PROVIDER MANUAL | 2021

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WELCOME LETTER

Dear Commonwealth Care Alliance Provider:

Welcome to the Commonwealth Care Alliance provider manual. The provider manual has recently undergone revisions and includes updates on doing business with Commonwealth Care Alliance. The manual includes information about our Senior Care Option and One Care programs.

Commonwealth Care Alliance is committed to partnering with providers to ensure our members receive the highest quality coordinated care possible, and we have designed this administrative resource to provide you with comprehensive information about our programs and plan. In addition to detailed Commonwealth Care Alliance program information, you will find our policies and procedures, referral and claim information, and other useful reference materials that we hope will make working with Commonwealth Care Alliance staff and members as simple as possible.

Commonwealth Care Alliance members are encouraged to be active participants in their health care. When members enroll in Commonwealth Care Alliance, they receive a Member Handbook, which outlines the terms of benefits. Copies of the handbook may be obtained by contacting the Commonwealth Care Alliance Member Services Department at 866-610-2273.

If you have any questions regarding the information in this provider manual, please email Provider Relations at providerrelations@commonwealthcare.org .

SECTION 1: KEY CONTACT INFORMATION

Key Contact Information

Contact	Telephone	Fax	Web/Email
Claims Office P.O. Box 548 Greenland, NH 03840-0548 TTY Massachusetts Relay Service	800-306-0732 800-439-2370 (TTY 711)		
Claims			
Claims Customer Service Refunds and escalations • Corrected Claims Claims status • Claim receipt, check run New providers, contracting, and EDI • Electronic billing set up or problems	800-306-0732		Email: ccaedisupport@pcgus.com
Member Services			
General questions • Initial contact Member appeals • Service denials - Process; how to respond Member benefits • Member information; coverage Member eligibility • MassHealth	866-610-2273 888-665-9993	617-426-1311	Email: memberservices@commonwealthcare.org
Member Enrollment			
Outreach and Marketing • Referrals for potential members	866-610-2273	617-830-0534	Email: rkatzman@commonwealthcare.org
Clinical Operations			
Clinical Decision Support Team and prior authorization • Benefit and service authorizations	866-610-2273	855-341-0720	
Dental			
Claims to be processed • SKYGEN Member eligibility • SKYGEN Claims issues • SKYGEN Provider relations • SKYGEN	855-434-9243		Website: www.CCAdentists.org Email NetworkDevelopment@skygenusa.com

Pharmacy			
General questions • Questions, vendor	866-610-2273	857-246-8891	Email: ccapharmacy@commonwealthcare.org
Provider Services			
Provider Services • Covered services • Authorization Status • Service Denials / Appeals Status • General Questions	866-420-9332		ProviderServices@commonwealthcare.org
Provider Network			
Provider Relations • Training, orientation, general questions			Email: providerrelations@commonwealthcare.org
Provider Enrollment • New provider enrollment, provider data edits			Email: pnmdepartment@commonwealthcare.org
Provider contracting • Requests to become a Commonwealth Care Alliance provider • Medical or Behavioral Health		617-517-7738	Email: ccacontracting@commonwealthcare.org
Compliance			
Concerns and reporting • Fraud, waste, and abuse and compliance concerns	800-826-6762 Compliance Hotline **anonymous**		Email: CCA_Compliance@commonwealthcare.org **not anonymous**
Third Party Liability			
COB, third party, Q & A	617- 960-0441 ext. 1904		Email: tplcoordinator@commonwealthcare.org
Interpreter Services			
Providers may contact the CCA's Provider Services department at 866-420-9332, along with the member and they will be connected to the appropriate interpreter telephonically. • Please have the following information available: Members name and ID number. Provider Services is available during the hours of 8:00 a.m. to 6:00 p.m. (Monday thru Friday). For assistance after business hours and weekends, please call CCA's Member Services at 866-610-2273. Member Services is available during the hours of 8:00 a.m. to 8:00 p.m. (Monday thru Friday) 8:00am to 6:00pm (Saturday and Sunday) to assist members with interpreter services.	Provider Services - 866-420-9332. Member Services - 866-610-2273		

SECTION 2: INTRODUCTION TO COMMONWEALTH CARE ALLIANCE

This section introduces Commonwealth Care Alliance and describes its mission, vision, and approach to giving the highest quality health care to its members.

What Is Commonwealth Care Alliance?

Commonwealth Care Alliance, Inc. is a not-for-profit care delivery system committed to providing integrated health care and related community support services. Created in 2003, Commonwealth Care Alliance is a "consumer-governed" organization offering a full spectrum of medical and social services for people with complex needs covered under Medicaid and for those "dually eligible" covered by both Medicaid and Medicare, including:

- Older adults (aged 65+)
- Individuals 21-64 years of age with serious physical, cognitive, or chronic mental health disability

Commonwealth Care Alliance is organized as a "consumer-governed care system" to ensure that the empowered consumer voice is built into all of our activities. The fact that the founding partners of Commonwealth Care Alliance are Community Catalyst, Health Care For All, and Boston Center for Independent Living attests to this commitment, and thus fundamentally breaks new ground for the role of health care advocacy.

A unique feature of our model of care is the importance of the value of community caregivers and respect for relationship forged in trust between members and member caregivers.

Our Mission

Our mission is to improve the health and well-being of people with significant needs by innovating, coordinating and providing the highest quality, individualized care.

Our Vision

Our vision is to lead the way in transforming the nation's healthcare for individuals with the most significant needs.

Our Approach

Although the characteristics of the varied populations to be served by Commonwealth Care Alliance are quite different, experience has demonstrated common care system principles that are key to improving care and managing costs. These principles include:

- A “top to bottom” clear exclusive mission to serve vulnerable populations
- Specialized administrative and clinical programmatic expertise
- New approaches to care management and care coordination that support primary care clinicians through a team approach involving nurse practitioners, nurses, behavioral health clinicians, and/or non-professional peer counselors
- 24 hour/7 day a week personalized continuity in all care settings at all times
- Selective comprehensive primary care networks and selective networks of physician specialists, health care facilities, human service agencies, community-based organizations, and institutional long- term care services facilities
- Flexible benefit designs
- Promotion of member empowerment and self-management strategies
- Full integration of medical, behavioral health and long-term care services
- State of the art clinical information technology support for the care delivery and payment system

SECTION 3: MEMBER ELIGIBILITY, APPEALS & GRIEVANCES

1. Senior Care Options Eligibility Requirements

Commonwealth Care Alliance Senior Care Options (SCO) is for elders who:

- Are age 65 or older
- Are eligible for MassHealth Standard*
- Live in the Commonwealth Care Alliance SCO service area
- Agree to receive all covered health and long-term services through Commonwealth Care Alliance

*The SCO program is open to MassHealth Standard members with or without Medicare

The program is open to elders in all living situations, including:

- Elders living independently
- Elders living in the community with support services
- Elders in long-term care facilities (the potential member cannot be an inpatient at a chronic or rehabilitative hospital, or reside in an intermediate care facility)

2. One Care Eligibility Requirements

Commonwealth Care Alliance One Care is for adults who:

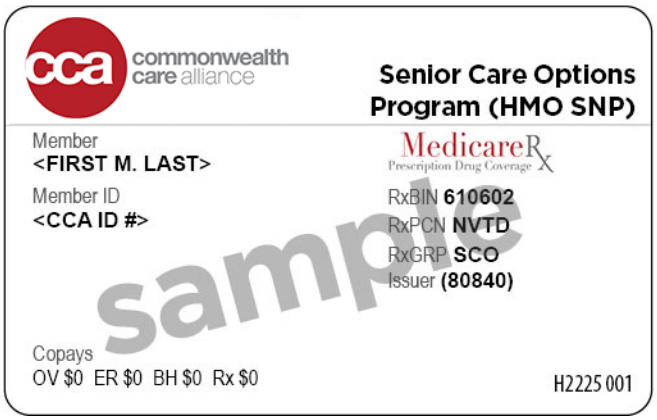
- Are age 21 through 64 at the time of enrollment
- Are eligible for MassHealth Standard or CommonHealth
- Are enrolled in Medicare Parts A and B and eligible for Part D
- Do not have access to other public or private health insurance that meets basic benefit level requirements
- Live in the Commonwealth Care Alliance One Care service area
- Agree to receive all covered medical, behavioral health, and long-term services and supports through Commonwealth Care Alliance

Note: One Care will not currently enroll people who are in a PACE or HCBS Waiver program.

Member Identification Card

Each member receives a Commonwealth Care Alliance identification card to be used for services covered by Commonwealth Care Alliance and prescription drug coverage at network pharmacies for both the Senior Care Options Program and the new One Care Program. Please see an example card below.

Senior Care Options



One Care

Please call Provider Services at 866-420-9332 to verify member eligibility and confirm that the membership is still active.

Interpreter Services

Commonwealth Care Alliance providers must ensure that members have access to medical interpreters, signers, and TDD/TTY services to facilitate communication, without cost to them.

If the member speaks a language that is not prevalent in the community and/or the provider does not have access to interpretation, CCA will provide telephonic language assistance services.

Providers, along with the member, may contact CCA's Provider Services department at 866-420-9332 and they will be connected to the appropriate interpreter telephonically.

- Please have the following information available: Member's name and CCA ID number.

Provider Services is available during the hours of 8:00 a.m. to 6:00 p.m. (Monday thru Friday). For assistance after business hours and weekends, please call CCA's Member Services at 866-610-2273.

Member Services is available during the hours of 8:00 a.m. to 8:00 p.m. (Monday thru Friday) 8:00am to 6:00pm (Saturday and Sunday) to assist members with interpreter services.

Prevent Discrimination

Commonwealth Care Alliance 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, or public assistance. Commonwealth Care Alliance 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, or public assistance.

All CCA Providers must:

- Make covered health services available to all Members
- Accept and treat Members without discrimination in comparison to such services rendered to your other patients and without discriminating based upon source of payment, sex, age, race, color, religion, national origin, health status, or disability
- Help our non-English-speaking Members get interpreter services if necessary (Providers can call Provider Services for translation services 866-420-9332)

Office Access Parity

Commonwealth Care Alliance providers will ensure that Commonwealth Care Alliance members have equal access or parity to providers as commercial members of other health plans, or as to individuals eligible to receive services through MassHealth's fee-for-service system. This parity may include hours of office operations, after-hours care and provider coverage.

Office Access and Availability

Commonwealth Care Alliance 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 timeframe requirement that the Commonwealth Care Alliance provider network needs to adhere to in order to support each member's needs. The timeframe requirements are as follows:

Primary Care Office Visits

Primary care office visits must be available within ten (10) calendar days, and specialty care office visits must be available within thirty (30) days of the Enrollee's request for non-urgent symptomatic care.

Urgent Care and Symptomatic Office Visits

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

Non-symptomatic Office Visits

All non-symptomatic office visits must be available to Enrollees within thirty (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 timeframes can be found in Section 11 of this Provider Manual.

Appeals and Grievances

Filing an Appeal or Grievance on Behalf of a Member

Providers may file an appeal or grievance on behalf of a member using the procedures described below. An Appointment of Representative form (AOR) is requested to file appeals and required to file a grievance on behalf of a member. An appeal will not be delayed for receipt of the AOR.

An AOR form can be printed from the following link: https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/Downloads/CMS1696.pdf. The form must be completed by the member and signed by the member and provider within 44 days of receipt of the Appeal request. Return the completed form to CCA via fax at 857-453-4517 or at the following address:

Commonwealth Care Alliance

Attn: Appeals & Grievances

30 Winter Street

Boston, MA 02108

Appeals

Appeals are procedures that deal with the review of adverse initial determinations made by Commonwealth Care Alliance regarding health care 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: IRE or Board or Hearing (BOH), ALJ, MAC 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. Providers may file a pre-service appeal on a member's behalf within 60 days of the denial by calling Provider Services at 866-420-9332, by sending a fax to the Appeals & Grievances Department at 857-453-4517 or via mail at the address listed above. A provider does not need to be the representative to initiate an appeal, but is required to submit an appointment of representative form (AOR) prior to the end of the appeal timeframe. The appeal will not be delayed by the requirement for an AOR. CCA includes as parties to the appeal the member, the Appeal Representative or legal representative of a deceased member's estate.

Appeal Resolution Timeframes

Appeal Type	Part C	Part B	Part D
Standard	30 Days	7 Days	7 Days
Expedited	72 Hours	72 Hours	72 Hours

Appeals can be submitted as expedited (also called a "Fast Appeal") or standard. If the provider indicates that applying the standard timeframe could seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function (the physician does not have to use these exact words), the plan will process the appeal as expedited.

CCA may extend these timeframes 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 are decided by a 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. Providers and members may submit supporting evidence for the appeal at any time during the appeal timeframe. 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 timeframe. If an appeal is denied, there are additional levels of review available. CCA requires that Members and their Appeal Representative exhaust CCA's Internal Appeals process before filing a Level 2 (external) appeal.

Any denial for a Medicare covered Part B or C service is automatically sent to the Medicare 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 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 Table).

External Appeals

CCA ensures that members have access to all Medicaid (MassHealth) and 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 an expression of dissatisfaction with any aspect of the operations, activities or behavior of a plan or its delegated entity in the provision of health care items, services, or prescription drugs, regardless of whether remedial action is requested or can be taken.

If a member expresses a grievance to a Provider, the Provider should 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 AOR.

Grievances are accepted orally and in writing at any time. CCA sends written acknowledgement of the receipt of each grievance to the member or Representative within one business day of receipt. When a grievance is received, the issue is investigated internally or with our vendors or providers and tracked for quality and reporting. CCA ensures that the decision-makers on quality of care grievances have the appropriate clinical expertise.

A resolution of the grievance is relayed to the member or representative. Resolution can be oral for OneCare grievances received orally, all other cases are responded to in writing. Grievances about quality of care are always responded to in writing.

Grievance Resolution Timeframes

Standard	30 days, plus extension up to 14 days, when applicable
Expedited	24 hours

Grievances are handled according to the standard timeframe unless the dissatisfaction is about the refusal to expedite an initial or appeal review, or the request to take an extension on an appeal or grievance. In those instances, the case is reviewed and responded to within 24 hours and a new determination is made on the expedited review or extension.

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 five 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: COVERED SERVICES & PRIOR AUTHORIZATION REQUIREMENTS

In accordance with the member's evidence of coverage, certain services performed by contracted providers require a prior authorization before being rendered. Commonwealth Care Alliance's Authorization and Utilization Management Department is responsible for reviewing prior authorization service requests from providers. All requests (except Behavioral Health, Specialized Radiology Services & Inpatient/Observation Admissions – please see below for details) must be faxed to **855-341-0720** using the Standardized Prior Authorization Request Form along with the necessary clinical documentation to support the request. Download the form.

- Behavioral Health prior authorization service requests must be faxed to **855-341-0720** using the appropriate form for the service requested along with the necessary clinical documentation to support the request. Download the forms.
- Specialized Radiology prior authorization service requests must be faxed to **855-341-0720** using the appropriate form for the service requested along with the necessary clinical documentation to support the request. Download the forms.
- Inpatient/Observation Admissions prior authorization service requests must be faxed to **855-811-3467** using the appropriate form for the service requested along with the necessary clinical documentation to support the request. Download the forms.

Prior authorization decisions will be made no later than fourteen (14) calendar days after CCA receives the request (or within seventy-two [72] hours for expedited requests). Medicare Part B medication requests are made no later than seventy-two (72) hours for standard request and twenty-four (24) hours for expedited request Services requiring prior authorization by CCA are listed below. If a requested service or item is not listed below, please call Commonwealth Care Alliance at **866-610-2273** for clarification.

Covered Services & Prior Authorization Requirements (pdf)

When to request an authorization to be expedited:

A member or any physician may request that CCA expedite an organization determination (prior authorization request) when the member or his/her physician believes that waiting for a decision under the standard time frame could place the enrollee's life, health, or ability to regain maximum function in serious jeopardy.

Medical Necessity Guidelines

All Medical Necessity Guidelines can be located on the Commonwealth Care Alliance website, under the Medical Guidelines section of the Provider Page. Please click here for more information.

Durable Medical Equipment (DME)

Click here for a code specific list of Durable Medical Equipment (DME) and other services requiring Prior Authorization (PA) for Commonwealth Care Alliance's One Care and SCO programs.

Emergency Medical Treatment and Labor Act

As defined by the Emergency Medical Treatment and Labor Act (EMTALA 42 CFR 489), the Commonwealth Care Alliance provider network will provide proper medical screenings and examinations for all individuals who seek care in a provider's emergency department by qualified hospital personnel. 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.

SECTION 5: CENTRALIZED ENROLLEE RECORD

Commonwealth Care Alliance utilizes Altruista Health as its electronic member record (EMR) or centralized enrollee record (CER).

In order to ensure the highest quality, most effective health care to members, all providers are reminded to review their provider agreement with Commonwealth Care Alliance for provider obligations regarding their documentation in all Commonwealth Care Alliance member clinical records and the obligation to share clinical information with Commonwealth Care Alliance primary care teams and interdisciplinary care teams.

SECTION 6: CLAIMS AND BILLING PROCEDURES

This section is intended for Commonwealth Care Alliance providers. The information here enables providers to comply with the policies and procedures governing Commonwealth Care Alliance's managed care plans.

Updates or changes to this section are made in the form of provider bulletins that Commonwealth Care Alliance provides to you by mail, facsimile, or Commonwealth Care Alliance's website.

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

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

Commonwealth Care Alliance accepts both electronic and paper claims with industry-standard diagnosis and procedure codes that comply with the Health Information Portability and Accountability Act (HIPAA) Transaction Set Standards. Detailed instructions for completing both the CMS HCFA 1500 and UB04 claim forms are available. Download instructions

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 Commonwealth Care Alliance before providing services. Please consult your contract, the "Covered Services and Prior Authorization" section of this manual, or contact Commonwealth Care Alliance's Provider Services Department to determine if prior authorization is needed.

Contact Information for Provider Claims, Billing Support and EDI Support

Claims, Customer Service is available Monday – Friday 8:30 a.m.–5:00 p.m.

- Telephone number 800-306-0732

EDI Support - ccaedisupport@pcgus.com

Billing Members

Providers **shall not** seek or accept payment from a Commonwealth Care Alliance member for any covered service.

Providers must accept Commonwealth Care Alliance payment as **payment-in-full** as detailed in the Provider's contract with Commonwealth Care Alliance. CCA members are Medicare and/or MassHealth beneficiaries and providers are prohibited from billing members, regardless of claims payment or denial.

Providers are responsible for obtaining Prior Authorization from Commonwealth Care Alliance before providing services. Please consult your contract, the "Covered Services and Prior Authorization" section of this manual or contact Commonwealth Care Alliance's Provider Services Department to determine if prior authorization is needed.

Eligibility

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

Eligibility may be confirmed by:

- Logging into the EZ NET Online Claims Web Portal
- Using the MassHealth Provider Online Service Center
- Using the NEHEN Provider Portal
- CCA Provider Services Department at 866-420-9332

Claims Submission

Commonwealth Care Alliance accepts submissions of properly coded claims from providers by means of Electronic Data Interchange (EDI), EZ Net Online Claims Web Portal, 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. Providers shall hold all members harmless, regardless of payment or denial.

Providers are responsible for obtaining Prior Authorization from Commonwealth Care Alliance before providing services. Please consult your contract, the "Covered Services and Prior Authorization" section of this manual or contact Commonwealth Care Alliance's Member Services Department to determine if prior authorization is needed.

Electronic Data Interchange Claims

Commonwealth Care Alliance accepts electronic claims through Electronic Data Interchange (EDI) as its preferred method of claims submission. All files submitted to Commonwealth Care Alliance 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. Commonwealth Care

Alliance has a Companion Guide and Training manual that further explains the requirements and operations. Click here to access the Companion Guide and Training manual.

At a minimum, EDI claims must include:

• Member First/Last Name • Date of Birth • Member ID • Rendering Provider • Rendering Provider NPI • Pay to Name	• Pay to Tax ID • Place of Service • Diagnosis Code • Procedure Code • Modifiers • Billed Amount • Quantity

Please email the EDI Department directly at ccaedisupport@pcgus.com if you have additional questions regarding EDI transaction data sets or getting set up for EDI claims submission. Contact Claims Customer Service or the secure EZ NET Online Claims Web Portal for all other claim inquiries.

For more information on EDI implementation, refer to the Medicare Billing Fact Sheet.

Initial EDI Set Up

In order to submit claims electronically to Commonwealth Care Alliance, providers must submit a completed EDI Questionnaire.

- Questionnaire may be emailed to our EDI Department at ccaedisupport@pcgus.com

  If you require assistance with completing this form, you may contact our EDI Department at ccaedisupport@pcgus.com.
- Upon receipt and review of a completed EDI Questionnaire, Commonwealth Care Alliance can assist a provider with a recommendation of an appropriate EDI option.

Three EDI Options

Commonwealth Care Alliance offers three 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 Commonwealth Care Alliance's payer ID number, 14315. 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 Commonwealth Care Alliance portal. Commonwealth Care Alliance offers a secure web portal where providers can obtain access to claim status, member eligibility and multiple claim submission options.

The easy-to-navigate web portal requires authorized billers and providers to obtain a login to access information. If you wish to request online access, you can send a request via email with your Tax ID and group NPI to ccaedisupport@pcgus.com with notation regarding which options you would like to access. Once you are a registered user, please click here to access the EZ NET Online Claims Web Portal

- **Option Three**

Single Claims Submitters

Single claims submissions are for professional claims only. This option is for those vendors that do not have the technical capabilities of creating an 837 file for batch submissions but need to make single submissions. Providers are given the opportunity to enter single claims directly into Commonwealth Care Alliance's secure web portal and are provided a detailed training via WebEx with technical support provided to assist in the transmissions.

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

Providers using electronic submission must submit clean claims to Commonwealth Care Alliance or its designee, as applicable, using the HIPAA compliant 837 electronic format or a CMS-1500/UB-04, or their successors, as applicable.

Reprocessing EDI Claims

The only way to correct an EDI claim is to submit a corrected claim by mail. A provider must submit and mail 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. Please click here to obtain the Request for Claim Review Form

Mail all corrected paper claims to:

Commonwealth Care Alliance

P.O. Box 548
Greenland, NH 03840-0548

Electronic Fund Transfer (EFT)

Commonwealth Care Alliance (in partnership with Payspan) has implemented an enhanced online provider registration process for electronic funds transfer (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 will save yourself and your company valuable time
- EFT eliminates excess paper and helps you automate your office
- HIPAA Compliance (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 Department of Health and Human Services (HHS) to establish national standards for electronic health care 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 compliance for electronic data interchange in health care.

Explanation of Payment (EOP) Statements

Commonwealth Care Alliance, in partnership with Payspan, provides online access to EOPs. Payspan 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 work-flow 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 Commonwealth Care Alliance electronically whenever possible. Commonwealth Care Alliance does recognize, however, that some providers may choose to submit for reimbursement using industry-standard paper claim forms. If the provider does submit paper claim forms, the following forms are acceptable.

- CMS-1500
- CMS-1450 (UB-04)
- American Dental Association (ADA) Dental Claim Form

All information must be typed and aligned within the data fields. Please do not stamp, handwrite or use correction fluid. For complete instructions please refer to the detailed instructions for completing both the CMS HCFA 1500 and UB04 claims forms. Download Instructions

Click here for more information about Medicare Billing: 837P and Form CMS-1500.

Mail all paper claims to:

Commonwealth Care Alliance

P.O. Box 548
Greenland, NH 03840-0548

Please note: While Commonwealth Care Alliance accepts paper claim submissions; Electronic Billing and Electronic Funds Transfer (EFT) are preferred. Please email ccaedisupport@pcgus.com to request online access. If providers utilize billing agencies to manage their account receivables, please grant them access to Payspan and to the secure EZ NET Online Claims Web Portal.

Use of Invoices

All providers are encouraged to submit single claims submissions and not use invoices for billing. Single claims submissions will deliver claims to Commonwealth Care Alliance in real time. However, in the **limited** circumstances that certain, identified providers use invoices for billing and not standard billing forms, Commonwealth Care Alliance has created an invoice that will be accepted for billing purposes.

To receive a blank copy of the Commonwealth Care Alliance invoice, please call Claims Customer Service at 800-306-0732. Commonwealth Care Alliance will work with your practice to enable them to successfully submit claims on standard CMS-1500, CMS-1450, or ADA forms going forward.

Use of Modifiers

Commonwealth Care Alliance 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 the Agreement, Providers must submit clean claims, initial, and corrected, to Commonwealth Care Alliance. 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 federal law or CMS, Commonwealth Care Alliance may deny payment of any claim that fails to meet Commonwealth Care Alliance’s submission requirements for clean claims or failure to timely submit a clean claim to Commonwealth Care Alliance.

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 timely:

- A clearinghouse electronic acknowledgement indicating claim was electronically accepted by Commonwealth Care Alliance; and

- 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)/claim(s) in question;
    - prior submission bill dates; and
    - Commonwealth Care Alliance product name or line of business.

Checking Claim Status

Once you are a registered user, providers may check claims status, member eligibility, and provider status through the EZ NET Online Claims Web Portal. All other providers requesting information on the status of a claim, including clarification of any explanation of payment code, must call Claims Customer Service at 800-306-0732.

Web Portal

Commonwealth Care Alliance offers a secure web portal where providers can obtain access to claim status, member eligibility and multiple claim submission options: EZ NET Online Claims Web Portal

The easy-to-navigate web portal requires authorized billers and providers to obtain a login to access this information. If you wish to request online access, you can send a request via email to ccaedisupport@pcgus.com. If providers utilize billing agencies to manage their account receivables, please grant them access to Payspan and to the secure EZ NET Online Claims Web Portal.

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 paper claim. CCA does not accept corrected claims electronically.

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.).

A Request for Claim Review Form must accompany each corrected claim; click here for the Request for Claim Review Form. For detailed instructions for completing both the CMS HCFA 1500 and UB04 claims forms click here to download the instructions.

Corrected claim must include:

1. Completed Request for Claim Review Form
    - The original claim number
    - An indication of the item(s) needing correction
2. A CMS HCFA 1500 or UB04 paper claim form with the corrections
    - No handwritten changes
    - No correction fluid on form
3. Any required supporting documentation

Submission Requirements:

The provider must submit a corrected claim accompanied by required 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 from receipt date.

Provider must submit their request to the address below:

Commonwealth Care Alliance
P.O. Box 548
Greenland, NH 03840-0548

Rejected Claims

If Commonwealth Care Alliance returns/rejects a claim due to missing or incomplete information, it is the provider's responsibility to re-submit a clean claim within original filing limits.

Mail all paper claims to:

Commonwealth Care Alliance
P.O. Box 548
Greenland, NH 03840-0548

Provider Appeals

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

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

Provider appeals do not include:

- Seeking resolution of a contractual issue payment disputes wherein the provider believes CCA is paying an amount different than was contractually agreed should be directed to CCAContracting@commonwealthcare.org.
- An appeal made by a provider on behalf of a specific Member should be directed to CCA's Provider Services Department 866-420-9332.
- Incomplete or incorrect claims - If CCA returns a claim due to missing or incomplete information, the claim may be resubmitted using CCA's Request for Claim Review Form.

All Provider Appeals must include:

- Request for Claim Review Form
- Provider's tax identification number
- Provider's contact information
- A clear identification of the appeals 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 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 appeal a timely filing denial

If a provider appeal 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 appeal receipt, the appeal will be dismissed.

Submission Requirements for Contracted Providers

The provider claim appeal by a contracted provider must be made in writing accompanied by required documentation stated above.

Appeal requests will be considered when received within 90 days from the original payment or denial date as indicated on the EOP with supporting documentation.

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

Submission Requirements for Non-Contracted Providers

The provider claim appeal by a non-contracted provider must be made in writing accompanied by required documentation stated above.

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.

Waiver of Liability - Non-contracted providers **must** include a signed Waiver of Liability form holding the enrollee harmless regardless of the outcome of the appeal. This form must be accompanied with the claim appeal. If a signed Waiver of Liability (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.

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

Contracted and non-contracted provider must submit their request to the address below:

Commonwealth Care Alliance
P.O. Box 548
Greenland, NH 03840-0548

For additional questions on Provider Appeals, please contact the Claims Customer Service Department at 800-306-0732.

Hospice

Senior Care Options - Beginning January 1, 2021, hospice organizations that have rendered services to Commonwealth Care Alliance SCO members with hospice elections should submit claims directly to CCA using standard EDI, web, or paper formats, for dates of service on or after January 1, 2021, and in accordance with their Provider Services Agreement. Claims for services to CCA SCO members who have a hospice election are limited to standard Medicare hospice services and any applicable service Intensity add-ons, unless otherwise indicated by the Transitional Care Team.

One Care - Services rendered to CCA OneCare members electing hospice should be billed to Medicare.

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 following CMS Medicare/Medicaid and the Executive Office of Health and Human Services. *CCA will follow additional guidance as deemed necessary in the development of all payment policies. References to policy guidance are provided within all payment policies.* Payment policies are located on the provider website under Policies and Guidelines: Provider Payment Policies

National Drug Coverage

Effective for claims with a date of service on or after January 1, 2018, CCA will begin enforcing the Physician, Health Care Professional, Facility and Ancillary Provider Administrative Guide for Commercial and Medicare Advantage Products national drug code (NDC) requirement. CCA will be implementing a new NDC requirement payment policy, effective January 1, 2018. As a result, CCA SCO and One Care members' professional claims submitted for reimbursement for drug-related codes must include the NDC number, quantity and the unit of measure. This requirement applies to paper claim form CMS-1500 and Electronic Data Interface (EDI) transaction 837P when billed for drug-related healthcare common procedure coding system (HCPCS) codes and drug related current procedure terminology (CPT) codes. The NDC, quantity and the 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 and will allow us to identify billing errors and improve reimbursement processes.

Note: Hospital facility outpatient claims will not be 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 Commonwealth Care Alliance members. The use of the codes detailed below will ensure proper processing and accurate payment. Please refer to section 4 “Covered Services & Prior Authorization” for 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 whereas the member cannot be treated in a community-based setting; lower intensity than sub-acute
Rev Code 120	Custodial 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—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 Commonwealth Care Alliance, the corresponding modifiers, and Commonwealth Care Alliance's policy regarding reimbursement.

Degree	License	Modifier	Commonwealth Care Alliance Policy
Physician	MD, DO	U6	May provide/bill for direct service
Psychologist: PhD, PsyD, EdD	LP	AH	May provide/bill for direct service
Advanced Practice Nurse; Clinical Nurse Specialist	APRN, RNCS	SA	May provide/bill for direct service
Independent Clinical Social Worker	LICSW	AJ	May provide/bill for direct service
Master's in counseling or social work with or without license	LMHC, LMFT, MSW, LCSW	HO	May provide/bill for direct service
Master's with Drug/Alcohol Counseling Certification, with or without license	LCDP, LADC, CAC, CADAC	U7	May provide/bill for direct service
Nurse	RN	TD	May provide/bill for direct service medical service
Bachelor's	None	HN	May provide/bill for Community Support Program, Collateral Contact, and Opioid Counseling only.
Psychology Intern	None	U3	May not provide or bill for direct service

Significant Events with Reimbursement Impact

Serious Reportable Events

According to the National Quality Forum (NQF), serious reportable adverse events (SRE)—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 health care facility. Therefore, in an effort to reduce or eliminate the occurrence of SREs Commonwealth Care Alliance will not provide reimbursement or allow hospitals to retain reimbursement for any care directly related to the “never event.” Commonwealth Care Alliance has adopted the list of serious adverse events in accordance with the Centers for Medicare & Medicaid Services (CMS).

Commonwealth Care Alliance 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, Commonwealth Care Alliance will follow CMS guidelines for the billing of "never events.” In the instance that the "never event" has not been reported, Commonwealth Care Alliance will use any means available to determine if any charges filed with Commonwealth Care Alliance 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, Commonwealth Care Alliance reserves the right to re-coup the payment from the provider. Commonwealth Care Alliance 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, in an effort to reduce or eliminate the occurrence of HACs, Commonwealth Care Alliance will not provide reimbursement or allow hospitals to retain reimbursement for any care directly related to the condition. Commonwealth Care Alliance has adopted the list of HACs in accordance with the Centers for Medicare & Medicaid Services (CMS).

Commonwealth Care Alliance 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 would be paid as though the secondary diagnosis were not present. Commonwealth Care Alliance 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 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 Commonwealth Care Alliance in a format and frequency as specified by EOHHS.

No payment shall be made by Commonwealth Care Alliance to the provider for a PPC. As a condition of payment from Commonwealth Care Alliance, 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 Commonwealth Care Alliance and/or EOHHS.

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

Preadmission Screening and Resident Review (PASRR) for Nursing Facilities

The Preadmission Screening and Resident Review (PASRR) process requires that all Enrollees 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 Enrollees who test positive at Level I, they are then evaluated in depth, called "Level II" 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 Enrollee's plan of care. It is a requirement and the responsibility of the facility to ensure that every Commonwealth Care Alliance Enrollee admitted for nursing care has a PASRR performed and related documentation is on file.

Commonwealth Care Alliance reserves the right to audit the facility to insure 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 Commonwealth Care Alliance Enrollee, Commonwealth Care Alliance reserves the right to deny or retract payment to the facility for that admission. Furthermore, the facility acknowledges that Commonwealth Care Alliance Enrollees 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 Commonwealth Care Alliance.

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 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
    - Assessment of relevant symptoms and physical examination findings at time of visit
    - Only contain diagnoses that are active or chronic and must be identified as such
    - List and address 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)
    - Continuations or changes to any related medications.

Coding Compliance

Commonwealth Care Alliance encourages providers to code to the most appropriate level of specificity as a general standard of practice (CPT, ICD10). Commonwealth Care Alliance and/or CMS may audit the provider at any point for over-coding and/or similar billing practices related to Fraud, Waste, and Abuse.

Educational Resources

Providers are encouraged to contact Commonwealth Care Alliance Provider Relations at providerrelations@commonwealthcare.org to request education about coding and documentation compliance.

Behavioral Health Screening Compliance

In collaboration with EOHHS, Commonwealth Care Alliance requires all of it contracted primary care providers (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 in this Provider Manual; how to make a behavioral health specialty care referral can be found in Section14, Provider Credentialing, subsection Role of the Credentialed Primary Care Provider, in this Provider Manual;

CCA recommends the use of the PHQ-9 Depression Assessment Tool, to assess patients for depression. The tool is a diagnostic measure to assess for Major Depression as well as other depressive disorders. The PHQ-9 can be administered repeatedly to reflect improvement or worsening of symptoms.

CCA recommends the use of the CAGE-AID Screening Tool to assess the use of alcohol and other drug abuse and dependence. The tool is 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 for 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 an NP, PA, LICSW, OT, or PT). Moreover, all active diagnoses must be 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

Commonwealth Care Alliance 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

Commonwealth Care Alliance requires providers 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 to Commonwealth Care Alliance, if requested.

SECTION 8: COORDINATION OF BENEFITS AND THIRD-PARTY LIABILITY

Coordination of benefits (COB) applies to members who are covered by more than one medical coverage plan or program. Examples of COB include secondary insurance through an employer sponsored health insurance plan, motor vehicle accident insurance, or worker's compensation coverage.

Third-party liability (TPL) occurs when members are injured as a result of an accident when 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. Because CMS and Commonwealth Care Alliance are payers of last resort, the automobile accident insurance, workers' compensation insurance, and general liability insurance are primary payers for these members' claims related to the accident.

Under TPL, Commonwealth Care Alliance is the secondary payer of coverage. Commonwealth Care Alliance will not make payment on related claims until the TPL case has reached a conclusion or settlement. For all claims relating to a TPL case, providers should submit to Commonwealth Care Alliance, the claim with the notice of settlement from the attorney representing the member within 60 days from the settlement date of the case. Claims submitted without a notice of settlement will be denied.

Member Covered by Employer Sponsored Health Insurance Plan

Commonwealth Care Alliance is the secondary payer of coverage. Commonwealth Care Alliance payment would include any remaining balance of medical claims such as deductibles and co-insurance amounts (up to the Commonwealth Care Alliance 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 Commonwealth Care Alliance 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 Commonwealth Care Alliance 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, workers' compensation insurer is primary, and Commonwealth Care Alliance is the secondary payer of coverage. Commonwealth Care Alliance will not make payment on claims until the TPL case has reached settlement. For all claims relating to a worker's 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.

In instances of a COB or TPL claim, a secondary claim form should be submitted along with other related documentation to the following address below:

Commonwealth Care Alliance

Attn: TPL/Subrogation Department
30 Winter Street, 11th Floor
Boston, MA 02108

For questions regarding medical liens, payments, third party liability, or coordination of benefits, please contact Commonwealth Care Alliance Third-Party Liability Coordinator at tplcoordinator@commonwealthcare.org or call 617-426-0600 extension 1221.

Note: Commonwealth Care Alliance 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 Commonwealth Care Alliance's pharmacy program, including details on our formulary and utilization management programs. Also included is a description of Commonwealth Care Alliance's Step Therapy, Medication Therapy Management (MTM), and Mail Order Programs.

Commonwealth Care Alliance has contracted with Navitus Health Solutions, a national pharmacy benefits management (PBM) company, to administer the pharmacy benefit on Commonwealth Care Alliance's behalf. Commonwealth Care Alliance has worked with its primary care partners to identify those community pharmacies in the neighborhoods of the primary care sites with whom Commonwealth Care Alliance's primary care providers have established relationships and members can access easily. In addition to many smaller independent pharmacies, Commonwealth Care Alliance's pharmacy network includes CVS, Rite Aid, Walgreen's, and many others. For a complete and up-to-date listing of contracted pharmacies, use the link below to access the online directory:

SCO online provider and pharmacy directory
One Care online provider and pharmacy directory

Formulary

Commonwealth Care Alliance has established a formulary that aims to provide prescribing clinicians with both a broad range of options for treatment while promoting the most cost-effective drug choices. Commonwealth Care Alliance will cover the drugs listed in the formulary as long as they are medically necessary. Use the links below to access the formulary list on our website:

SCO Formulary
One Care Formulary

Please be advised of formulary changes as well as our preferred arrangement with Abbott Diabetes Supplies for glucometer and test strips, which must be obtained through Commonwealth Care Alliance's pharmacy network.

Prior Authorization

Certain medications require prior authorization (prior approval) before a pharmacy can fill the prescription. Clinicians may request prior authorization by calling 866-270-3877. Clinicians may also complete and mail or fax the Coverage Determination Request Form and a doctor's supporting statement to: 855-668-8552. Click here to access the Coverage Determination Request Form. If prior authorization is not granted, the drug may not be covered.

Click here to access the list of medications that require prior authorization. Information regarding pharmacy related grievances, appeals and exceptions may be found here as well.

Part B vs. D Coverage Determination

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

Step Therapy Program

In support of efforts to provide members with the best medical care at a reasonable cost, Commonwealth Care Alliance has worked closely with health care 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 prior to enrolling with Commonwealth Care Alliance, the new member is allowed to remain on the second-line drug, per Commonwealth Care Alliance's transition policy.

Click here to review the Commonwealth Care Alliance transition policy. Click here to access step therapy program information for One Care, and click here to access step therapy program information for Senior Care Options.

Extended Day Supply

Commonwealth Care Alliance members can get an extended day supply (up to 90 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 will still be able to fill their medications at $0 copay. For more, information please click here.

Medication Therapy Management Program

Commonwealth Care Alliance offers medication therapy management (MTM) programs to members who take a number of different drugs, have chronic diseases (such as asthma, diabetes, or COPD), and have high annual drug costs. If members meet these three qualifications, they may be eligible for extra help in taking their medications. This program improves patients' knowledge of their medications. This includes: prescription, non-prescription, over the counter, herbals or other supplements. Moreover, MTM helps to identify and to address problems or concerns that the patient may have and 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 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 Commonwealth Care Alliance's designated care team authorizing the Extended Care Facility to render specified covered services to a Commonwealth Care Alliance member. Payment to a facility for covered services requires prior authorization. For more information, please see Section 8 of this manual.

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.
- Skilled nursing level of care—short term, goal-oriented treatment plan whereas the member cannot be treated in a community-based setting; lower intensity than sub-acute.
- Custodial level of care—absent of a defined treatment goal, yet the member's functional 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/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 return 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/her admission shall be accommodated upon the availability of a bed, unless otherwise arranged.

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 Commonwealth Care Alliance clinical staff and/or those designated and authorized by Commonwealth Care Alliance to direct member care. The following Conditions and Criteria for Levels of Care Determination are as follows:

SUB ACUTE CARE

Conditions & Criteria for the Assignment of Sub Acute Level of Care

Conditions:

There has been a determination by the CCA care team that a short term, goal oriented treatment plan is necessary; patient care needs requiring sub-acute nursing care and/or skilled rehabilitation; the patient requires a greater

number of MD/NP visits, skilled nursing care hours, or rehabilitation services than are normally provided at a basic skilled level of care; there is active management of the treatment plan by the care team to stabilize the patient

Criteria:

Care is at a Sub-Acute reimbursement level when the following criteria are met:

1. Presence of serious injury or illness that requires inpatient treatment but not acute

   hospital care

2. Active management of the treatment plan by the care team to stabilize the patient

3. Sub-Acute nursing care to manage complex medical issues:

   *Frequent assessment

   *Complex IV regimens

   *Respiratory Care

   *Complex pain management

4. Rehabilitation Therapy services (PT, OT, Speech Therapy) 2 or more hours of direct care daily 6 or 7 times per week, as part of a treatment plan that is goal oriented, measurable, and designed to promote recovery (dependent upon Patient's individual condition, Rehabilitation Therapy services may or may not be present as part of the Sub Acute level plan of care, but if present, the patient must have the ability to participate in this level of therapy intensity, or level of care will be subject to change).

5. Sub-Acute / Skilled days shall be limited to 100 days per benefit period.

SKILLED CARE

Conditions & Criteria for the Assignment of Skilled Nursing Level of Care

Conditions:

There has been a determination by the CCA care team that a goal-oriented treatment plan is necessary, and that the patient cannot, as a practical matter, be treated in a community-based setting; patient care needs requiring skilled nursing care and/or skilled rehabilitation; such care is needed on a daily basis, at least 5 days per week;

Criteria:

Care is at a Skilled Nursing reimbursement level when the following criteria are met:

1. Less medically complex illnesses or injuries

2. Availability of skilled nursing care 24 hours a day

3. Daily skilled nursing care:

   *Assessment

   *Skilled observation

   *Simple IV therapies, or injection needs

*Dressing changes

4. Rehabilitation Therapy services (PT, OT, Speech Therapy) up to 2 hours a day, 5 times a week, as part of a treatment plan that is goal oriented, measurable, and designed to promote recovery (dependent upon Patient's individual condition, Rehabilitation Therapy services may or may not be present as part of the Skilled Nursing level plan of care, but if present, the patient must have the ability to participate in this level of therapy intensity, or level of care will be subject to change).

5. Sub Acute/Skilled days shall be limited to 100 days per benefit period.

CUSTODIAL CARE

Conditions & Criteria for the Assignment of Custodial Care Level of Care

Conditions:

There has been a determination by the CCA care team that there is an absence of a defined skilled need or treatment goal that the patient is expected to achieve; the patient's functional or cognitive status is such that the support of a facility setting is necessary, as patient cannot be safely managed in the community with long term care supports

Criteria:

Care is at a Custodial Care reimbursement level when the following criteria are met:

1. Less than daily skilled needs
2. Stable medical status
3. Care is not goal directed, focus is to maintain status

*Assist with ADLs

*Administration of routine medications

Rehabilitative Services in a Skilled Nursing Facility

Rehabilitation services provided intermittently while at the custodial level of care. Intermittent therapy cannot exceed four calendar days per week as approved by CCA staff. Prior authorizations are required for all evaluations and treatment.

Notice of Medicare Non-Coverage (NOMNC)

The Extended Care Facility shall deliver the Notice of Medicare Non-Coverage (NOMNC) on behalf of CCA no later than 2 days before an Enrollee'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 timeframe as the Member for monitoring and documentation purposes.

Status Change Form (SC-1) For SCO Members

In the instance when a SCO member is admitted to an extended care facility, the facility must submit a Status Change Form (SC-1) to Commonwealth Care Alliance and the appropriate member enrollment center with "Commonwealth Care Alliance SCO Member" clearly indicated on the form. Please see the chart below for additional requirements:

Event Triggers	Approvals and/or Forms	Where to Send Information
Short Term Stays		
Less than 2 months	Nursing facility calls Commonwealth Care Alliance's Provider Services to request authorization for SNF stay; Provider Services forwards call to appropriate Clinical Coordinator	866-420-9332
Greater than 2 full months but less than 6 months	a) Status Change Form (SC-1) indicating member is short term with "SCO Member" clearly written on form. Appropriate boxes on form should be checked and physician's signature is required.	a) MassHealth Enrollment Center, 45–47 Spruce Street Chelsea, MA 02150, fax 617-889-3285 and fax a copy to Commonwealth Care Alliance -617-830-0534
	b) *MMQ	b) Electronic submission of MMQ through MassHealth system and fax a copy to Commonwealth Care Alliance 617-830-0534
	c) MDS 3.0	c) Submit MDS 3.0 to SCO Clinical Coordinator via fax to Commonwealth Care Alliance 617- 507-0416
Short Term Discharges		
Upon discharge of short term Stay greater than 2 months but less than 6 months	Status Change Form (SC-1) indicating member is short term with "SCO Member" clearly written on form. Appropriate boxes on form should be checked and physician's signature is required.	MassHealth Enrollment Center, 45–47 Spruce Street Chelsea, MA 02150, fax 617-889-3285 and fax a copy to Commonwealth Care Alliance 617-830-0534
Long Term Stays		
If the admission is long term (more than 6 months)	a) Status Change Form (SC-1) indicating long term status with "SCO Member" clearly written on form. Appropriate boxes on form should be checked. **Note:** When the SCO member is admitted for a long term stay in a nursing facility, eligibility for MassHealth is redetermined and	a) Submit to MassHealth Enrollment Center where the nursing facility is located and fax a copy to Commonwealth Care Alliance 617-830-0534

	Patient Paid Amount is calculated upon completion of additional MassHealth forms as LTC Supplement.	
	b) MDS 3.0 In compliance with State and Federal Regulations	b) Submit MDS 3.0 to SCO Clinical Coordinator via fax to Commonwealth Care Alliance 617-507-0416
If a short-term stay becomes a long term stay after 3 months	Status Change Form (SC-1) indicating the member will be long term, with "SCO Member" clearly written on form. Appropriate boxes on form should be checked. Note, when the SCO member is admitted for a long term stay in a nursing facility, eligibility for MassHealth is redetermined and Patient Paid Amount is calculated upon completion of additional MH forms as LTC Supplement	Submit to MassHealth Enrollment Center where the nursing facility is located and fax a copy to Commonwealth Care Alliance 617-830-0534
At the end of the 3rd month	*MMQ—needs to be posted at the end of the 3rd calendar month.	Electronic submission of MMQ through MassHealth system and fax a copy to Commonwealth Care Alliance 617-830-0534
Status Changes		
(e.g. when a member meets the MMQ significant change criteria or member is changing from short term to long term status)	a) *MMQ	a) Electronic submission of MMQ through MassHealth system and fax a copy to: Commonwealth Care Alliance 617-830-0534
	b) MDS 3.0	b) Submit MDS 3.0 to SCO Clinical Coordinator via fax to Commonwealth Care Alliance 617-830-0534

*MMQs are also required on scheduled assigned by MassHealth

**Long Term Care Screening form is not required to be completed for SCO Members

Member Enrollment Centers (MEC)

1. 45-47 Spruce Street

   Chelsea, MA 02150

   Toll free 800-841-2900

   Fax 617-887-8777

   Please note: When submitting or inquiring about a long-term care applicant residing in a nursing facility serviced by the Chelsea MEC, use this new fax number 617-889-3285.

2. 88 Industry Avenue, Suite D
   Springfield, MA 01104-3259
   Toll free 800-841-2900

3. 21 Spring Street, Suite 4

   Taunton, MA 02780

   Toll free 800-841-2900

4. 367 East Street

   Tewksbury, MA 01876

   Toll free 888-665-9993 or 800-841-2900

Durable Medical Equipment

Commonwealth Care Alliance contracts with local, statewide and national vendors to provide durable medical equipment (DME) and medical/surgical supplies for its members.

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 time; and (d) appropriate for home use. Includes, but is 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, special beds, monitoring equipment, orthotic and prosthetic devices, and the rental of personal emergency response systems (PERS). Coverage includes related supplies, repair, and replacement of the equipment.

Medical/Surgical Supplies

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

Prior Authorization

All services provided must be approved by the member's PCP 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.

Eligibility

All providers are required to confirm eligibility on a regular basis, even if the prior authorization covers a long period. Eligibility may be confirmed by contacting Commonwealth Care Alliance's Provider Services or by utilizing the current MassHealth Provider Online Service Center.

Service Specifications for Durable Medical Equipment

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

Accessibility

- Maintain 24 hours a day, 7 days a week availability to provide services, and be accessible by telephone directly by on call coverage at all times
- Provide all emergently needed supplies, services, or equipment within 2 hours of receiving the request. Emergently needed services or equipment shall include that which malfunctions or absence presents an immediate life-threatening situation to the member, including, but are 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 PCP 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
- Make every effort to fill a same day order if requested

- 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 Commonwealth Care Alliance members

Capped Rentals

- Payments for this category are made on a monthly rental basis not to exceed a continuous 13-month period. For the first three rental months, the monthly rental fee schedule is limited to 10% of the average allowed purchase price. For each of the remaining months, the monthly rental is limited to 7.5% of the average allowed purchase price. This means that months 1–3 are paid at the fee schedule allowed rental rate, and months 4–13 are paid at 75% of fee schedule allowed rate. At the end of the capped rental period (after 13 paid rental months), the title of ownership for capped rental devices transfers from the provider to the patient.

- Reimbursement claims for capped rental items must be submitted with the appropriate modifier. Claims submitted without the appropriate modifier will be denied. When billing a capped rental item, please include the modifier “RR” as primary modifier. The “KH” modifier shall only be used for the first month of billing, the “KI” modifier shall only be used for the second and third months of billing, and the “KJ” modifier shall then be used for the remainder of the capped rental period (months 4–13).

- Payment for routinely purchased equipment category is made in a lump sum and the total payment may not exceed the actual charge or the fee for a purchase. New equipment should be billed with modifier “NU” and used equipment with modifier “UE.”

Repairs

- Make every effort to complete repair with one service call. Provider shall contact the PCP and/or care team prior to subsequent visits if a repair requires more than one service call
- Notify PCP and/or care team in writing, if rebuilt parts are used in a repair
- As requested, make available to PCP and/or care team the expected life of consumables such as batteries and provide warranties, serial or model numbers for equipment such as wheelchairs, batteries, beds, lifts, etc.

Equipment Delivery and Removal

- Contact Commonwealth Care Alliance member to make arrangements for delivery of equipment
- Fit all equipment properly to the member’s specifications at the time of delivery
- Instruct member or caretaker in the safe and proper use of equipment (i.e. lifts, walkers, oxygen concentrators, etc.)
- Remove any rental items within 48 hours of notification

Note: Emergently needed supplies are defined as services or equipment including that which malfunctions or absence presents an immediate life-threatening situation.

Prescriptions

In accordance with CMS requirements, Commonwealth Care Alliance 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 includes, but not limited to, disposable items, purchases, rentals, order changes, replacement items or the supplying Provider changes.

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 Commonwealth Care Alliance. The proof of delivery documentation verifies that the Member received the item(s) including but not limited to, the Member's name, description of item(s), quantity and date delivered.

Dental

Commonwealth Care Alliance (CCA) has contracted with SKYGEN Dental, a dental benefits administrator specializing in customized Medicaid dental program management, to administer all Commonwealth Care Alliance member dental benefits. On Commonwealth Care Alliance's behalf, SKYGEN manages all related dental provider operations including utilization review (prior authorization), claims processing; and provider relations, contracting, and credentialing. All member related operations are handled by CCA. Should your patient have questions regarding their dental benefits, please instruct them to contact CCA Member Services 866-610-2273 (TTY 711). Member Services is available 8 a.m. to 8 p.m., 7 days a week.

All dental providers are required to be a contracted Commonwealth Care Alliance provider, in order to render services to Commonwealth Care Alliance members. SKYGEN Dental administers Commonwealth Care Alliance's relationship with its contracted dental providers.

SKYGEN Contact Information

Provider Services:

855-434-9243 (general line)

NetworkDevelopment@skygenusa.com

SKYGEN Provider Portal

www.ScionDental.com, Click on "Dentist" to log in with unique ID and password

Covered Services

Covered Services are dental services to which a member is entitled in accordance with Commonwealth Care Alliance's benefit plan which are consistent with provider training, licensure and the specific scope and conditions. Commonwealth Care Alliance offers a robust dental plan which includes, but is not limited to, diagnostic and routine preventative care, emergency care visits; extractions; restorative services including root canals, crowns and bridges, prosthetics such as partials and dentures; and oral surgery.

Prior Authorization

Certain services may require prior authorization before performing the service. Payment to providers for those covered services requiring prior authorization is contingent upon the provider receiving Prior Authorization from SKYGEN before services are rendered.

All Commonwealth Care Alliance contracted providers should refer to the Commonwealth Care Alliance Office Dental Provider Manual, available on the provider page at https://www.commonwealthcarealliance.org/providers/provider-manual/ or the SKYGEN Provider Portal for service specifications and covered services.

Vision

The plan covers professional care of the eyes for the purpose of preventing, diagnosing, and treating all pathological conditions. Additional services include, but are not limited to, services related to the care and maintenance of glasses and contact lenses.

SCO

The plan pays for eyewear less than or equal to a combined total of $200, no authorization required. The plan covers up to $200 of routine vision hardware including upgrades. When the $200 Medicare Mandatory Supplemental benefit is exhausted, the Medicaid benefit can be used by the SCO member with prior authorization.

One Care

Frames: Limited to one set up to $125 per calendar year without prior authorization. Authorization is required for any amount over $125.

Please see below chart for delineation between SCO and OneCare routine vision services, and coverage by Medicare or Medicaid. Routine Vision Benefit

Routine Vision Benefit	**SCO**	**OneCare**
Medicare Mandatory Supplemental Benefit	Yes	None
Eye Exam	No	Does not apply. No Medicare benefits.
Frames and lenses	The plan pays up to $200 per calendar year for prescription eyewear purchased separately or together without prior authorization, including: • Contact lenses • Eyeglasses, including frames and lenses purchased separately or together For one or more frames that exceed the combined total of $200, authorization is required.	Does not apply. No Medicare benefits.

Member reimbursements	Yes, up to the $200 per calendar year limit	Does not apply. No Medicare benefits.
Medicaid Benefit	Yes	Yes
Eye Exam	Yes	Comprehensive eye exam covered. No PA required.
Frames	For one or more frames that exceed the $200 Medicare Mandatory Supplemental benefit above, a prior authorization is required.	Limited to one set up to $125 per calendar year.
Single Vision Lenses (Plastic or Glass)	Covered only with a written and dated prescription based on an eye exam by the prescriber.	Covered only with a written and dated prescription based on an eye exam by the prescriber.
Bifocal Lenses (Plastic or Glass)	Covered with a written and dated prescription based on an eye exam by the prescriber.	Covered with a written and dated prescription based on an eye exam by the prescriber.
Lenses (high-index and polycarbonate) Low-vison aids (i.e. hand-held magnifying glasses) Unlisted services	Prior Authorization required	Prior Authorization required
Not Covered	1. Contact lenses used for cosmetic purposes (colored lenses) 2. Designer frames 3. Prescription sunglasses (only in a rare circumstance would these be covered)	1. Contact lenses used for cosmetic purposes (colored lenses) 2. Designer frames 3. Prescription sunglasses (only in a rare circumstance would these be covered) 4. Progressive Lenses

Vision Care Services

After the SCO ($200) and One Care ($125.00) benefit is met, CCA vision plans follow the Medicaid Benefit 130 CMR 402.

Service Specifications for Vision

Commonwealth Care Alliance vision providers are responsible for meeting specified standards for accessibility, repairs, and eyewear care. The standards are listed below:

Accessibility

- Provide all needed vision supplies, services, and lenses/frames within one week of receiving request and notify the care team at the time of request of any anticipated delay or back order in the provision of supplies, services, and/or lenses/frames
- Make every effort to fill a same day order if requested
- Designate a liaison to accept requests and coordinate supplies, services and lenses/frames for Commonwealth Care Alliance members

Repairs

- Make every effort to complete repair with one service call. Provider shall contact the primary care provider and/or care team if a repair requires more than one service call
- Notify care team in writing if rebuilt parts are used in a repair
- As requested, make available to primary care provider and/or care team with expected life of consumables, and provide warranties, serial or model numbers for materials, etc.

Eyewear Care

- Contact Commonwealth Care Alliance member to make arrangements for delivery of lenses/frames
- Fit all glasses properly to the member's specifications at the time of delivery
- Instruct member or caretaker in the safe and proper use of glasses/lenses and related vision supplies

SECTION 11: BEHAVIORAL HEALTH SERVICES PROVIDERS

Philosophy and Components of Service:

CCA's person centered approach is an integral part of who we are as a leading health care organization. Senior Care Options (SCO) and One Care (OC) enrollees are the principal voices in the planning and management of their care. Interprofessional Care Teams (ICTs) compose our Members preferred professional support system, including CCA care partners, primary care providers, specialty providers, behavioral health providers, home- and community-based services providers, and Long-Term Services and Support (LTSS) coordinators. CCA identifies and engages enrollees in care management programs to enable them to overcome barriers that limit their ability to manage their own health and well-being. This is conducted in a manner consistent with each enrollee's personal and cultural values, predicated on Recovery and Wellness principals and with the goal of helping Members reach their self-defined level of optimal functioning.

Commonwealth Care Alliance is committed to full integration of Behavioral Health Services that includes our members self-directed components of a care team members as noted above. We hold our providers to the highest standard of care and expect that contracted Behavioral Health (BH) providers will work closely with our ICTs including CCA teams, PCPs and LTSS support coordinators as well as any specialty BH or other provider. Our network of outpatient and diversionary services providers is built to ensure that each member has access to a provider within a fifteen (15) mile, thirty (30) minute radius of their zip code.

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 Commonwealth Care Alliance Members. Behavioral Health services fall into the categories described below, all of which are covered by Commonwealth Care Alliance and some of which are subject to prior authorization requirements.

Process Specifications:

The provider complies with all provisions of the corresponding section in the service specific performance specifications for each level of care for which they are contracted.

Access, Care Planning and Documentation

- The Provider ensures that services are managed in a way that minimizes or eliminates waiting lists for services
- Providers must ensure access to twenty-four (24) hour Emergency Service Programs for all Members.
- Providers should contact CCA' s Provider Services at 866-420-9332 for assistance with claims, payment, appeals, member eligibility/member ID, inpatient admission notification, substance use service notification, BH prior authorization requests or clinical concerns regarding Members care.
- With consent, the Member and their guardian/caregiver, family members or other natural supports are active and integral participants throughout the service delivery process, including assessment, treatment planning, treatment services, discharge planning, and related meetings.
- Office visits must be available within the following timeframes to CCA Members for Behavioral Health Services other than emergency services, Emergency Service Programs or Urgent Care:
    - Services described in the Inpatient or 24-Hour Diversionary Services Discharge Plan:

  - 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
  - In addition to our contracted Network, CCA's Behavioral Health Licensed Clinicians are available 24/7 on call. BH Clinicians are also available for in person home, office, or telehealth appointments within 48 hours of discharge and 48 hours for medication assessment and management.

- The provider makes best efforts to offer meetings, such as treatment planning meetings, and services and family therapy sessions, at times and locations convenient to the Member and the family's schedule, including evening and weekend meeting times and the use of telemedicine.
- With consent, the Member's CCA Individual Care Team (ICT), other behavioral health providers, state agency staff, and other supports are engaged in treatment and discharge planning meetings.
- The provider completes an initial written, comprehensive assessment for all Members entering any level of care, which is documented in the Member's health record.
- The assessment includes, but is not limited to: history of presenting problem; chief complaints and symptoms; strengths; behavioral health, substance use, medical, developmental, family, and social history; linguistic and cultural background; mental status examination including assessment of suicide and violence risk; previous and current medications, and any allergies to medications; DSM-5 diagnosis and clinical formulation that are supported by the clinical data gathered, rationale for treatment, and treatment recommendations; name of the CCA Care Partner and other key providers.

- For Members, the initial outcome measurement is administered prior to or on the date of the comprehensive assessment completion to document that the clinical data was integrated into the initial assessment process. Information in the assessment may be gathered from the Member, family/guardian/caregiver, the referral source, past and current treaters, and/or other collateral contacts, with appropriate consent.
- When requested and/or as indicated by the members clinical presentation, the provider conducts and documents in the Member's health record a substance use disorder assessment either directly or by linkage with a provider trained in substance use disorders.
- The provider completes a comprehensive and individualized initial treatment plan based on the assessment and developed with the Member and/or guardian/caregiver, and, with consent, family members, the CCA ICT, PCP, state agencies, recovery and peer support specialist or other involved providers and supports identified by the Member.
  - The treatment plan is signed, dated, and documented in the Member's health record and includes but is not limited to: objective and measurable goals, time frames, expected outcomes, the Member's strengths, links to primary care especially for Members with active co-occurring medical conditions, a plan to involve a state agency case manager, when appropriate, and treatment recommendations consistent with the service plan of the relevant state agency, if involved.
  - The time frames for the completion of the initial treatment plan are delineated in each of the service-specific performance specifications.

- The provider assigns a multi-disciplinary treatment team to each Member within the time frames delineated in each of the service- specific performance specifications. A multi-disciplinary treatment team meets to review the assessment and initial treatment plan and discharge plan within time frames delineated in each of the service- specific performance specifications.
- The treatment plan is implemented, reviewed, and revised throughout the course of treatment, based on the provider's continual reassessment of the Member and with the Member's participation.

- The Member's progress in achieving the treatment goals is documented in progress notes and treatment plan updates in the Member's health record.
- If the Member terminates treatment without notice, every effort is made to contact the Member to re-engage in treatment or to provide assistance to transfer the Member to another appropriate source of care prior to discharging the Member. Such activity is documented in the Member's health record.

Care Coordination:

- The provider seeks informed consent from the Member in order to coordinate admissions, assessment, treatment/care planning, and discharge planning with the following collaterals, as appropriate to the level of care. The type and amount of information shared is appropriate to the purpose and the role of those to/from whom the information is being communicated/requested, including the following:
    - Caregivers/family/significant others/natural supports;
    - CCA's ICT;
    - PCP;
    - Emergency Services and Community Crisis Stabilization (CCS);
    - 24-hour levels of care, including psychiatric hospitals;
    - State agency involved teams, including DMH, DPH, DDS, MCB, MCDHH, EOEA and/or DTA;
    - Police departments and local court systems;
    - Outpatient therapists, medications prescribers and all other community supports including Community Support Programs (CSPs), and substance use programs.

Discharge Planning and Documentation: The provider complies with all provisions of the corresponding section in the service-specific performance specifications for each level of care for which they are contracted.

- The provider ensures that staff who are responsible for discharge planning are knowledgeable about the continuum of behavioral health and medical services as well as other services and supports in the community, and discharge planning skills and strategies.
- Staff involved in discharge planning are expected to locate appropriate step-down and other aftercare services for CCA Members.
- Providers are expected **to contact the CCA Care Team by calling CCA' s Provider Services at 866-420-9332 (option #4) for all discharge and aftercare planning, transportation support and other service needs.**

- The provider identifies barriers to discharge planning and aftercare and develops strategies to assist the Member with arranging and utilizing aftercare services, making best efforts to ensure that the discharge plan (or other such document(s) that contain the required elements) is consistent with their benefit coverage.
- As appropriate, the provider assists the Member in scheduling a follow-up appointment for the Member with their PCP and the CCA ICT.
- With the Member's consent, the provider, in collaboration with the Member, their family, and/or their supports, develops a written, individualized, person-centered, strengths-based discharge plan, prior to the Member's discharge from any inpatient service or, if appropriate, any other behavioral health service, that is documented in the Member's health record. Prior to the Member's discharge, the provider provides the Member with a copy of the discharge plan (or other such document(s) that contain the required elements). The plan includes but is not limited to Identification of the Member's Social Determinants of Health needs.

- The Provider is expected to reach out to the CCA Care Partner to notify CCA's ICT of Members discharge plan and collaborate with coordinating aftercare.
- For Members discharged from inpatient mental health services and for other Members as clinically indicated, an updated crisis and/or safety prevention plan that follows the principles of recovery and resilience, a list of the services and supports that are recommended post-discharge, including identified providers, and other community resources available to deliver each recommended service;
- A list of prescribed medication, dosages, and potential side effects; and
- Treatment recommendations consistent with the service plan of the relevant state agency for Members who are state-agency involved.

Quality Management

Clinical Provider Engagement Department: is responsible for building collaborative relationships with providers and driving provider performance through use of data and education. The team utilizes data to help support community relations with providers as well as support clinical improvement in the care delivered to CCA members. Provider Engagement works to educate providers about CCA's mission, vision and the value that each provider is delivering to CCA's 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 transition of care. Provider Engagement 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, Provider Engagement will support provider activities consistent with provider and CCA priorities, including but not limited to HEDIS® metrics, discharge planning, readmissions and community tenure.

Quality Measurement and Improvement Initiatives

Providers are expected to participate in and implement results from the quality measurements and improvement initiatives conducted by CCA. Providers integrate these quality improvement opportunities into their Quality Improvement Plans as referenced below. CCA quality measurement and improvement initiatives include but are not limited to:

- On-site program reviews;
- HEDIS Follow-up after hospitalization for Mental Illness (FUH);
- HEDIS Initiation and Engagement of Alcohol and other Substances (IET);
- Health record reviews;
- Outcomes measurement initiatives;
- Utilization management initiatives;
- Member Experience Surveys (MES)

The provider maintains utilization management policies and procedures to ensure that medical necessity and level of care criteria are met and documented in the assessment, treatment plan, and progress notes in each Member's health record, and that appropriate lengths of stay are managed across the program.

Measurement of Treatment Outcomes

Providers are expected to select and utilize a standardized outcomes measurement tool and implement all requirements relative to this initiative as outlined in CCA's Provider Manual in the Quality Management section.

Provider Quality Improvement Programs and Plans

- Network providers are required to have internal processes, policies, procedures, programs and/or activities aimed at monitoring and improving quality of care.
- Network Providers are required to provide health records as requested for quality initiatives, member grievances, HEDIS etc.
- Network Providers are to submit quality data as requested for quality initiatives member grievances, HEDIS

etc.

- The provider identifies a manager responsible for the provider's quality improvement process.
- Providers work collaboratively with CCA's Provider Engagement staff in developing, implementing and monitoring quality improvement plans in response to quality of care concerns and grievances, or such quality initiatives, health record reviews, etc.
- Providers engage Members, families, and other relevant stakeholders in their quality management activities.

Incident Reports

Network providers will comply with all applicable laws and regulations including but not limited to any and all applicable Medicare and/or Medicaid laws, regulations and instructions of CMS and/or EOHHS relating to addressing and reporting Serious Reportable Events (SREs). Network providers will comply with all requirements contained in their contract with CCA including any corrective actions required by CCA or applicable regulatory agencies.

Serious Adverse Events (SREs) related to Behavioral Health include but are not limited to:

- Any death (include cause of death if known)
- Any absence without authorization (AWA)
- Any serious injury resulting in hospitalization
- Any sexual assault or alleged sexual assault
- Any sexual activity in a 24-hour level of care facility
- Any violation or alleged violation of the Department of Mental Health physical restraint and/or seclusion regulations
- Any physical assault or alleged physical assault on or by a covered individual, or by staff
- Any contraband found prohibited by provider policy
- Any injury or illness requiring transportation to an acute care hospital for treatment while in a 24-hour program
- Any unscheduled event that results in the evacuation of a program or facility

Network providers are required to report all SREs that occur in a hospital or SNF within 24 hours of their occurrence to DPH with notification to CCA as soon as possible.

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's Provider Services Line 866-420-9332.

Health Record Maintenance

Providers are required to meet all requirements related to maintenance of health records, including documentation of the following in the Member's health record: acknowledgement of member rights, consent to treatment, releases of information, demographic information; clinical history; behavioral health clinical assessments; treatment plans; safety plans, discharge plans including transition of care plans for all services provided; contacts with the Member, their family,

guardians, or significant others; and treatment outcomes. Health records are made available to CCA when requested. Requests to review health records on-site or remotely can occur within 24 hours of notice.

Levels of Care:

Behavioral Health Services that require Authorization or Notification of Admission

Type of Service	Level of Care	Forms/ Resources	PA or Notification for admission	Notification Process	PA and/or Medical Necessity Review Process	Continued Authorization Process	Determination Turnaround Time
Inpatient Services:	Level 4 Medical Detox		PA not required for admission. Admitting facility required to notify CCA BH UM within 48 hours of admission @ 866-610-2273	Admitting facility required to notify CCA BH UM within 48 hours of admission @ 866-610-2273	No authorization required. Medical necessity determination is made by the provider.	No continued authorization required. Medical necessity determination is made by the provider	Not applicable
Inpatient Services:	Psychiatric Inpatient Level of care		Emergency admissions: PA not required; ESPs are required to notify CCA BH UM @ 866-610-2273 before bed placement. Non-emergency admissions: require a PA (includes DMH State Hospital admissions)	Emergency admissions: PA not required; ESP are required to provide notification by calling CCA BH UM @ 866-610-2273 before bed placement Non-emergency admissions: not applicable; requires PA	Emergency admissions: see notification process Non-emergency admissions: ESP/ED or admitting provider calls CCA BH UM to request PA for non-emergency admissions. CCA BH UM will provide an initial authorization	Admitting facility calls CCA BH UM on the last covered day. Continued stay review process is conducted by phone and medical necessity is determined for continued authorization	Emergency admission: verbal notification confirming receipt of notification of admission within 30 minutes; written notification within 24 hours Non-emergency admission: verbal notification of decision within 2 hours; written notification of decision within 24 hours
Inpatient Services:	Observation Beds/Holding Beds (OBS)		No PA required. Notification is required within 24 hours	See process for medical	No authorization or medical necessity review process required	No continued authorization required	Not applicable
Inpatient Services:	Administratively Necessary Days (AND)		Prior authorization is required	Not applicable	Requesting provider calls BH UM at 866-610-2273 to request AND	Requesting provider calls CCA BH UM on the last covered day to request AND	Within 72 hours
Diversionary Services	Acute Treatment Service (ATS): ASAM Level 3.7 (including Enhanced ATS/EATS)		PA not required for admission; Admitting facility required to notify CCA BH UM within 48 hours of admission @ 866-610-2273	Admitting facility required to notify CCA BH UM within 48 hours of admission @ 866-610-2273	No authorization required. Medical necessity determination is made by the provider	No continued authorization required. Medical necessity determination is made by the provider	Not applicable
Diversionary Services	Community Crisis Stabilization (CCS)		PA not required	Notification of admission within 24 hours to CCA	No authorization or medical necessity review process required	No continued authorization required	Not applicable

			Notification of admission required within 24 hours.	BH UM @ 866-610-2273			
Diversionary Services	Enhanced Community Crisis Stabilization (CCS)		PA not required until day 6 Notification of admission required within 24 hours.	Notification of admission within 24 hours to CCA BH UM @ 866-610-2273	Provider calls CCA BH UM on day 6 to request authorization if additional days are needed	Continued stay review process is conducted by phone and medical necessity is determined for continued authorization	Within 72 hours
Diversionary Services	Clinical Stabilization Services for Substance Use Disorders (CSS)		PA not required for admission; Admitting facility required to notify CCA BH UM within 48 hours of admission @ 866-610-2273	Admitting facility required to notify CCA BH UM within 48 hours of admission @ 866-610-2273	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 Special Services	Electro Convulsive Therapy (ECT)	Standardized Prior Authorization Form	Prior authorization is required	Provider faxes form to 855-341-0720	BH UM will review request for medical necessity	Same as prior authorization process	Within 14 calendar days
Behavioral Health Special Services	Neuropsychological/ Psychological Testing	PA Form – Psychological and Neuropsychological Assessment	Prior authorization is required	Provider faxes form to 855-341-0720	CCA Psychologist will review request for medical necessity	Not applicable	Within 14 calendar days
Behavioral Health Special Services	rTMS Services	PA Form – RTMS	Prior authorization is required	Provider faxes form to 855-341-0720	BH UM will review request for medical necessity	Same as prior authorization process	Within 14 calendar days
Behavioral Health Special Services	**Esketamine**		Prior authorization is required	Provider faxes form to 855-341-0720	BH UM will review request for medical necessity	Same as prior authorization process	Within 14 calendar days
Behavioral Health Special Services	Specialing		Prior authorization is required		BH UM will discuss request with provider	Same as prior authorization process	Within 72 hours

Behavioral Health services that do not require an Authorization or Notification of Admission:

Diversionary Services:

- Partial Hospitalization and Day Treatment (PHP):
- Intensive Outpatient Programs (IOP):
- Program of Assertive Community Treatment (PACT)
- Psychiatric Day Treatment
- Community Support Program (CSP)
- Community Support Program for Chronically Homeless Individuals (CSP-CHI)
- Residential Rehab Services for SUD (RRS): ASAM Level 3.1

Behavioral Health Emergency Service:

- Emergency Service Program – Risk Management/Safety planning service (ESP)
- Medication Management Crisis
- Diagnostic Evaluation
- Emergency Department Visit

Outpatient Services:

- Behavioral Health Outpatient Treatment
- Diagnostic Evaluation
- Urgent Outpatient: (UOS)
- Dialectical Behavioral Therapy (DBT)
- Case Consultation
- Bridge Consultations Inpatient/Outpatient
- Consultations in the ED

- Medication Management
- Ambulatory Withdrawal Services (AWS):
- Structured Outpatient Addiction Programs (SOAP)
- Opioid Replacement Therapy (ORT)
- Office based Opioid Treatment (OBOT)
- Medication Assisted Treatment
- Methadone Maintenance
- Acupuncture for Withdrawal Management
- Recovery Coach
- Recovery Support Navigator

Behavioral Health Inpatient Services

Level 4 Medical Detox: provides a planned substance use disorder treatment program offering 24-hour, medically managed evaluation and treatment for individuals who are experiencing severe withdrawal symptoms and/or acute biomedical complications as a result of a substance use disorder. 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 multi-disciplinary 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.

Psychiatric Inpatient Level of Care (IPLOC): represent 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) or a private psychiatric hospital licensed by DMH. Multi-disciplinary 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 disorder. Typically, the Member poses a significant danger to self or others, and/or displays severe psychosocial dysfunction. Inpatient mental health providers comply with the following **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 (ESP) provider, regardless of the availability of capacity or clinical presentation. Providers are expected to **collaborate and communicate with CCA' s BH UM team within 48 hours of admission from inpatient psychiatric level of care**.

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 on-site 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. Duration of services at this level of care may not exceed 24 hours. Admissions to Observation/Holding Beds occur 24/7 and 365 days a year and are on a voluntary basis only. Members on an involuntary status who require observation will be 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 Members are clinically ready for discharge, but an appropriate setting is not available. Services shall include appropriate continuing clinical services.

Behavioral Health Diversionary Covered Services

Diversionary services for mental health and substance use disorder services are provided as clinically appropriate alternatives to Behavioral Health inpatient services, or to support a member returning to the community after an inpatient admission. Diversionary services are more clinically intensive than typical weekly outpatient care but less intensive than inpatient treatment. Diversionary services are provided in facility and community settings, and range in intensity from 24-hour acute treatment to 6 or fewer hours per week. CCA's providers of BH Diversionary Services are expected to collaborate with CCA's BH UM, giving notice within 48 hours of admission so that the CCA ICT team can coordinate discharge planning and aftercare.

Acute Treatment Services (ATS) ASAM Level 3.7: consists of 24/7 medically monitored addiction treatment services that provides evaluation, counseling, education, and withdrawal management, in a non-hospital setting. Medical withdrawal services are delivered by nursing and counseling staff under the supervision of a licensed physician. Services include: biopsychosocial evaluation; individual and group counseling; psycho-educational 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 an alcohol and/or other substance use disorder. 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 CCA's BH UM team within 48 hours of admission and discharge from an Acute Treatment Facility.

Enhanced Acute Treatment Services for individuals with Co-Occurring Mental Health and Substance Use Disorders (E-ATS) ASAM Level 3.7: provides diversionary and/or step-down services for Members in need of acute, 24-hour substance use disorder 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 disorder requires a 24-hour, medically monitored evaluation, care, and treatment program, including the prescription and dosage of medications typically used for the treatment of mental health disorders. E-ATS services for individuals with co-occurring mental health and substance use disorders 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 disorders 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 (ESP) providers, or as a transition from inpatient services. Members with co-occurring disorders receive specialized services within Enhanced Acute Treatment Services (E-ATS). E-ATS is for Individuals with Co-occurring Mental Health and Substance Use Disorders to ensure treatment for their co-occurring psychiatric conditions. E-ATS also serves pregnant women 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: consist of 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, and 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 multi-disciplinary 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 disorder manageable at this level. Members may be admitted to CSS directly from the community or as a transition from inpatient services.

Residential Rehab Services for SUD (RRS) ASAM Level 3.1: This service requires a 24-hour, safe, structured environment, located in the community, which supports Members' recovery from addiction and moderate to severe mental health conditions while 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. Clinical services are provided a minimum of five hours a week and additional outpatient levels of care may be accessed concurrently as appropriate. RRS Services are available for Member with substance use, pregnant/postpartum, families and co-occurring disorders.

Community Crisis Stabilization (CCS): program 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 hospitalization's. CCS provides a distinct level of care where the primary objectives of multi-disciplinary treatment include: restoration of functioning; strengthening the resources and capacities of the Member, family, and other natural supports; 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 bio-psychosocial assessment; care coordination; psychiatric evaluation and medication management; peer support and/or other recovery-oriented services. CCS services are short-term, providing 24-hour observation and supervision, and continual re-evaluation. CCS provides a home-like, consumer-friendly, and comfortable environment conducive to recovery. Treatment is carefully coordinated with existing and/or newly established treatment providers. **Providers are expected to collaborate and communicate with CCA's BH UM team within 24 hours of admission and discharge from an ESP Provider.**

Enhanced Community Crisis Stabilization (E-CCS): E-CCS service is an alternative to or diversion from inpatient hospitalization, offering psychiatric stabilization to Members with a more acute psychiatric presentation and/or medical co-morbidity than is typically managed at CCS, including provision of withdrawal management services. E-CCS is primarily used as a diversion from an inpatient level of care; however, the service may be used secondarily as an alternative to boarding for voluntary inpatient/Enhanced Acute Treatment Services (E-ATS)/Acute Treatment Services (ATS) level of care, or as transition from inpatient services if there is sufficient service capacity and the admission criteria are met. E-CCS provides a distinct level of care where primary objectives of active multi-disciplinary treatment include: detox protocol, medication management, accommodation of Members with co-morbid medical conditions not typically admitted to CCS, and those with more acute psychiatric symptomology not typically managed in CCS. In addition, E-CCS will also offer all other services provided in a CCS setting.

Partial Hospitalization and Day Treatment (PHP): is a non-24-hour diversionary treatment program that is 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 there is a staff-to-Member ratio 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.

Intensive Outpatient Programs (IOP): offer a time-limited, multi-disciplinary, multimodal structured treatment in an outpatient setting. Such programs are less intensive than a partial hospitalization program or psychiatric day treatment but are 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 psycho-educational 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.

Program of Assertive Community Treatment (PACT): entails the provision of an array of clinical, rehabilitative, and recovery-oriented services, delivered by a community-based, mobile, multi-disciplinary team of professionals, paraprofessionals, and peer specialists, to support a Member's personal recovery journey. PACT is a service are for Members with challenging and persistent concerns, related to psychiatric illness, who have not responded to more traditional services.

PACT multi-disciplinary teams provide active, flexible, ongoing, and community-based psychiatric treatment, assertive outreach, rehabilitation, and support. The goal of services is not only to support stabilizing a Member but also community integration and improved quality of life. Services are not time-limited. The team provides assistance to Members in: maximizing their recovery; ensuring Member-directed goal setting; assisting Members in gaining a sense of hope and empowerment; and providing assistance in helping Members become better integrated within the community. PACT services measure the following key outcomes for Members: self-determination, independence, and empowerment; life satisfaction; symptom relief and self-management; community tenure/fewer incidents of relapse; housing stability and quality; employment; and family satisfaction. Services are provided in natural community settings and are available, as needed by the Member, 24/7 and 365 days a year. PACT directly provides clinical services and is not merely a case management or referral program. PACT provides all clinical non-acute behavioral health and substance use disorder interventions in addition to linking Members to community-based, self-help resources and providing direct rehabilitation, vocational, and housing related services.

Psychiatric Day Treatment: provides a coordinated set of individualized, integrated, and therapeutic supportive services to Members with psychiatric disorders, 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.

Psychiatric Day Treatment assists Members in beginning the recovery and wellness process and provides supportive transitional services to Members who require moderate supervision to avoid risk, and/or are not fully able to re-enter the community or the workforce. Psychiatric Day Treatment offers the Member opportunities and support for involvement in community, social, and leisure time programs, as well as opportunities to pursue personal, ethnic, and cultural interests. Services are provided in a community setting. A goal-directed treatment plan developed with the Member and/or Member's family guides the course of treatment.

Community Support Program (CSP): provide an array of services delivered by community- based, mobile, paraprofessional staff, supported by a clinical supervisor, to Members with psychiatric or substance use disorder diagnoses, and/or to Members for whom their psychiatric or substance use disorder diagnoses interfere with their ability to access essential medical services. These programs provide support services that are necessary to ensure Members access and utilize behavioral health services. CSPs do not provide clinical treatment services. CSP provides 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 disorder 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. In combination with outpatient and other clinical services, CSP services are designed 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 skills (ADL's) 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 health care;
- Collaborating with Emergency Services Programs/Mobile Crisis Intervention (ESP/MCIs) and/or outpatient providers; including working with ESP's to develop, revise and/or utilize Member crisis prevention plans and/or safety plans as part of the Crisis Planning Tools for youth, and
- Fostering empowerment, recovery, and wellness, including linkages to recovery-oriented, peer support and/or self-help supports and services.

Community Support Program for Chronically Homeless Individuals (CSP- CHI formally C-SPECH): CSP-CHI is a more intensive form of CSP for chronically homeless individuals who have identified a Permanent Supportive Housing (PSH) housing opportunity. Once housing is imminent with members moving within 120 days, members receiving CSP may receive CSP-CHI services. CSP-CHI 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 in searching for PSH, preparing for and transitioning to an available housing unit, and, once housed, coordinating access to physical health, behavioral health, and other needed services geared towards helping them sustain tenancy and meet their health needs. The types of CSP-CHI services available may be categorized as:

- Pre-Tenancy: engaging the member and assisting in the search for an appropriate and affordable housing unit;
- Transition into Housing: assistance arranging for and helping the member move into housing; and
- Tenancy Sustaining Supports: assistance focused on helping the member remain in housing and connect with other community benefits and resources.

Services should be flexible with the goal of helping eligible members attain the skills and resources needed to maintain housing stability.

Providers should refer to Mass Health Bulletin 44 for Provider Requirements, Care Coordination, Rate Structure and Record Keeping Detail.

Behavioral Health Emergency Service Programs (ESPs)

Emergency Service Program – Risk Management/Safety planning service (ESP): provides crisis assessment, intervention, and stabilization services 24/7 and 365 days per year to Members who are experiencing a behavioral health crisis. The purpose of the ESP is to respond rapidly, assess effectively, and deliver a course of treatment intended to promote recovery, ensure safety, and stabilize the crisis in a manner 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 ESP provides a core service including:

- Crisis assessment, intervention, and stabilization including a crisis behavioral health assessment.
- Offers 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.
- Arranges after-care referrals for the behavioral health services that the Member selects to further treat their behavioral health or substance use.
- Provides the Member and their family with resources and referrals for additional services and supports, such as recovery-oriented and consumer operated resources in their community.

ESP providers are expected to include the three basic components of crisis assessment, intervention, and stabilization with the understanding that ESP 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.

ESP 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, courts, etc. ESP 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 ESPs provide crisis behavioral health services in the community, through mobile crisis intervention services, accessible community-based locations, and Community Crisis Stabilization (CCS) programs. The mission of the ESP is to deliver high quality, culturally competent, clinically and cost- effective, integrated community-based behavioral health crisis assessment, intervention, and stabilization services that promote resiliency, wellness, and recovery.

For CCA Members, Emergency Services shall be provided immediately on 24/7 days a week, 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 not limited to, response to a call with a live voice; or face-to-face visit within 60 minutes of outreach.
ESP services also includes the following components:

- Medication Management Crisis
- Diagnostic Evaluation
- Safety Planning
- Emergency Department Visit
- Specialing Services

Behavioral Health Outpatient Services

Outpatient Behavioral Health Services are services that are rendered in an ambulatory care setting, such as an office, clinic environment, a Member's home, 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.

Commonwealth Care Alliance is committed to providing convenient access and availability of Behavioral Health Services that support the needs of each member and support each member's care plan. Excluding, Emergency Services (ESP) and Urgent Care, Behavioral Health office visits will be made available within the following timeframes to Members for the following Behavioral Health Services:

- 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's Behavioral Health Clinician (Licensed Clinicians) are available 24/7 on call. Behavioral Health Services are also available for in person home or office appointments within 48 hours of discharge and 48 hours for medication assessment and management.

Behavioral Health Outpatient Treatment: should result in positive outcomes within a reasonable time frame for specific disorders, 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 disorders 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; and Members must have flexibility in accessing outpatient treatment, including transferring.

Diagnostic Evaluation: is 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): is an evidenced-based manual directed outpatient treatment developed by Marsha Linehan, PhD, and her colleagues that combines strategies from behavioral, cognitive, and other supportive psychotherapies for enrollees with borderline personality disorder who exhibit chronic parasuicidal behaviors. DBT may be used for other disorders. DBT includes individual therapy, DBT skills group, therapeutic consultation to the member on the telephone or telehealth, and the therapists' internal consultation meeting(s). Through an integrated treatment team

approach to services, DBT seeks to enhance the quality of the member's life through group skills training and individual therapy with a dialectical approach of support and confrontation. Providers of this service must consult with the Members Care Team to discuss 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.

Urgent Outpatient Services (UOS): are 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. UOS provide a same or next business day response to the Member's urgent request that assists him/her by providing assessment, stabilization and service linkages. UOS are provided to Members enrolled in the UOS provider's outpatient service as well as to Members who are new to the outpatient provider. UOS are not intended to replace or be interchangeable with Emergency Services Program/Mobile Crisis Intervention (ESP/MCI) services, which provide emergent services for Members experiencing a more acute crisis. 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 him/her 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 refers him/her to appropriate community supports and services, when needed.

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, as required.

Case Consultation: is 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; and revise the treatment plan, as required. Case Consultation shall not include clinical supervision or consultation with other clinicians within the same provider organization.

Bridge Consultations Inpatient/Outpatient: is a single-session consultation conducted by a Network Outpatient Provider at a: - Psychiatric inpatient unit) or as Enhanced Acute Treatment Services (EATS) 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 EATS treatment team, the primary outpatient clinician or masters 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 EATS program. During the consultation it is expected that the outpatient clinician will meet face-to-face with the Member and attend the inpatient or EATS treatment team meeting or meet with the clinician who is a member of the treatment team.

Consultations in the ED: are an in-person meeting of at least 15 minutes' duration between a psychiatrist or Advanced Practice Registered Nurse Clinical Specialist and a member, at the request of the medical unit or attending physician, to assess the member's mental status, provide greater diagnostic clarity and/or assist the unit medical and nursing staff with a BH or psychopharmacological treatment plan for the member.

Medication Management: is the level of outpatient treatment where the primary service is provided by a qualified prescribing provider, either a psychiatrist or an advanced practice registered nurse (APRN). The prescriber evaluates the Member's need for psychotropic medications and provides a prescription and ongoing medical monitoring for efficacy and side effects of medication administration. There is also coordination of care with other mental health, medical, and substance use disorder providers. Telehealth services are available for Members with specific geographic, cultural, linguistic or special needs that cannot be met in their community but can be provided using a combination of interactive video, audio, and externally acquired images through a networking environment between a Member and a provider. 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 w/other physicians, other qualified health care professionals or agencies.

Behavioral Health Outpatient Services for Substance Use Disorder

Ambulatory Withdrawal Services (also known as ambulatory detoxification) ASAM Level 2.D: is provided in an outpatient clinical setting, under the direction of a physician, and is designed to stabilize the medical condition of an individual experiencing an episode of substance use or withdrawal complications. Ambulatory withdrawal services are indicated when the individual experiences physiological distress during withdrawal, but where 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.

Structured Outpatient Addiction Programs (SOAP): consists of short-term, clinically intensive, structured, day and/or evening substance use disorder 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 Disorders ASAM level 3.7; Members, including those who are pregnant, who need outpatient services, but also need more structured treatment for substance use disorders; and Members being stepped down from Clinical Stabilization Services (CSS) for Substance Use Disorders ASAM level 3.5.

SOAP provides multi-disciplinary treatment to address the sub-acute needs of Members with addictions and/or co-occurring disorders, 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.

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

Opioid Replacement Therapy (ORT): medically monitored administration of methadone, Buprenorphine, or other U.S. Food and Drug Administration (FDA)-approved medications to treat opioid use disorder (OUD), 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 (OTPs):** are 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 (FDA)-approved medications to treat opioid use disorder (OUD) 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 (OTP) is provided under a defined set of policies and procedures, including admission, continued stay, and discharge criteria stipulated by Massachusetts state regulations and the 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.

- **Office Based Opioid Treatment (OBOT's):** refers to outpatient treatment services provided outside of licensed OTPs by clinicians to patients with addiction involving opioid use, and 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

Acupuncture for Withdrawal Management: is a treatment program providing acupuncture services for individuals experiencing the dysfunctional effects of the use of alcohol and/or other drugs, whose primary need is detoxification to manage withdrawal symptoms, and thereafter, support services for maintenance of sobriety. An Acupuncturist is defined as an individual licensed by the Board of Registration in Medicine in accordance with M.G.L. c. 112, §§ 150 through 156.

Recovery Coaching/Comprehensive Community Support (RC): are individuals currently in recovery who have lived experience with addiction and/or co-occurring mental health disorders and have been trained to help their peers with a similar experience to gain hope, explore recovery, and achieve life goals. RCs are actively engaged in their own personal recovery and share real-world knowledge and experience with others who are on their own recovery path. RCs share their recovery story and personal experiences to establish an equitable relationship and support Members in obtaining and maintaining recovery.

The primary responsibility of RCs is to support the voices and choices of the Members they support, minimizing the power differentials as much as possible. The focus of the RC role is to create a relationship between equals that is non-clinical and focused on removing obstacles to recovery; linking Members to a recovery community and serving as a personal guide and mentor. The RC will work with the Member to develop a Wellness Plan that orients the activities of the RC service.

Members can access RC services based on medical necessity and a referral by a medical or behavioral health provider, Community Partner (CP), or other care manager who has contact with the Member and is able to identify the need for Recovery Coaching services.

RCs are employed by an organization that is licensed by the DPH to offer RC services and can provide supervision, an organizational culture that supports fidelity to the model, and an environment that is conducive to the needs of RCs and the Members they serve. The RC service is based within a Licensed Behavioral Health Outpatient Clinic or Opioid Treatment Center, and RCs can be deployed to any setting.

Recovery Support Navigator/Community Support Program (RSN): services are staffed by paraprofessionals who provide care management and system navigation supports to Members with a diagnosis of substance use disorder and/or co-occurring mental health disorders. The purpose of RSN services is to engage Members as they present in the treatment system and support them in accessing treatment services and community resources.

Members can access RSN services based on medical necessity and/or a referral by a medical or behavioral health provider, Community Partner (CP), or other care manager who has contact with the Member and is able to identify the need for RSN services.

RSN services are appropriate for Members with substance use disorder and/or co-occurring disorders who need additional support in remaining engaged in treatment; identifying and accessing treatment and recovery resources in the community including prescribers for addiction and psychiatric medications; and/or developing and implementing personal goals and objectives around treatment and recovery from addiction and/or co-occurring disorders. The RSN explores treatment recovery options with the Member, helps clarify goals and strategies, provides education and resources, and assists Members in accessing treatment and community supports.

The RSN is not responsible for a Member's comprehensive care plan or medical or clinical service delivery but supports the Member in accessing those services and participates as part of the overall care team when appropriate. The RSN service is based within a Licensed Behavioral Health Outpatient Clinic or an Opioid Treatment Center and Recovery Support Navigators can be deployed to any setting.

Behavioral Health Special Procedures

Electro Convulsive Therapy (ECT): is a procedure during which an electric current is passed briefly through the brain, via electrodes applied to the scalp, to induce generalized seizure activity. The individual receiving ECT is placed under general anesthesia, and muscle relaxants are given to prevent body spasms. ECT electrodes can be placed on both sides of the head (bilateral placement) or on one side of the head (unilateral placement). Unilateral placement is usually to the non-dominant side of the brain, with the aim of reducing cognitive side effects. The amount of current to induce a seizure (the seizure threshold) can vary up to 40-fold among individuals. ECT may cause short- or long-term memory impairment of past events (retrograde amnesia) and of current events (anterograde amnesia). 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 (3) times per week. Maintenance ECT is most commonly administered at one- to three-week intervals.

The decision to recommend the use of ECT derives from a risk/benefit analysis for the specific individual. 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 and efficacy of ECT, the medical risks, and anticipated adverse side effects. These factors should be considered against the likely speed of action, efficacy, and medical risks of alternative treatments in making a determination to use ECT.

Neuropsychological/Psychological Testing (Testing): testing is the use of standardized assessment tools to gather information relevant to a Member's intellectual and psychological functioning. Psychological assessment (testing) involves the culturally and linguistically competent administration and interpretation of standardized tests to assess a Member's psychological or cognitive functioning. Psychological tests are used to assess a Member's:

- Cognitive, emotional, behavioral, and intra-psychic functioning on the central assumption that individuals have identifiable and measurable differences that can be elicited by means of objective testing
- Used to determine differential diagnosis and assess overall cognitive functioning related to a Member's mental health or substance use disorder status.
- The psychologist's aim is to obtain data from standardized, valid, and reliable instruments that
- Lead to an accurate diagnosis;
- Allow for hypotheses to be generated about the Member's problems and difficulties in functioning;
- Point to effective treatment strategies

Testing includes both standard psychological as well as neuropsychological assessment procedures.

Neuropsychological assessment (testing) often includes specifically designed tasks used to measure a psychological function known to be linked to a particular brain structure or pathway in an effort to assess cognitive functioning. Neuropsychological tests are a core component of the process of conducting neuropsychological assessment, along with personal, interpersonal, and contextual factors.

The term psychologist will refer to both psychologists and neuropsychologists interchangeably.

Psychological Assessment (Testing) is defined by a referral driven by behavioral health and/or substance use disorder treatment/assessment issues. A medical co-morbidity may exist, but the primary purpose of the assessment is related to behavioral health and/or substance use disorder treatment/assessment.

Referrals may also be driven by specific, medical (non-psychiatric) treatment/assessment issues such as documented neurological injury or other medical/neurological condition (e.g., stroke, traumatic brain injury, multiple sclerosis). A behavioral health and/or substance use disorder co-morbidity may exist, but the primary purpose of the assessment is related to a medical (non-psychiatric) treatment/assessment issue.

Repetitive Transcranial Magnetic Stimulation Services (rTMS): is a noninvasive method of brain stimulation. In rTMS, an electromagnetic coil is positioned against the individual's scalp near his or her forehead. Magnetic Resonance Imaging (MRI)-strength, pulsed, magnetic fields then induce an electric current in a localized region of the cerebral cortex, which induces a focal current in the brain and temporary modulation of cerebral cortical function. Capacitor discharge provides electrical current in alternating on/off pulses. Depending on stimulation parameters, repetitive TMS to specific cortical regions can either decrease or increase the excitability of the targeted structures. rTMS does not induce seizures or involve complete sedation with anesthesia in contrast to ECT. The FDA approval for this treatment modality was sought for Members with treatment resistant depression.

Additionally, the population for which efficacy has been shown in the literature is that with treatment resistant depression. Generally speaking, in accordance with the literature, individuals would be considered to have treatment-resistant depression if their current episode of depression was not responsive to two trials of medication in different classes for adequate duration and with treatment adherence. rTMS is usually administered four to six times per week and for six weeks or less. It is typically performed in an outpatient office. rTMS is not considered proven for maintenance treatment. The decision to recommend the use of rTMS derives from a risk/benefit analysis for the specific Member. This analysis considers the diagnosis of the Member and the severity of the presenting illness, the Member's treatment history, any potential risks, anticipated adverse side effects, and the expected efficacy. Licensure and credentialing requirements specific to facilities and individual practitioners do apply and are found in our provider manual/credentialing information.

Esketamine for Treatment-Resistant Depression (TRD): 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 therapy is 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 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. The medication administration is completed under the direct observation of healthcare provider, and patients are required to be monitored by a healthcare provider for at least 2 hours. Also, 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. It's only prescribed for people with major depressive disorder (MDD) with acute suicidal ideation or behavior and who haven't been helped by at least two other depression medications.

SECTION 12: LONG-TERM SERVICES AND SUPPORT PROVIDERS

Commonwealth Care Alliance is committed to full integration of long-term service and support (LTS), and of behavioral health (BH), in addition to the medical service needs in each member's care plan. Accordingly, we cover a wide range of LTS and BH services for all Commonwealth Care Alliance members.

Long-Term Services and Supports

Long-term services and supports (LTS) are covered for Commonwealth Care Alliance members. LTS are considered covered services when (a) delivered consistent with provider training, licensure, certification and/or other designation by the Commonwealth of Massachusetts; (b) delivered consistent with the specific scope and conditions referenced in the provider's contractual agreement, this Provider Manual, and Commonwealth Care Alliance policies; and (c) authorized in accordance with Commonwealth Care Alliance's service authorization policies.

LTS include day programs for frail seniors and disabled adults who need supervision, structure, and/or health services during the daytime, but who return to their homes and caregivers at the end of the day. Members are transported to day programs such as:

Adult Day Health (ADH) offers nursing care, therapies, personal care assistance, social and recreational activities, meals, and other services in a community group setting.

Day habilitation programs serve individuals with developmental disabilities, by offering a structured, goal-oriented program of medically oriented, therapeutic, and habilitation services to raise members' levels of functioning and facilitate independent living.

Social Day Supportive Day Programs provide support services in a group setting to help participants recover and rehabilitate from an acute illness or injury, or to manage a chronic illness, or for participants who have an assessed need for increased social integration and/or structured day activities. The services include assessments and care planning, health-related services, social services, therapeutic activities, nutrition, and transportation. These services focus on the participant's strengths and abilities, while maintaining their connection to the community and helping them to retain their daily skills.

Other LTS may be brought to the member in his/her home or residence.

Examples include:

Adult Foster Care (AFC): A program for frail elderly adults and adults with disabilities who cannot live alone safely. AFC adults live with trained, paid caregivers who provide daily care, meals, companionship, personal assistance, and 24-hour supervision. Caregivers may be family members (except legally responsible relatives), or non-family members.

Group Adult Foster Care (GAFC): A program that provides nursing oversight and personal care services for eligible seniors and adults with disabilities who live in GAFC-approved housing.

Home care services: Several types of support to promote independence and self-determination including provision of, assistance with and/or skills training in, general household tasks, personal care and ADLs, personal finance, health, shopping, use of community resources, community safety, and other social and adaptive skills to live in the community.

Home care services also include providing a worker or support person to perform general household tasks such as preparing meals, doing laundry and routine housekeeping, and/or to provide companionship to the member, as well as providing a range of personal support and assistance to enable an Enrollee to accomplish tasks that they would normally do for themselves if they could, like assisting with bathing, dressing, personal hygiene and other activities of daily living.

Such assistance may take the form of hands-on assistance or cueing and supervision to prompt the Enrollee to perform a task.

Medically necessary non-emergency medical transportation takes members to medically related services.

Personal Care Management & Personal Care Attendant: Personal Care Management (PCM) organizations, certified by EOHHS to provide PCM services, are responsible for evaluating members (One Care only) who are being considered for the Personal Care Attendant (PCA) program and providing skills training, determine the need for surrogacy, and support to enable a member to employ and direct his/her own PCA. Each Enrollee has the right to hire, fire, schedule and train his or her Personal Care Attendant. PCAs provide authorized and scheduled services to assist a member with Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs).

Commonwealth Care Alliance may cover additional LTS, sometimes referred to as Flexible Services and Expanded Services, when it deems it necessary and appropriate for members and their individual circumstances. Flexible Services and Expanded Services include but are not limited to:

Home modifications: Physical adaptations in a member's private residence, such as widening of doorways, installation of ramps, installation of specialized electric and plumbing systems to accommodate needed medical equipment and supplies. Excluded modifications include those that do not provide direct medical or remedial benefit or would normally be the landlord's responsibility. Modifications to increase total square footage are covered only when necessary to complete a covered adaptation.

Medication management: Support to a member capable of self-administering medications, and includes reminders to take medication, checking the package for correct member name and dosage, opening medication containers, reading the medication name, reading and explaining instructions, and observation and documentation of the member's actions regarding the medication.

Non-medical transportation is provided to enable the member to access community services, activities and resources.

Peer support services by persons with lived experience similar to a member's, to provide training, instruction and mentoring to individuals about self-advocacy, participant direction, civic participation, leadership, benefits, and ability to function in the home and participate in the community.

Respite care: Services provided to relieve a member's informal caregivers from the daily stresses and demands of caring for a member in order to strengthen or support the informal support system. Respite care may be provided for at any time duration in a member's home, or as a short term stay in an overnight facility.

Clinical Conditions, Criteria & Authorization for Long Term Services and Supports

In addition to factors considered in determining the necessity and appropriateness of medical services, Commonwealth Care Alliance also evaluates:

- Likelihood that the enrollee would require admission to a treatment facility with and without the proposed service
- Value of an environmental assessment in implementing the member's care plan
- Member's ability to safely leave the home
- Member's dependency on others to safely leave the home

Long-Term Services and Supports Coordinator (LTSC)

One Care members may elect to have an independent Long-Term Services and Supports Coordinator (LTSC) to assist with coordination of their LTS needs. LTSCs provide expertise in community supports to the member and his/her care team, advocate for the member's LTS 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 LTS Coordination services.

Geriatric Support Services Coordinator (GSSC)

As a member of the primary care team (PCT) for SCO members, the GSSC participates in initial and ongoing assessments of members including developing community-based care plans as well as determining the appropriateness of institutional long-term care services. The GSSC also arranges, coordinates, and authorizes with the agreement of the PCT the provision of Long-Term Services.

SECTION 13: QUALITY IMPROVEMENT PROGRAM

Commonwealth Care Alliance is committed to providing the highest quality, most effective health care to its members. In pursuance, Commonwealth Care Alliance's framework for quality improvement is designed to integrate quality assessment and performance improvement activities throughout all levels of its care delivery system. As a 'consumer experience' governed organization, Commonwealth Care Alliance's Quality Program is structured to ensure that the member's perspective is built in to all elements of its quality improvement 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.

The Quality Program is designed to:

- Understand the needs, expectations, and satisfaction of members and caregivers and implement improvements to incorporate these perspectives into care delivery and system operations
- Continually improve organizational and clinical processes throughout the delivery system based upon analysis of available data and clinical, administrative, and member input from across the network
- Improve clinical quality by identifying and disseminating best clinical practices throughout the network

Quality Program Objectives

- To ensure the effective, timely and safe delivery of care and care coordination to members at the optimal level of quality
- To assess and evaluate the quality and appropriateness of care across the provider network
- To design effective mechanisms for problem identification, assessment and resolution at the individual, practice site, and system-wide levels
- To assess, evaluate and monitor key areas of clinical care and care coordination and identify opportunities for improvement when indicated
- To promote mechanisms for the integration of risk management, utilization review and other activities in a comprehensive Quality Improvement Program
- To identify deviations from standards and address such deviations in a manner that optimizes health outcomes
- To ensure that professional competency and practices are routinely and reliably monitored and evaluated
- To ensure program compliance with state, federal, contractual and other regulatory requirements

Quality Program Structure

Board of Directors

The Board of Directors is comprised of up to 15 members appointed by Commonwealth Care Alliance's corporate members. The Board of Directors assumes final authority and responsibility for quality of care and professional practices including:

- Approval of Commonwealth Care Alliance's annual Quality Program
- Recommendations related to Commonwealth Care Alliance's quality assessment and performance improvement activities

The Board of Directors delegates responsibility for the development and oversight of Commonwealth Care Alliance's Quality Program to the Chief Executive Officer/Chief Medical Officer who delegates responsibility for components of the program to Commonwealth Care Alliance Chief Quality Officer, Quality and Clinical staff.

Board Quality Committee

The Board of Directors of Commonwealth Care Alliance (CCA) established the Quality Committee to assist the Board in fulfilling its responsibilities for oversight of CCA's quality program to ensure the quality of CCA's clinical care, patient safety and customer service. The Quality Committee operates under a written charter which is approved by the Board of Directors. The Quality Committee's oversight includes: (i) CCA's Quality Strategy, (ii) CCA's annual Quality Improvement Work Plan, and (iii) reviewing progress towards achievement of CCA's quality strategic objectives as measured by key quality indicators. The Quality Committee is comprised of at least 3 members (including the Chair of the Committee) who are voting members of the Board and appointed by the Board Chair in consultation with the CEO. The Chair of the Board and the CEO are ex-officio members of the Committee and the Chief Quality Officer and Chief Medical Officer are Staff Liaisons to the Committee.

Ethics Committee

The CCA Ethics Committee serves in an advisory capacity to CCA leadership. The Committee provides education, consultation, and advice to CCA leadership around clinical and organizational ethical issues. The Committee operates under written policies and procedures and provides input to decision-making including end-of-life issues and advance directives. A particular focus of the Committee is to provide guidance to assist clinicians in balancing their professional concerns for enrollees with the concept of the "dignity of risk" inherent in truly supporting self-determination for every enrollee. In addition to the Ethics Committee, has also established monthly leadership rounds where high-risk members with medical, ethical, or compliance issues are discussed, and a weekly member risk and safety committee which addresses member care issues which fall in the in the ethics realm.

Management Quality Committee

The Management Quality Committee is an internal Commonwealth Care Alliance committee, with responsibilities that include the development, coordination, and facilitation of all quality improvement activities throughout the organization, including monitoring and evaluation, and the development of the organization's annual Quality Program Work Plan for recommendation to the Board Quality Committee for review and approval.

The Management Quality Committee assumes responsibility for:

- Designating areas to be monitored and evaluated
- Generating suggestions for quality improvement activities
- Designing mechanisms for problem identification and prioritization, assessment, resolution, and follow-up evaluation
- Selecting criteria for monitoring activities
- Reviewing and analyzing all monitoring activities and assisting in developing focused improvement plans
- Evaluating the annual Quality Program regarding its effectiveness in addressing issues of quality of patient care and professional practice
- Reviewing policies and procedures annually and as needed, related to implementation of quality improvement initiatives

Utilization Management Committee

The Utilization Management Committee, a standing committee of Commonwealth Care Alliance, oversees the development and implementation of an effective utilization management program. The Utilization Management Committee is responsible for monitoring the quality, continuity, and coordination of care, including monitoring for overutilization and underutilization of services. These activities are coordinated closely with Commonwealth Care Alliance's Quality Program.

Utilization Management Committee responsibilities include the regular review, monitoring, and analysis of utilization and cost information associated with the delivery of care and services to Members across the network.

Members include appropriate Commonwealth Care Alliance clinical staff, consultants, and multidisciplinary clinical representation from the provider network, as well as others as appropriate on an ad hoc basis.

Scope of the Quality Program

The Quality Improvement program is designed to:

- Attend to all aspects of quality of care and service, including a particular focus on assessing and improving patient-centeredness and empowerment
- Understand the needs, expectations, and satisfaction of enrollees and their caregivers and implement improvements to incorporate these perspectives into care delivery and system operations
- Continually improve organizational operational and clinical processes throughout the enterprise and the network delivery systems based upon analysis of available data and clinical, administrative and enrollee input from across the network
- Improve clinical and service quality by identifying and disseminating best practices

Annual Quality Improvement Plan

Commonwealth Care Alliance annually chooses activities that facilitate the organizations achievement of its quality improvement goals. Activities are tracked in the Commonwealth Care Alliance Annual Quality Improvement Plan.

A number of factors are considered when establishing the Quality Improvement Plan. Factors include:

- Alignment with Commonwealth Care Alliance's mission and strategic goals
- Fit with previous work plan projects
- Performance in prior initiatives and quality metrics
- Predicted impact on overall health and well-being of membership
- Predicted impact on member and clinician satisfaction
- Scope and urgency

Measurement and evaluation are fully integrated into the Improvement Plan, and progress toward Improvement Plan objectives is tracked and monitored throughout the year.

Program Monitoring and Evaluation

The Board of Directors, Board Quality Committee, and the Management Quality Committee review the annual Quality Improvement Work Plan and assess the results of the plan annually. This evaluation guides next steps and the development of a Quality Improvement Plan for the coming year.

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

Commonwealth Care Alliance 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 Commonwealth Care Alliance's contracted providers is critical to Improvement Plan generation, execution, and evaluation. Commonwealth Care Alliance collaborates with contracted providers to identify opportunities for improvement.

Prioritized Quality Initiatives

Though they change over time, Commonwealth Care Alliance'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 Commonwealth Care Alliance compliance with CMS and MassHealth quality related standards and expectations, priority initiatives for 2021 include:

- Dementia identification and care
- Life Choices: palliative and end of life care
- Cardiovascular disease prevention
- Behavioral health integration
- Fall prevention
- Increasing cervical cancer screening

- Preventive dental care

Compliance with CMS and MassHealth

Commonwealth Care Alliance must comply with a number of CMS and MassHealth quality-related standards and expectations. Requirements for compliance include a number of 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
- Critical Incident Reporting
- Model of Care Description development and maintenance
- Quality Improvement Program Description
- Quality Improvement Program Evaluation
- Annual Quality Improvement Plan, inclusive of Quality Improvement Program (QIP) Descriptions and Chronic Care Improvement Program (CCIP) Descriptions

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

Healthcare Effectiveness Data and Information Set Guidelines (HEDIS)

Commonwealth Care Alliance assesses its performance using a number of different 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 many significant public health issues 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 US. A subset of the HEDIS performance measures are reported to certain regulatory bodies on an annual basis according to state requirements.

Commonwealth Care Alliance is assessed on eight domains of HEDIS:

- Prevention/Screenings
- Respiratory/Cardiovascular conditions
- Respiratory/Cardiovascular conditions
- Diabetes/Musculoskeletal/Behavioral care
- Medication Management/Care Coordination
- Overuse/Appropriateness of care
- HOS/CAHPS
- Access and Availability

Specifications for HEDIS measurement are updated annually by NCQA.

Performance results, assessed and reported annually, are sourced by administrative claims data as well as medical record reviews. Commonwealth Care Alliance 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 are used to calculate Commonwealth Care Alliance's Medicare Star Rating.

Consumer Assessment of Healthcare Providers and Systems (CAHPS®)

In addition to HEDIS, Commonwealth Care Alliance also uses a standardized survey of consumers' experiences to evaluate its performance in areas such as customer service, access to care, and claims possessing. The survey used is called the Consumer Assessment of Healthcare Providers and Systems (CAHPS®). CAHPS is sponsored, supported, and maintained by the Agency for Healthcare Research and Quality (AHRQ).

Data are collected from a random sample of Commonwealth Care Alliance's Membership each spring. A subset of CAHPS results are used to calculate Commonwealth Care Alliance's Medicare Star Rating.

Health Outcomes Survey (HOS)

The Medicare Health Outcomes Survey (HOS), another standard tool, is employed by Commonwealth Care Alliance to evaluate the health care 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 are used to calculate Commonwealth Care Alliance's Medicare Star Rating.

Quality of Care Concerns

Commonwealth Care Alliance is committed to providing the highest quality, most effective health care to its members. Commonwealth Care Alliance relies heavily on its provider network to identify potential Quality of Care concerns and to escalate such concerns according to standard policy.

Confidentiality

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

SECTION 14: PROVIDER CREDENTIALING

The Commonwealth Care Alliance Credentialing Committee oversees the credentialing and recredentialing process for all provider applicants to the Commonwealth Care Alliance 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, Commonwealth Care Alliance delegates Primary Source Verification to another entity. Notwithstanding delegation, Commonwealth Care Alliance retains the right to approve, suspend, or terminate practitioners from our network.

Credentialing and Recredentialing Process

Types of Providers Credentialed

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

- Chiropractors
- Dentists
- Masters level behavioral health clinicians, including:
    - Alcohol and drug addiction counselors (CADAC-II and LADAC-i)
    - Licensed marriage and family therapists (LMFT)
    - Licensed Mental Health Counselors (LMHC)
    - Social Workers (LICSW, LCSW)
- Nurses—nurse practitioners and other advanced practice nurses (ARNP, CNS, CRNP, NP, PNMHCS, RN, RNCS)
- Oral surgeons
- Physicians (MD and DO), including locum tenens physicians
- Physician assistants
- Podiatrists
- Psychologists (EDD, LP, PhD, PsyD)
- Speech, occupational, and physical therapists

Information Required for Credentialing

Commonwealth Care Alliance requires the following information for credentialing:

Application: A completed, signed and dated practitioner application form that includes 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 10 years of history, and all other practitioners 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 Units (CEU) trainings they have participated in on substance use disorder

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

Either Commonwealth Care Alliance or a delegated contracted, NCQA certified 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: Commonwealth Care Alliance 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 timeframe 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/recredentialing 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 is 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 60 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 60 calendar days from the Committee's decision. Practitioners who are recredentialed in the ordinary course do not receive written notice.

Notice to Members

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

Reporting

Commonwealth Care Alliance 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/Recredentialing Criteria

Practitioners are credentialed and recredentialed based on the following credentialing criteria:

- Contract with Commonwealth Care Alliance: Practitioner must be contracted with Commonwealth Care Alliance
- 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/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/her profession and specialty
- DEA and CDS Certification: as applicable
- Professional Liability Insurance: You 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 Commonwealth Care Alliance 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 Commonwealth Care Alliance's Board Certification Policy, physicians, podiatrists, oral surgeons and nurse practitioners must be:
  - Board certified by a Commonwealth Care Alliance-recognized specialty board; or
  - In the process of achieving initial board certification by a Commonwealth Care Alliance -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 Commonwealth Care Alliance only when necessary for Commonwealth Care Alliance to maintain adequate member access
- Hospital privileges: Physicians must have hospital admitting privileges at a hospital contracted with Commonwealth Care Alliance, 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 in its discretion. Alternative Admitting Arrangements:
  - If you do not have hospital admitting privileges at a hospital contracted by Commonwealth Care Alliance, 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 Commonwealth Care Alliance-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 recredentialing.) The Credentialing Committee will review these references and in 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 Commonwealth Care Alliance-contracted hospital (which can be an arrangement with a Commonwealth Care Alliance-contracted covering physician who does have privileges at a Commonwealth Care Alliance-contracted hospital, provided that the covering physician sends confirmation of these arrangements to the Credentialing department)

- Federal/state program exclusions: That you are not currently excluded, terminated or suspended from participation in Medicare, Medicaid or any other federal or state health care program
- Criminal Proceedings: That you have not been involved in any criminal proceedings that may be grounds for suspension or termination of your license to practice
- Compliance with Legal Standards: That you are 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, that you can be reasonably expected to provide quality and cost-effective clinical care and services to plan members
  - That you have not engaged in behavior which may adversely impact member care or service, including but not limited to: behavior which negatively impacts on the ability of other participating providers to work cooperatively with you; reflects a lack of good faith and fair dealing in your dealings with Commonwealth Care Alliance, its provider network or its members; reflects a lack of commitment to managed care principles or a repeated failure to comply with Commonwealth Care Alliance's managed care policies and procedures; indicates a lack of cooperation with Commonwealth Care Alliance's Quality improvement or Utilization Management Programs; or constitutes unlawful discrimination against a member under any state of federal law or regulation. Provider shall not discriminate by product and shall maintain access and hours equally for all CCA Members.
  - That the practitioner has not engaged in any behavior which could harm the other health care professionals, patients or Commonwealth Care Alliance employees. Such behavior includes, but is not limited to, acts of violence committed within or outside the practitioner's practice, whether or not directed towards other health care professionals, patients, or Commonwealth Care Alliance employees, and must be judged by the Credentialing Committee to create a significant risk to other health care professionals, patients or Commonwealth Care Alliance 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). For NPs: the NP 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., 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 Commonwealth Care Alliance participating providers and must adhere to all Commonwealth Care Alliance standards applicable to PCPs. Covering practitioners for the specialist-PCP must be credentialed by Commonwealth Care Alliance

- Access and Availability: As part of its credentialing determinations, the Credentialing Committee may consider, in its discretion, Commonwealth Care Alliance network access and availability needs

You are not entitled to be credentialed or recredentialed 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 Commonwealth Care Alliance-contracted entity. Commonwealth Care Alliance, in its sole discretion, credentials and re-credentials practitioners based on its credentialing criteria set forth in its Credentialing Policies and summarized in this manual. Commonwealth Care Alliance is responsible for all final determinations regarding whether a practitioner is accepted or rejected as a participant in our network. No Commonwealth Care Alliance credentialing or re-credentialing decisions are based on a practitioner's race, ethnic/national identity, 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.

Recredentialing

You will be required to update and re-attest to your information every three years. If a practitioner does not keep his/her information current, or re-attest to information to ensure it is available for re-credentialing, termination may result, in which case the practitioner would need to re-apply to Commonwealth Care Alliance as an initial applicant.

Please note that, unlike initial credentialing, re-credentialing includes an assessment of quality-related information collected by Commonwealth Care Alliance 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 Commonwealth Care Alliance site reviews or audits of practitioner records.

Ongoing Monitoring and Off-Cycle Credentialing Reviews and Actions

Between re-credentialing cycles, Commonwealth Care Alliance 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 or 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 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 Commonwealth Care Alliance programs.

If information is received through the monitoring process that causes the Commonwealth Care Alliance Medical Director and/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 Commonwealth Care

Alliance. 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 Commonwealth Care Alliance receives a direct notification from MassHealth or the Connector to suspend or terminate a practitioner, Commonwealth Care Alliance is required to suspend or terminate the practitioner from its network. In such a case, Commonwealth Care Alliance will notify the practitioner in writing, with the reasons therefore, no later than three business days from the date Commonwealth Care Alliance 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 Commonwealth Care Alliance’s Credentialing Policies, you are entitled to appeal the disciplinary action. A disciplinary action is an adverse action taken by Commonwealth Care Alliance’s Credentialing Committee, up to and including termination from Commonwealth Care Alliance, on the basis of a Committee determination that the practitioner does not meet Commonwealth Care Alliance 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 Commonwealth Care Alliance.

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

- An “Adverse Administrative Action”—an adverse action taken by the Credentialing Committee against a practitioner, up to and including termination from Commonwealth Care Alliance, that is not related to the Committee’s assessment of your competence or professional conduct. Examples include, but are not limited to, a denial or termination due to failure to meet Commonwealth Care Alliance board certification requirements, failure to maintain adequate professional liability coverage, or failure to meet other contractually-specified obligations; or
- A Commonwealth Care Alliance 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 Commonwealth Care Alliance’s Credentialing Committee Chairperson postmarked no more than 30-calendar days following your receipt of Commonwealth Care Alliance’s notice of disciplinary action. Commonwealth Care Alliance will not accept provider appeals after the 3- 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 Commonwealth Care Alliance to hear the appeal. The hearing will occur no earlier than 30 calendar days and no later than 90 calendar days following Commonwealth Care Alliance's receipt of your appeal request, unless otherwise determined by the Commonwealth Care Alliance. The hearing shall consist, at a minimum, of the Panel's review of the written submissions by Commonwealth Care Alliance and the practitioner, but may, at Commonwealth Care Alliance's sole discretion, allow for presentation of live testimony by Commonwealth Care Alliance 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, Commonwealth Care Alliance will not reconsider his/her reapplication for credentialing for 2 years following the effective date of denial or termination, unless the Credentialing Committee, in 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 where ever possible and a review of the Covered Services and Prior Authorization Requirements, found in Section 4 of this Provider Manual. The PCP provides 24-hour, 7 days-a-week coverage for members. A PCP is a provider selected by the member, or assigned by Commonwealth Care Alliance, 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 (NP) may also function as the PCP, 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/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 Commonwealth Care Alliance standards. We will conduct an onsite assessment if the facility is not accredited and has not had a recent Department of Public Health survey.

We credential the following types of medical/ancillary organizational providers:

- Acute care hospitals
- Addiction disorder facilities
- Certified home health agencies
- Community-based organizations
- Community health centers
- Community mental health centers
- Durable medical equipment suppliers
- Freestanding diagnostic radiology centers
- Freestanding outpatient dialysis centers
- Freestanding laboratories
- Hospices
- Inpatient psychiatric facilities
- Intermediate care facilities for the mentally disabled
- Long-term acute care hospitals (LTAC)
- Long-term service and support providers
- Nursing facility (NF)
- Outpatient behavioral health clinics
- Rehabilitation hospitals
- Residential treatment centers for psychiatric and addiction disorders
- Skilled nursing facilities (SNF)

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

- An 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 Commonwealth Care Alliance site visit to that facility is required.

- AAAHC: Accreditation Association for Ambulatory Health Care
- AAAASF: American Association for the Accreditation of Ambulatory Surgery Facilities
- ACHC: Accreditation Commission for Health Care
- ACR: American College of Radiology
- CARF: Commission on Accreditation of Rehabilitation Facilities
- CHAP: Community Health Accreditation Program
- CCAC: Continuing Care Accreditation Commission
- COA: Counsel on Accreditation
- DNV: Det Norske Veritas Healthcare, Inc.
- HFAP: Healthcare Facilities Accreditation Program
- TJC: The Joint Commission

Recredentialing of Organizational Providers

All contracted organizational providers are recredentialed every three 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 if a pattern of quality of care problems has been identified by Commonwealth Care Alliance. 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

Credentialing Department

Commonwealth Care Alliance

2 Avenue de Lafayette
Boston, MA 02111

credentialingdepartment@commonwealthcare.org

SECTION 15: MARKETING GUIDELINES

Providers may market Commonwealth Care Alliance 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 beneficiary in an objective assessment of his/her needs and potential options to meet those needs, they may do so. Contracted providers may engage in discussions with beneficiaries should a beneficiary seek advice. However, Commonwealth Care Alliance 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 beneficiaries to enroll in a specific plan based on financial or any other interests of the provider
- Mail marketing materials on behalf of Commonwealth Care Alliance
- Offer anything of value to induce plan enrollees to select them as their provider
- Offer incentives to persuade beneficiaries 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 and/or participate
- Provide information and assistance in applying for the low-income subsidy (LIS)
- Make available and/or distribute plan marketing materials in common areas
- Refer their patients to other sources of information, such as SHIPs, Commonwealth Care Alliance marketing representatives, their State Medicaid Office, local Social Security Office, CMS' website www.medicare.gov/, or 1-800-MEDICARE
- Share information with patients from 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 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 (1) Plan/Part D Sponsor. This may be done through direct mail, email, or by telephone. Neither the Plan/Part D Sponsor nor the contracted provider is required to notify beneficiaries 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. Commonwealth Care Alliance is responsible to work with the contracted provider to ensure approval is granted from both MassHealth and CMS.

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

SECTION 16: COMPLIANCE and FRAUD, WASTE & ABUSE programs

Commonwealth Care Alliance'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). This Compliance Program applies to all of CCA's lines of business. CCA's 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.

CCA's Compliance Program contains the following core elements including fraud, waste and abuse (FWA):

- 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

CCA's 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 non-compliance;
- Prevent, detect, investigate, mitigate and appropriately report suspected incidents of fraud, waste and abuse; and
- Promote and enforce CCA's Code of Conduct.

Commonwealth Care Alliance's Fraud, Waste & Abuse Program

CCA is committed to preventing, identifying, investigating, correcting, and appropriately reporting suspected cases of fraud, waste, and abuse. CCA looks to its providers to assist in this effort.

The mission of CCA's FWA Program is to assist in protecting the integrity of CCA, federal and state programs by working to prevent, identify, investigate, correct and report suspected incidents of fraud, waste and abuse. This FWA Program is an integral part of CCA's Compliance Program. CCA must work collaboratively to combat fraud, waste and abuse. Anyone conducting business with CCA is expected to report any suspected cases of fraud, waste or abuse to CCA through one of the following reporting mechanisms without fear of retaliation or retribution for reports made in good faith:

1. Contact CCA's Chief Compliance Officer

   James Moran - jmoran@commonwealthcare.org

   617-426-0600 x6991

2. Report to CCA's Compliance Hotline 800-826-6762
3. Email CCA_Compliance@commonwealthcare.org
4. Mail directly to:
   Commonwealth Care Alliance
   Attn: Fraud, Waste and Abuse Department
   30 Winter Street, 11th Floor
   Boston, MA 02108

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 health care 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 health care 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-CCA member 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. An example of abuse includes 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.

CCA's FWA Program, as well as 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 FWA, including, but not limited to, the federal Anti-Kickback Statute, the federal False Claims Act, the Massachusetts False Claims Law, and federal and state whistleblower protections.

The Anti-Kickback Statute prohibits the exchange, or offer to exchange, anything of value in an effort to induce (or reward) the referral of federal health care program business. It is an intent-based statute requiring that the party "knowingly and willingly" engaged in the prohibited conduct.

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. Using the Massachusetts False Claims law, the False Claims Division conducts civil investigations and prosecutions against companies and individuals who mislead or defraud state or municipal entities through the use of false or fraudulent claims, records or statements.

A whistleblower is a person who exposes any kind of information or activity that is deemed illegal, unethical, or not correct within an organization that is either private or public. Whistleblower protections protect reporters against retaliation and grant Federal and State Protection.

- https://www.whistleblowers.gov/know_your_rights
- http://www.mass.gov/eopss/whistleblowerfraud-waste-and-abuse-information.html

Click here to access CCA's Compliance and FWA resources information on CCA's 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 & Abuse Training

All providers contracted with CCA are required to complete General Compliance and FWA 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 and Medicaid Services (CMS) has developed a training program "Medicare Parts C and D General Compliance Training" and a "Medicare Parts C and D Fraud Waste and Abuse 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, including suspected incidents of FWA related to CCA member or program, please report it in one of the following methods:

- Call CCA's Compliance Officer at 617-426-0600 x6991
- Call CCA's Compliance Hotline at 800-826-6762. The Compliance Hotline is a confidential and anonymous avenue for reporting a compliance concern such as a suspected fraud, waste, or abuse case.
- Email CCA_Compliance@commonwealthcare.org. Please note that this is not an anonymous method.

Policies and Procedures

The following CCA compliance and FWA policies and procedures are available to providers upon request by contacting the company's Compliance Officer at 617-426-0600 x1300.

- Compliance Training and Education (Compliance 027)
- Fraud, Waste, and Abuse (Compliance 025)
- Reporting, Investigating and Externally Reporting a Compliance Concern (Compliance 088)
- Compliance Monitoring (Compliance 099)
- Compliance Auditing (Compliance 016)
- Whistleblower Protections, False Claims Act and Deficit Reduction Act (Compliance 028)
- Anti-Kickback Statute and Stark Law (Compliance 057)

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 members.

Provider Training Requirements

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 Commonwealth Care Alliance oversight can be found on our website here.

Primary Care Providers

In addition to the training above, Commonwealth Care Alliance providers contracted as primary care providers, and their downstream and related entities, must comply with state requirements for training which include trainings for compliance, cultural competency, and model of care.

Commonwealth Care Alliance reserves the right to request verification that all primary care site providers and their downstream and related entities have completed required trainings. Failure to demonstrate compliance with training requirements may result in Commonwealth Care Alliance terminating its contract with the primary care site.

Behavioral Health Facility Human Rights

All contracted Behavioral Health Facilities that offers inpatient care are required to have human rights protocols in place. These protocols must be consistent with the Department of Mental Health (DMH) protocols and periodically reviewed. The protocols include, but are not limited to, staff training and education. In addition to training, the facility should also have, if not designate, a human rights officer, a human rights oversight committee and be able to provide written documentation to members regarding these rights.

All licensed clinicians must obtain CEUs to maintain their license. It is the provider's responsibility to ensure that staff have valid licensure and documented on an annual basis. CCA has the right to request documentation to audit the validity of all licenses to ensure they are current and valid.

One Care Specific Training for Providers

One Care Providers on Care Teams

Commonwealth Care Alliance provides training to all contracted providers serving on a One Care interdisciplinary care team (ICT). The required training focuses on topics designed to help improve health care quality through person-centered coordinated care.

Additionally, the two Massachusetts One Care plans have worked with MassHealth and its contactor, UMass, to develop a single coordinated training program to address the numerous federal and state training requirements. The required training topics include:

Part One:

Part one is a five-module training series developed by key stakeholders to focus on topics designed to provide foundational information on the One Care program and to help improve health care quality through person-centered, coordinated care. Topics include:

- Introduction to the Duals Demonstration
- Contemporary models of disability (Independent Living, the Recovery Model, Self-Determination)
- Cultural competence
- Americans with Disabilities Act (ADA) compliance
- Enrollee Rights

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 all the training options available to you and to learn how to enroll for your preferred option, go to https://onecarelearning.ehs.state.ma.us/. UMass and the One Care Plans will coordinate the tracking of your participation in part one of the training requirements.

To receive credit for attending the training, you will need to follow a link provided at the end of the module to attest to completion of the training. You only need to complete these five required modules once. To help ease your administrative burden and time commitment as a network provider, the three 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. Once you have completed this section of the training, you will receive a Certificate of Completion for your records.

Part Two: Training for our Health Home and Behavioral Health Home Partners

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

- Commonwealth Care Alliance model of care, benefits, and authorizations, LTS coordination and care transitions
- Wellness
- MDS, assessment, and care planning

For your benefit, Commonwealth Care Alliance has also developed additional optional trainings including:

- Care planning and care teams
- Overview of behavioral health topics
- Overview of motivational interviewing

SECTION 18: FORMS

Forms

Appointment of Representative (Form CMS-1696)*

EDI Transactions Questionnaire

Notice of Privacy Practices

Prior Authorization Standardized Request Form – Mass Collaborative

Prior Authorization Form - Cardiac Imaging

Prior Authorization Form - CT/CTA/MRI/MRA

Prior Authorization Form - PET – PET CT

Prior Authorization Form – Massachusetts Medication Requests

Prior Authorization Form – Repetitive Transcranial Magnetic Stimulation Request

Prior Authorization Form – Psychological and Neuropsychological Assessment

Provider Referral Form: SCO

Provider Referral Form: One Care

The Patient Health Questionnaire 2 Overview (PHQ 2)

The Patient Health Questionnaire- (PHQ 9)

Mental Status Exam

CAGE Questionnaire

Form Instructions

Claims Requirements 1500 Professional Form (pdf)

Claims Requirements UB Institutional Form (pdf)