who is CCA?

Our history traces back to the 1970s when visionary healthcare leaders in Massachusetts came together to build a statewide community health movement that is still unique in the nation. Inspired by the values of human dignity, individual empowerment, and fair access to care, it introduced care delivery innovations that improved the health and independence of people with the most significant needs, including the elderly, the sick, and those with disabilities.

Today, Commonwealth Care Alliance® (CCA) is a mission-driven healthcare services organization that offers innovative health plans and care delivery programs designed for individuals with the most significant needs. CCA delivers comprehensive, integrated, and person-centered care by coordinating the services of local staff, provider partners, and community organizations.

The CCA uncommon care® model is consistently recognized as one of the best in the country at finding and engaging traditionally hard-to-reach individuals. It includes a community focus to ensure the most appropriate site of care, seamless integration of care coordination, care delivery, and innovation to address members' unmet needs, particularly related to non-clinical drivers of health, such as food, housing, and transportation.

SECTION 3: MEMBER ELIGIBILITY, APPEALS & GRIEVANCES

Commonwealth Care Alliance, Inc. (CCA) Senior Care Options (FIDE-SNP) and CCA One Care (FIDE-SNP) plans are healthcare plans committed to helping members get the care they need. Both plans require that members have both MassHealth and Medicare coverage. MassHealth eligibility requirements can be found here: https://www.mass.gov/info-details/senior-care-options-eligibility

Eligibility Verification

Providers should verify member eligibility prior to providing services. To verify member eligibility, please use one of the following methods:

Eligibility Verification
Use the Availity Essentials Provider Portal*
Use the MassHealth Provider Online Service Center
Use the NEHEN Provider Portal*
Contact CCA Provider Services at 866-420-9332 from 8 am to 5 pm ET, Monday, Tuesday, Wednesday, and Friday, and from 8:30 am to 5 pm ET, Thursday.

**Supports batch eligibility transactions*

Dual-Eligible Members Who Lose Medicaid Eligibility/Status

CMS requires D-SNP plans to provide a member a period of at least 30 days to allow those dual-eligible members who have lost their MassHealth (Medicaid) eligibility to regain it. This is called a deemed period. These members remain enrolled in the plan and have Medicare coverage only while we work with them to regain their MassHealth coverage. It is important that eligibility is checked daily prior to providing service to members to ensure appropriate eligibility. For questions related to eligibility or plan-covered services, please contact Provider Services at the number listed above. During this deemed period, CCA will apply the appropriate payment methodology to process claims.

PCPs can obtain a monthly list of members who have chosen them or were assigned to them by reaching out to contracting@commonwealthcare.org. This list does not prove eligibility for benefits or guarantee coverage. Please use one of the above methods to verify member eligibility. All providers should always verify member eligibility before rendering services, even if services have been authorized, except in an emergency. This helps prevent unpaid claims.

Requesting Member Disenrollment from Panel

Contracted providers may request that a CCA member be involuntarily disenrolled from their panel if the member displays repeated disruptive behavior and/or fails to adhere to recommended treatment patterns to the degree the behavior substantially impairs the provider's ability to provide services to the member. Examples include consistently missing scheduled appointments, persistent non-compliance with medication schedules, or failure to modify inappropriate behavior as requested.

Providers must proactively notify CCA's Care Management department of any unresolved member issues as they are identified. Providers must make a concerted effort to resolve member issues prior to requesting disenrollment, including making at least three attempts to warn the member about the disruptive/noncompliant behavior and documenting the attempts in the member's patient record.

Providers must additionally issue the member at least two written notices before requesting disenrollment:

1. Written notice detailing the member's disruptive/noncompliant behavior and explaining that continuation of such behavior may result in disenrollment from provider's panel and, (should the issues persist)

2. Written notice that the provider is requesting CCA's permission to disenroll the member from its panel.

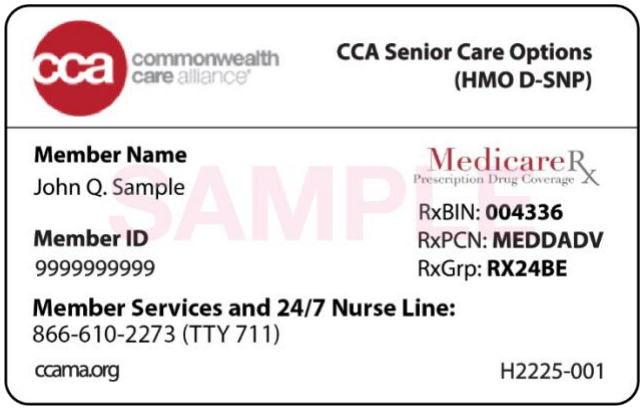
If the provider's attempts to resolve the member's issues are unsuccessful, the provider may submit a written request to CCA's Provider Services Department for member disenrollment from its panel. The request must include the member's name, date of birth, full details of disruptive/noncompliant behavior, any member complaints or communications made to the provider, copies of the provider's documented attempts to address the member's behavior (including the required written notices to member), and other relevant supporting documentation as requested by CCA.

If the provider's request is approved by CCA, the provider will be required to give the member at least 30 days' advance written notification (or more, if CCA determines reasonably necessary) of the disenrollment effective date and must provide the member continued care throughout such period. The written notice must include the reason for disenrollment, a summary of provider's prior attempts to work with the member to correct the behavior, the effective date of disenrollment, and instructions to contact CCA Member Services for assistance selecting a new provider. The provider must assist CCA in facilitating the transfer of the member's care and provision of services to a new provider.

Member Identification Card

Each member receives a CCA identification card to be used for services covered by CCA and prescription drug coverage at network pharmacies for both CCA Senior Care Options and CCA One Care. Please see example cards below.

CCA Senior Care Options (FIDE-SNP)


commonwealth care alliance

CCA Senior Care Options (HMO D-SNP)

Member Name
John Q. Sample

Member ID
9999999999

MedicareRx Prescription Drug Coverage
RxBIN: **004336**
RxPCN: **MEDDADV**
RxGrp: **RX24BE**

Member Services and 24/7 Nurse Line:
866-610-2273 (TTY 711)

ccama.org

H2225-001

SAMPLE


CCA Senior Care Options is a managed care plan that contracts with both Medicare and MassHealth (Medicaid)

Members: In an emergency, call 911 or go to the nearest emergency room. Please call your PCP or care coordinator as soon as possible.

MA Behavioral Health Help Line: 833-773-2445
Pharmacy Help Desk: 866-693-4620

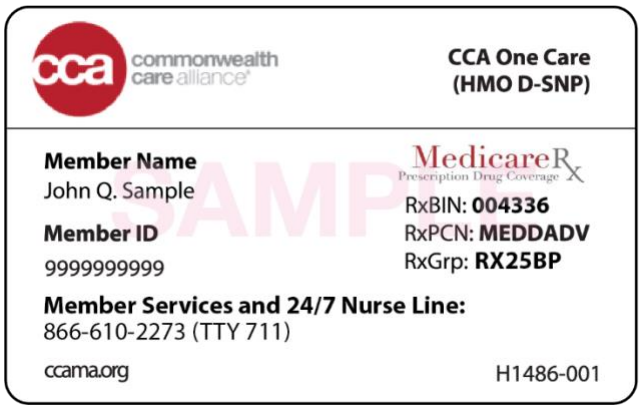
Provider Services: 866-420-9332

Send claims to:
Commonwealth Care Alliance Claims
PO Box 3085
Scranton, PA 18505

Send dental claims to:
CCA Claims
PO Box 508
Milwaukee, WI 53201

SAMPLE

CCA One Care (FIDE-SNP)


commonwealth care alliance

CCA One Care (HMO D-SNP)

Member Name
John Q. Sample

Member ID
9999999999

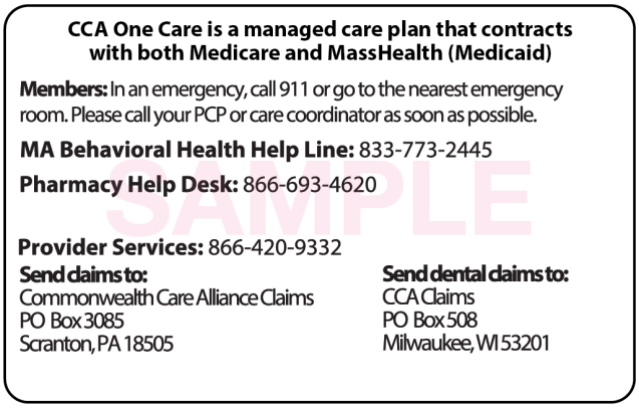
MedicareRx Prescription Drug Coverage
RxBIN: **004336**
RxPCN: **MEDDADV**
RxGrp: **RX25BP**

Member Services and 24/7 Nurse Line:
866-610-2273 (TTY 711)

ccama.org

H1486-001

SAMPLE


CCA One Care is a managed care plan that contracts with both Medicare and MassHealth (Medicaid)

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Milwaukee, WI 53201

SAMPLE

Interpreter Services

In accordance with Title VI of the Civil Rights Act of 1964, providers are required to provide interpreter services for CCA members with limited English proficiency, at the provider's expense. Providers are also required to provide communications in an accessible format for members with a disability, such as signers or TTD/TTY services, **at the provider's expense**. Providers may not charge members for these services. CCA is available to help providers locate interpreters and/or accessibility services upon request.

If a provider does not have access to needed interpretation for a CCA member, CCA will provide telephonic language assistance services for members who are eligible on the date of service. A provider may contact CCA Provider Services at 866-420-9332 from 8 am to 5 pm ET, Monday, Tuesday, Wednesday, and Friday, and from 8:30 am to 5 pm ET, Thursday, to be connected to the appropriate interpreter telephonically. For assistance during evening hours (5 to 8 pm) or weekends (8 am to 6 pm), call CCA Member Services at 866-610-2273 and have the member's name and CCA ID number available.

Note: CCA reserves the right to recover the cost of interpretation services from providers who utilize CCA to arrange services.

Member Rights and Responsibilities

CCA members deserve the best service and healthcare possible. CCA is committed to maintaining a mutually respectful relationship with its members. Clearly outlined member rights and responsibilities help foster cooperation among members, practitioners, and CCA. Member rights and responsibilities are updated annually. You can find the most up-to-date versions of the member rights and responsibilities by following the links below.

- Member Rights and Responsibilities
  - CCA One Care (FIDE-SNP)
  - CCA Senior Care Options (FIDE-SNP)

Prevent Discrimination

CCA complies with applicable federal civil rights laws and does not discriminate on the basis of medical condition, health status, receipt of health services, claims experience, medical history, disability (including mental impairment), marital status, age, sex (including sex stereotypes and gender identity), sexual orientation, national origin, race, color, religion, creed, public assistance, or place of residence. CCA does not exclude people or treat them differently because of medical condition, health status, receipt of health services, claims experience, medical history, disability (including mental impairment), marital status, age, sex (including sex stereotypes and gender identity), sexual orientation, national origin, race, color, religion, creed, public assistance, or place of residence.

All CCA providers must:

1. Provide all medically necessary covered services to members
2. Provide services without resulting in unlawful discrimination against members
3. Assist non-English-speaking members with interpreter services if needed

Office Access Parity

CCA members must have equal access or parity to network providers as those individuals enrolled in a commercial plan or MassHealth fee-for-service. This parity may include hours of office operations, after-hours care, and provider coverage.

Office Access and Availability

CCA is committed to providing provider access and availability to its members in a timely manner. In addition to this commitment, the state has provided a time frame requirement that the CCA provider network must adhere to in order to support each member's needs. The time frame requirements are as follows:

Primary Care Office Visits

- Primary care office visits must be available within 10 calendar days
- Specialty Care Office Visits
- Specialty care office visits must be available within 30 days of the member's request for non-urgent symptomatic care.

Urgent Care and Symptomatic Office Visits

All urgent care and symptomatic office visits must be available to members within 48 hours. A symptomatic office visit is an encounter associated with the presentation of medical symptoms or signs that do not require immediate attention. Examples include recurrent headaches or fatigue.

Non-symptomatic Office Visits

All non-symptomatic office visits must be available to members within 30 calendar days. Examples of non-symptomatic office visits include, but are not limited to, well and preventive care visits for covered services, such as annual physical examinations or immunizations. Behavioral health providers' access and availability time frames can be found in SECTION 11: Behavioral Health Services Providers.

After-Hours Care: Telephone Arrangements

PCPs and specialists must ensure 24/7 access to covered services. Requirements include:

- Office phones answered during business hours.
- Timely response to member calls.
- Prioritize and schedule appointments, including follow-ups and rescheduling no-shows.
- Address special needs (e.g., wheelchair access, language interpretation, cognitive impairments).
- Maintain availability of professional and support staff during normal hours; have coverage protocols for absences.
- Document after-hours calls and transfer notes to the member's medical record.

After-Hours Options

- Answering service that contacts the PCP or designee for call-back.
- Recorded message directing members to another number for PCP or designee.
- Call forwarding to a location where staff can reach the PCP or designee.

Member Appeals and Grievances

Relevant Definitions

Appeal (hereafter referred to as Member Appeals): As defined at 42 CFR §422.561 and §423.560, the procedures that deal with the review of adverse initial determinations made by the plan on healthcare services or benefits under Part C or D the member/enrollee believes he or she is entitled to receive or on any amounts the member/enrollee must pay for a service or drug as defined in 42 CFR §422.566(b) and §423.566(b).

Authorized Representative: An individual appointed by a member or other party, or authorized under state or other applicable law, to act on behalf of a member involved in a grievance, organization determination, or appeal.

Note: *Pre-service appeal requests made by providers are allowed and do not need an Appointment of Representative (AOR) form. More details are in the Filing an Appeal or Grievance on Behalf of a Member section below.*

Dismissal: A decision not to review a request for a grievance, initial determination, or appeal because it is considered invalid or does not otherwise meet Medicare Advantage or Part D requirements.

Grievance: An expression of dissatisfaction with any aspect of the operations, activities, or behavior of a plan or its delegated entity in the provision of healthcare items, services, or prescription drugs, regardless of whether remedial action is requested or can be taken.

Non-Contract Provider: A provider or supplier that does not contract with CCA to provide services covered by the member's CCA Senior Care Options or CCA One Care plan.

Provider Payment Dispute: CCA-contracted providers (including subcontracted entities) do not have appeal rights under the appeal provisions in CMS guidance. Contract provider disputes involving plan payment denials are governed by the dispute resolution process in this document as described in SECTION 6: Claims and Billing Procedures.

Filing an Appeal or Grievance on Behalf of a Member

Providers may file an appeal on behalf of a member using the procedures described below. Providers may also file a grievance on behalf of a member, but only when acting as the member's representative using the below Appointment of Representative (AOR) form. A **pre-service appeal** request can be filed by the provider without the provider being the member's representative.

Post-service appeals and grievances can only be filed when providers are acting as the member's authorized representative. A member appoints representatives through use of an AOR form. The preferred form for this is the CMS-1696. If an AOR form is needed but is defective or missing, the CCA Appeals and Grievances team will attempt to collect that form from the provider and member. If the completed form (signed and dated by provider and member) is not supplied within 44 days of the appeal request, the request will be dismissed.

An AOR form (CMS-1696) can be printed from the following link: cms.gov/medicare/cms-forms/cms-forms/downloads/cms1696.pdf.

Return the completed form to CCA via fax at 857-453-4517 or by mail at the following address:

Commonwealth Care Alliance
Attn: Appeals and Grievances 30 Winter Street
Boston, MA 02108

Member Appeals

Appeals are procedures that deal with the review of adverse initial determinations made by CCA regarding healthcare services or medication. Appeals processed by CCA are called Level 1 appeals. Depending on whether the service or drug is covered by Medicare or Medicaid or both, there are additional levels of appeals available, including: Medicare Independent Review Entity or Board of Hearing, administrative law judge, Medicare Appeal Counsel, and federal court.

Instructions for filing a Level 1 appeal with CCA are listed on the initial denial notification and include both standard and expedited options for pre-service requests. Providers may file a pre-service appeal on a member's behalf within 65 days of the denial by calling Provider Services at 866-420-9332, by sending a fax to the Appeals and Grievances department at 857-453-4517 or via mail at the address listed above.

A participating provider does not need to be the representative to initiate a pre-service appeal but is required to submit an Appointment of Representative form for post-service member appeals prior to the end of the appeal time frame. CCA includes as parties to the appeal the member and the appeal representative, or the legal representative of a deceased member's estate.

Note: *Participating providers filing a dispute regarding how a claim was processed must utilize the Provider Payment Disputes and Appeals process found in SECTION 6: Claims and Billing Procedures.*

Non-network providers may file appeal requests within 60 days of the original payment or denial date as indicated on the EOP if the appeal includes a signed Waiver of Liability (WOL) form. Non-network provider appeals without the WOL will be dismissed if the WOL is not received within 60 days of the appeal request.

Appeal Resolution Time Frames			
Appeal Type	**Part C**	**Part B**	**Part D**
Standard pre-service*	30 days	7 days	7 days
Expedited pre-service	72 hours	72 hours	72 hours
Post-service	60 days	60 days	14 days

**Pre-service appeal requests that are not entirely pre-service will be split, addressing pre-service appeals and post-service claim appeals separately. Participating providers filing a dispute regarding how a claim was processed must utilize the provider payment disputes and appeals process found in SECTION 6: Claims and Billing Procedures.*

Pre-service appeals can be submitted as expedited (also called a "fast appeal") or standard. If the provider indicates that applying the standard time frame could seriously jeopardize the life or health of the member or the member's ability to regain maximum function (the physician does not have to use these exact words), the plan will process the appeal as expedited.

In some cases, CCA may extend these time frames up to 14 calendar days if the member requests the extension or if CCA justifies the need for additional information and how the extension will benefit the member.

Appeals decided by a medical director during the utilization review will be reviewed on appeal by another medical director who has not been involved in the initial level of review and does not report to the individual who made the initial determination. Appeals will be reviewed by a physician with the same or similar specialty as the appealing provider.

Providers and members may submit supporting evidence for the appeal at any point during the appeal time frame. Upon decision, the member and provider are notified in writing. For expedited appeals, the member and provider will also receive verbal notification of the decision.

If an appeal is approved, authorization will be entered within the appeal time frame. If an appeal is denied, there are additional levels of review available. CCA requires that members and their appeal representative exhaust the CCA internal appeals process before filing a Level 2 (external) appeal. Members in the deemed eligibility period without an active Medicaid benefit do not have access to the Medicaid Board of Hearings to appeal a decision regarding the provision of or payment for a service by CCA.

Any denial for a Medicare covered Part B or C service is automatically sent to the Medicare Independent Review Entity (IRE) for a second-level review. For Part D appeals, a second-level review must be requested in writing to the IRE as directed on the denial letter. For Medicaid covered services, the member or provider may file a request for a Level 2 review with the Board of Hearing (BOH). For services covered by both Medicare and Medicaid, both processes may be used and the decision most favorable to the member is effectuated (See External Appeals table below).

External Appeals		
CCA ensures that members have access to all Medicare appeal processes.		
Level	**Type**	**Entity**
1	Internal	CCA
2	External	The Independent Review Entity (IRE) (Medicare); Board of Hearing (Medicaid)
3	External	Administrative law judge (ALJ)
4	External	Medicare Appeals Council (MAC)
5	External	Federal district court

Grievances

Grievances are defined as a member/enrollee expression of dissatisfaction with any aspect of the operations, activities, or behavior of a plan or its delegated entity in the provision of healthcare items, services, or prescription drugs, regardless of whether remedial action is requested or can be taken.

If a member expresses a grievance about the provider to a provider, the provider should follow internal processes on how to research/resolve that grievance. The provider may also encourage the member to contact CCA directly. If a provider wishes to file a grievance on a member's behalf, they must be the member's appointed representative with a valid Appointment of Representative CMS-1696 form.

Grievances are accepted orally and in writing at any time and are resolved within 30 days.

Note: *It is the responsibility of all network providers to participate in our grievance review process. Providers are expected to respond to a request for information from CCA within 5 business days. This turnaround time is required to ensure that the plan meets its regulatory and accreditation requirements to the member and remains compliant with all state and federal requirements. A finding letter is sent to the provider and member at the end of the investigation.*

SECTION 4: PRIOR AUTHORIZATION REQUIREMENTS

The Commonwealth Care Alliance, Inc. (CCA) Authorization and Utilization Management department is responsible for reviewing prior authorization service requests from providers. In accordance with the member's Evidence of Coverage, certain services performed by contracted providers require prior authorization before being rendered.

Services requiring prior authorization by CCA can be found here: CCA SCO and One Care Prior Authorization List. If a requested service or item is not listed, please call CCA at 866-420-9332 for clarification.

All requests require a completed Standard Prior Authorization Request form and supporting clinical documentation in accordance with relevant Medical Necessity Guidelines to be submitted via fax to 855-341-0720. CCA contracted providers who are registered on CCA's Provider Portal will have the option of submitting service authorization requests directly in the "Authorization Request" section of the portal.

Exceptions:

- **Behavioral Health:** Inpatient behavioral health admissions require a Notification of Admission within 72 hours of admission. This can be submitted via fax to 617-830-0118 using the BH Inpatient Notification of Admission Form. A complete list of behavioral health services that require prior authorization or a Notification of Admission can be found in SECTION 11: Behavioral Health Services Providers
- **Inpatient/Observation Admissions:** Authorization service requests must be faxed to 855-811-3467 using the standard prior authorization form for the service requested along with the necessary clinical documentation to support the request. CCA SCO and One Care Prior Authorization List
    - CCA utilizes Bamboo Health, a secure third-party admission and discharge notification software system
    - CCA will create the admission authorization once notified of the member's admission for facilities who contract and participate in the use of Bamboo Health, preventing late authorizations
    - If you do not contract with Bamboo Health, admission notification is required within 24 to 48 hours of facility admission
- CCA does not require submission of clinical information for those facilities which have granted electronic medical record (EMR) access to CCA staff for medical necessity (MN) review (except for members who have restricted EMR access).
    - Network providers must review their contracts with CCA to determine EMR agreements
    - All facilities that have not granted CCA EMR access are required to submit clinical information in a timely manner for medical necessity review
- **CCA Provider Portal**
    - For more information, please refer to SECTION 6: Claims and Billing Procedures.

- Medicare Outpatient Observation Notice (MOON) is a standardized form (CMS-10611) that acute care hospitals are required to issue to CCA members who receive hospital outpatient observation services. CCA members are not responsible for any cost-share and therefore shall not be billed, though they are still expected to receive and sign the MOON when they receive observation services.
    - Providers may access instructions and the MOON forms in English and Spanish on the CMS website at https://www.cms.gov/medicare/forms-notices/beneficiary-notices-initiative/ffs-ma-moon

Durable Medical Equipment (DME)

For a code-specific list of DME and other services requiring prior authorization (PA) for CCA One Care and CCA Senior Care Options, click here: CCA SCO and One Care Prior Authorization List

Utilization Determination Time Frames

CCA will review and make utilization management decisions in keeping with the time frames referenced in the table below. To meet these time frames, we ask that providers submit all relevant information and documentation in a timely manner. If CCA needs to request an extension, we will communicate clearly why we need additional time and adhere to CMS rules.

Expedited organization determinations (prior authorization requests) are made when the member or their physician believes that waiting for a decision under the standard time frame could place the member's life, health, or ability to regain maximum function in serious jeopardy. Expedited organizational determinations may not be requested for cases in which the only issue involves a claim for payment for services that the member has already received. Expedited requests must be indicated on the prior authorization form.

Category of Utilization Management Decision	Review and Determination Time Frame
Standard	Determination and notification within 7 calendar days after receipt of request, and as quickly as needed based on the member's health condition
Standard extension	Up to 14 additional calendar days (not to exceed 21 calendar days) after receipt of the original request
Expedited	Determination and notification as quickly as the member's health condition requires, but no later than 72 hours after receipt of the request
Expedited extension	Up to 14 additional calendar days (not to exceed 17 calendar days) after receipt of the original request
Concurrent	Determination and notification as soon as medically indicated; usually within 72 hours of request
Medicare Part B standard request	Determination no later than 72 hours of request
Medicare Part B expedited request	Determination within 24 hours of request

CCA Utilization Management decision-making is based only on appropriateness of care and service, existence of coverage, and prior authorization. The organization does not specifically reward practitioners or other individuals for issuing denials of coverage. There are no financial incentives for CCA Utilization Management decision-makers.

Clinical Decision-Making

CCA uses criteria based on CMS Medicare requirements defined in CMS national coverage determinations (NCDs), relevant local coverage determinations (LCDs), generally accepted criteria such as InterQual®, and Mass Health Guidelines and CCA's Medical Necessity Guidelines (MNGs).

We use InterQual® criteria to review certain services (such as imaging, DME, and inpatient). These criteria are available on the CCA website and upon request, to members and providers impacted by a denial decision.

All Medical Necessity Guidelines can be located on the CCA website. Please click here for more information.

Note: *Failure to obtain the required prior authorization may result in a claim being denied or in a reduction in payment. CCA members cannot be billed for services that require prior authorization and are delivered without prior authorization.*

About Medical Criteria Request

CCA uses written criteria based on sound clinical evidence to evaluate the medical appropriateness of healthcare services. These criteria are objective, based on current clinical and medical evidence, and applied with consideration of individual needs and characteristics (e.g., age, comorbidities, prior treatment, and complications) and the availability of services within the local delivery system. You can download these policies/criteria from CCA website or contact Provider Services for a hard copy at 866-420-9332.

Discharge Notification and Planning

We believe it is critical that the member or member's authorized representative, CCA, the admitting provider, and the primary care provider (PCP) are all in agreement about the treatment plan and next steps by the time the member is to be discharged from a facility.

The facility or admitting physician is required to contact CCA and provide clinical information to support discharge decisions for:

- Requests for facility stay extensions (contact must be made prior to the expiration of the approved days)
- Requests to move members to a different level of care
- Discharge plans that include any of the following:
    - Home health services or specialized durable medical equipment
    - Multiple medications
    - Programs for lifestyle changes like weight management, nutrition, smoking cessation, exercise, diabetes education, or stress management

Facilities are requested to submit all discharge documentation within 24 hours of member's discharge. Discharge information must include all the following at minimum:

- The practitioner responsible for the member's care during the inpatient stay
- Procedures or treatment provided
- Diagnoses at discharge
- Current medication list
- Testing results, or documentation of pending tests or no tests pending
- Instructions for patient care post-discharge, including follow-up appointments

Please fax completed discharge summary to the Transitions of Care team at 855-811-3467. For behavioral health discharges, please fax completed discharge summary to 617-830-0118.

Emergency Medical Treatment and Labor Act

As required by the Emergency Medical Treatment and Labor Act (EMTALA), hospital providers will perform proper medical screenings and examinations by qualified hospital personnel for all individuals who seek care in a hospital's emergency department. A provider will either provide stabilizing treatment for that individual or arrange for another qualified provider to do so. Nothing shall impede or obstruct a provider from rendering emergency medical care to an individual.

Referrals

All contracted providers in the CCA network are required to direct members to network CCA providers when arranging for covered services related to a member's care. A list of in-network CCA providers can be found in the Provider Directory or by contacting CCA Provider Services at 866-420-9332.

Continuity of Care

CCA will honor covered services provided by an out-of-network provider during the continuity of care period, which is the first 90 days after member enrollment. Please refer to our Out of Network Provider Payment Policy.

Contracted providers are required to assist in the redirection to a network provider for services to continue after the continuity of care period if services are still considered medically necessary.

SECTION 5: CENTRALIZED ENROLLEE RECORD

Commonwealth Care Alliance, Inc. (CCA) collects and maintains all data elements required for the member's centralized enrollee record, as defined in the CCA One Care and CCA Senior Care Options contracts. To ensure the highest-quality, most effective healthcare to members, all providers are reminded to review their provider agreement with CCA for provider obligations regarding their documentation and the obligation to share clinical information with CCA care teams when appropriate.

SECTION 6: CLAIMS AND BILLING PROCEDURES

The information here enables providers to comply with the policies and procedures governing Commonwealth Care Alliance, Inc. (CCA) Senior Care Options and CCA One Care plans.

Updates or changes to this section are made in the form of provider notices that CCA provides to you by mail, facsimile, email, or the CCA website.

CCA pays clean claims submitted for covered services provided to eligible CCA members. In most cases, CCA pays clean claims within 30 days of receipt.

The receipt date is the day that CCA receives the claim. Claim turnaround timelines are based on the claim receipt date. Filing limits are strictly adhered to and are specified in your contract.

Please note that network providers must file claims no later than 90 days from date of service unless the filing limit is stipulated otherwise in their contract. Non-network providers must file claims no later than 12 months, or 1 calendar year, after the date the services were furnished.

CCA accepts both electronic and paper claims with industry-standard diagnosis and procedure codes that comply with the Health Information Portability and Accountability Act of 1996 (HIPAA) Transaction Set Standards. For detailed instructions for completing both the CMS-1500/HCFA-1500 and UB-04 claim forms, please use the links below.

- CMS HCFA-1500
- CMS UB-04 claim

If CCA has returned a rejected paper or electronic claim due to missing or incomplete information, please make the necessary correction as indicated in the rejection letter and resend the claim following the standard billing practice for clean claims submission within the required timely filing limit.

Providers are responsible for obtaining prior authorization from CCA before providing services. Please review SECTION 4: Prior Authorization Requirements or contact CCA Provider Services to determine if prior authorization is needed.

Contact Information for Provider Claims, Billing Support, and EDI Support
CCA Provider Services at 866-420-9332 Available from 8 am to 5 pm ET, Monday, Tuesday, Wednesday, and Friday, and from 8:30 am to 5 pm ET, Thursday
EDI Support: Availity Client Services at 800-Availity (800-282-4548), from 8 am to 8 pm, Monday to Friday
Availity Essentials Provider Portal To register, click on ”Get Started” in the upper right corner and follow the instructions.

Billing Members

Providers shall not seek or accept payment from a CCA member for any covered service if the member is wholly enrolled and eligible for both Medicare and MassHealth.

Providers must accept CCA payment as payment in full, as detailed in the provider's contract with CCA. CCA members are Medicare and MassHealth beneficiaries, and providers are prohibited from billing dual-eligible members, regardless of claims payment or denial.

Providers are responsible for obtaining prior authorization from CCA before providing services. Please review SECTION 4: Prior Authorization Requirements or contact CCA Provider Services to determine if prior authorization is needed. Please see "Deeming Period" below if the member loses their MassHealth eligibility.

Eligibility

Providers are required to confirm member eligibility on a regular basis prior to rendering services, even if prior authorization covers a long period.

Eligibility Verification
Use the Availity Essentials Provider Portal*
Use the MassHealth Provider Online Service Center
Use the NEHEN Provider Portal*
Contact CCA Provider Services at 866-420-9332 from 8 am to 5 PM ET, Monday, Tuesday, Wednesday, and Friday, and from 8:30 am to 5 pm ET, Thursday.

**Supports batch eligibility transactions*

Deeming Period

If a member is in a deeming period (temporary loss of MassHealth eligibility), providers must determine if the member is still eligible for services by confirming their eligibility for the plan. The plan has a 30-day deeming period, in which members are still eligible for their Medicare-covered services under the plan, but have lost access to their MassHealth benefits. This begins on the first of the month they begin their deeming period. While CCA will not pay for MassHealth services during this period, it is important that providers also check whether members are enrolled in a Medicare Savings program. Members who are Qualified Medicare Beneficiaries (QMBs) cannot be billed for cost-sharing nor offer to pay for cost-sharing. Please refer to CMS's newsletter, MLN SE1128, : https://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnmattersarticles/downloads/se1128.pdf for a more complete list of restrictions providers must be mindful of for QMBs. Members may also have Extra Help, meaning they will have some support paying for Medicare-covered services and prescription drugs. The provider should determine member cost responsibility based on these criteria. MassHealth may cover cost sharing for QMBs through fee-for-service even if a member has lost their full MassHealth eligibility.

Members remain responsible for fulfilling any MassHealth requirements to maintain eligibility and may have Medicare or Medicaid cost-sharing obligations (such as co-insurance or copays) during the deeming period.

CCA will process claims according to Medicare coordination of benefits guidelines during this period. The member is responsible for the cost of MassHealth covered services if they do not have MassHealth eligibility, as well as cost sharing for any Medicare-covered services if they also lost eligibility for their Medicare Savings program. Providers should continue to check member eligibility because members may regain MassHealth eligibility during the deeming period and have their MassHealth coverage reinstated retroactively through MassHealth fee-for-service.

Eligibility Verification
Use the Availity Essentials Provider Portal*
Use the MassHealth Provider Online Service Center
Use the NEHEN Provider Portal*
Contact CCA Provider Services at 866-420-9332 from 8 am to 5 PM ET, Monday, Tuesday, Wednesday, and Friday, and from 8:30 am to 5 pm ET, Thursday.

**Supports batch eligibility transactions*

Claims Submission

CCA accepts submissions of properly coded claims from providers by means of Electronic Data Interchange (EDI) or industry-standard paper claims. The provider acknowledges and agrees that each claim submitted for reimbursement reflects the performance of a covered service that is fully and accurately documented in the member's medical record prior to the initial submission of any claim. No reimbursement or compensation is due should there be a failure in such documentation. Receipt of claims does not guarantee payment. Providers shall hold all members harmless, regardless of payment or denial.

Providers are responsible for obtaining prior authorization from CCA **before** providing services. Please review SECTION 4: Prior Authorization Requirements or contact the CCA Member Services department to determine if prior authorization is needed.

Electronic Data Interchange Claims

CCA accepts electronic claims through Electronic Data Interchange (EDI) as its preferred method of claims submission. All files submitted to CCA must be in the ANSI ASC X12N format, version 5010A, or its successor version.

Claims submitted via EDI must comply with HIPAA transaction requirements. EDI claims are sent via modem or via a clearinghouse. The claim transaction is automatically uploaded into the claims processing system. CCA has a Companion Guide and Training Manual that further explains the requirements and operations.

Minimum Requirements for EDI Claims:

- Member first and last name
- Date of birth
- Member ID
- Rendering provider
- Rendering provider NPI
- Pay-to name
- Pay-to tax ID number
- Place of service
- Diagnosis code
- Procedure code
- Modifiers
- Billed amount
- Quantity

EDI Claim Submission

Initial EDI Setup

To view member eligibility, claims status and submit claims electronically to CCA, providers must register with Availity Essentials. To register with Availity, click on the "Create a Free Account button and follow the instructions. Providers using electronic submission must submit clean claims to CCA or its designee, as applicable, using the HIPAA-compliant 837 electronic format or a CMS-1500/HCFA-1500/UB-04, or their successors, as applicable.

If you have additional questions or need assistance, please contact Availity Client Services at 800-Availity (800-282-4548), from 8 am to 8 pm ET, Monday to Friday.

Four EDI Options

CCA offers 4 options for submitting EDI claims. With the appropriate option in place for your electronic workflow, electronic billing results in fewer errors, lower costs, and increased efficiency for businesses on both ends of the transaction. These options are detailed below:

Option One: Clearinghouse Submitters

Standard 837 file submissions through a clearinghouse using the CCA payer ID number, **A2793**. This PIN is the identifier at the clearinghouse to route claims directly to the Claims Operation department.

Option Two: Direct Submitters

This option is for those entities that choose to create their own 837 file and submit that file directly to the Availity Essentials Provider Portal with the CCA payer ID number **A2793**. The easy-to-navigate web portal requires authorized billers and providers to register to access information.

Option Three: ***Single Claims Submitters***

Single claims submissions are for industry-standard claim forms. Providers are required to register with the

Availity Essentials Provider Portal for claims submission and to validate member eligibility and claim status.

Option Four: ***Manual Entry of Claims in the Availity Portal***

For providers who have system limitations where an EDI file cannot be created, manual entry of claims is available. Providers are required to register with the Availity Essentials Provider Portal and complete all required fields in the standard template. Providers are required to validate all member eligibility prior to submitting the claim.

Note: *Options Two and Three allow vendors to use our automated secure web portal interface to transmit HIPAA-compliant claims for processing. They also provide the ability to view member and provider data and claim processing status, per level of authorization.*

EDI Claim Resubmission

Reprocessing EDI Claims

Providers may submit corrected claims electronically or by mailing a corrected paper claim to correct a claim that was previously submitted and paid or denied. Corrected claim submissions do not apply to an original or first-time submission.

Electronic Funds Transfer (EFT) for All Dates of Service

CCA (in partnership with Payspan) has implemented an enhanced online provider registration process for EFT and electronic remittance advice (ERA) services.

Once a provider has registered, this no-cost secure service offers a number of options for viewing and receiving remittance details. ERAs can be imported directly into a practice management or patient accounting system, eliminating the need to rekey remittance data.

Multiple practices and accounts are supported. Providers can reuse enrollment information to connect with multiple payers. Different payers can be assigned to different bank accounts.

Providers will no longer receive paper Explanation of Payments (EOPs). EOPs can be viewed and/or downloaded and printed from Payspan's website once registration is completed. Providers can register using Payspan's enhanced provider registration process at payspanhealth.com.

Payspan Health Support can be reached via email at providersupport@payspanhealth.com, by phone at 877-331-7154 (Option #1), or online at payspanhealth.com.

EFT Advantages

By using EFT, you eliminate the risks associated with lost, stolen, or misdirected checks. With EFT, you save yourself and your company valuable time. EFT eliminates excess paper and helps you automate your office EFT is HIPAA compliant (ASC X12 835 Health Care Payment and Remittance Advice or subsequent standard).

The Administrative Simplification provision of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires the U.S. Department of Health and Human Services (HHS) to establish national standards for electronic healthcare transactions for health plans and providers.

The 835 X12N Implementation Guides were implemented as the standard documents to be used in order to comply with claims transaction requirements for Electronic Data Interchange in healthcare.

Explanation of Payment (EOP) Statements

CCA, in partnership with Payspan/Zelis, provides online access to EOPs. Payspan/Zelis delivers remittance information and electronic payment information to CCA providers, replacing the paper delivery of EOP statements. This service offers providers online access to current EOP statements.

EOPs can be printed from the Payspan website, and ANSI 835 electronic remittance advice (ERAs) are also available for download. The website has tools and workflow management options to manage your payments and remittances.

To get started, providers can register using Payspan's enhanced provider registration process at payspanhealth.com.

Payspan Health Support can be reached via email at providersupport@payspanhealth.com, by phone at 877-331-7154 (Option #1), or online at payspanhealth.com.

Paper Claims

All providers are encouraged to submit claims to CCA electronically. CCA recognizes, however, that some providers may choose to submit reimbursement using industry-standard paper claim forms. If a provider does submit paper claim forms, the following forms are acceptable:

- CMS-1500/HCFA-1500
- CMS-1450 (UB-04)
- American Dental Association (ADA) Dental Claim Form (for use when billing Scion for dental services)

All information must be typed and aligned within the data fields. Please do not stamp, handwrite, or use correction fluid. For detailed instructions for completing both the CMS-1500 also known as the HCFA 1500 claim form and the UB-04 claim forms, please use the links below.

- CMS HCFA-1500
- CMS UB-04 claim

Click here for more information about Medicare Billing: Form CMS-1500.

Paper Claim Submission
Mail all paper claims to: Commonwealth Care Alliance – Claims P.O. Box 3085 Scranton, PA 18505
Note: *While CCA accepts paper claim submissions, electronic billing and electronic funds transfer are preferred.* Please register with the Availity Essentials Provider Portal. If providers utilize billing agencies to manage their account receivables, please grant them access to Payspan.

Use of Modifiers

CCA follows MassHealth and CMS guidelines regarding modifier usage. Pricing modifier(s) should be placed in the first position(s) of the claim form.

Timely Claims Submission

Unless otherwise stated in your CCA contract, providers must submit clean claims, initial and corrected, to CCA. The start date for determining the timely filing period is the “from” date reported on a CMS-1500 or 837-P for professional claims or the “through” date used on the UB-04 or 837-I for institutional claims.

Unless prohibited by law or CMS, CCA may deny payment of any claim that fails to meet CCA submission requirements for clean claims or failure to timely submit a clean claim to CCA.

Please note that contracted providers must file claims no later than 90 days from the date of service unless the filing limit is stipulated otherwise in the contract. Non-contracted providers must file claims no later than 12 months, or 1 calendar year, after the date the services were furnished.

The following items are accepted as proof that a claim was submitted in a timely manner:

- A clearinghouse electronic acknowledgement indicating claim was electronically accepted by CCA
- A provider's electronic submission sheet that contains all the following identifiers:
  - Patient name
  - Provider name
  - Date of service to match Explanation of Payment (EOP) and/or claim(s) in question
  - Prior submission bill dates
  - CCA product name or line of business

Claim Status

Checking Claim Status

Providers requesting information on the status of a claim, including clarification of any Explanation of Payment may call CCA Provider Services at 866-420-9332. If providers utilize billing agencies to manage their account receivables, please grant them access to Payspan.

Web Portal

CCA offers two secure web portals where providers can obtain access to claim status, member eligibility, and other options:

CCA Provider Portal

CCA offers a secure provider portal, where active and participating providers, provider groups, hospitals, and ancillaries may register to obtain access to member assignment and authorization status; to access and download CCA documentation, forms, and templates; or access the claims portal; and to access Explanation of Payments.

To access the CCA Provider Portal, you will need to create a new account. Be sure to have the most recent CCA Explanation of Payment (EOP) available, along with "check number" and corresponding "payment amount" to assist in the validation process.

Availity Essentials Provider Portal: The easy-to-navigate claims Availity Essentials Provider Portal requires authorized billers and providers to register. Once you are a registered user, providers may check claims status, member eligibility, and provider status.

Corrected Claims

To modify a claim that was originally submitted on paper or via EDI submission and paid or denied, providers must submit a corrected claim via either paper or 837 submissions. If the corrected claim requires the inclusion of additional information, invoice, prescription, etc., the submission must be manual.

How to Submit a Corrected Claim

A provider may submit a corrected paper claim to modify a claim that was previously submitted and paid or denied (e.g., changing units, dates of service, bill type, etc.).

Corrected Claim Submission Requirements:

1. The original claim number MUST be listed
2. Any necessary modifications from the original claim
3. Any required supporting documentation
4. CMS-1500/HCFA-1500 or UB-04 paper claim form with corrections MUST NOT contain any of the following:
   - Handwritten changes
   - Correction fluid on form

Incomplete or Incorrect Claims

If CCA returns a claim due to missing or incomplete information, the claim may be resubmitted using the CCA Request for Claim Review form.

Please click here to obtain the Request for Claim Review form.

Submission Requirements

The provider may submit a corrected claim accompanied by requirements documentation stated above. Corrected claim requests will be considered when received within **90 days from the original payment or denial date** as indicated on the EOP and accompanied by supporting documentation when applicable. CCA reviews all corrected claim requests within 60 calendar days of receipt date.

Corrected Paper Claim Submission
Providers must submit their corrected paper claim requests to the address below within 90 days from the original payment or denial date as indicated on the EOP: Commonwealth Care Alliance – Claims P.O. Box 3085 Scranton, PA 18505
Rejected Claims If CCA returns/rejects a claim due to missing or incomplete information, it is the provider's responsibility to resubmit a clean claim within original filing limits to the address below: Commonwealth Care Alliance – Claims P.O. Box 3085 Scranton, PA 18505

Submitting Invoices

Invoices are required for certain claim types. CCA does not accept invoices electronically through standard electronic claims submission at this time. If a claim denies for missing invoice, the provider must submit the invoice separately by mail or fax for review and reprocessing. All invoices must be mailed or faxed.

Invoices must have the following:

- Claim number
- Members name and ID number

Where to Send

Mail:
Commonwealth Care Alliance – Claims – Invoice Submission
PO BOX 3085
Scranton PA 18505

Fax: 855-885-8134

Note: *You do not need to resubmit a copy of the claim form.*

Payment Dispute Submission Requirements for Contracted Providers

A payment dispute from a contracted provider must be made in writing, accompanied by the required documentation stated below. Payment dispute requests will be considered when received **within 90 days of the original payment or denial date**, as indicated on the EOP, with supporting documentation.

CCA reviews all payment disputes within 60 calendar days.

Provider Payment Disputes and Appeals

If a contracted provider disagrees with CCA's decision of denial or reimbursement of a claim, the contracted provider can file a payment dispute for reconsideration. All contracted provider payment disputes must be received in writing. Examples of why a provider might submit a payment dispute for a claim decision include:

- Denials due to timely filing
- Claims believed to be adjusted incorrectly
- Disputing a request for recovery of overpayments

Provider payment disputes do not include:

- Seeking resolution of a contractual issue wherein the provider believes CCA is paying an amount different than was contractually agreed. Please direct these concerns to: ccacontracting@commonwealthcare.org
- An appeal made by a provider on behalf of a specific member. Please refer to SECTION 3: Member Eligibility, Appeals & Grievances for filing a per-service request and to the Non-contracted Provider Payment dispute process in the subsections below for post-service or claim requests.

All Contracted-Provider Payment Disputes Must Include:

- Request for Claim Review form
- Provider's tax identification number
- Provider's contact information
- A clear identification of the disputed item
- A concise explanation for which the provider believes the payment amount, request for additional information, or other CCA action is incorrect
- The remittance advice (or the member's name, date of service, CPT or HCPC codes, original claim number)
- Copy of the authorization (if authorization was required)
- An explanation for good cause if attempting to dispute a timely filing denial

If a provider dispute does not include all required information listed above, a request for additional information may be issued to the requesting provider. If the request for additional information is not returned with the required information by the **60th day from the initial payment dispute receipt**, the payment dispute will be dismissed.

Request for Contracted Provider Payment Disputes
Contracted providers must complete the Request for Claim Review form and submit their request to this email address: ProviderDisputes@commonwealthcare.org Please click here to obtain the Request for Claim Review form. For additional questions on provider payment disputes or appeals, please contact CCA Provider Services at 866-420-9332 from 8 am to 5 pm ET, Monday, Tuesday, Wednesday, and Friday, and from 8:30 am to 5 pm ET, Thursday. Payment dispute requests will be considered when received **within 90 days from the original payment or denial date**, as indicated on the EOP, with supporting documentation.

Appeal Submission Requirements for Non-contracted Providers

All requests for reconsideration/claim appeal by non-contracted providers must be made in writing accompanied by the required documentation stated below. Appeal requests will be considered when received **within 60 days from the original payment or denial date** as indicated on the EOP, per CMS regulations.

All Non-contracted Provider Payment Disputes Must Include:

- Waiver of Liability form
- Request for Claim Review form
- Provider's tax ID number
- Provider's contact information
- A clear identification of the disputed item

- A concise explanation for which the provider believes the payment amount, request for additional information, or other CCA action is incorrect
- The remittance advice (or the member's name, date of service, CPT or HCPC codes, original claim number)
- Copy of the authorization (if authorization was required)
- An explanation for good cause if attempting to dispute a timely filing denial

Waiver of Liability (WOL): Non-contracted providers **must** include a signed Waiver of Liability form holding the member harmless regardless of the outcome of the appeal. This form must be accompanied with the claim appeal. If a signed WOL is not received with the appeal request, the provider will be issued a letter requesting the documentation accompanied by a blank WOL. If a signed WOL is not received within the appeal time period, the appeal will be dismissed.

CCA reviews all appeals within 60 calendar days. CCA will review all supporting documentation submitted with the appeal to make a determination.

Request for Non-contracted Provider Payment Dispute
Non-contracted providers must submit their request to the fax number below: Fax: 857-453-4517 For additional questions on provider payment disputes, please contact CCA Provider Services at 866-420-9332 from 8 am to 5 pm ET, Monday, Tuesday, Wednesday, and Friday, and from 8:30 am to 5 pm ET, Thursday.

Hospice

Services rendered to CCA One Care and CCA Senior Care Options members electing hospice should be billed to Medicare. For additional information please see CCA's hospice payment policy: CCA Payment Policies.

Payment Policy

CCA has developed a payment policy program to provide guidance to providers on current coding and billing practices set by CCA. All payment policies are designed to assist providers with claim submission. All payment policies are guides in helping CCA make determinations on plan coverage and reimbursement. Payment policies will be consistently updated to ensure accurate coding and billing guidance comply with requirements of CMS and the Massachusetts Executive Office of Health and Human Services. References to policy guidance are provided within all payment policies. Payment policies are located on the provider website: CCA Payment Policies.

National Drug Coverage

Effective for claims with a date of service on or after January 1, 2018, CCA enforces the Physician, Health Care Professional, Facility and Ancillary Provider Administrative Guide for Commercial and Medicare Advantage Products national drug code (NDC) requirement. CCA's NDC requirement payment policy went into effect January 1, 2018. As a result, CCA Senior Care Options and CCA One Care professional claims submitted for reimbursement for drug-related codes must include the NDC number, quantity, and unit of measure. This requirement applies to paper claim form CMS-1500/HCFA-1500 and Electronic Data Interchange (EDI) transaction 837-P when billed for drug-related healthcare common procedure coding system (HCPCS) codes and drug-related current procedure terminology (CPT) codes. The NDC, quantity, and unit of measure will be enforced in addition to the corresponding HCPCS, and CPT codes and the units administered for each code. If you do not include the NDC with your claims submission, your claim will be denied, and you will be required to follow the Claim Reconsideration policy. Enforcing the NDC will allow CCA to differentiate and target drugs that share the same HCPCS code for drug preferences and rebates, to identify billing errors, and to improve reimbursement processes.

Note: *Hospital facility outpatient claims are not subject to enforcement of the NDC requirement at this time.*

Extended Care Facility Billing Information

Extended care facilities are required to submit claims with the appropriate codes for services rendered to CCA members. The use of the codes detailed below will ensure proper processing and accurate payment. Please refer to SECTION 4: Prior Authorization Requirements.

Revenue Code	Description
Rev Code 192	Sub-acute level of care: short-term, goal-oriented treatment plan requiring nursing care or rehabilitation at a high intensity level; lower intensity than acute care
Rev Code 191	Skilled nursing level of care: short-term, goal-oriented treatment plan while the member cannot be treated in a community-based setting; lower intensity than sub-acute
Rev Code 100	Custodial and/or long-term level of care: absent of a defined treatment goal, yet the member's functional or cognitive status requires the support of a facility setting
Rev Code 185	Medical leave of absence (MLOA) days (20 days max per admission)
Rev Code 183	Non-medical leave of absence (NMLOA) days will be paid an amount equal to the provider's current Medicaid reimbursement rate for up to 10 days (10 days max per year). A bed is guaranteed for the member if he or she returns to the facility during the 1st day through the 10th day after transferring out of the facility. If the member returns after this period, his or her admission shall be accommodated upon the availability of a bed, unless otherwise arranged.

Behavioral Health Billing Information

Licensure and Modifiers

Claims for behavioral health outpatient services must include the appropriate modifier for the license of the clinician who provided the service. The table below shows licensures accepted by CCA, the corresponding modifiers, and CCA policy regarding reimbursement.

Degree	License and/or certification	Modifier	CCA Policy
Physician	MD, DO	U6, AF	May provide/bill for direct services
Physician assistant	PA	SA	May provide/bill for direct services
Clinical psychologist: PhD, PsyD, EdD	LP	AH	May provide/bill for direct services
Advanced practice registered nurse, certified clinical nurse specialist, psychiatric nurse mental health clinical specialist	APRN, CCNS, PNMHCS	SA	May provide/bill for direct services
Licensed independent clinical social worker	LICSW	AJ	May provide/bill for direct services
Licensed independent clinical social worker, licensed mental health counselor; licensed marriage and family therapist, licensed clinical social worker	LICSW, LMHC, LMFT, LCSW	HO	May provide/bill for direct services
Licensed alcohol and drug counselor I, certified alcohol and drug counselor II	LADC I, CADC II	HO	May provide/bill for direct services
Post-master's degree level in social work, counseling, clinical psychology	MSW, MA, MS	HL	May provide/bill for direct services only under the direct personal supervision of an independently licensed clinician at a mental health center, community health center, or community behavioral health center
Certified alcoholism counselor, certified alcohol and drug counselor, licensed alcohol and drug counselor II (LADC II)	CAC, CADC, LADC II	HL	May provide direct services only under the direct personal supervision of an independently licensed clinician
Master's-level interns, including psychology interns, mental health counselors and marriage and family interns	Intern-level clinician	HL	May provide/bill for direct services only under the direct personal supervision of an independently licensed clinician at a mental health center, community health center, or community behavioral health center

Significant Events with Reimbursement Impact

Serious Reportable Events

According to the National Quality Forum (NQF), serious reportable adverse events (SREs)—commonly referred to as "never events"—are errors in medical care that are clearly identifiable, preventable, and serious in their consequences for patients, and that indicate a real problem in the safety and credibility of a healthcare facility. To reduce or eliminate the occurrence of SREs, CCA will not provide reimbursement or allow hospitals to retain reimbursement for any care directly related to "never event." CCA has adopted the list of serious adverse events in accordance with the Centers for Medicare & Medicaid Services (CMS).

CCA will require all participating providers to report SREs by populating present-on-admission (POA) indicators on all acute care inpatient hospital claims and ambulatory surgery center outpatient claims, where applicable. Otherwise, CCA will follow CMS guidelines for the billing of "never events." In the instance that the "never event" has not been reported, CCA will use any means available to determine if any charges filed with CCA meet the criteria, as outlined by the NQF and adopted by CMS, as a serious reportable adverse event.

In the circumstance that a payment has been made for an SRE, CCA reserves the right to recoup the payment from the provider. CCA will require all participating acute care hospitals to hold members harmless for any services related to "never events" in any clinical setting.

Hospital-Acquired Conditions

According to CMS, hospital-acquired conditions (HACs) are selected conditions that were not present at the time of admission but developed during the hospital stay and could have been prevented through the application of evidence-based guidelines. Therefore, to reduce or eliminate the occurrence of HACs, CCA will not provide reimbursement or allow hospitals to retain reimbursement for any care directly related to the condition. CCA has adopted the list of HACs in accordance with CMS.

CCA will require all participating providers to report present-on-admission information for both primary and secondary diagnoses when submitting claims for discharge. Hospitals will not receive additional payment for cases in which one of the selected conditions was not present on admission. That is, the case is paid as though the secondary diagnosis were not present. CCA will require all participating acute care hospitals to hold members harmless for any services related to HACs in any clinical setting.

Provider Preventable Conditions

A provider preventable condition (PPC) is a condition that meets the definition of a "health care–acquired condition" (HCAC) or an "other provider preventable condition" (OPPC) as defined by the Centers for Medicare & Medicare Services (CMS) in federal regulations at 42 CFR 447.26(b).

Providers shall participate in, and comply with, programs implemented by the Commonwealth of Massachusetts through its agencies, including but not limited to the Massachusetts Executive Office of Health and Human Services (EOHHS), to identify, report, analyze, and prevent PPCs.

When a provider is required to provide notification of a PPC, the provider shall provide notification to CCA in a format and frequency as specified by EOHHS.

No payment shall be made by CCA to the provider for a PPC. As a condition of payment from CCA, the provider must comply with reporting requirements on PPC as described at 42 C.F.R. sec. 447.26(d) and as may be specified by CCA and/or EOHHS.

CCA reserves the right to apply regulations and guidelines promulgated by CMS that relate to PPCs to support CCA actions in the application of state-specific determinations.

Preadmission Screening and Resident Review (PASRR) for Nursing Facilities

The PASRR process requires that all members going to Medicaid-certified nursing facilities be given a preliminary assessment to determine whether they might have serious mental illness (SMI) or intellectual disability (ID).

This is called a “Level I screen.” Those members who test positive at Level I are then evaluated in depth, called “Level II,” or PASRR. The results of this evaluation outline a determination of need, determination of appropriate setting, and a set of recommendations for services to inform the member’s plan of care. It is a requirement and the responsibility of the facility to ensure that every CCA member admitted for nursing care has a PASRR performed and related documentation is on file.

CCA reserves the right to audit the facility to ensure compliance with the PASRR. In addition to the audit, if it is then determined that there is no evidence of a completed PASRR on file for any admitted CCA member, CCA reserves the right to deny or retract payment to the facility for that admission. Furthermore, the facility acknowledges that CCA members do not have a financial obligation in this matter and will not be subject to any balance-billing from the facility; for any balance-billing attempts, the facility may be in breach of its contract with CCA.

SECTION 7: CLINICAL DOCUMENTATION AND MEDICARE RISK ADJUSTMENT

Clinical Documentation Processes

The Centers for Medicare & Medicaid Services (CMS) use a risk-adjustment system to account for medical expenses and care coordination costs for beneficiaries with special needs. As part of that system, CMS requires providers to support all diagnoses billed with "substantive documentation" in the provider's medical record. Commonwealth Care Alliance, Inc. (CCA) and CMS may audit providers at any point for compliance with documentation standards.

The definition of "substantive documentation" is that each diagnosis billed must be supported by three items in the medical record:

1. An **evaluation** for each diagnosis
   - Assesses relevant symptoms and physical examination findings at time of visit
   - Only contains diagnoses that are active or chronic (which must be identified as such)
   - Lists and addresses all past and recent diagnosis if they are active and of medical significance

2. A **status** for each diagnosis to indicate progress or lack thereof; for example:
   - Stable, progressing or worsening, improving
   - Not responding to treatment or intervention

3. A **treatment plan** for each diagnosis; for example:
   - Observation or monitoring for exacerbation, responses to treatment, etc.
   - Referrals to specialists or services (e.g., cardiologist or PT)
   - Discontinuations of or changes to any related medications

Coding Compliance

CCA encourages providers to code to the most appropriate level of specificity as a general standard of practice (CPT, ICD10). CCA and/or CMS may audit the provider at any point for overcoding and/or similar billing practices related to fraud, waste, and abuse.

Educational Resources

Providers are encouraged to contact the CCA Clinical Documentation team at rahub@commonwealthcare.org to request education about coding and documentation compliance.

Behavioral Health Screening Compliance

In collaboration with EOHHS, CCA requires all its contracted PCPs to screen and assess each member for behavioral health needs. The early identification of behavioral health needs can lead to successful referrals, intervention, and integrated treatment in a timely manner.

The EOHHS-approved behavioral health screening tool and how to evaluate results can be found in SECTION 18: Forms. How to make a behavioral health specialty care referral can be found in SECTION 14: Provider Enrollment and Credentialing.

CCA recommends the use of the PHQ-9 depression assessment tool to assess patients for depression. The tool is a self-rated, 9-item measure that assesses the severity of depressive symptoms. The PHQ-9 can be administered repeatedly to reflect improvement or worsening symptoms.

CCA recommends use of the Screening, Brief Intervention and Referral to Treatment (SBIRT) Standard Screening Process, including the Alcohol Use Disorders Identification Test (AUDIT) or Drug Abuse Screening Test (DAST) to assess the use of alcohol and other drug abuse and dependence. These tools are not diagnostic but can identify the existence of alcohol or other drug problems.

In addition, CCA recommends that providers conduct a mental status exam to further evaluate other behavioral health symptoms.

Medicare Risk Adjustment: General Guidelines and Recommendations

General Medicare Risk Adjustment Guidelines

For the findings and coding of clinical encounters to be accepted by CMS for risk adjustment purposes, a clinical encounter must be in the form of a face-to-face visit by a physician or advanced practice clinician (such as a nurse practitioner (NP), physician assistant (PA), licensed independent clinical social worker (LICSW), occupational therapist (OT), or physical therapist (PT)). Moreover, all active diagnoses must be assessed and documented during a face-to-face encounter at least once per calendar year for the diagnoses to count for risk adjustment purposes.

Annual Assessment Process

CCA encourages providers to adopt the practice of an annual comprehensive assessment to ensure that all active conditions are reviewed at least once during the calendar year. The process of reviewing active conditions may be tied to an annual wellness exam or an annual physical exam.

The documentation and coding compliance practices and general risk adjustment guidelines described above should be adhered to in documenting and coding the findings of an annual comprehensive assessment visit.

Collaboration with Contracted Providers

CCA requires providers to monitor the quality, access, and cost-effectiveness of their services and identify and address opportunities for improvement on an ongoing basis. Providers may be required to submit clinical data and/or clinical documentation to CCA upon request.

SECTION 8: COORDINATION OF BENEFITS AND THIRD-PARTY LIABILITY

Coordination of benefits (COB) applies to members who are covered by more than one insurance policy and serves to determine which insurance is primarily responsible for payment to ensure claims are paid correctly. An example of coverage is an employer-sponsored plan. COB is administered by Commonwealth Care Alliance, Inc. (CCA) based on the member's benefit plan and applicable law.

Subrogation, also referred to as third-party liability (TPL), occurs when members are injured as a result of an accident and another party may be liable for the payment of the member's medical claims. The most common types of TPL cases are motor vehicle accidents, workers' compensation injuries, work-related or occupational injuries, and slip-and-fall injuries.

In some circumstances, as provided under the member's benefits and applicable state and federal law, CCA has the right to recover from third parties.

Member Covered by Other Health Insurance Plan

CCA is the secondary payer of coverage. When a member has another health insurance plan, CCA payment includes any remaining balance of medical claims, such as deductibles and co-insurance amounts (up to the CCA contractual amount). When a claim has been paid by a member's primary insurance carrier, providers should submit the Explanation of Benefits (EOB) indicating payment amounts and any outstanding balance. The EOB must be submitted to CCA **within 60 days from the primary insurance payment date**. Claims submitted without an EOB will be denied.

Member Involved in a Motor Vehicle Accident

In the event of a motor vehicle accident, the motor vehicle insurer is the primary payer for the full $8,000 personal injury protection (PIP) coverage. Once the provider has received a PIP exhaustion letter, if further payment is requested, the provider should submit a bill and copy of the PIP letter to CCA **within 60 days from the date the motor vehicle insurer issued the EOB form**.

Occupational Injuries

In instances where a member suffers a work-related accident, the workers' compensation insurer is primary, and CCA is the secondary payer of coverage. For all claims relating to a workers' compensation case, the provider should submit the claim and include additional information, when possible, such as date of injury, name of the workers' compensation insurance carrier, and claim number.

Subrogation and Records Request Information

MultiPlan (Claritev), handles all CCA subrogation and workers' compensation recovery matters. Please direct all inquiries to MultiPlan (Claritev):

Email: SUBROFAX@MultiPlan.com
Customer Service: 866-223-9974 (TTY: 711)
Fax: 866-926-0046

Records

For any third-party records requests, please send a letter of representation and compliant HIPAA authorization to:

CareSource
Attn: Office of General Counsel
230 N. Main St
Dayton, OH 45402

Phone: 937-224-3300
Fax: 937-487-1921
legalsubrogation@caresource.com

Note: *CCA remains the primary payer in all cases for the provision of services not related to the TPL or COB issue.*

SECTION 9: PHARMACY PROGRAM

This section outlines the Commonwealth Care Alliance, Inc. (CCA) pharmacy program, including details on our formulary and utilization management programs. Also included is a description of the CCA Step Therapy, Medication Therapy Management (MTM), and Mail Order programs.

CCA has contracted with CVS Caremark, a national pharmacy benefits management company, to administer the pharmacy benefit on behalf of CCA. CCA has worked with its primary care partners to identify those community pharmacies in the neighborhoods of the primary care sites with whom CCA primary care providers have established relationships and members can access easily. In addition to many smaller independent pharmacies, the CCA pharmacy network includes CVS, Stop & Shop, Walmart, and many others. For a complete and up-to-date listing of contracted pharmacies, please use the following link: CCA Pharmacy Directory

Formulary

CCA has established a formulary that provides prescribing clinicians with a broad range of options for treatment while promoting the most cost-effective drug choices. CCA covers the drugs listed in the formulary if they are medically necessary. Please use the links below to access the formulary list on our website.

CCA Senior Care Options Formulary

CCA One Care Formulary

The CCA formulary is updated monthly and posted on our website. CCA covers both Abbott FreeStyle and Roche Accu-Chek diabetic testing supplies. As of 2026, CCA no longer covers LifeScan OneTouch diabetic testing supplies. Please refer to our website for a complete list of the supplies covered.

Prior Authorization

Certain medications require prior authorization (prior approval) before a pharmacy can fill the prescription. Clinicians may request prior authorization by calling 855-344-0930. Fax can be sent to 855-633-7673. If prior authorization is not granted, the drug may not be covered. Please check the formularies linked above to access the list of medications that require prior authorization.

Part B vs. D Coverage Determination

Some medications require specific information to help ensure appropriate payment under Medicare Part B or Medicare Part D per the Centers for Medicare and Medicaid Services (CMS).

Part D Medications

Medications covered under the pharmacy benefit can be oral, injectable, infusible, or topical. Prescription drugs under the pharmacy benefit may require authorization.

CCA Senior Care Options Covered Drugs and Authorization Requirements

CCA One Care Covered Drugs and Authorization Requirements

Part B Medications

Outpatient (Part B) medications are covered when, in accordance with Medicare coverage criteria, they are furnished incident to a physician service for drugs that are "not usually self-administered by the patient."

View the list of Part B Drugs Requiring Prior Authorization:

CCA Senior Care Options Covered Drugs and Authorization Requirements

CCA One Care Covered Drugs and Authorization Requirements

Note: *Requests for outpatient part B medical pharmacy drugs are reviewed by the CCA Utilization Management department.*

For medications not addressed in this document, refer to the Medicare Coverage Database to search for applicable coverage policies.

Part B vs. D

Medicare medical insurance, or part B, also covers other selected medications, including:

- Oral antiemetics if used within 48 hours after chemotherapy administration
- Immunosuppressants for members who received a Medicare covered transplant
- Immune globulins for members with primary immune deficiency when provided in the home
- Infusion/injectable drugs that require a pump for infusion
- Nebulized drugs for members in the home that require administration via DME

Where to Submit a Prior Authorization

1. Medications that are processed under the pharmacy benefit and filled at retail pharmacies as well as self-administered specialty medications (that is, Part D medications) should be submitted to CVS Caremark:

Phone: 855-344-0930
Fax: 855-633-7673
Mail: CVS Caremark Part D Appeals and Exceptions
P.O. Box 52000, MC109
Phoenix, AZ 85072-2000

The standard prior authorization request form used for submitting requests for medications to be obtained by the member using their pharmacy benefit can be found here.

Medications requiring prior authorizations that are processed under the medical benefit and administered by healthcare professionals in the physician office setting (Part B medications) should have a standard prior authorization request form filled out and faxed to the Utilization department at 855-341-0720. The standard prior authorization request form used for submitting requests CCA-Standard-Prior-Auth-Form here.

Where to Submit an Appeal

1. Appeals for medications that are processed under the pharmacy benefit and filled at retail pharmacies, as well as self- administered specialty medications, should be submitted to CCA within 65 days upon notice of denial using the Request for Redetermination of Medicare Prescription Drug Denial form.

Phone: 855-344-0930
Fax: 855-633-7673
Mail: CVS Caremark Part D Appeals and Exceptions
P.O. Box 52000, MC109
Phoenix, AZ 85072-2000

2. Appeals for medications that are processed under the medical benefit and administered by healthcare professionals in the physician office setting can be submitted to CCA.

Mail: Commonwealth Care Alliance
Appeals and Grievances Department
2 Avenue de Lafayette, 5th Floor
Boston, MA 02110

Avoid delays

Completing and submitting the correct Prior Authorization form ensures there is sufficient information for processing your request. This prevents delays and unnecessary denials. Please be sure to include:

- Prescriber name
- Office phone number
- Member name
- Member ID
- Requested medication/J-Code
- Anticipated treatment start date
- Dosing information and frequency
- Diagnosis
- Past therapeutic failures or contraindications
- Any pertinent clinical notes
- Pathology reports
- Lab test results

Note: *The processing time for coverage determinations is 24 hours for expedited requests and 72 hours for standard requests. To ensure efficient review of prior authorization requests, please submit complete requests.*

Step Therapy Program

In support of efforts to provide members with the best medical care at a reasonable cost, CCA has worked closely with healthcare professionals to develop step therapy programs. These programs initiate drug therapy for a medical condition with the most cost-effective and safest drug and step up through a sequence of alternative drug therapies as a preceding treatment option fails.

Step therapy applies coverage rules at the pharmacy point of service (e.g., a first-line drug must be tried before a second- line drug can be used). If a prescription is written for a second-line drug and the step therapy rule was not met, the claim is rejected. A message is transmitted to the pharmacy indicating that the patient should be treated with the first-line drug before coverage of the second-line drug can be authorized. If a new member has been stabilized on a second-line drug prior to enrolling with CCA, the new member is allowed to remain on the second-line drug, per the CCA transition policy.

Please review the CCA transition policy and access step therapy program information for CCA One Care and CCA Senior Care Options linked below.

CCA Senior Care Options Covered Drugs

CCA One Care Covered Drugs

Extended Day Supply

CCA members can get an extended day supply (up to 100 days) at contracted community pharmacies for medications that are used for the treatment or management of chronic conditions. This is in addition to members being able to receive extended day supply through mail order. Whether members choose to get their extended day supply through a community pharmacy or mail order, members are able to fill their medications at $0 copay if they have active Medicaid and Medicare benefits. For more information, please click here.

Medication Therapy Management Program

CCA offers a Medication Therapy Management (MTM) program to members who take a number of different drugs, have chronic diseases (such as asthma, diabetes, or COPD), and have a high annual drug cost. If members meet these three qualifications, they may be eligible for support through the CCA MTM program. This program improves patients' knowledge of their medications and reviews the member's prescription, non-prescription, and over-the-counter medications along with supplements. Moreover, MTM programming helps identify and address problems or concerns that the patient may have, and it empowers patients to self-manage their medications and their health conditions. For more information, please click here.

SECTION 10: INFORMATION FOR ANCILLARY PROVIDERS—EXTENDED CARE FACILITIES, DURABLE MEDICAL EQUIPMENT & VISION

Extended Care Facilities

Commonwealth Care Alliance, Inc. (CCA) provides benefit coverage to its members at extended care facilities or nursing facilities. The protocols for benefit coverage take into account covered services, exclusions, clinical conditions and criteria, authorizations, and operational expectations.

Prior Authorization

Prior authorization is required and shall be granted from the designated CCA care team authorizing the extended care facility to render specified covered services to a CCA member. Payment to a facility for covered services requires prior authorization. For more information, please see SECTION 4: Prior Authorization Requirements.

Covered Services Include:

- Sub-acute level of care: short-term, goal-oriented treatment plan requiring nursing care or rehabilitation at a high intensity level; lower intensity than acute care. Sub-acute/skilled days shall be limited to 100 days per benefit period
- Skilled nursing level of care: short-term, goal-oriented treatment plan while the member cannot be treated in a community-based setting; lower intensity than sub-acute. Sub-acute/skilled days shall be limited to 100 days per benefit period
- Custodial/long-term care level of care: absent of a defined treatment goal, yet the member's functional (activities of daily living) or cognitive status requires the support of a facility setting
- Medical leave of absence (MLOA) days: a bed is guaranteed for the member if he or she returns to the facility during the 1st day through the 20th day after transferring out of the facility. If the member returns after this period, his or her admission shall be accommodated upon the availability of a bed, unless otherwise arranged
- Non-medical leave of absence (NMLOA): a bed is guaranteed for the member if he or she returns to the facility during the 1st day through the 10th day after transferring out of the facility. If the member returns after this period, his or her admission shall be accommodated upon the availability of a bed, unless otherwise arranged
- Inpatient rehabilitation: intensive rehabilitation program for members. Members who are admitted must be able to tolerate an intensive level of rehabilitation services and benefit from a team approach
- Long-term acute care facility services: treatment of patients with serious medical conditions that require care on an ongoing basis but no longer require intensive care or extensive diagnostic procedures

Level-of-Care Determinations

All level-of-care determinations prior to and during a member's admission to an extended care facility are made at the discretion of CCA clinical staff and/or those designated and authorized by CCA to direct member care.

Conditions and criteria for Skilled Nursing Facility (SNF) Services Under Medicare Part A are determined in the Medical Necessity Guidelines found here: CCA Medical Necessity Guidelines

Conditions and criteria for Determination and Documentation of Medical Necessity in an Inpatient Rehabilitation Facility are determined in the Medical Necessity Guidelines found here: CCA Medical Necessity Guidelines

Conditions and criteria for Long-Term Acute Care Hospital (LTACH) are determined by InterQual guidelines.

Rehabilitative Services in a Skilled Nursing Facility

Rehabilitation services provided intermittently while at the custodial level of care. Intermittent therapy **cannot exceed 4 calendar days per week as approved by CCA staff**.

Notice of Medicare Non-coverage (NOMNC)

The extended care facility shall deliver the NOMNC on behalf of CCA **no later than 2 days before a member's covered services end** in accordance with Medicare requirements. The extended care facility shall provide CCA with a copy of the notice within the same time frame as the member for monitoring and documentation purposes.

Service Specification of Extended Care Facilities

1. Always maintain 24/7 availability to provide extended care facility services in accordance with state and federal regulations, and be accessible by phone, directly

2. Upon request, provide admission for extended care facility services within 24 hours of the request subject to bed availability and with the prior authorization of CCA nursing staff and/or those designated and authorized by CCA to direct patient care

3. Always maintain and respect the rights of members

4. Inform CCA nursing staff and/or those designated and authorized by CCA to direct patient care as to the availability of beds upon their request

5. Ensure that personnel providing services under this agreement meet current applicable federal, state, and local licensing standards for the provision of healthcare services, and are fully MA state credentialed healthcare providers, as described in SECTION 14: Provider Enrollment and Credentialing. The extended care facility agrees to notify CCA of changes in provider(s) status that would disqualify provider(s) from meeting above standards

6. Before or during admission, a full written transfer summary with appropriate physician orders signed by the primary care provider (PCP) will be provided to the facility by the member's PCP or designee

7. Provide extended care facility services to members in conformance and full cooperation with the treatment plan developed by the PCP or primary care team (PCT). Facility agrees to allow the member's PCP or designee to continue as the member's physician of record

8. Contact the PCP or PCT immediately upon notice of significant changes and/or relevant findings in regard to the status of the member

9. Agree to meet with PCT clinical staff as needed

10. **A) Skilled Nursing Facility**. Conform to CCA's protocols for timely updates and submissions of SC1, MDS, and Medications List forms upon CCA request; provide the PCT and/or CCA with timely clinical updates appropriate to the member's status in a mutually agreed upon format and frequency. Additionally, the quarterly submission of facility care plans is required to be sent to the Transitions of Care team via fax: 855-811-3467.

    B) **Rehabilitation Facility**. Provide CCA with timely clinical updates appropriate to the member's status in a mutually agreed upon format and frequency

    C) **Long-Term Acute Care Facility Services.** Provide CCA with timely updates of Medications List forms upon CCA request; provide the PCT and/or CCA with timely clinical updates appropriate to the member's status in a mutually agreed upon format and frequency

11. For long-term care members, providers are encouraged to download members CCA's quarterly care plans from the CCA provider portal.

A Skilled Nursing Facility (SNF) Documentation Submission Guide

The following information applies to CCA Senior Care Options and CCA One Care skilled nursing facilities (SNFs). For more information on SNF claim submission and coverage, please refer to the applicable payment policy.

Level of Care	Facility Responsibilities
Skilled care (member will be returning home)	
Upon admission	Complete and fax the Standardized Prior Authorization Request form to Commonwealth Care Alliance • Utilization Management department/Transitions of Care: 855-811-3467
Custodial care (short-term/non-skilled stay; the member will be returning home)	
Upon admission and discharge (e.g., transfer to facility or home)	Complete and fax the Standardized Prior Authorization Request form to Commonwealth Care Alliance • Utilization Management department/Transitions of Care: 855-811-3467 Complete and fax or email the Status Change form (SC-1) and MDS 3.0 to at Commonwealth Care Alliance: • **Attention: Eligibility** (Upon request, submit within 1–3 business days) - Fax: 617-830-0534 - Email: eligibility@commonwealthcare.org Send the following documents to the MassHealth Enrollment Center: • Status Change form (SC-1)—required upon admission and any level of care changes • Minimum Data Set (MDS) 3.0—required upon admission and as scheduled by MassHealth

Long-term care (SNF will be the member's residence)	
Upon admission	Complete and fax the Standardized Prior Authorization Request form to Commonwealth Care Alliance • Utilization Management department/Transitions of Care: 855-811-3467 Complete and fax or email Status Change form (SC-1) and MDS 3.0 to at Commonwealth Care Alliance: • **Attention: Transitions of Care** - Fax: 855-811-3467 - Email: transitionsofcare@commonwealthcare.org Send the following documents to the MassHealth Enrollment Center: • Status Change form (SC-1)—required upon admission and any level of care changes • MDS 3.0—required upon admission and as scheduled by MassHealth
Status changes	Status Change form (SC-1)—submit completed form to: • MassHealth Enrollment Center • Commonwealth Care Alliance departments: **Attention: Eligibility** (Upon request, submit within 1–3 business days) - Fax: 617-830-0534 - Email: eligibility@commonwealthcare.org MDS 3.0—submit completed form to: • MassHealth Enrollment Center • Commonwealth Care Alliance departments: - **Attention: Transitions of Care** - Fax: 855-811-3467 - Email: transitionsofcare@commonwealthcare.org

**MDS assessments are also required as determined by MassHealth.*

Note: *The Long-Term Care Screening form is not required to be completed for CCA members*

Member Enrollment Centers (MEC)
Charlestown 529 Main Street Charlestown, MA 02129 Toll-free: 800-841-2900
Chelsea 45 Spruce Street Chelsea, MA 02170 Toll-free: 800-841-2900 Fax: 617-887-8777
Quincy 100 Hancock Street, 1st floor Quincy, MA 02171 Toll-free: 800-841-2900
Springfield 88 Industry Avenue, Suite D Springfield, MA 01104-3259 Toll-free: 800-841-2900
Taunton 21 Spring Street, Suite 4 Taunton, MA 02780 Toll-free: 800-841-2900
Tewksbury 367 East Street Tewksbury, MA 01876 Toll-free: 800-841-2900
Worcester 50 SW Cutoff, Suite 1A Worcester, MA 01604 Toll-free: 800-841-2900

Durable Medical Equipment (DME)

CCA contracts with local, statewide, and national vendors to provide DME and medical/surgical supplies for its members. CCA uses Tomorrow Health for processing DME orders and assisting members with finding a DME supplier to suit their needs. Members can contact Tomorrow Health at 844-402-4344. Referring providers can send orders to Tomorrow Health online at tomorrowhealth.com for full order visibility from start to end or via fax at 888-616-2361.

Durable Medical Equipment

DME are products that are (a) fabricated primarily and customarily to fulfill a medical purpose; (b) generally not useful in the absence of illness or injury; (c) able to withstand repeated use over an extended period of time; and (d) appropriate for home use. DME services includes, but are not limited to, the purchase of medical equipment, replacement parts, and repairs for such items such as canes, crutches, wheelchairs (manual, motorized, custom fitted, and rentals), walkers, commodes, hospital beds, monitoring equipment, orthotic and prosthetic devices, and the rental of personal emergency response systems (PERS). Coverage includes related supplies, repairs, and replacement of the equipment.

Medical/Surgical Supplies

Medical and surgical supplies are products that are (a) fabricated primarily and customarily to fulfill a medical or surgical purpose; (b) used in the treatment of a specific medical condition; and (c) non-reusable and disposable. This includes, but is not limited to, items such as urinary catheters, wound dressings, glucose monitor supplies, and diapers.

Prior Authorization

All services provided must be deemed appropriate by the member's primary care provider and/or care team. Certain equipment and supplies may require prior authorization. Payment to providers for those covered services requiring prior authorization is contingent upon the provider receiving prior authorization before services are rendered. Please reference SECTION 4: Prior Authorization Requirements.

All providers are required to confirm member eligibility on the date (or dates) of service, even if the prior authorization covers a long period.

Eligibility May Be Confirmed by:
Using the Availity Essentials Provider Portal*
Using the MassHealth Provider Online Service Center
Using the NEHEN Provider Portal*
Contacting CCA Provider Services at 866-420-9332, from 8 am to 5 pm ET, Monday, Tuesday, Wednesday, and Friday, and 8:30 am to 5 pm ET, Thursday.

**Supports batch eligibility transactions*

Service Specifications for Durable Medical Equipment (DME)

CCA DME providers are responsible for meeting specified standards for accessibility, repairs, and equipment delivery and removal. The standards are listed below:

Accessibility

- Use best efforts to maintain 24/7 availability to provide services, and be accessible by telephone directly via on-call coverage at all times. A supplier must maintain a primary business telephone listed under the name of the business in a local directory or a toll-free number available through directory assistance. The exclusive use of a beeper, answering machine, answering service, or cell phone during posted business hours is prohibited
- Provide all emergently needed supplies, services, or equipment **within 2 hours of receiving the request**. Emergently needed services or equipment shall include that for which malfunctions or absence presents an immediate life-threatening situation to the member, including, but not limited to, oxygen and respiratory services and equipment
- Provide all other needed supplies, services, or equipment, including wheelchairs and wheelchair repairs, **within 24 hours of receiving request**, and notify the primary care provider or primary care site (PCS), at the time of request, of any anticipated delay or back order in the provision of supplies, services, and/or equipment
- Provide the closest available substitute wheelchair on loan, free of charge, for the duration of any wheelchair repair service
- Designate a liaison to accept requests and coordinate supplies, services, and equipment for CCA members

Capped Rentals

For capped rental information, please review the Durable Medical Equipment payment policy.

DME repairs, maintenance, delivery and removal are subject to CCA's DME payment policy and prior authorization requirements.

Prescriptions

In accordance with CMS requirements, CCA requires a prescription for all DME and medical supply orders. Prescriptions become an important source of supporting documentation if a provider is asked to submit records for a claims audit or other necessary reviews. Examples of when a prescription is required include, but are not limited to, disposable items, purchases, rentals, order changes, replacement items, or a change in supplying provider.

Proof of Delivery

In accordance with CMS requirements, providers are expected to ensure proof of delivery protocols are met and that documentation is available if requested by CCA. The proof of delivery documentation verifies that the member received the item(s) and includes, but is not limited to, the member's name, description of item(s), quantity, and date delivered.

Dental

CCA uses Skygen for preventive and comprehensive dental services. Skygen's provider line is 855-434-9243. Medical dental services, such as emergency care, should be billed through CCA's medical claims. Please refer to SECTION 1: Key Contact Information for claims information.

Skygen portal: pwp.sciondental.com
Electronic submission payer ID: SCION

Paper claim via current ADA Dental Claim form, sent via postal mail:
Commonwealth Care Alliance – Claims
PO Box 508
Milwaukee WI 53201

Vision

CCA uses EyeMed Vision Care (EyeMed) for routine eye care and eyewear. EyeMed's provider line is 877-493-4586 for CCA Senior Care Options and 877-493-4588 for CCA One Care.

Non-routine vision services, such as emergency care, must be billed through CCA's medical claims.

Please refer to SECTION 1: Key Contact Information for claims information. EyeMed's portal: https://claims.eyemedvisioncare.com/claims/loginForm.emvc

Provider claims address:
EyeMed Vision Care/First American Administrators
P.O. Box 8504
Mason, OH 45040-7111

Hearing

CCA uses NationsHearing for routine hearing services, including hearing exams and hearing aids. NationsHearing's provider line is 800-921-4559.

Medical hearing services, such as emergency care, should be billed through CCA medical claims. Please refer to SECTION 1: Key Contact Information for claims information.

NationsHearing Provider Portal: providers.nationshearing.com

NationsHearing Claims Address:
NationsBenefits
Attn: Claims
1801 NW 66th Avenue, Suite 100
Plantation, FL 33313

SECTION 11: BEHAVIORAL HEALTH SERVICES PROVIDERS

Philosophy and Components of Service

Commonwealth Care Alliance, Inc. (CCA)'s person-centered approach is an integral part of who we are as a leading healthcare organization. CCA Senior Care Options and CCA One Care members are the principal voices in the planning and management of their care. CCA's multidisciplinary clinical care teams make up our members' central professional support system, including CCA care managers, primary care providers, specialty providers, behavioral health providers, home- and community-based services providers, and long-term services and support (LTSC and GSSC) coordinators. CCA identifies and engages members in care management programs to enable them to overcome barriers that limit their ability to manage their own health and well-being. This process is conducted in a manner consistent with each member's personal and cultural values, predicated on recovery and wellness principles, and with the goal of helping members reach their self-defined level of optimal functioning.

CCA is committed to full integration of behavioral health services that include our members' self-directed components of care team members as noted above. We hold both our internal and external providers to the highest standard of care and expect that contracted behavioral health providers will work closely with our CCA care teams, PCPs, and LTSC and GSSC support coordinators as well as any specialty behavioral health providers, state agencies, or other providers. Providers should talk with their patients about the benefits of sharing essential clinical information. It is also essential to coordinate care with state agencies, including but not limited to the Department of Developmental Services (DDS), Department of Mental Health (DMH), Department of Transitional Assistance (DTA), Department of Corrections (DOC), Probation and Parole, and the Executive Office of Aging and Independence (AGE). Our network of outpatient and diversionary services providers is built to ensure that each member has access to a provider within a 15-mile, 30-minute radius of their zip code. If a member needs to change from one behavioral health provider to another for any reason, CCA member services and/or care managers are available to assist the member to locate a new provider as needed. It is expected that the behavioral health providers work to obtain the appropriate release of information so that coordination of care may occur.

Providers may provide services utilizing telehealth and are responsible for ensuring telehealth services are HIPAA compliant and follow MassHealth guidelines for the use of telehealth to deliver covered services. Accordingly, a full continuum of behavioral health services is available to all CCA members. Behavioral health services fall into the categories described below, all of which are covered by CCA and some of which are subject to prior authorization requirements. Providers should make members aware of available clinical options and all available care options.

Behavioral Health Performance Specifications

CCA-contracted providers are expected to read, understand, and follow the Behavioral Health Performance Specifications. Providers are expected to comply with all the provisions outlined in the CCA behavioral health performance specifications, including:

- Covered services
- Components of treatment/provider responsibilities

- Training, inclusive language, culturally responsive care, and trauma-informed care
- Staffing requirements
- Assessments, treatment planning, and documentation
- Collateral and care coordination
- Discharge planning, aftercare, and collateral linkages
- Quality management

Behavioral Health Department

The Behavioral Health department is responsible for building collaborative relationships with providers and driving provider performance through the use of data and education. The team utilizes data to help support community relations with providers and to support clinical improvement in the care delivered to CCA members. The Behavioral Health department works to educate providers about the CCA mission and vision and the value that each provider delivers to CCA members, including a focus on creating linkages between all behavioral health and substance use levels of care, from psychiatric inpatient to community-based services, for improved transitions of care. The Behavioral Health department analyzes network utilization and shares provider performance with our network. By highlighting key areas of focus, including monitoring and interpreting utilization data, we are better able to support understanding of meaningful utilization patterns and strategic analysis of clinical issues using member specific data to inform larger system trends. In response to provider data and performance, the Behavioral Health department supports provider activities consistent with provider and CCA priorities, including but not limited to Healthcare Effectiveness Data and Information Set (HEDIS®) metrics, discharge planning, readmissions, and community tenure.

Provider Concerns

CCA encourages its network providers to relay any concerns they have regarding any aspect of care for CCA members. This includes, but is not limited to, quality of care, administrative operations, and access to care. These concerns should be reported to CCA Provider Services at 866-420-9332.

Health Record Maintenance

Providers must meet all requirements related to maintenance of health records, including documentation of the following in the member's electronic medical record: acknowledgement of member rights, consent to treatment, releases of information, and demographic information; clinical (medical and behavioral health) history; comprehensive clinical biopsychosocial/behavioral health assessments; individualized treatment plans; progress notes; safety plans (if applicable), recovery plans (if applicable), relapse prevention plans (if applicable), and discharge plans and/or transition of care plans for all services provided; documentation of contact with the member, their family, guardians, or significant others; and documentation of treatment outcomes. Health records are made available to CCA upon request. Health records should conform to CCA documentation standards, to the standards of the community, and to all applicable laws and regulations, including, but not limited to, state licensing, Centers for Medicare & Medicaid Services (CMS), and/or national certification board standards. Providers should be aware that CCA can make a request to review records (onsite or remotely) at any time, with the expectation of the review being able to be conducted within 48 hours of this request. For detailed information on behavioral health documentation requirements, please click here.

Adverse Incident Protocol

An adverse incident is defined as an occurrence that represents actual or potential serious harm to the well-being of a member, or to others by the actions of a member, who is receiving services managed by the contractor or has recently been discharged from services managed by the contractor.

Some common examples of adverse incidents that should be reported to CCA include but are not limited to:

- Death
- Injuries/accidents
- Absence without authorization
- Any sexual assault, or alleged sexual assault, to or by members
- Serious injury/medical emergency requiring transport and admission to an acute care facility (whether the care rendered is ambulatory or requires admission for treatment)
- Violations, or alleged violations, of Department of Mental Health (DMH) restraint and/or seclusion regulations
- Any physical assault, or alleged physical assault, to or by members
- Unscheduled event that results in the evacuation of the program
- Public health hazard, including but not limited to food contamination and lice or bedbug infestation
- Medication errors or incidents, including but not limited to missed medication administration, administration of the wrong medication, member medication refusal, and member sharing/distributing their prescribed medication with/to others
- Riot

All adverse incidents and/or serious reportable events (SRE) should be reported to the CCA Serious Reportable Events team by faxing a copy of the Massachusetts incident report form, found at Behavioral Health – Reporting Adverse Incidents, to the CCA Senior Quality of Care Specialist at 857-317-8405 within 24 hours. Specify CCA as the managed care entity.

Levels of Care

Behavioral Health Services That Require Prior Authorization or Notification of Admission

As stated on the CCA website, CCA annually develops, selects, and/or approves clinical criteria to ensure medical necessity. CCA utilizes the following criteria for determining and authorizing services:

- National coverage determinations (NCDs)
- Local coverage determinations (LCDs)
- Applicable state Medicaid guidelines
- InterQual or ASAM
- CCA Medical Necessity Guidelines (MNGs)

Behavioral Health (BH) Services That Require a Notification of Admission (NOA)					
Type of Service	**Level of Care**	**Notification of Admission**	**Notification Process**	**PA and/or Medical Necessity Review Process**	**Continued Authorization Process**
Inpatient services	Inpatient services for substance use disorder (ASAM level 4)	Prior authorization (PA) not required for admission NOA is required within 48 hours.	Admitting facility required to notify CCA BH UM within 48 hours of admission at 866-420-9332	No authorization required Medical necessity determination is made by the provider.	No continued authorization required Medical necessity determination is made by the provider.
Inpatient services	Inpatient for behavioral health services	NOA is required within 2 business days of admission. Inpatient notification may be submitted via fax, 24/7.	All BH inpatient admissions require the BH Inpatient NOA form to be faxed to 617-830-0118.	Emergency admissions: See notification process	All BH inpatient admissions require the BH Inpatient NOA form to be faxed to 617-830-0118.
Inpatient services	Observation/holding beds	PA not required for admission Notification is required within 24 hours.	See process for medical	No authorization or medical necessity review process required	No continued authorization required
Diversionary services	Acute Treatment Service (ATS) for substance use disorders (ASAM Level 3.7)	PA not required for admission NOA is required within 48 hours.	Admitting facility required to notify CCA BH UM within 48 hours of admission at 866-420-9332	No authorization required Medical necessity determination is made by the provider.	No continued authorization required Medical necessity determination is made by the provider.

Diversionary services	Enhanced Acute Treatment Services (E-ATS) for substance use disorders (ASAM Level 3.7_	PA not required for admission NOA is required within 48 hours.	Admitting facility required to notify CCA BH UM within 48 hours of admission at 866-420-9332	No authorization required Medical necessity determination is made by the provider.	No continued authorization required Medical necessity determination is made by the provider.
Diversionary services	Individualized treatment and stabilization for substance Use disorders (ASAM 3.5/3.7)	PA not required for admission NOA is required within 48 hours.	Admitting facility required to notify CCA BH UM within 48 hours of admission at 866-420-9332	No authorization required Medical necessity determination is made by the provider.	No continued authorization required Medical necessity determination is made by the provider.
Diversionary services	Clinical Stabilization Services (CSS) for substance use disorders (ASAM Level 3.5)	PA not required for admission NOA is required within 48 hours.	Admitting facility required to notify CCA BH UM team within 48 hours of admission at 866-420-9332	No authorization required Medical necessity determination is made by the provider.	No continued authorization required Medical necessity determination is made by the provider.

Behavioral Health Services That Require a Prior Authorization (PA)					
Type of Service	**Level of Care**	**PA Required**	**PA Submission Process**	**Medical Necessity Review Process**	**Determination Turnaround Time**
Inpatient services	Administratively Necessary Days (AND)	Yes	Provider contacts CCA BH UM reviewer during telephonic concurrent review	Provider contacts CCA BH UM reviewer during telephonic concurrent review	Standard requests: within 72 hours
Diversionary services	Residential eating disorder treatment services	Yes	Provider faxes Prior Authorization form to 855-341-0720	BH UM will review request for medical necessity at time of admission and for concurrent review(s).	Standard requests: Within 7calendar days
Behavioral health special procedures	rTMS Services	Yes	Provider faxes Prior Authorization form to 855-341-0720	BH UM team will review request for medical necessity.	Standard requests: Within 7 calendar days
Behavioral health special procedures	Esketamine for treatment-resistant depression	Yes	Provider faxes Prior Authorization form to 855-341-0720	BH UM team will review request for medical necessity.	Standard requests: Within 7 calendar days
Behavioral health special procedures	Specialing	Yes	Provider contacts CCA BH UM reviewer during telephonic concurrent review	Requesting provider calls BH UM team at 866-420-9332	Standard requests: Within 72 hours

Behavioral Health Services That Do Not Require Prior Authorization or Notification of Admission

24-Hour Diversionary Services

- Adult community crisis stabilization
- Residential rehabilitation services (RRS) for substance use disorders (SUD) ASAM Level 3.1
  - Adult residential rehabilitation services for SUD
  - Co-occurring residential rehabilitation services for SUD (COE-RRS)
  - Family residential rehabilitation services for SUD
  - Pregnancy-enhanced residential rehabilitation services for SUD
  - Young adult residential rehabilitation services for SUD (CCA One Care only)

Note: *All 24-hour diversionary services require notification of discharge. Please fax discharge summary to 413-733-1924 within 24 hours of the member's discharge.*

Non-24-Hour Diversionary Services

- Certified peer specialist
- Community Support Program (CSP)
- Community Support Program for Homeless Individuals (CSP-HI)
- Community Support Program for Justice Involved Individuals (CSP-JI)
- Community Support Program for Tenancy Preservation Program (CSP-TPP)
- Intensive outpatient program (IOP)
- Partial hospitalization program (PHP)
- Program of assertive community treatment (PACT)
- Psychiatric day treatment
- Recovery coaching
- Recovery support navigator (RSN)
- Structured Outpatient Addiction Program (SOAP)

Behavioral Health Crisis Services

- Adult Mobile Crisis Intervention (AMCI)
- Behavioral health crisis evaluations/intervention services in the emergency department or on medical/surgical floors
- Behavioral health crisis management services in the emergency department or on medical/surgical floors

Behavioral Health and Substance Use Disorder Outpatient Services

- Acupuncture for withdrawal management
- Ambulatory withdrawal management (ASAM Level 2WM)
- Behavioral health outpatient treatment
  - Couples/family treatment
  - Group treatment
  - Individual treatment
- Case consultation
- Diagnostic evaluation
- Dialectical behavioral therapy (DBT)
- Electroconvulsive therapy (ECT)
- Family consultation
- Inpatient/outpatient bridge visit
- Medication-assisted treatment (MAT)
- Medication management
- Neuropsychological/psychological testing
- Office-based opioid treatment (OBOT)
- Opioid replacement therapy (ORT)
- Opioid treatment program (OTP)
- Psychiatric consultation on inpatient medical unit
- Urgent outpatient

Behavioral Health Inpatient Covered Services

Office visits must be available within the following time frames to CCA members for behavioral health services other than emergency services, emergency service programs, or urgent care:

- Non-24-hour diversionary services: within 2 calendar days of discharge
- Appointments to review and refill medications: within 14 calendar days of discharge
- Other outpatient services: within 7 calendar days of discharge
- All other behavioral health services: within 14 calendar days

For members discharging from 24-hour levels of care, it is expected that the discharging facility arranges follow-up appointments for the member within the above referenced time frames and that they are documented on the members' discharge plan.

In addition to our contracted network, CCA-licensed behavioral health clinicians or registered nurses are on call 24/7. BH clinicians are also available for office or telehealth appointments within 2 business days of discharge.

Inpatient Services for Substance Use Disorder (ASAM Level 4): Provides a planned substance use treatment program offering 24-hour, medically managed evaluation and treatment for individuals who are experiencing severe withdrawal symptoms and/or acute biomedical complications because of substance use. Level IV services are rendered in a hospital that can provide life support in addition to 24-hour physician and nursing care. Daily individual physician contact is required for this level of care. A multidisciplinary staff of clinicians trained in the treatment of addictions and mental health conditions, as well as overall management of medical care, are involved in the member's treatment.

Inpatient for Behavioral Health Services: Provides the most intensive level of psychiatric care, which is delivered in a general hospital with a psychiatric unit licensed by the Department of Mental Health (DMH), a private psychiatric hospital licensed by the DMH, or a state-operated hospital setting. Multidisciplinary assessments and multimodal interventions are provided in a 24-hour, locked, secure and protected, medically staffed, and psychiatrically supervised treatment environment. Twenty-four -hour skilled nursing care, daily medical care, and a structured treatment milieu are required. The goal of acute inpatient care is to stabilize members who display acute psychiatric conditions associated with either a sudden onset and a short, severe course, or a marked exacerbation of symptoms associated with a more persistent, recurring condition. Typically, the member poses a significant danger to self or others and/or displays severe psychosocial dysfunction.

Observation/Holding Beds (OBS/HB): Provide up to 24 hours of care in a locked, secure, and protected, medically staffed, psychiatrically supervised treatment environment that includes 24-hour skilled nursing care and an onsite or on-call physician. The goal of this level of care is prompt evaluation and/or stabilization of members who display acute psychiatric conditions. Upon admission, a comprehensive assessment is conducted, and a treatment plan is developed. The treatment plan emphasizes crisis intervention services necessary to stabilize and restore the member to a level of functioning that does not require hospitalization. This level of care may also be used for a comprehensive assessment to clarify previously incomplete member information, which may lead to a determination of a need for a more intensive level of care. This service is not appropriate for members who, by history or initial clinical presentation, are very likely to require services in an acute care setting exceeding 24 hours. The duration of services at this level of care may not exceed 24 hours. Admissions to observation/holding beds occur 24/7, 365 days a year, and are on a voluntary basis only. Members on an involuntary status who require observation are authorized for a one-day inpatient admission. Observation/holding beds providers agree to adhere to both the inpatient mental health services performance specifications and to the observation/holding beds performance specifications. Where there are differences between the inpatient mental health services and observation/holding beds performance specifications, these observation/holding beds specifications take precedence.

Administratively Necessary Days (AND): One or more days of inpatient hospitalization provided to members when said members are clinically ready for discharge, but an appropriate setting is not available. Services shall include appropriate continuing clinical services.

Specialing: Therapeutic services provided to a member in a variety of 24-hour settings, on a one-to-one basis, to maintain the individual's safety. **Note:** Specialing requires prior authorization.

No Reject Policy: The provider accepts for admission all individuals in need of inpatient mental health services who are referred by an emergency services program (AMCI) provider, regardless of the availability of capacity or clinical presentation. Providers are expected to collaborate and communicate with the CCA BH Transitions of Care team within one business day after admission, and then every 3 business days throughout the duration of the admission, to collaborate on discharge planning for CCA members admitted to the inpatient psychiatric unit.

Behavioral Health Diversionary Covered Services

Diversionary services for mental health and substance use treatment are provided as clinically appropriate alternatives to behavioral health inpatient services, or to support a member returning to the community following a 24-hour acute admission; or to provide intensive support to maintain functioning in the community. There are two categories of diversionary services: those provided in a 24-hour facility; and those provided in a non-24-hour setting or facility.

Network CCA providers of diversionary services are expected to collaborate with the CCA Behavioral Health Utilization Management department, giving notice within 48 hours of admission so that the CCA Transitions of Care and care teams can coordinate discharge planning and aftercare.

24-Hour Diversionary Services

Adult Community Crisis Stabilization (ACCS): Provides staff-secure, safe, and structured crisis stabilization and treatment services in a community-based setting that serves as a medically necessary, less restrictive, and voluntary alternative to inpatient psychiatric hospitalizations. ACCS provides a distinct level of care where the primary objectives of multidisciplinary treatment include: restoration of functioning; strengthening the resources and capacities of the member, family, and other natural supports; and timely return to a natural setting and/or least restrictive setting in the community. Services at this level of care include crisis stabilization; initial and continuing biopsychosocial assessment; care coordination; psychiatric evaluation and medication management; peer support; and/or other recovery-oriented services. ACCS services are short-term, providing 24-hour observation and supervision, and continual reevaluation. ACCS provides a home-like, consumer-friendly, and comfortable environment conducive to recovery. Treatment is carefully coordinated with existing and/or newly established treatment providers.

Acute Treatment Services (ATS) ASAM Level 3.7: Provides 24/7 medically monitored addiction treatment services that include evaluation, counseling, education, and withdrawal management in a non-hospital setting. Medical withdrawal management services are delivered by nursing and counseling staff under the supervision of a licensed physician. Services include biopsychosocial evaluation, individual and group counseling, psychoeducational groups, and discharge planning. Acute treatment services are provided to members experiencing, or at significant risk of developing, an uncomplicated, acute withdrawal syndrome as a result of alcohol and/or other substance use. Members receiving ATS do not require the medical and clinical intensity of a hospital-based, medically managed detoxification service, nor can they be effectively treated in a less intensive outpatient level of care.

Providers are expected to collaborate and communicate with the CCA BH UM team within 48 hours of admission and discharge from an acute treatment facility.

Enhanced Acute Treatment Services (E-ATS) for Individuals with Co-occurring Mental Health and Substance Use ASAM Level 3.7: Provides diversionary and/or step-down services for members in need of acute, 24-hour substance use treatment, as well as psychiatric treatment and stabilization. Detoxification services are provided through a planned program of 24-hour, medically monitored evaluation, care, and treatment and are tailored for individuals whose co-occurring mental health and substance use diagnosis require such a program, including the prescription and dosage of medications typically used for the treatment of mental health. E-ATS services for individuals with co-occurring mental health and substance use are rendered in a licensed, acute care, or community-based setting with 24-hour physician and psychiatrist consultation availability, 24-hour nursing care and observation, counseling staff trained in

substance use and mental health treatment, and overall monitoring of medical care. Services are provided under a defined set of physician-approved policies, procedures, and clinical protocols.

Individuals may be admitted to an E-ATS program directly from the community, including referrals from emergency services program (AMCI) providers, or as a transition from inpatient services. Members with co-occurring conditions receive specialized services within enhanced acute treatment services. E-ATS is for individuals with co-occurring mental health and substance use diagnoses, to ensure treatment for their co-occurring psychiatric conditions. E-ATS also serves pregnant people who require specialized services, including obstetrical care, in addition to substance use treatment. These services are provided in licensed freestanding or hospital-based programs.

Clinical Stabilization Services (CSS) ASAM Level 3.5: Provides 24-hour, clinically managed detoxification services that are provided in a non-medical setting. These services, which usually follow Acute Treatment Services (ATS), include supervision, observation, support, intensive education, counseling regarding the nature of addiction and its consequences, relapse prevention, outreach to families and significant others, and aftercare planning for members beginning to engage in recovery. CSS provides multidisciplinary treatment interventions and emphasizes individual, group, family, and other forms of therapy. Linkage to aftercare, relapse prevention services, and peer support and recovery-oriented services, such as Alcoholics Anonymous and Narcotics Anonymous, are integrated into treatment and discharge planning. CSS is intended for members with a primary substance use diagnosis that is manageable at this level of care. Members may be admitted to CSS directly from the community or as a transition from inpatient services.

Residential Rehabilitation Services (RRS) for SUD ASAM Level 3.1: Provides a 24-hour, safe, structured environment, located in the community, which supports members' recovery from addiction and moderate to severe mental health conditions while supporting member reintegrating into the community and returning to social, vocation/employment, and/or educational roles. Scheduled, goal-oriented, clinical services are provided in conjunction with psychiatry and medication management to support stabilization and development of skills necessary to achieve recovery. RRS services can include:

- Adult residential rehabilitation services for substance use disorders
- Co-occurring enhanced residential rehabilitation services for substance use disorders
- Family residential rehabilitation services for substance use disorders
- Pregnancy & postpartum enhanced residential rehabilitation services for substance use disorders
- Young adult (21–25) residential rehabilitation services for substance use disorders (CCA One Care only)

Residential Eating Disorder Treatment: Provides a 24-hour, safe, structured environment, located in the community, which supports members with eating disorders. This level of care is a structured therapeutic program that is intended to replicate real-life experiences with the support of a multidisciplinary team who deliver evidence-based behavioral health and medical approaches along with nutritional approaches to support members in recovery.

Non-24-Hour Diversionary Services

Certified Peer Specialist: Mentoring, advocacy, and facilitation of support for members experiencing a mental health disorder, provided by self-identified persons with lived experience of a mental health disorder and wellness who have been trained by an agency approved by the Massachusetts DMH.

Community Support Program (CSP): Provides an array of services delivered by community-based, mobile, paraprofessional staff to members with psychiatric and/or substance use diagnoses, and for whom their psychiatric or substance use diagnoses interfere with their ability to access essential medical services. CSP staff are supported by a clinical supervisor. CSPs do not provide clinical treatment services. CSPs provide outreach and support services to enable members to utilize clinical treatment services and other supports. The CSP service plan assists the member with attaining their goals in their clinical treatment plan in outpatient services and/or other levels of care and works to mitigate barriers to doing so.

In general, a member who can benefit from CSP services has a mental health, substance use, and/or co-occurring diagnosis that has required psychiatric hospitalization or the use of another 24-hour level of care or has resulted in serious impairment with a risk of admission. CSP services are used to prevent hospitalization and, in combination with outpatient and other clinical services, to respond to the needs of individuals whose pattern of service utilization or clinical profile indicates high risk of readmission into any 24-hour behavioral health inpatient/diversionary treatment setting. These services are designed to be maximally flexible in supporting individuals to implement their clinical treatment plans in outpatient and/or other levels of care and attain the skills and resources needed to maintain community tenure.

Such services may include:

- Assisting members in improving their activities of daily living (ADL) skills so they can perform ADL more independently or access services to support them in doing so
- Providing service coordination and linkage, including:
    - Assistance with transportation to essential medical and behavioral health appointments
    - Assisting with obtaining benefits, housing, and healthcare
    - Collaborating with emergency services programs/mobile crisis intervention (AMCIs) and/or outpatient providers; including working with AMCIs to develop, revise, and/or utilize member crisis prevention plans and/or safety plans as part of the crisis planning tools for youth
    - Fostering empowerment, recovery, and wellness, including linkages to recovery-oriented peer support and/or self-help supports and services

Community Support Program for Homeless Individuals (CSP-CH, formerly CSP-CHI & C-SPECH): A specialized CSP service to address the health-related social needs of members who: (1) are experiencing homelessness and are frequent users of acute health services; (2) are experiencing chronic homelessness, as defined by the U.S. Department of Housing and Urban Development and (3) have identified a permanent supportive housing (PSH) housing opportunity. Once housing is imminent (members moving within 120 days), members receiving CSP may receive CSP-HI services. CSP-HI includes assistance from specialized professionals who, based on their unique skills, education, or lived experience, have the ability to engage and support individuals experiencing chronic homelessness. Their support includes helping members search for permanent supportive housing, prepare for and transition to an available housing unit, and once housed, coordinate access to physical health, behavioral health, and other needed services geared toward helping them sustain tenancy and meet their health needs.

Community Support Program for Tenancy Preservation Program (CSP-TPP): A specialized CSP service to address the health-related social needs of members who are at risk of homelessness and facing eviction because of behavior related to a disability. CSP-TPP works with the member, the Housing Court, and the member's landlord to preserve tenancies by connecting the member to community-based services

to address the underlying issues causing the lease violation. To qualify for participation as a CSP-TPP provider, a provider must have an active contract with the Department of Housing and Community Development or Mass Housing to provide tenancy preservation program services. CSP-TPP providers are not required to be licensed by DPH. CSP-TPP includes help from specialized professionals who have the education and/or lived experience required, and who can engage and support members facing eviction by:

- Assessing the underlying causes of the members' eviction, and identifying services to address both the lease violation and the underlying causes
- Developing a service plan to maintain the tenancy
- Providing clinical consultation services as well as short-term, intensive case management and stabilization services to members
- Making regular reports to all parties involved in the eviction until the member's housing situation stabilizes

Community Support Program for Justice Involved (CSP-JI): A more intensive form of CSP for individuals who have experienced involvement with the justice system, including re-entry following incarceration, parole supervision, and probation supervision. CSP-JI is a community-based service and support program that works with members in coordinating their behavioral health supports and related resources that support members in achieving and sustaining community tenure. Community-based service coordination and support services such as CSP-JI should be flexible, with the goal of maximizing the ability of members who have experienced involvement with the justice system to engage with behavioral health services and other supportive care that support the goal of attaining and maintaining community tenure. Providing low-threshold, high-support, services to these members has been shown to significantly decrease the likelihood of admission to a 24-hour level of care.

Intensive Outpatient Program (IOP): Provides a time-limited, multidisciplinary, multimodal structured treatment in an outpatient setting. Such programs are less intensive than a partial hospitalization program or psychiatric day treatment but significantly more intensive than standard outpatient services. This level of care is used to support and treat complex clinical presentations and is differentiated from longer-term, structured day programs intended to achieve or maintain stability for individuals with severe and persistent mental illness. IOPs may be developed to address the unique needs of a special population. Clinical interventions are targeted toward the specific clinical population or presentation and generally include modalities typically delivered in office-based settings, such as individual, couple, and family therapy; group therapies; medication management; and psychoeducational services. Adjunctive therapies such as life planning skills (assistance with vocational, educational, and financial issues) and expressive therapies may be provided but must have a specific function within a given member's treatment plan. As the targeted clinical presentation and the member's functioning improve, treatment intensity and duration are modified. All treatment plans are individualized and focus on acute stabilization and transition to community-based outpatient treatment and supports as needed.

Partial Hospitalization and Day Treatment (PHP): Provides a non-24-hour diversionary treatment program that can be hospital-based or community-based. The program provides diagnostic and clinical treatment services on a level of intensity similar to an inpatient program, but on less than a 24-hour basis. These services include therapeutic milieu; nursing; psychiatric evaluation; medication management; individual, group, and family therapy; peer support and/or other recovery-oriented services; substance use evaluation and counseling; and behavioral plan development. The environment at this level of treatment is highly structured, and the staff-to-member ratio is sufficient to ensure necessary therapeutic services, professional

monitoring, and risk management. PHP may be appropriate when a member does not require the more restrictive and intensive environment of a 24-hour inpatient setting but does need up to eight hours of clinical services, multiple days per week. PHP is used as a time-limited response to stabilize acute symptoms. As a transitional level of care and a step-down from inpatient services, this level of care can maximize stabilizing a member's deteriorating condition, support him/her in remaining in the community, and avert hospitalization.

Program of Assertive Community Treatment (PACT): A multidisciplinary team approach to providing acute, active, ongoing, and long-term community-based psychiatric treatment, assertive outreach, rehabilitation and support. The program team provides assistance to members to maximize their recovery, ensure consumer-directed goal setting, assist individuals in gaining a sense of hope and empowerment, and provide assistance in helping the members served become better integrated into the community. Services are provided in the community and are available, as needed by the member, 24/7, 365 days a year. This program is rendered through contracted MassHealth vendors.

Psychiatric Day Treatment: Provides a coordinated set of individualized, integrated, and therapeutic supportive services to members with psychiatric diagnosis, who need more active or inclusive treatment than is typically available through traditional outpatient mental health services. While less intensive than partial hospitalization, psychiatric day treatment is an intensive, clinical program that includes diagnostic, medical, psychiatric, psychosocial, and adjunctive treatment modalities in a structured setting. Psychiatric day treatment programs provide rehabilitative, pre-vocational, educational, and life-skill services to promote recovery and attain adequate community functioning, with focus on peer socialization and group support.

Recovery Coaches (RC): A non-clinical service provided by an individual with at least 2 years of sustained recovery who holds, or is actively working to obtain, credentialing as a certified addiction recovery coach (CARC) through the Massachusetts Board of Substance Abuse counselor certification, or alternative licensure or certification process, as directed by EOHHS. Eligible members are connected with RCs at critical junctures in the members' treatment and recovery. The focus of the recovery coach role is to create a relationship between equals that is non-clinical and focused on removing obstacles to recovery, to facilitate initiation and engagement to treatment, and to serve as a guide and motivating factor for the member to maintain recovery and community tenure. Peer RCs must have lived experience with substance use and other addictive disorders and/or co-occurring mental health disorders and have been trained to help their peers with similar experiences to gain hope, explore recovery, and achieve life goals.

Recovery Support Navigator (RSN): A specialized care coordination service intended to engage members with substance use disorder(s) in accessing and continuing substance use disorder treatment. RSNs may be located in a variety of substance use disorder treatment environments, doing outreach and building relationships with members in programs, including withdrawal management and step-down services. If a member accepts RSN services upon leaving a substance use disorder treatment program, the RSN will work with the member on accessing appropriate treatment and staying motivated for treatment and recovery.

Structured Outpatient Addiction Programs (SOAP): Short-term, clinically intensive, structured, day and/or evening substance use services. These programs are used as a transition service in the continuum of care for members being discharged from community-based acute treatment services (ATS) for substance use ASAM level 3.7, and members being stepped down from clinical stabilization services (CSS) for substance use ASAM level 3.5. SOAP provides multidisciplinary treatment to address the sub-acute needs of members with addictions and/or co-occurring diagnosis, while allowing them to maintain participation in the community, work or school, and involvement in family life. SOAP services are only provided in Department of Public Health (DPH)–licensed, freestanding facilities skilled in addiction recovery treatment, outpatient departments in acute-care hospitals, or licensed outpatient clinics and facilities.

Behavioral Health Covered Crisis Services

Adult Mobile Crisis Intervention Program (AMCI): Provides crisis assessment, intervention, and stabilization services 24/7, 365 days per year, to members experiencing a behavioral health crisis. The purpose of the AMCI is to respond rapidly, assess effectively, and deliver a course of treatment intended to promote recovery, ensure safety, and stabilize the crisis in a way that allows a member to receive medically necessary services in the community, or if medically necessary, in an inpatient or 24-hour diversionary level of care. In all encounters with a member in crisis, the AMCI provides a core service, including:

- Crisis assessment, intervention, and stabilization, including a crisis behavioral health assessment
- Short-term crisis counseling that includes active listening, solution-focused/strengths-oriented crisis intervention aimed at working with the member and their family and/or other natural supports to understand the current crisis, identify solutions, and access resources and services for comfort, support, assistance, and treatment
- Arrangement of after-care referrals for the behavioral health services that the member selects to further treat their behavioral health or substance use
- Resources and referrals for additional services and supports for the member and their family, such as recovery-oriented and consumer-operated resources in their community

AMCI providers are expected to include the three basic components of crisis assessment, intervention, and stabilization with the understanding that AMCI providers require flexibility in the focus and duration of the initial intervention, the member's participation in the treatment, and the number and type of follow-up services.

AMCI services are directly accessible to members who seek behavioral health services on their own and/or who may be referred by any other individual or resource, such as family members, guardians, community-based agencies, service providers, primary care physicians, residential programs, state agency personnel, law enforcement, or courts. AMCI services are community-based in order to bring treatment to members in crisis, allow for member choice, and offer medically necessary services in the least restrictive environment that is most conducive to stabilization and recovery. Local AMCIs provide crisis behavioral health services in the community, through mobile crisis intervention services, accessible community-based locations, and adult community crisis stabilization (ACCS) programs. The mission of the AMCI is to deliver high-quality, culturally competent, clinically, and cost-effective care focused on stabilization, resiliency, wellness, and recovery.

For CCA members, emergency services shall be provided immediately, 24/7, with unrestricted access to members who present at any qualified provider, whether a network provider or a non-network provider. Examples of emergency services include, but are not limited to, response to a call with a live voice or a face-to-face visit within 60 minutes of outreach.

Behavioral Health Crisis Evaluations and Intervention Services in the Emergency Department or on Medical/Surgical Floors: Includes the initial comprehensive assessment of risk, diagnosis, and treatment needs, the initial crisis interventions, the initial documentation and coordination of appropriate disposition, and the required reporting and community collaboration for members presenting in a behavioral health crisis. Behavioral health crisis management services may be provided in person or via telehealth as requested by the individual and as clinically appropriate. Acute hospitals are responsible for the provisions of behavioral health crisis evaluations, including a comprehensive assessment, crisis interventions, disposition planning

and coordination, reporting, and community collaboration, 24/7, 365 days per year, for members who are presenting in the emergency department or on medical/surgical floors with behavioral health crisis.

Behavioral Health Crisis Management Services in the Emergency Department or on Medical/Surgical Floors: Are provided on days subsequent to the initial behavioral health crisis evaluation and interventions for individuals in the emergency department or medical/surgical floors experiencing a behavioral health crisis in need of ongoing behavioral health crisis supports. Behavioral health crisis management services include ongoing behavioral health crisis interventions, ongoing determination and coordination of appropriate disposition, and ongoing reporting and community collaboration. Behavioral health crisis management services may be provided in person or via telehealth as requested by the individual, and as clinically appropriate. Acute hospitals are responsible for following procedural components of this service, including crisis interventions, disposition planning, and care coordination procedures. All members who present with opioid use who are discharged to the community shall be offered nasal naloxone and given resources for medication-assisted treatment (MAT)/medication for opioid disorder (MOUD) and other support services.

Hospitals must follow the expedited psychiatric inpatient admission (EPIA) protocol for reporting all members awaiting psychiatric inpatient placement (EPIA protocol may be accessed here: www.mass.gov/info-details/expedited-psychiatric-inpatient-admissions-epia-policy). All hospitals shall establish and maintain referral relationships with their local community behavioral health centers (CBHCs). They shall participate in ongoing collaboration, planning, and process implementation to ensure a successful and seamless experience for individuals in crisis, and to ensure continued enhancement to the crisis system.

Behavioral Health & Substance Use Disorder Outpatient Covered Services

Outpatient behavioral health services are services that are rendered in an ambulatory care setting such as an office, a clinic environment, a member's home, telehealth or other locations appropriate for psychotherapy or counseling. Services consist of time-effective, defined episodes of care that focus on the restoration, enhancement, and/or maintenance of a member's optimal level of functioning, and the alleviation or amelioration of significant and debilitating symptoms impacting at least one area of the member's life domains (e.g., family, social, occupational). The goals, frequency, intensity, and length of treatment vary according to the needs of the member and the response to treatment. A clear treatment focus, SMART goals, measurable outcomes, and a discharge plan including the identification of realistic discharge criteria are developed as part of the initial assessment and treatment planning process and are evaluated and revised as needed.

CCA is committed to providing convenient access and availability of behavioral health services that support the needs of each CCA member and support each member's care plan. Excluding emergency services (AMCI) and urgent care, behavioral health office visits will be made available to members within the following time frames:

- Non-24-hour diversionary services: Within 2 calendar days of discharge
- Urgent care services access: Within 48 hours
- Other outpatient services: Within 7 calendar days of discharge
- Appointments to review and refill medications: Within 14 calendar days of discharge
- All other behavioral health services: Within 14 calendar days

In addition to our contracted network, CCA-licensed behavioral health clinicians or registered nurses are on call 24/7. BH clinicians are also available for office or telehealth appointments within 2 business days of discharge

Acupuncture for Withdrawal Management: A treatment program providing acupuncture services for individuals experiencing side effects from the use of alcohol and/or other drugs. An acupuncturist is defined as an individual licensed by the Board of Registration in Medicine in accordance with M.G.L. c. 112, §§ 150–156.

Ambulatory Withdrawal Services (also known as ambulatory detoxification) ASAM Level 2WM: Provided in an outpatient clinical setting, under the direction of a physician, and are designed to stabilize the medical condition of an individual experiencing an episode of substance use or withdrawal complications. Ambulatory withdrawal services are indicated when an individual experiences physiological distress during withdrawal, but when the situation is not life threatening. The individual may or may not require medication, and 24-hour nursing is not required. The severity of the individual's symptoms determines the setting, as well as the amount of nursing and physician supervision necessary, during treatment. Ambulatory withdrawal services can be provided in an intensive outpatient program.

Behavioral Health Outpatient Treatment: Should result in positive outcomes within a reasonable time frame for specific diagnosis symptoms and/or problems. The evaluation of goals and treatment should be based on the member's diagnosis, symptoms, and level of functioning. Treatment should be targeted to specific SMART goals that have been mutually negotiated between the provider and the member. Goals of initial and extended outpatient therapy may include crisis resolution, symptom reduction, stabilization, improvement in adaptation, and/or recovery from addiction.

Treatment modality, frequency, and length of treatment should be individualized for each member. Most clinical situations can be effectively managed using a short-term and/or intermittent model of treatment with varying modalities and frequency of contact as needed.

Individuals with chronic or recurring behavioral health conditions may require a longer-term approach with intermittent visits over extended periods, or sustained contacts with increased intensity of services around periods of relapse or decompensation. Members must have flexibility in accessing outpatient treatment, including transferring.

Couples/Family Treatment: The use of psychotherapeutic or counseling techniques in the treatment of individuals in a committed relationship or family unit.

Group Treatment: The use of psychotherapeutic or counseling techniques in the treatment of a group, most of whom are not related by blood, marriage, or legal guardianship.

Individual Treatment: The use of psychotherapeutic or counseling techniques in the treatment of an individual on a one-to-one basis.

Case Consultation: A documented meeting of at least 15 minutes' duration, either in person or by telephone, between the treating provider and other behavioral health/medical clinicians or physician, concerning a member who is a client of the BH provider to identify and plan for additional services, coordinate a treatment plan, review the member's progress, or revise the treatment plan. Case consultation shall not include clinical supervision or consultation with other clinicians within the same provider organization.

Diagnostic Evaluation: An assessment of a member's level of functioning, including physical, psychological, social, educational, and environmental strengths and challenges for the purpose of diagnosis and treatment planning.

Dialectical Behavioral Therapy (DBT): An evidence-based, clinician directed, outpatient treatment modality that combines strategies from behavioral, cognitive, and other supportive psychotherapies for members with a diagnosis of borderline personality who exhibit chronic parasuicidal behaviors, as well as members with other diagnoses who struggle with safely managing incidences of emotional dysregulation. DBT includes individual therapy, DBT skills groups, therapeutic consultation to the member on the telephone or telehealth, and the therapist/therapists' internal consultation meetings. Through an integrated treatment team approach to services, DBT seeks to enhance the quality of the member's life through components that are grounded in a dialectical approach of support and confrontation. Providers of this service must consult with the members' care team to discuss the clinical appropriateness of this treatment. CCA prefers DBT-certified clinicians as providers of this service, but exceptions can be made pending discussion with the CCA clinical team.

Electroconvulsive Therapy (ECT): The initiation of generalized seizure activity with an electric impulse while the member is placed under anesthesia. This procedure is administered in a hospital facility or community facility licensed to do so by the Department of Mental Health (DMH). ECT may be administered on either an inpatient or outpatient basis, depending on the member's mental and medical status. Providers should follow DMH regulations that govern administration of this procedure. ECT may cause short- or long-term memory impairment of past or current events. The number of sessions undertaken during a course of ECT usually ranges from 6 to 12. ECT is most commonly performed at a schedule of three times per week. Maintenance ECT is most commonly administered at intervals of one to three weeks. The decision to recommend the use of ECT derives from a risk/benefit analysis for members. This analysis considers the diagnosis of the individual and the severity of the presenting illness, the individual's treatment history, the anticipated speed of action/efficacy of ECT, the medical risks, and anticipated adverse side effects. Providers must complete a workup including medical history, physical examination, and any indicated pre-anesthetic lab work to determine that there are not contraindications to ECT and that there are no less intrusive alternatives to ECT before scheduling administration of ECT.

Esketamine for Treatment-Resistant Depression: An outpatient or inpatient service that focuses on treating individuals living with major depressive disorder (MDD) who are not responding to standard treatments. In addition, those who are experiencing severe symptoms of depression or other mental illness that are threatening their health or safety may be good candidates for esketamine, which can often work more quickly than other treatments. Esketamine treatment has been shown to be an effective intervention for severe depression, with or without anxiety, particularly for individuals who have struggled with standard therapies. Esketamine is used to help depressed individuals who have not responded to at least two courses of medications most often prescribed for depression or are experiencing acute suicidal thoughts or behaviors and urgently require a fast-acting intervention. The FDA-approved drug esketamine nasal spray allows the drug to be taken more easily in an outpatient treatment setting (under the supervision of a doctor), making it more accessible for patients. Medication administration is completed under the direct observation of a healthcare provider, and patients are required to be monitored by a healthcare provider for at least 2 hours. Esketamine is only part of the treatment for a person with depression. To date, it has only been shown to be effective when taken in combination with an oral antidepressant. For these reasons, esketamine is not considered a first-line treatment option for depression and is only prescribed for people who have MDD with acute suicidal ideation or behavior and who have not been helped by at least two other depression medications.

Family Consultation: A meeting of at least 15 minutes' duration, either in person or by telephone, with family members or others who are significant to the member and clinically relevant to a member's treatment to identify and plan for additional services, coordinate a treatment plan, review the individual's progress, or revise the treatment plan.

Inpatient/Outpatient Bridge Visit: A single-session visit conducted by an in-network outpatient provider at a psychiatric inpatient unit or as enhanced acute treatment services (E-ATS) program. The bridge consultation is intended to provide therapeutic contact between an outpatient therapist and the member to facilitate aftercare treatment planning prior to discharge and may be requested by the member or the member's family/guardian, the inpatient team, the E-ATS treatment team, or the primary outpatient clinician or master's-level outpatient liaison who is attempting to engage the member in outpatient treatment. Regardless of the initiation source, the outpatient provider will arrange and coordinate the bridge consultation with the inpatient unit or E-ATS program. During the consultation it is expected that the outpatient clinician will meet face-to-face with the member and attend the inpatient or E-ATS treatment team meeting or meet with the clinician who is a member of the treatment team.

Medication-Assisted Treatment (MAT): The use of a medication approved by the U.S. Food and Drug Administration (FDA), in combination with counseling and behavioral therapies, for the treatment of opioid-related substance use.

Medication Management: The level of outpatient treatment at which the primary service is provided by a qualified prescribing provider: a psychiatrist, an advanced practice registered nurse (APRN), or a certified clinical nurse specialist (CCNS). The prescriber evaluates the member's need for psychotropic medications and provides a prescription and ongoing medical monitoring for efficacy and medication side effects. Psychiatric medication prescribers are expected to coordinate care with other mental health, medical, and substance use providers. Telehealth services are available for members with specific geographic, cultural, linguistic, or special needs that cannot be met in their community. Telehealth can be provided using a combination of interactive video and audio. Medication visits may consist specifically of a psychopharmacological evaluation, prescription, review, and/or monitoring by the prescriber. Visits may also include counseling and/or coordination of care with other physicians or other qualified healthcare professionals or agencies.

Neuropsychological/Psychological Testing: The culturally and linguistically competent administration and interpretation of standardized tests to assess a member's psychological, cognitive, behavioral, and emotional functioning. Testing goals include determining identifiable and measurable differences, determining a baseline of functioning, and/or determining a deviation from a baseline of functioning along the domains listed above. Using standardized, valid, and reliable testing tools, the psychologist aims to develop a hypothesis regarding the member's difficulties in functioning, determine an accurate diagnosis, and provide targeted information to guide effective treatment strategies. Testing can include standard psychological as well as neuropsychological assessment procedures. The categories are differentiated from each other by the referral question and the assessment procedures used.

Office-Based Opioid Treatment (OBOT): Outpatient treatment services provided outside of licensed opioid treatment programs by clinicians to patients with addiction involving opioid use. OBOT typically includes a prescription for the partial opioid agonist buprenorphine, the provision of naltrexone, or the dispensing of methadone, in concert with other medical and psychosocial interventions to achieve and sustain remission.

Opioid Replacement Therapy (ORT): The medically monitored administration of methadone, buprenorphine, or other U.S. Food and Drug Administration (FDA)–approved medications to treat opioid use, in conformance with FDA and Drug Enforcement Administration (DEA) regulations. This service combines

medical and pharmacological interventions with counseling, educational, and vocational services and is offered on a short-term (detoxification) and long-term (maintenance) basis.

Opioid Treatment Program/Methadone Maintenance (OTP): Licensed and accredited opioid agonist treatment programs, often called methadone maintenance treatment (MMT) programs, currently authorized to dispense methadone and buprenorphine in highly structured protocols defined by federal and state law. These programs medically monitor the administration of methadone, buprenorphine, or other U.S. Food and Drug Administration–approved medications to treat opioid use as a medication-assisted treatment (MAT), as well as for pain management. This service combines medical and pharmacological interventions with counseling, educational, and vocational services and is offered on a short-term (withdrawal management) and long-term (maintenance) basis. An opioid treatment program is provided under a defined set of policies and procedures, including admission, continued stay, and discharge criteria stipulated by Massachusetts state regulations and federal regulations. Unless contraindicated, the family, guardian, and/or natural supports are actively involved in the treatment as required by the treatment plan, or there are active efforts being made and documented to involve them.

Psychiatric Consultation on Inpatient Medical Unit: An in-person meeting of at least 15 minutes' duration between a psychiatrist or advanced practice registered nurse clinical specialist and an member at the request of the medical unit to assess the member's mental status and consult on a behavioral health or psychopharmacological plan with the medical staff on the unit.

Repetitive Transcranial Magnetic Stimulation (rTMS): A multisession treatment that uses magnetic fields to stimulate nerve cells associated with mood control and depression. rTMS temporarily modulates cerebral cortical function and changes the level of neuronal activity in key regions of the brain related to higher-level cognitive function and is used to treat medication-resistant major depression; however, there is also emerging evidence of its efficacy in treating PTSD. The treatment has been approved by the FDA since 2008 for the treatment of refractory major depressive disorder (MDD), defined as less than a 50% response to medication and outpatient therapy trials. rTMS is approved for readministration if a member has had a successful outcome on an initial trial of rTMS. The procedure takes place in an outpatient setting, is noninvasive, and does not require anesthesia. The procedure is generally administered daily, 5 days a week, over a four- to seven-week period but could be shorter depending on rating scale assessment results. Tapering occurs following the active treatment phase and lasts approximately three weeks. Side effects include lightheadedness and mild headaches. Serious side effects are rare and include seizures. Medications can be continued but should not be changed during treatment, and members are encouraged to continue with outpatient therapy. Providers and members should conduct a risk/benefit assessment when determining if rTMS is an appropriate treatment.

Urgent Outpatient Services (UOS): Rapid responses provided by the outpatient mental health provider to members in response to their perceived urgent behavioral health needs that, if left unattended, may lead to the need for more acute services. Urgent outpatient services provide a same- or next-business-day response to the member's urgent request that assists the member by providing assessment, stabilization, and service linkages. UOS are not intended to replace or be interchangeable with emergency services or mobile crisis intervention services. UOS are ideally provided on the same day as the request and no later than within 24 hours or one business day. These services focus on clinical assessment, brief crisis intervention, stabilization of the crisis, and the alleviation of immediate symptoms that are interfering with the member's functioning. The goal of UOS is to stabilize the member and make the needed aftercare arrangements to transition the member to ongoing outpatient services or other appropriate behavioral health services as soon as possible. In addition, the UOS provider provides the member with information regarding local resources and makes a referral to appropriate community supports and services, when needed.

SECTION 12: LONG-TERM SERVICES AND SUPPORT PROVIDERS

Long-term services and supports (LTSS) are available to eligible members based on specific criteria used to determine medical and functional eligibility. In addition, access to LTSS is dependent on the benefits included in the members' individual health plan.

Long-Term Services and Supports

Long-term services and supports (LTSS) may be covered for Commonwealth Care Alliance, Inc. (CCA) members. Refer to the CCA Senior Care Options and CCA One Care Member Handbooks for a list of covered services by CCA Senior Care Options and CCA One Care plans. LTSS include certain services the member receives in their home and/or community. Examples of LTSS received in the community include:

- Adult day health (ADH): Community-based services such as nursing, assistance with activities of daily living, social, therapeutic, recreation, nutrition at a site outside the home, and transportation to a site outside the home
- Day habilitation (DH): A structured, goal-oriented, active treatment program of medically oriented, therapeutic, and habilitation services for individuals with developmental disabilities who need active treatment

Examples of LTSS typically received in the home include:

- Adult foster care (AFC): Daily assistance in personal care, managing medication, meals, snacks, homemaking, laundry, and medical transportation.

Clinical Conditions, Criteria and Authorization for Long-Term Services and Supports (LTSS)

Prior authorization is required for all LTSS services. The member and their care team review the members' needs and available services. Service requests must align with the covered services applicable to the members' plan, either CCA Senior Care Options or CCA One Care. Members must meet clinical eligibility to be approved for LTSS.

Long-Term Services and Supports Coordinator (LTSC)

CCA One Care members may elect to have an independent LTSC to assist with coordination of their LTSS needs. LTSCs provide expertise in community supports to the member and the member's care team, advocate for the member's LTSS needs, and participate as a member of the interdisciplinary care team (ICT), all at the member's discretion. Most aging services access points (ASAPs), some independent living centers (ILCs), and some recovery learning centers (RLCs) provide LTSS coordination services.

Geriatric Support Services Coordinator (GSSC)

As a member of the primary care team for CCA Senior Care Options members, the GSSC participates in initial and ongoing assessments of members, including developing community-based care plans and determining the appropriateness of institutional long-term care services. The GSSC also arranges and coordinates services with the LTSS providers.

Flexible Benefits

As One Care transitions to a FIDE-SNP plan, certain Home and Community Based Services (HCBS) that were covered under the Medicare-Medicaid demonstration are no longer covered as standard benefits. However, MassHealth allows plans the flexibility to cover these services if a member's needs are not met by standard Medicare and Medicaid services. These services are covered through Flexible Benefits through a service exception, when they are medically necessary, have an impact on improving health outcomes, are documented on a member's care plan and authorized.

SECTION 13: QUALITY IMPROVEMENT PROGRAM

Commonwealth Care Alliance, Inc. (CCA) is focused on sustainable and evidence-based healthcare that addresses the population health needs and improves the health and well-being of people with significant and special needs. This includes advocating for affordable, high-quality, and cost-effective healthcare policies that promote equitable healthcare for the individuals who need it most. The Quality Improvement program is integral to providing evidence-based feedback through measuring outcomes, identifying a strategy for quality improvement, and overseeing the implementation of those improvement activities. CCA strives to improve the health and well-being of our members by innovating, coordinating, and providing the highest-quality, individualized care.

Quality Management Program Overview

CCA's Quality program is structured to ensure that our members' perspective is built into elements of its quality assurance activities. An underlying tenet of the program is that a true partnership between those receiving care and those providing and managing care can promote autonomy, independence, and better health outcomes for the plan's members, regardless of product or benefit package. The Quality Improvement program is responsible for measuring outcomes, identifying a strategy for quality improvement, and overseeing the implementation of those improvement activities.

The Quality Management program is designed to:

- Support quality of care and service, including a focus on assessing and improving member experience and empowerment
- Understand the needs, expectations, and experience of members and their caregivers and implement improvements to incorporate these perspectives into care delivery and system operations
- Improve organizational, operational, and clinical processes throughout the enterprise and the network based upon analysis of available data as well as clinical, administrative, and practitioner input
- Improve clinical care and service quality by collaborating with our network of providers and implementing innovative network quality programs
- Improve care and services for CCA members including members with behavioral health needs, other special needs and those in need of long-term services and supports (LTSS)

The goal of the CCA Quality Management program is to improve performance in the five components of the Institute for Healthcare Improvement's (IHI) "Quintuple Aim":

1. Health of a population
2. Experience of care
3. Cost of care
4. Workforce well-being
5. Safely advancing health equity

CCA achieves the Quality Improvement program goal by focusing on the Institute of Medicine's (IOM) "Six Aims for Improvement":

1. Safety: Member/Patient injury avoidance is maintained or improved by engagement with CCA
2. Effectiveness: Care and services are evidence-based; and our network provides effective care, avoiding low-value care and underuse of effective care and service
3. Timeliness: Care and services are delivered when they are needed; excessive wait times and delays are continually monitored and reduced when possible
4. Person-centeredness: The care and services provided honor the individual's choices, culture, context, and specific needs
5. Efficiency: Care and service processes are developed with the intent to avoid excess costs and waste of human and capital resources
6. Equity: There is consistency in the appropriate provision of person-centered care and services across CCA and the network for individuals with different racial, ethnic, gender and cultural identities

Core to CCA's ongoing quality strategy are the following five organizational capabilities believed to be essential to delivering consistently high quality, member-centered care and services:

- Knowing the consumers we serve as a population: What needs they have, what matters to them, what obstacles and barriers they face
- Including our customers' point of view early and often: Seeing the voices of our consumers and our provider network as guidance into operational, clinical, and strategic decision-making
- Understanding the impact of our actions on consumers: Assessing potential impact on our members of organizational decisions, policies, and programs and seeking mitigation strategies when members may perceive the impact as negative
- Embedding awareness of our consumers' needs into the culture of the organization: Creating a shared understanding of consumer needs the organization is solving and how every staff member, regardless of functional area, contributes to solving those needs every day
- Creating accountabilities with our community partners, contract providers, and vendors to ensure delivery of consumer-centered care and services: Including and measuring attributes of consumer centricity in contracts with third party care delivery partners as a requirement for doing business with CCA

To be successful, CCA also embraces a population health strategy to improve care and health for target populations. CCA employs a dedicated Population Health team to perform analysis and to provide actionable information to different operational and clinical departments across the organization as well as network providers. The team plays a key role in supporting the pursuit of the Quintuple Aim. In addition, the team offers dedicated resources for CCA's strategic goals of improving health equity, decreasing disparities in care, and advancing provisions of the National Standards for Culturally and Linguistically Appropriate Services (CLAS).

CCA is committed to ensuring all CCA members are treated fairly in all healthcare interactions and have equitable access to high-quality healthcare services. CCA defines health equity as “when everyone has a fair and just opportunity to be as healthy as possible regardless of age, race, ethnicity, gender identity, sexual orientation, disability status, socioeconomic status, or English proficiency.” CCA wants to create a partnership with the provider network to accelerate the effectiveness of broader health equity efforts across the healthcare system.

Our members come from a multitude of backgrounds and different life experiences that make everyone unique. It is important to recognize that all members do not have the same needs and may require a variety of medical, behavioral, and social supports to obtain their optimal health and well-being. To be responsive to these differences, CCA is committed to making its services culturally and linguistically appropriate and embedding the National Standards for CLAS principles throughout the organization. CCA aims to ensure that all interactions with members are culturally and linguistically accessible and that all internal processes reflect these standards.

By developing a deeper understanding of people as individuals, we improve our ability to design interventions tailored to their needs and preferences and gain better insight of the collective needs across all populations. CCA believes this is best accomplished when we partner with our provider network to focus quality improvement efforts toward improving the provision of culturally and linguistically appropriate services and decreasing healthcare disparities.

Quality Improvement Program

A Quality Work Plan is developed annually with specific improvement targets on a range of measures covering standardized quality measures, CCA administrative functions, care management services, provider network clinical services, behavioral health, LTSS, and others. The Work Plan includes monitoring of issues and opportunities that the organization identifies as requiring additional follow-up.

The performance goals and targets are set against external benchmarks (when available) and include year-over-year comparisons. CCA also considers targets for subsets of the population to eliminate disparities. Disparity analysis is often done by race, ethnicity, language, disability status, sexual orientation, gender identity, sex, age, geography, and additional demographics as appropriate.

CCA prepares a comprehensive Quality Improvement program evaluation annually to review program activities and performance data. This evaluation summarizes ongoing quality improvement activities, evaluates the overall effectiveness of the quality program, and identifies opportunities for improvement. The report includes highlights of goals that have been achieved and analyses of relevant measures and other data to identify potential contributing factors and barriers for those initiatives where targets have not been met. The data analyzed in the evaluation, together with the input from collaborating teams, help guide next steps for long-range initiatives and projects to inform the Quality Improvement program description and Quality Work Plan in the subsequent year.

The Quality Committee structure at CCA is designed to be effective, ensuring functional areas such as clinical, behavioral health, utilization management, and network contracting have dedicated committees where relevant data and documentation can be reviewed and input provided. This operational framework allows for the review of data, policies, and other materials at the sub-committee level, with subsequent reporting discussions and resolutions to the Management Quality Committee.

The Board of Directors holds the ultimate responsibility for ensuring the quality of care, services, and professional practices at CCA. The board oversees the organization's quality strategy, approves the annual Quality Improvement Work Plan, and reviews performance outcomes to ensure alignment with strategic goals and regulatory requirements. Responsibility for detailed oversight is delegated to the Board Quality Committee, while the Chief Medical Officer (CMO) manages the development and execution of the Quality program through the Vice President and Sr. Director in Quality. The board reviews progress, evaluates strategy, and makes key decisions impacting organizational quality and performance.

Management Quality Committee

The Management Quality Committee is tasked with providing operational oversight and strategic guidance on quality and value of services provided to CCA members across markets and products. This committee reviews both clinical and non-clinical data to ensure compliance with NCQA standards and regulatory reporting requirements, such as HEDIS and quality grievances. It also oversees delegation activities and ensures effective implementation of NCQA operations. This committee is responsible for approving the quality improvement program description, quality improvement workplan, and the yearly evaluation of the quality improvement program. Membership includes senior leaders with expertise in medicine, pharmacy, behavioral health, and quality programs.

Quality Improvement Committee (QIC) & Stars Workgroup

The QIC & Stars Workgroup serves as the organizational forum for overseeing clinical quality and performance improvement initiatives. It focuses on advancing the Quality Improvement Work Plan, monitoring key performance indicators (KPIs) such as HEDIS, CAHPS, Stars ratings, and withhold measures, and collaborating with the Management Quality Committee to enhance member outcomes. The committee reviews performance data, provides guidance on improvement actions, and compliance with regulatory requirements. Membership includes clinical leaders, quality experts, and operational stakeholders.

Collaboration with Contracted Providers in the Creation, Implementation, and Monitoring of the Quality Program Improvement Plan

Provider Advisory Council

CCA strongly believes that its provider network has a substantial and fundamental role in determining the success of its annual Improvement Plan. Specifically, collaboration with and cooperation of CCA-contracted providers is critical to Improvement Plan development, execution, and evaluation. CCA collaborates with contracted providers to identify opportunities for improvement. To this end, CCA has established a Provider Advisory Council, a group of network-contracted healthcare providers practicing in primary care and behavioral health to engage with CCA leadership to facilitate the open exchange of ideas and promote collaboration and mutual accountability between CCA and the network.

- CCA convenes diverse, multidisciplinary network, contracted healthcare providers to provide feedback on processes and systems to improve health, access, cost and experience of members

and providers up to four times a year. In this forum, the Provider Advisory Council and health plan leadership:

- Have an open exchange of ideas, share values, goals, and visions, and promote collaboration and mutual accountability between CCA and the Provider Network
- Discuss evidence-based and emerging best practices to support our network in empowering CCA members to achieve their health goals, removing barriers to care while advancing health equity
- Provide input and recommendations to CCA on its policies, procedures, activities, clinical guidelines, clinical model of care and population health initiatives
- Discuss how to identify quality improvement opportunities and provide input to CCA on the provider experience, including moments that matter and pain points in our work together
- Discuss how to assist CCA with developing effective communications across the provider network and enable a robust provider engagement strategy
- Recommended efficiencies and best practices regarding service availability and consumer choice, including ways to close gaps in clinical services and access to care, particularly for underserved populations

Network Quality Improvement Programs

CCA's Performance Incentive program was designed to align with the organization's mission and goal to improve health equity. The program focuses on measures with variation in practice, where CCA overall is not performing at the target level, and where there are opportunities for improvement in specific sub-populations (race, ethnicity, language disability (RELD), or social determinants of health). CCA has built incentives into our contracts with primary care provider entities to promote and recognize their achievement in clinical and service quality on specific performance measures. The model involves shared performance goals based on population-based assessment and work toward overall improvement in member health in alignment with CCA funding source quality requirements, such as CMS Star and MMP Withhold. Understanding the capacity of primary care provider entities is an essential element in our collaboration and quality improvement programs. Understanding baseline performance in the following HEDIS domains:

- Effectiveness of care coordination (transitions)
- Effectiveness of care for chronic conditions
- Effectiveness of care prevention and screening
- Access and availability of care
- Utilization and risk-adjusted utilization

CCA is available for performance management support to review performance and discuss opportunities for improvement, to identify ways CCA can collaborate on gap in care closure campaigns, and to review how to engage members who, for example, have not accessed primary care within the calendar year.

Data Integration and Reporting

Data from multiple sources is integrated to produce quality metric reports on CCA performance overall, and where feasible, at the primary care practice site and the individual clinician level. Reports include, but are

not limited to, measures from HEDIS, CAHPS, HOS, Medicare Part D Patient Safety, Medicare Part C Reporting, Complaints, Appeals, Provider Summary reports, and CCA-specific metrics developed and reported for priority quality evaluation and improvement initiatives. These reports are reviewed multiple times throughout the year on the committee, department, or individual level. They serve as one factor of the need for the development and implementation of quality improvement and clinical initiatives. As a key component in our expression of the Plan-Do-Study-Act (PDSA) model, data serves to drive better care and services to our members.

Collaborating for Quality Through Data

Throughout the year, CCA produces gap reports and site reports for network contracted provider distribution. CCA analyzes and reports HEDIS measure results at the primary care practice level whenever the site level sample size is adequate for meaningful reporting and comparisons. These performance reports include blinded comparisons to other primary care sites and provide delivery throughout the year of member-level, detailed reports on clinical gaps in care that are reviewed with practice leadership. Performance reports are provided to large–medium group network–contracted practitioners to provide them with a global view of the care and services being provided to their members. This includes utilization, cost, and clinical measure data. Quality works with practice leadership to review and assess this data to make comparisons between patterns of care, opportunities for improvement, and best practices to leverage based on member outcomes. These reports and collaborative reviews serve as the basis for developing annual priorities and improvement at each site.

Prioritized Quality Initiatives

Though they may change over time, CCA's priority quality initiatives, as outlined in each year's Improvement Plan, typically focus on protocols, processes, and procedures to improve the effectiveness and/or efficiency of care delivery.

In addition to ongoing monitoring and maintenance of CCA compliance with CMS and MassHealth quality-related standards and expectations, priority initiatives for 2026 include:

- **Admissions and Readmissions:** Reducing ambulatory-sensitive conditions through PCP access and coordinated transitions into the community
- **Social Determinants of Health (SDOH):** Removing barriers such as transportation, housing instability, and hunger
- **Chronic Condition Management:** Managing diabetes, kidney disease, COPD, and metabolic syndrome through care management coordination, medication adherence, and building self-management skills
- **Behavioral Health Integration:** Integrating medical and behavioral health services, screening for depression, and creating wellness plans to support improved community tenure and lessening disease burden
- **Preventive Care and Vaccination Rate improvement:** Continuing to support access to annual primary care wellness visits and physical exams that are key to supporting healthy behaviors, and preventive services that improve health outcomes such as influenza vaccination and cancer screenings

Compliance with CMS and MassHealth Requirements

CCA must comply with a number of CMS and MassHealth quality-related standards and expectations. Requirements for compliance include several ongoing data submissions, including but not limited to:

- Healthcare Effectiveness Data and Information Set (HEDIS®)
- Consumer Assessment of Healthcare Providers and Systems (CAHPS®)
- Health Outcomes Survey (HOS)
- Quality-of-care grievances
- Model of care description development and maintenance
- Quality Improvement program description
- Quality Improvement program evaluation
- Quality Improvement Work Plan
- Performance improvement projects (PIPs)
- Chronic care improvement projects (CCIPs)

In addition, CCA is committed to using evidence-based guidelines as a basis for quality measurement and improvement.

Healthcare Effectiveness Data and Information Set Guidelines (HEDIS®)

CCA assesses its performance using several tools and measurement methodologies, including HEDIS. HEDIS is a standardized set of performance measures widely used by managed care organizations to enable comparisons of performance over time. The performance measures in HEDIS are related to significant diagnoses such as cancer, heart disease, asthma, and diabetes. HEDIS is sponsored, supported, and maintained by the National Committee for Quality Assurance (NCQA), which defines standards for accreditation of health plans in the U.S. A subset of the HEDIS performance measures is reported to required regulatory entities on an annual basis, per state requirements.

With HEDIS, CCA is assessed on six domains of care:

- Effectiveness of care
- Access/availability of care
- Experience of care
- Utilization and risk adjusted utilization
- Health plan descriptive information
- Measures reported using electronic clinical data systems Specifications for measurement are updated annually by the NCQA.

Performance results, assessed and reported annually, are sourced by administrative claims data as well as medical record reviews. CCA works with each of its providers to ensure uniformity in understanding around documentation requirements to support the medical record review component of this annual assessment.

A subset of HEDIS results is used to calculate the CCA Medicare star rating.

Consumer Assessment of Healthcare Providers and Systems (CAHPS®)

In addition to HEDIS, CCA participates in CAHPS, a standardized survey of consumers' experiences to evaluate its performance in areas such as customer service, access to care and claims possessing. CAHPS is sponsored, supported, and maintained by the Agency for Healthcare Research and Quality (AHRQ).

Data are collected from a random sample of CCA members each spring. A subset of CAHPS results is used to calculate the CCA Medicare star rating.

Health Outcomes Survey (HOS)

The Medicare Health Outcomes Survey (HOS), another standardized tool, is performed on behalf of CCA to evaluate the healthcare status and health-related quality of life of its members by comparing response data from year one to response data provided by the same set of members in year two.

Data are collected each spring. A subset of HOS results is used to calculate the CCA Medicare star rating.

Quality-of-Care Concerns

CCA is committed to providing the highest-quality, most effective healthcare to its members. CCA relies heavily on its provider network to identify potential quality-of-care concerns and to escalate such concerns according to policy.

Confidentiality

All persons participating in quality improvement activities adhere to the CCA confidentiality policy, which is compliant with HIPAA rules and regulations. Results of improvement activities and reports do not contain any identified patient information and, when necessary, are coded or reported in aggregate. All information generated by improvement activities is protected by applicable state and federal laws and regulations.

Critical Incident Reporting

All critical incidents must be reported to the Commonwealth Care Alliance team. To do this, email a copy of the MassHealth Critical Incident Report form to the CCA Senior Quality of Care Specialist at CCAcriticalincident@commonwealthcare.org. This form must be sent to CCA within 24 hours of discovery.

Common examples of adverse incidents that should be reported to CCA include, but are not limited to:

- Premature death of a member resulting from or related to any of the following:
  - Suicide, homicide, drug overdose, suspected medication error, direct medical care, fire or natural disaster
  - Mistreatment, or allegation of mistreatment, of a member, including but not limited to abuse, neglect, emotional harm, or sexual or financial exploitation
- Serious physical or psychological injury, regardless of the location where the injury occurred, related to any of the following:
  - Delivery of care provided directly by the care staff of an individual care plan (ICP)
  - Motor vehicle accident related to a member's substance use disorder or involving ICP-provided transportation
  - Medical equipment failure or failure to deliver medical equipment in a timely manner
  - Second-degree or higher burns
  - Suicide attempt, self-injurious behavior, or overdose related to substance use
  - Falls with a fracture that meet any of the following four conditions:
    - Requiring hospitalization (admission or observation stay more than 23 hours) related directly to the fall
    - Involving a member with a history of falls within the past six months
    - Associated with a head injury
    - Exposure to hazardous materials (including lead, chemical, or bloodborne pathogens)
  - Suspected medication error
  - Mistreatment, or allegation of mistreatment, of a member, including but not limited to abuse, neglect, emotional harm, or sexual or financial exploitation
  - Suspected or alleged criminal activity against the member
  - Preventable pressure injury (Stage 3 and 4)
  - Any use of restraints, restrictive interventions, or seclusion
- Incident that does not involve an injury and is related to one of the following:
  - Member wandering away or leaving an area without supervision or authorization and presenting a safety threat to the member and/or others
  - Member missing from scheduled care, resulting in potential serious harm
  - Displacement of member from permanent or temporary housing due to unsafe living conditions, including but not limited to fire, serious flooding, pest infestation, hoarding, or natural disaster
  - Failure to follow policies and procedures involving the use of restraints, restrictive interventions, or seclusion
  - Mistreatment, or allegation of mistreatment, of a member, including but not limited to abuse, neglect, emotional harm, or sexual or financial exploitation
  - Suspected or alleged criminal activity against the member

SECTION 14: PROVIDER ENROLLMENT AND CREDENTIALING

Provider Enrollment

Practitioners and facilities are responsible for notifying Commonwealth Care Alliance, Inc. (CCA) of any changes to provider enrollment information. Examples of these changes include, but are not limited to:

- Adding new providers to a practice or facility
- Terminating providers from a practice or facility
- Changes to demographic information
- Changes to panel status (seeing patients/accepting new patients/closing panel)
- Changes to a group NPI or tax ID number

Request	Form	Source
Add a new provider under an existing practice or facility	• HCAS Provider Enrollment form • Signed W-9	• HCAS Provider Enrollment form • W-9
Terminate a provider under an existing practice or facility	• Provider Information Change form	• Provider Information Change form
Add, terminate, or update information for **10** or more providers under an existing practice or facility	• CCA Provider Roster Template	• Forms and Referrals > Provider Roster
Add a new location under an existing practice or facility	• Provider Information Change form • Signed W-9 • HCAS Provider Enrollment form (If affiliating fewer than **10** practitioners to the new location) • CCA Provider Roster Template (If affiliating **10** or more practitioners to the new location)	• Provider Information Change form • W-9 • HCAS Provider Enrollment form • Forms and Referrals > Provider Roster
Add a new group NPI under an existing contracted entity	• CCA App • Signed W-9 • MassHealth Disclosure form	• CCA App • W-9 • MassHealth Disclosure form
Update or terminate a location under an existing practice or facility	• Provider Information Change form	• Provider Information Change form

Terminate a group NPI under an existing contracted entity	• Provider Information Change form	• Provider Information Change form
Changes to demographic information	• Provider Information Change form • Copy of medical license	• Provider Information Change form
Changes to panel status	• Provider Information Change form	• Provider Information Change form

All requests must be sent to the Provider Data Management (PDM) department by email at PNMDepartment@commonwealthcare.org **45 days prior to the change or update**.

As part of CCA's provider data validation process, your practice or facility can receive a monthly provider roster. If you're interested, please send your request via email to PNMDepartment@commonwealthcare.org with the subject line "Interest in Monthly Provider Roster." Be sure to provide your group NPI and tax ID number and include a distribution list. Provider Data Management (PDM) will work with CCA's Business Intelligence department to provide this information **within 60 days of receipt of the request**.

Provider Credentialing

The CCA Credentialing Committee oversees the credentialing and re-credentialing process for all provider applicants to the CCA network. The Credentialing Committee approves or denies the provider's participation in our network based upon the review of the application, supporting documents, and results of the credentialing verification process.

In some specific instances, CCA delegates primary source verification to another entity. Notwithstanding delegation, CCA retains the right to approve, suspend, or terminate practitioners from our network. If you have any questions, please contact the Credentialing department at credentialing@commonwealthcare.org.

Credentialing and Re-credentialing Process

Types of Providers Credentialed

CCA credentials providers that are permitted to practice independently under Massachusetts law, including but not limited to:

- Acupuncturists
- Audiologists
- Chiropractors
- Hearing instrument specialists
- Optometrists
- Alcohol and drug addiction counselors (CADC-II and LADC-I)
- Licensed marriage and family therapists (LMFT)

- Licensed mental health counselors (LMHC)
- Licensed independent clinical social workers (LICSW)
- Licensed clinical social workers (LCSW)
- Nurses—nurse practitioners and other advanced practice nurses (ARNP, CNS, CRNP, NP, PNMHCS, RNCS)
- Oral surgeons
- Physicians (MD and DO)
- Physician assistants
- Podiatrists
- Psychologists (EdD, LP, PhD, PsyD)
- Speech, occupational, and physical therapists

Information Required for Credentialing

CCA requires the following information for credentialing:

Application: A completed, signed, and dated practitioner application form (i.e., HCAS, CAQH) that includes supporting documents, work history, education and training, attestation, authorization and release, professional liability insurance information, malpractice history, disciplinary action information, board certification status, primary hospital, and names of all other hospitals where you have privileges.

Work history must be submitted via the application or a CV. As of the date the application is signed, physicians must submit 5 years of history. Each entry of work history must be dated with the month and year. Any gap of employment of greater than 6 months must include a written explanation.

For behavioral health providers treating substance use disorders, providers need to report on continuing education unit (CEU) trainings on substance use disorder they have participated in.

Physicians must give written confirmation from their primary hospital stating that they are credentialed or re-credentialed pursuant to Massachusetts state law.

Either CCA or a delegated contracted, NCQA-certified credentials verification organization (CVO) will perform and document primary source verification on certain information that you have provided to us. Examples of this information include verification of full license to practice, DEA certificate, board certification, highest level of education or training, professional liability claims history, work history, Medicare/Medicaid sanctions, and disciplinary action history. Sources of primary source verification include, but are not limited to, the National Practitioner Data Bank, state licensing agencies, malpractice carriers, and the Office of the Inspector General.

Credentialing Quality: CCA assembles internal quality issues related to the practitioner that have been identified and documented through our ongoing quality monitoring process, including adverse events, member grievances, appeals and complaints, and audits of practitioner records.

Your Right to Review and Correct Erroneous Information

You have a right to review information that we have obtained to evaluate your credentialing application, including information from outside sources, except for references, recommendations, or other peer-review protected information.

If the information we receive from outside sources varies substantially from information submitted to us by you, we will notify you in writing of the discrepancy. Our letter to you will include a description of the discrepancy, a request for an explanation and/or correction from you, who you should return the letter to, and the time frame you have to do so. We will document receipt of your response.

Your Right to Be Informed

You have a right to be informed, upon request, of the status of your application at any time during the credentialing process. If you make an inquiry to the Credentialing department, we will respond to any questions you have, inform you of any outstanding information needed by us prior to a credentialing/re-credentialing determination, and, if none, inform you of the date your application is scheduled to be reviewed for a final credentialing determination.

Credentialing File Review, Determinations, Notice, and Reporting

After all necessary information has been collected and verified, provider credentialing files are reviewed by the Credentialing Committee to determine if credentialing criteria are met. Based on this review, practitioners may be credentialed, approved with conditions, denied initial credentialing, or terminated from participation in our programs.

Notice to Practitioners

All applicants granted initial credentialing are notified in writing of the approval no later than 45 calendar days from the approval date. Any initial applicant who is denied credentialing, or a participating practitioner whose credentials are approved with conditions or terminated, is notified in writing of the action, and the reasons therefore, within 45 calendar days from the Committee's decision. Practitioners who are re-credentialed in the ordinary course do not receive written notice.

Notice to Members

If a primary care provider or certain specialists are terminated for any reason, CCA is required to notify members who have been obtaining services from these practitioners that the practitioner is no longer participating with CCA.

Reporting

CCA complies with all regulatory and government reporting requirements. All denials, conditional approvals, or terminations that constitute disciplinary actions under state law and/or adverse professional review actions under federal law will be reported as required. Reports to the Board of Registration in Medicine are required to be made within 30 days of the date of the Credentialing Committee action.

Credentialing/Re-credentialing Criteria

Practitioners are credentialed and re-credentialed based on the following credentialing criteria:

- Contract with CCA: Practitioner must be contracted with CCA
- Current attested CAQH application with all current documents
- Completed credentialing application: Practitioner must have submitted an accurate and fully completed credentialing application
- Education and training: Practitioner must have appropriate education and training consistent with his or her profession and specialty, as further described in our Credentialing Policies and Procedures
- License: Practitioner must have an active and valid Massachusetts license, and additional certifications where required, to practice his or her profession and specialty
- DEA and Massachusetts Controlled Substances Registration (MCSR)/Certified Director of Safety (CDS) certification: Practitioner must have DEA or MCSR/CDS certification, as applicable
- Professional liability insurance: Practitioner must maintain professional liability insurance no less than $1,000,000 per claim/$3,000,000 annual aggregate, or higher if required by the Commonwealth of Massachusetts, or be covered under the Federal Tort Claims Act (FTCA). Applicants who meet the professional liability requirements because they are covered under the FTCA and are credentialed by CCA may only deliver services to members who are patients of the entity that is covered by the FTCA. Dentists must maintain at least $1,000,000/$2,000,000, or as specified by the Commonwealth of Massachusetts.
- Board certification: In accordance with the CCA Board Certification Policy, physicians, podiatrists, oral surgeons, and nurse practitioners must be:
    - Board certified by a CCA–recognized specialty board; or
    - In the process of achieving initial board certification by a CCA-recognized specialty board and achieve board certification in a time frame relevant to the guidelines established by the applicable specialty board. Waivers will be considered by CCA only when necessary for CCA to maintain adequate member access.
- Hospital privileges: Physicians must have hospital admitting privileges at a hospital contracted with CCA, unless the physician has alternative admitting arrangements as described below. If there are any restrictions on the physician's hospital privileges, the physician must provide a detailed description of the nature and reason for such restrictions, which shall be considered and evaluated by the Credentialing Committee at its discretion
- Alternative admitting arrangements: If you do not have hospital admitting privileges at a hospital contracted by CCA, you must provide an explanation of arrangements you have put in place for members to be admitted to plan-contracting hospitals (which can be an arrangement with a contracted physician who does have privileges at the hospital, provided that the covering physician sends confirmation of these arrangements to the Credentialing department)
- If you do not have hospital admitting privileges at any hospital, you must:
    - Provide the names of two CCA-contracted physicians (who are not financially linked to your practice) who can provide reference letters attesting to your clinical competence. Credentialing department staff will request reference letters from these two physicians at the time of initial

credentialing and re-credentialing. The Credentialing Committee will review these references and at its sole discretion determine whether they are adequate for an exception to be made

  - Provide an explanation of arrangements you have put in place for your members to be admitted to a CCA-contracted hospital (which can be an arrangement with a CCA-contracted covering physician who does have privileges at a CCA-contracted hospital, provided that the covering physician sends confirmation of these arrangements to the Credentialing department)

- Federal/state program exclusions: Practitioner must not be currently excluded, terminated, or suspended from participation in Medicare, Medicaid, or any other federal or state healthcare program
- Criminal proceedings: Practitioner must not have been involved in any criminal proceedings that may be grounds for suspension or termination of your license to practice
- Compliance with legal standards: Practitioner must be in compliance with all applicable legal requirements relating to the practice of your profession, including meeting all continuing education requirements
- Quality care and service:
  - Based on all the information collected as part of the credentialing process, practitioner must reasonably be expected to provide quality and cost-effective clinical care and services to plan members
  - Practitioner must not have engaged in behavior which may adversely impact member care or service, including but not limited to behavior that negatively impacts the ability of other participating providers to work cooperatively with you; reflects a lack of good faith and fair dealing in your dealings with CCA, its provider network, or its members; reflects a lack of commitment to managed care principles or a repeated failure to comply with CCA managed care policies and procedures; indicates a lack of cooperation with the CCA Quality Improvement or Utilization Management programs; or constitutes unlawful discrimination against a member under any state or federal law or regulation. Provider shall not discriminate by product and shall maintain access and hours equally for all CCA members
  - Practitioner must not have engaged in any behavior which could harm other healthcare professionals, patients, or CCA employees. Such behaviors include, but are not limited to, acts of violence committed within or outside the practitioner's practice, whether or not directed toward other healthcare professionals, patients, or CCA employees, and must be judged by the Credentialing Committee to create a significant risk to other healthcare professionals, patients, or CCA employees
- Primary care providers (PCPs): In addition to meeting the above criteria, applicants applying for credentials as PCPs must be:
  - A physician or osteopathic physician trained in family medicine, geriatric medicine, internal medicine, general practice, adolescent and family medicine, pediatric medicine, or obstetrical and gynecological medicine (for female members only); or a nurse practitioner (NP). NPs must submit the name of the participating supervising physician. NPs are required to be trained as an adult nurse practitioner, pediatric nurse practitioner, or family nurse practitioner

- PCPs (who are physicians or osteopathic physicians) must be board certified in family medicine, internal medicine, pediatric medicine, or obstetrics & gynecology or must meet the criteria specified in the Board Certification Policy
- Exceptions: The Credentialing Committee may authorize a specialist physician to serve as a member's PCP if the member has a life-threatening, degenerative, or disabling condition or disease that requires prolonged specialized care (e.g., human immunodeficiency virus (HIV), end-stage renal disease, or an oncology diagnosis), and the Committee believes it will be in the best interest of the member to make this exception. Specialists acting in the capacity of a PCP must be or must become CCA-participating providers and must adhere to all CCA standards applicable to PCPs. Covering practitioners for the specialist-PCP must be credentialed by CCA
- Access and availability: As part of its credentialing determinations, the Credentialing Committee may consider, at its discretion, CCA network access and availability needs

You are not entitled to be credentialed or re-credentialed on the basis that you are licensed by the state to practice a particular health profession, or that you are certified by any clinical board or have clinical privileges in a CCA-contracted entity. CCA, at its sole discretion, credentials and re-credentials practitioners based on its criteria set forth in its credentialing policies and summarized in this manual. CCA is responsible for all final determinations regarding whether a practitioner is accepted or rejected as a participant in our network. No CCA credentialing or re-credentialing decisions are based on a practitioner race, ethnic/national identify, gender, age, sexual orientation, or the types of procedures in which the practitioner specializes. We may include practitioners in our network who meet certain demographic, specialty, or cultural needs of members.

Re-credentialing

You will be required to update and re-attest to your information every 3 years. If a practitioner does not keep his or her information current, or re-attest to information to ensure it is available for re-credentialing, termination may result, in which case the practitioner will need to re-apply to CCA as an initial applicant. Please note that, unlike initial credentialing, re-credentialing includes an assessment of quality-related information collected by CCA as a result of its ongoing clinical and service quality monitoring process. This information may include, but is not limited to, adverse events, member grievances, appeals and complaints, member satisfaction surveys, utilization management information, and information generated from CCA site reviews or audits of practitioner records.

Ongoing Monitoring and Off-Cycle Credentialing Reviews and Actions

Between re-credentialing cycles, CCA conducts ongoing monitoring of information from external sources, such as sanctions from state licensing boards (e.g., Massachusetts Board of Registration in Medicine), Medicare/Medicaid, the Office of Inspector General, and internal sources, such as member grievances and adverse clinical events. This information is routinely included in practitioner file reviews during re-credentialing cycles, but it may also be reviewed by a medical director or the Credentialing Committee at any time between re-credentialing cycles. After review, the Committee may take no action, may continue the practitioner's credentials with conditions, may require the practitioner to complete a full off-cycle credentialing application and review, or may terminate the practitioner from CCA programs.

If information is received through the monitoring process that causes the CCA Medical Director or the Chief Medical Officer to believe that a practitioner has placed or is at substantial risk for placing a member in

imminent danger and that failure to summarily suspend credentials is contrary to the immediate best interests of member care, he or she may summarily suspend a practitioner's credentials. In such event, the practitioner is notified in writing immediately, including the reasons for the action, and the subsequent procedure to be followed by CCA. Any summary suspension will be reviewed by the full Credentialing Committee at its next regularly scheduled meeting. The Committee may reinstate the practitioner, or take any action described in the preceding paragraph.

Under its state contracts, if CCA receives a direct notification from MassHealth or the Connector to suspend or terminate a practitioner, CCA is required to suspend or terminate the practitioner from its network. In such a case, CCA will notify the practitioner in writing, with the reasons therefore, no later than three business days from the date CCA receives such notice. There is no right of appeal from a suspension or termination based on a termination directive from MassHealth or the Connector.

Credentialing Appeals Process for Practitioners

Right of Appeal

If the Credentialing Committee denies your initial credentialing application, approves your network participation with conditions, or terminates your network participation, and such action constitutes a "disciplinary action" as defined in the CCA Credentialing Policies, you are entitled to appeal the disciplinary action. A disciplinary action is an adverse action taken by the CCA Credentialing Committee, up to and including termination from CCA, on the basis of a Committee determination that the practitioner does not meet CCA credentialing criteria related to the competence or professional conduct of the practitioner (i.e., quality of care or service.) Examples include, but are not limited to, a denial or termination due to the volume or nature of malpractice suits against the practitioner, or the quality or quantity of adverse clinical events generated during a practitioner's affiliation with CCA.

Practitioners have no right of appeal from an action that is either of the following:

- An "adverse administrative action"—an adverse action taken by the Credentialing Committee against a practitioner, up to and including termination from CCA, that is not related to the Committee's assessment of the practitioner's competence or professional conduct. Examples include, but are not limited to, a denial or termination due to failure to meet CCA board certification requirements, failure to maintain adequate professional liability coverage, or failure to meet other contractually specified obligations
- A CCA termination based on a directive from MassHealth or the Connector to terminate or suspend a practitioner who is contracted with the plan for MassHealth or Commonwealth Care

Notice

If the Credentialing Committee takes a disciplinary action, the practitioner will be notified in writing (by signature-requested delivery) within 30 calendar days following the date of the action. The notice will contain a summary of the reasons for the disciplinary action and a detailed description of the appeal process.

Practitioner Request for Appeal

You may request an appeal in writing by sending a letter to the CCA Credentialing Committee chairperson postmarked no more than 30 calendar days following your receipt of CCA's notice of disciplinary action. CCA will not accept provider appeals after the 30-calendar-day period. You have a right to be represented in an appeal by another person of your choice (including an attorney). Your appeal should include any supporting documentation you wish to submit.

When we receive a timely appeal, we will send you an acknowledgement letter. The Credentialing Committee Chairperson will arrange for your case to be sent back to the Credentialing Committee for reconsideration.

If no appeal request is received by the filing deadline, the Credentialing Committee's action is final.

Credentialing Committee Reconsideration

Upon timely receipt of an appeal request, the Credentialing Committee will review the appeal and reconsider its original decision. Upon reconsideration, if the Committee overturns its original decision, you will be notified in writing. If the Committee upholds its original decision or modifies it such that another type or level of disciplinary action is taken, you will be notified in writing that an appeals panel will be assembled to review the appeal, the date and time of the appeal panel hearing, whether you are invited to attend the hearing, and other administrative details.

Appeals Panel Hearing and Notice

The appeals panel is a medical peer-review committee that is appointed by CCA to hear the appeal. The hearing will occur no earlier than 30 calendar days and no later than 90 calendar days following CCA's receipt of your appeal request, unless otherwise determined by CCA. The hearing shall consist, at a minimum, of the panel's review of the written submissions by CCA and the practitioner, but may, at the sole discretion of CCA, allow for presentation of live testimony by CCA and/or the practitioner. The panel is empowered to uphold, modify, or overturn the Credentialing Committee's decision. The appeals panel's decision is final.

You will be notified of the decision of the appeals panel, and the reasons therefore, no later than 45 calendar days from the date of the hearing.

Re-application Following Denial or Termination

In the event initial credentialing is denied, or if a practitioner is terminated from the network, CCA will not reconsider his or her reapplication for credentialing for 2 years following the effective date of denial or termination, unless the Credentialing Committee, at its sole discretion, deems a shorter period to be appropriate.

Role of the Credentialed Primary Care Provider (PCP)

A PCP is responsible for supervising, coordinating, and providing initial and basic care of members who have selected that provider for general healthcare services. The PCP also initiates referrals for specialty care and assessments needed by a member and maintains overall continuity of a member's care. Examples of specialty care services may include medical, behavioral, and long-term support services. The referral process may include PCPs utilizing the CCA directory of contracted providers wherever possible and a

review of the prior authorization requirements, found in SECTION 4: Prior Authorization Requirements. The PCP provides coverage for members 24/7. A PCP is a provider selected by the member, or assigned by CCA, to provide and coordinate the member's care.

PCPs are physicians practicing in one of the following specialties: family medicine, internal medicine, geriatrics, general practice, adolescent and family medicine, pediatric medicine, and obstetrics/gynecology (for female members only). Nurse practitioners (NPs) may also function as PCPs if they are trained in internal medicine, pediatrics, family medicine, or women's health.

Specialists as Primary Care Provider (PCP): When designated as a PCP, a specialist assumes all administrative and clinical responsibilities of a PCP, including responsibility for making necessary referrals to other specialists and addressing the preventive and routine care needs of the assigned member. A PCP who believes that one of his or her plan members should receive primary care from a specialist should contact our Care Management department.

Role of the Credentialed Specialist

Credentialed specialists are physicians who are board-certified in a specific specialty recognized by the American Board of Medical Specialties. In addition to specialty physicians, contracted providers may be credentialed in the disciplines of podiatry, chiropractic, audiology, or other specialties where an accrediting body has established criteria for education and continuing medical education. We must credential all covering providers.

Organizational Providers

We assess the quality of all organizational providers prior to contracting. We will confirm that the provider is in good standing with all state and federal regulatory bodies, has been reviewed and approved by an accrediting body, or if not accredited, we will compare the facility's most recent Department of Public Health survey against CCA standards. We will conduct an onsite assessment if the facility is not accredited and has not had a recent Department of Public Health survey.

The facilities credentialed include, but are not limited to, the following provider types:

- Acute care hospitals
- Addiction disorder facilities
- Adult day health
- Adult foster care
- Ambulatory surgery centers
- Assisted living facilities
- Certified home health agencies
- Community-based organizations
- Community health centers
- Community mental health centers
- Durable medical equipment suppliers
- Freestanding diagnostic radiology centers
- Freestanding laboratories
- Freestanding outpatient dialysis centers
- Hospices

- Inpatient psychiatric facilities
- Intermediate care facilities for the mentally disabled
- Long-term acute care hospitals (LTACs)
- Long-term service and support providers
- Nursing facilities (NFs)
- Outpatient behavioral health clinics
- Rehabilitation hospitals
- Residential treatment centers for psychiatric and addiction disorders
- Skilled nursing facilities (SNFs)

The initial network application process for organizational providers includes the submission of the following, at a minimum:

- A CCA facility/group application
- A state license
- Medicare and Medicaid certification
- Professional liability insurance
- A copy of accreditation status

We may request other documentation, based on provider type. For those facilities not accredited by one of the accreditation agencies listed below or not recently visited by the Department of Public Health, a CCA site visit to that facility is required.

- AAAASF: American Association for the Accreditation of Ambulatory Surgery Facilities
- AAAHC: Accreditation Association for Ambulatory Health Care
- AASM: American Academy of Sleep Medicine
- ACDD: Accreditation Council for Developmental Disabilities
- ACHC: Accreditation Commission for Health Care
- ACR: American College of Radiology
- CAP: College of American Pathologists
- CARF: Commission on Accreditation of Rehabilitation Facilities
- CCAC: Continuing Care Accreditation Commission
- CHAP: Community Health Accreditation Program
- CLIA: Clinical Laboratory Improvement Amendment
- COA: Council on Accreditation
- COLA: Commission on Office Laboratory Accreditation
- DNV: Det Norske Veritas Healthcare, Inc.
- HFAP: Healthcare Facilities Accreditation Program
- HQAA: Healthcare Quality Association on Accreditation
- IAC: Intersocietal Accreditation Commission
- NCQA: National Committee for Quality Assurance
- TCT: The Compliance Team, Inc., of Exemplary Providers
- TJC: The Joint Commission

Re-credentialing of Organizational Providers

All contracted organizational providers are re-credentialed every 3 years, or more often, as determined necessary or as requested by the Credentialing Committee.

Quality-of-Care Issues

Organizational providers may be required to have a site visit in the event that a serious quality of care issue has been identified, the provider has been sanctioned, the provider's accreditation has been withdrawn, or a pattern of quality-of-care problems has been identified by CCA. Organizational providers are required to notify us within 10 business days of any actions by a state agency that might affect their credentialing status with us, including, but not limited to, a change in license status, change in ability to perform specific procedures, or a freeze in admissions, type, or number of patients the provider is allowed to admit.

Credentialing Contact Information

Commonwealth Care Association – Credentialing department
2 Avenue de Lafayette, 5th Floor
Boston, MA 02111
credentialing@commonwealthcare.org

SECTION 15: MARKETING GUIDELINES

Providers may market Commonwealth Care Alliance, Inc. (CCA) to prospective members; however, they must follow current Medicaid and Medicare marketing guidelines.

Provider-Based Activities

To the extent that a provider can assist a member in an objective assessment of his or her needs and potential options to meet those needs, they may do so. Contracted providers may engage in discussions with members should a member seek advice. However, CCA must ensure that contracted providers are aware of their responsibility to remain neutral when assisting with enrollment decisions and **do not**:

- Offer scope-of-appointment forms
- Accept Medicare enrollment applications
- Make phone calls or direct, urge, or attempt to persuade members to enroll in a specific plan based on financial or any other interests of the provider
- Mail marketing materials on behalf of CCA
- Offer anything of value to induce plan members to select them as their provider
- Offer incentives to persuade members to enroll in a particular plan or organization
- Conduct health screening as a marketing activity
- Accept compensation directly or indirectly from the plan for enrollment activities
- Distribute materials/applications in an exam room

Contracted providers **may**:

- Provide the names of plans/Part D sponsors with which they contract or participate
- Provide information and assistance in applying for the low-income subsidy (LIS)
- Make available or distribute plan marketing materials and enrollment forms in common areas
- Refer their patients to other sources of information, such as State Health Insurance Assistance Program (SHIP), CCA marketing representatives, their state Medicaid office, local Social Security Office, the CMS website (http://www.medicare.gov/), or 1-800-MEDICARE
- Share information with patients from the CMS website, including the Medicare and You Handbook or Medicare Plan Finder (www.medicare.gov/plan-compare), or other documents that were written by or previously approved by CMS
- Share information with patients from the MassHealth Senior Care Options website, www.mass.gov/senior-care-options-sco
- Share information with patients from MassHealth's One Care website, www.mass.gov/one-care

Provider Affiliation Information

Plans/Part D sponsors may allow contracted providers to announce new or continuing affiliations.

Continuing affiliation announcements may be made through direct mail, email, phone, or advertisement. The announcement must clearly state that the provider may also contract with other plans/Part D sponsors.

New provider affiliation announcements may be made once within the first 30 days of a new contract agreement. In the announcement, plans/Part D sponsors may allow contracted providers to name only one plan/Part D sponsor. This may be done through direct mail, email, or telephone. Neither the plan/Part D sponsor nor the contracted provider is required to notify members that the provider may contract with other plans/Part D sponsors in new affiliation announcements. Any affiliation communication materials that describe plans in any way, (e.g., benefits, formularies), must be approved by MassHealth and CMS. CCA is responsible for working with the contracted provider to ensure approval is granted from both MassHealth and CMS.

For more detail, please see the current Marketing Guidance for Massachusetts Medicare-Medicaid Plans. Marketing guidelines are updated minimally once per year.

SECTION 16: COMPLIANCE AND FRAUD, WASTE & ABUSE PROGRAM

CCA's Compliance Program

Commonwealth Care Alliance, Inc. (CCA) is committed to conducting its business operations in compliance with ethical standards, internal policies and procedures, contractual obligations, and all applicable federal and state statutes, regulations, and rules, including but not limited to those pertaining to the Centers for Medicare and Medicaid Services (CMS) Part C and D programs; the Massachusetts Executive Office of Health and Human Services (EOHHS), MassHealth, and the Office of Inspector General (OIG). The Compliance program applies to all CCA lines of business. The CCA compliance commitment includes its internal business operations, as well as its oversight and monitoring responsibilities related to its first-tier, downstream, and related entities (FDR).

CCA has formalized its compliance activities through a comprehensive Compliance program. The Compliance program incorporates the fundamental elements of an effective compliance program identified by CFR 422.503(b) (4) (vi) and CFR 423.504(b) (4) (vi) and the OIG federal sentencing guidelines.

The CCA Compliance program and Anti-Fraud plan contains the following core elements, including measures to prevent, detect, and correct fraud, waste, and abuse:

- Code of Conduct and written policies and procedures
- Compliance Officer, Compliance Committee, and appropriate oversight
- Compliance training and education program
- Effective lines of communication and reporting
- Well-publicized disciplinary standards and enforcement
- Effective system for routine monitoring, auditing, and identification of compliance risks
- Procedures for prompt response to compliance issues and remediation
- First-tier, downstream, and related entity compliance oversight

The CCA Compliance program is developed to:

- Promote compliance with all applicable federal and state laws and contractual obligations
- Prevent, detect, investigate, mitigate, and appropriately report suspected incidents of program noncompliance
- Prevent, detect, investigate, mitigate, and appropriately report suspected incidents of fraud, waste, and abuse
- Promote and enforce the CCA Code of Conduct

CCA Compliance Expectations of CCA's Network Providers

Commonwealth Care Alliance, Inc. (CCA), Inc., holds its providers to the same standards as required under Medicare and MassHealth, including requirements CCA holds providers to by virtue of its Medicare Advantage or MassHealth Managed Care Entity contract functions. As such, providers in-network are required to ensure compliance with the following:

- Providers must maintain good standing with Medicare and enroll in Medicaid
- Providers enrolling in Medicaid must comply with all screening requirements, including 42 CFR 455 Subparts B and E
- Providers must follow Medicare opt-out rules, in that any provider who is eligible to enroll in Medicare and opts out is not allowed to remain in-network and is not permitted to serve members out-of-network
- Providers must not engage in any practice with respect to any member that constitutes unlawful discrimination under any other state or federal law or regulation, including, but not limited to, practices that violate the provisions of 45 CFR Part 80, 45 CFR Part 84, 45 CFR Part 90, 45 CFR Part 92, MGL 151B
- Providers must not be excluded from participation in a federal or state healthcare program under either Section 1128 or Section 1128A of the Social Security Act, nor any rules or regulations under any state's Medicaid program
- Providers must report their inclusion on any state or federal exclusion or debarment list, and they shall submit repayment of any claims for dates of service after the exclusion or debarment date
- CCA must terminate relationships with any trustee, officer, employee, provider, or vendor who is identified to be debarred, suspended, or otherwise excluded from participation. If you become aware that you, your corporate entity, those with more than 5 percent ownership in your corporate entity, or your office management staff have a prohibited affiliation, you must notify CCA immediately by emailing PNMDepartment@commonwealthcare.org
- Providers must maintain records confidentiality and PHI protections as per HIPAA and Massachusetts state privacy laws, including but not limited to 45 CFR 160 and 45 CFR 164 (HIPAA), MGL 111 Sections 70, 70E, and 70F, and the Massachusetts SHIELD Act 2.0
    - Providers may refer to CCA's Notice of Privacy Practices available in the linked Forms Section 18 further in the manual for more information.
- Providers must notify CCA of any changes which may impact their listing in the provider directory, including but not limited to accessibility, languages spoken by providers, specialization, location, and panel status

Disclosure of Ownership, Debarment and Criminal Convictions

Before CCA enters or renews an agreement with your practice or corporate entity, you must disclose any debarment, proposed for debarment, suspension, or declared ineligible status related to federal programs of yourself and your managing employees and anyone with an ownership or controlling interest in your practice or corporate entity. You must also notify CCA of any federal or state government current or pending legal actions, criminal or civil, convictions, administrative actions, investigations, or matters subject to arbitration.

In addition, if the ownership or controlling interest of your practice or corporate entity changes, you have an obligation to notify us immediately. This includes ownership and controlling interest by a spouse, parent, child or sibling. Please contact us by emailing PNMDepartment@commonwealthcare.org.

If you have ownership of a related medical entity where there are significant financial transactions, you may be required to provide information on your business dealings upon request.

If you fail to provide this information, we are prohibited from doing business with you. Please refer to the Code of Federal Regulations 42 CFR 455.100-106 for more information and definitions of relevant terms.

Inform Members of Advance Directives

The federal Patient Self-Determination Act (PSDA) gives patients the legal right to make choices about their medical care before incapacitating illness or injury through advance directives. Under the federal act, providers must provide a member written information about state laws concerning the member's right to make decisions about their medical care, accept or refuse treatment, and the right to formulate an advance directive. Providers must also supply the member with written information about the providers' own policies regarding advance directives, including a statement of limitation if the provider cannot implement an advance directive on the basis of conscience. Providers must clearly document in the member's medical record whether the member has executed an advance directive, may not discriminate against a member based on whether the member has an advance directive, must ensure compliance with Massachusetts law regarding advance directives, and must educate staff and community on advance directives.

CCA Senior Care Options and CCA One Care plans reserve the right to audit medical records for the presence of advanced directives.

The CCA Fraud, Waste, and Abuse Program

Healthcare fraud, waste, and abuse hurts everyone, including members, providers, taxpayers, and CCA. As a result, CCA has a comprehensive fraud, waste, and abuse program in our Program Integrity department. Please help us by reporting questionable activities and potential fraud, waste, and abuse situations.

The Program Integrity department routinely monitors for potential billing discrepancies or potential fraud, waste, and abuse. When found, an investigation is initiated and if warranted, corrective action is taken.

Corrective actions can include, but are not limited to:

- Member and/or provider education
- Recommendations for provider termination with or without cause
- Provider summary suspension
- Recovery of overpaid funds
- Member disenrollment
- Contract termination
- Employee disciplinary actions
- Reporting to one or more applicable state and federal agencies
- Legal actions

How to Report Fraud, Waste, or Abuse

It is CCA's policy to detect and prevent any activity that may constitute fraud, waste, or abuse, including violations of the federal False Claims Act. Federal and state law as well as CCA policy prohibit any retaliation or retribution against persons who report suspected violations. If you have knowledge or information that any such activity has possibly taken place, please contact our Program Integrity department. Reporting fraud, waste, or abuse can be anonymous or not anonymous.

Options for Reporting Anonymously

Phone: Call 1-844-415-1272 and tell our IVR system that you are calling to report fraud.

Mail**:**
CareSource
Attn: Program Integrity
P.O. Box 1940
Dayton, OH 45401-1940

Options for Reporting That Are Not Anonymous

Fax: 800-418-0248

Email: fraud@caresource.com

Web: Use the Fraud, Waste, and Abuse Reporting form located on **CareSource.com** > Providers > Tools & Resources > Forms

When you report fraud, waste, or abuse, please give as many details as you can, including names and phone numbers. You may remain anonymous, but if you do, we will not be able to call you back for more information. Your reports will be kept confidential to the extent permitted by law.

https://secure.ethicspoint.com/domain/media/en/gui/78536/index.html

Physician Education Materials

The Office of the Inspector General (OIG) has created free materials for providers to assist you in understanding the federal laws designed to protect Medicaid and Medicare programs and program beneficiaries from fraud, waste, and abuse. This brochure can be found on the OIG website at https://oig.hhs.gov/compliance/physician-education/index.asp.

Thank you for helping CCA keep fraud, waste, and abuse out of healthcare.

Definitions of fraud, waste, and abuse

- Fraud is defined as knowingly, intentionally, and willfully executing, or attempting to execute, a scheme or artifice to defraud any healthcare benefit program; or to obtain, by means of false or fraudulent pretenses, representations, or promises, any money or property owned by or under the custody or control of any healthcare benefit program. Examples of fraud include but are not limited to

a provider billing for services or supplies that were not provided; or a member knowingly sharing their CCA ID card with a non-member of CCA in order to obtain services.

- Waste is defined as the overutilization of services, or other practices that directly or indirectly result in unnecessary costs. Waste is generally not considered to be caused by criminally negligent actions but rather the misuse of resources. Examples of waste include but are not limited to a mail-order pharmacy sending medications to members without first confirming the member still needs them; or a physician ordering excessive diagnostic tests.
- Abuse involves payment for items or services when there is no legal entitlement to that payment even when the provider has not knowingly and/or intentionally misrepresented facts to obtain payment. Examples of abuse include but are not limited to a medical professional providing treatment to a patient that is inconsistent with the diagnosis; or misusing codes and modifiers on a claim, such as upcoding or unbundling codes.

Improper payments are any payments that should not have been made, or that were made in an incorrect amount (including overpayments and underpayments) under statutory, contractual, administrative, or other legally applicable requirements. This includes any payment to an ineligible recipient, any payment for an ineligible good or service, any duplicate payment, any payment for a good or service not received (except for such payments where authorized by law), and any payment that does not account for credit for applicable discounts. Anyone who identifies an improper payment should report it to CCA using one of the reporting methods above.

Examples of Fraud, Waste, and Abuse

Member Fraud, Waste, and/or Abuse

- Inappropriately using services, such as selling prescribed narcotics, or seeking controlled substances from multiple providers or multiple pharmacies
- Altering or forging prescriptions (i.e., changing prescription forms to get more than the amount of medication prescribed by their physician)
- Non-disclosure of other health insurance coverage
- Obtaining unnecessary equipment and supplies
- Committing identity theft/sharing ID cards—i.e., member receiving services under someone else's ID, sharing their ID with others, or submitting prescriptions under another person's ID
- Providing inaccurate symptoms and other information to providers to get treatment, drugs, etc.

Provider Fraud, Waste and/or Abuse

- Prescribing drugs, equipment or services that are not medically necessary
- Billing for services not provided
- Billing more than once for the same service
- Intentionally using improper medical coding to receive a higher rate of reimbursement
- Purchasing drugs from outside the United States
- Prescribing high quantities of controlled substances without medical necessity

- Unbundling services to obtain higher reimbursement
- Scheduling more frequent return visits than are needed
- Billing for services outside of your medical qualifications
- Using patient lists for the purpose of submitting fraudulent claims
- Billing drugs for inpatients as if they are outpatients
- Payments stemming from kickbacks or Stark Law violations
- Not reporting overpayments or overbilling
- Preventing members from accessing covered services, resulting in underutilization of services offered
- Pharmacy Fraud, Waste, and/or Abuse
- Not dispensing prescription drugs as written
- Submitting claims for a more expensive brand-name drug when a less expensive generic prescription is dispensed
- Dispensing less than the prescribed quantity without arranging for the additional medication to be received with no additional dispensing fees
- Splitting prescriptions into two orders to seek higher reimbursement
- Dispensing expired, fake, diluted, or illegal drugs
- Billing prescriptions not filled or picked up

It is also important for you to tell us if a CCA employee or vendor acts inappropriately.

Employee Fraud, Waste, and/or Abuse

- Receiving gifts or kickbacks from vendors for goods or services
- Inappropriately marketing our company to potential members
- Behaving in an unethical or dishonest manner while performing company business

Vendor Fraud, Waste and/or Abuse

- Falsifying business reports
- Not reporting or taking action on employees that are debarred
- Billing for services not rendered or products not received
- Billing for a more expensive service, but providing a less expensive service

Network providers are to report and return to CCA any overpayment within sixty (60) calendar days of identification and notify CCA in writing of the reason for the overpayment.

The Federal and State False Claims Acts and Other Fraud, Waste, and Abuse Laws

Using the False Claims Act (the Act), you can help reduce fraud against the federal government. The Act allows everyone to bring "whistleblower" lawsuits on behalf of the government—known as "qui tam" suits against businesses or other individuals that are defrauding the government through programs, agencies or contracts.

The Act addresses anyone who:

- Knowingly* presents, or causes to be presented, a false or fraudulent claim for payment or approval
- Knowingly* makes, uses, or causes to be made or used, a false record or statement material to a false or fraudulent claim
- Conspires to commit a violation of any other section of the Act
- Has possession, custody, or control of property or money used, or to be used, by the government and knowingly delivers, or causes to be delivered, less than all that money or property
- Is authorized to make or deliver a document certifying receipt of property used, or to be used by the government, and, intending to defraud the government, makes or delivers the receipt without completely knowing that the information on the receipt is true
- Knowingly* buys, or receives as a pledge of an obligation or debt, public property from an officer or employee of the government, or a member of the armed forces, who lawfully may not sell or pledge property
- Knowingly* makes, uses, or causes to be made or used, a false record or statement material to an obligation to pay or transmit money or property to the government, or knowingly conceals or knowingly and improperly avoids or decreases an obligation to pay or transmit money or property to the government

**"Knowingly" means acting with actual knowledge or with reckless disregard or deliberate indifference to the truth or falsity of information.*

A violation of the federal Anti-Kickback Statute constitutes a false and fraudulent claim under the federal False Claims Act.

An example is if a provider, such as a hospital or a physician, knowingly "upcodes" or overbills, resulting in overpayment of the claim using Medicaid and/or Medicare dollars.

The period for a claim to be brought under the False Claims Act is the later of:

- Within six years from the date of the illegal conduct, or
- Within three years after the date the government knows or should have known about the illegal conduct, but in no event later than ten years after the illegal activity

Protection for Reporters of Fraud, Waste, or Abuse

Federal and state law as well as CCA's policy prohibit any retaliation or retribution against persons who report suspected violations of these laws to law enforcement officials or who file "whistleblower" lawsuits on

behalf of the government. Anyone who believes that he or she has been subject to any such retribution or retaliation should also report this to our Program Integrity department. Learn more at https://www.whistleblowers.gov/know_your_rights.

Other Fraud, Waste, and Abuse Laws

- Under the federal Anti-Kickback Statute, and subject to certain exceptions, it is a crime for anyone to knowingly and willfully solicit or receive, or pay anything of value, including a kickback, bribe or rebate in return for referring an individual to a person for any item or service for which payment may be made in whole or in part under a federal healthcare program. 42 U.S.C. §1320a-7b.
- Under the federal Stark Law, and subject to certain exceptions, providers are prohibited from referring federal healthcare program patients for certain designated health services to an entity with which the physician or an immediate family member has a financial relationship. The Stark Law imposes specific reporting requirements on entities that receive payment for services covered by federal healthcare programs. 42 U.S.C. §1395(a) and §1903(s).
- As part of the Health Insurance Portability and Accountability Act (HIPAA), the U.S. Criminal Code was amended, and it is a crime to knowingly and willfully execute or attempt to execute a scheme or artifice to defraud any federal healthcare program or obtain by means of false or fraudulent pretenses, representations or promises, any money or property owned by or under the custody or control of any federal healthcare program. 18 U.S.C. §1347.
- The Deficit Reduction Act of 2005 (DRA) contains many provisions reforming Medicare and Medicaid that are designed to reduce program spending. As an entity that offers Medicaid and Medicare coverage, CareSource is required to comply with certain provisions of the DRA. One such provision prompted this communication, as it requires us to provide you with information about the federal False Claims Act, state False Claims Acts, and other state laws regarding Medicare and Medicaid fraud. In addition, the DRA requires you and your contractors and agents to adopt our policy on fraud, waste, and abuse when handling CCA business.

The CCA Fraud, Waste, and Abuse program and specific policies and procedures are designed to prevent, detect, investigate, mitigate, and appropriately report suspected cases of fraud, waste, and/or abuse. CCA is subject to several laws and regulations pertaining to fraud, waste, and abuse, including, but not limited to, the federal Anti-Kickback Statute, the federal False Claims Act, the applicable state False Claims Acts, and federal and state whistleblower protections.

The Federal False Claims Act imposes civil liability on any person who knowingly submits or causes the submission of a false or fraudulent claim to the federal government. Additionally, the Massachusetts False Claims law allows for state prosecution of companies and individuals who mislead or defraud state or municipal entities through the use of false or fraudulent claims, records, or statements.

Click here to access CCA compliance and fraud, waste, and abuse resources information on the CCA website.

Regulations

In accordance with 42 C.F.R. §§ 422.504(i)(4)(v), all business conducted by CCA, and its contracted entities must be in compliance with applicable federal and state requirements, laws, and regulations; applicable local laws and ordinances; and the ethical standards/practices of the industry.

General Compliance and Fraud, Waste, and Abuse Training

All providers contracted with CCA are required to complete general compliance and fraud, waste, and abuse training on an annual basis. If a provider is enrolled in the Medicare Part A or B program, these training and education requirements are determined to have been satisfied. The Centers for Medicare & Medicaid Services (CMS) has developed a Medicare Parts C and D Fraud, Waste, and Abuse Training and Medicare Parts C and D General Compliance Training. There is a certificate of completion at the end of the training, and we encourage all providers and their employees to retain a copy of the certificate in their records. CCA reserves the right to request verification and/or conduct audits of our providers to verify adherence to this training requirement.

How to Report any Suspected Compliance Concerns

If you suspect any compliance concern, outside of suspected incidents of fraud, waste, and abuse, please report it via one of the following methods:

- Call the CCA Compliance Hotline at 844-784-9583 (confidential and anonymous)
- Submit a Compliance Incident Report
- Email CareSourceComplianceOfficer@caresource.com (not an anonymous method)
- Mail:
  - CareSource Ethics & Compliance
  - PO Box 273
  - Dayton, OH 45401

Policies and Procedures

CCA maintains compliance and fraud, waste, and abuse policies, including on the following relevant topics:

- Compliance training and education
- Fraud, waste, and abuse
- Reporting, investigating, and externally reporting a compliance concern
- Compliance monitoring
- Compliance auditing
- Whistleblower protections, False Claims Act, and Deficit Reduction Act
- Anti-Kickback Statute and Stark Law

SECTION 17: PROVIDER TRAINING

Training and shared learning among our contracted providers is a key element of our strategy for communicating best practices and assuring the quality and integration of services delivered to Commonwealth Care Alliance, Inc. (CCA) members. CCA reserves the right to request verification that all providers and their downstream and related entities have completed the required training. Failure to demonstrate compliance with training requirements may result in CCA terminating its contract. All of CCA's required and recommended trainings can be found on our website here.

Provider Training Requirements

Model of Care

The Centers for Medicare & Medicaid Services (CMS) requires FIDE-SNP plans to provide initial and annual model of care (MOC) training to all network providers contracted to see dual-eligible members and all out-of-network providers seen by dual-eligible members routinely. Providers are required by CMS to attest to completing the model of care training annually.

Compliance, Fraud, Waste, and Abuse

All contracted providers, and their downstream and related entities, must comply with federal and state requirements for fraud, waste, and abuse training and annual compliance training of all employees. Instructions for performing these trainings and CCA oversight can be found on our website.

Cultural Competency Training

CCA has developed required cultural competency training courses specifically for network practitioners and office staff to support them in delivering high-quality care that meets the social, cultural, and linguistic needs of our members. Please find our cultural competency training here.

CCA One Care–Specific Training for Providers Serving on CCA One Care Interdisciplinary Care Teams (ICTs)

CCA offers training to all contracted providers who are on a CCA One Care ICT. The required training focuses on topics designed to help improve healthcare quality through person-centered coordinated care. CCA One Care plans have worked with the University of Massachusetts Medical School and MassHealth to develop this single training program that coordinates the numerous federal and state training requirements for this program.

The required training topics include:

- Person centered
- Cultural competence
- Accessibility & accommodations
- Independent living & recovery
- Wellness principles

To accommodate different learning styles, these trainings are offered via live and recorded webinars, self-paced online modules, and regional seminars. To learn more about the training options available and to enroll for your preferred option, go to https://onecarelearning.ehs.state.ma.us/. You need only complete these required modules once. To receive credit for attending the training, you will need to follow a link provided at the end of the module to attest to completion, and you will receive a certificate of completion for your records. UMass and the CCA One Care plans will coordinate the tracking of your participation.

Training for Our Health Home and Behavioral Health Home Partners

The required training is more specific to your day-to-day work as a network provider with the CCA One Care plan. This training includes topics in the plan-specific model for the One Care program. The requirements to complete these modules vary depending on your role and your organization's role with CCA:

In addition to the above required trainings, you can refer to our website to review recommended trainings that CCA offers: Training and programs for CCA providers

SECTION 18: FORMS

Commonly used forms may be accessed utilizing this link: Forms and referrals