commonwealth care alliance® MASSACHUSETTS

CCA Senior Care Options (HMO D-SNP) and CCA One Care (Medicare-Medicaid Plan)
Provider Manual | 2024

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Welcome Letter

Dear Commonwealth Care Alliance Provider:

Welcome to the Commonwealth Care Alliance (CCA) provider manual. This manual includes information about how providers can do business with CCA, as well as information about our CCA Senior Care Options and CCA One Care plans.

CCA is committed to partnering with healthcare providers to ensure that our members receive the highest-quality coordinated care. To facilitate this, we have created an administrative resource that provides comprehensive information about our programs and plans. Along with detailed CCA program information, you will find our policies and procedures, referral and claim information, as well as other useful reference materials. We hope providing these materials will make working with CCA staff and members as seamless as possible.

CCA members are encouraged to be active participants in their healthcare. When members enroll in a CCA plan, they receive a Member Handbook, which outlines the terms of benefits. Copies of the handbook may be obtained by contacting our Member Services department at 866-610--2273.

If you need any further information about the contents of this provider manual, please feel free to contact Provider Relations by sending an email to providerrelations@commonwealthcare.org. Thank you for choosing to be a part of our network.

SECTION 1: Key

Contact Information

Contact	Telephone	Fax	Email	Website/Portal
Claims – Includes Medical, Non-routine Vision, and Hearing				
For Dates of Service: Through March 31, 2023 Claims Customer Service • Refunds and escalations • Corrected claims • Claims status • Claim receipt • Check run New providers, contracting, and EDI electronic billing setup TTY Massachusetts Relay Service	800-306-0732 800-439-2370 (TTY 711)		Email: ccaedisupport@pcgus.com	
For Dates of Service: April 1, 2023 - Onward Claims Customer Service • Refunds and escalations • Corrected claims • Claims status • Claim receipt New providers, contracting, and EDI, electronic billing setup or problems (Availity)	866-420-9332 800-Availity 800-282-4548	855-865-1814	E-ticketing: Availity Essentials Provider Portal - Select Help & Training > Availity Support Submit an online support request or chat online.	Portal: apps.availity.com/web/welcome/#/edi Registering (1st time): availity.com/Essentials-Portal-Registration

SECTION 1: Key Contact Information

Contact	Telephone	Fax	Email	Website/Portal
Member Services				
General questions • Initial contact Member appeals • Service denials (process; how to respond) Member benefits • Member information; coverage	866-610-2273	617-426-1311	Email: memberservices@commonwealthcare.org	
Member Appeals and Grievances				
Member appeals Member grievances	866-610-2273		Email: agdepartment@commonwealthcare.org	
Member Enrollment				
Outreach and marketing • Referrals for potential members	866-610-2273	617-830-0534	Email: marketdevelopment@commonwealthcare.org	
Clinical Operations				
Prior authorization • Benefit and service authorizations Transitions of Care team and facility inpatient authorization	866-420-9332 857-246-8822	855-341-0720 855-811-3467		
Dental Benefit Administrator: SKYGEN				
• Claims processing • Member eligibility • Prior authorization submission • Provider Relations	855-434-9243		Email providerservices@skygenusa.com	Portal: pwp.sciondental.com *Dental Provider Manual located in the dental provider portal*

Hearing (Routine) Benefit Administrator: NationsHearing				
• Claims processing • Member eligibility • Provider Relations • Hearing Provider Manual NationsHearing Attention: Claims 1801 NW 66th Avenue, Suite 100 Plantation, FL 33313	800-921-4559			Portal: providers.nationshearing.com
Pharmacy				
General questions Pharmacy coverage determinations (e.g., prior authorization) • Electronic prior authorizations-pharmacy Pharmacy redeterminations (appeals)	866-420-9332 866-270-3877 866-610-2273	 855-668-8552 857-453-4517	Email: providerservices@commonwealthcare.org	
Provider Services				
Provider Services • Covered services • Authorization status • Service denials/appeals status • Provider Portal • General questions	866-420-9332			

Contact	Telephone	Fax	Email	Website/Portal
Provider Network				
Provider Relations • Training, orientation, general questions			Email: providerrelations@commonwealthcare.org	
Provider data management • Provider enrollment • Provider demographic updates • Provider enrollment status		857-465-7465	Email: pnmdepartment@commonwealthcare.org	
Credentialing • Credentialing status • Submission of updated licensure			Email: credentialing@commonwealthcare.org	
Provider contracting • Requests to become a Commonwealth Care Alliance provider, medical or behavioral health		617-517-7738	Email: ccacontracting@commonwealthcare.org	

Contact	Telephone	Fax	Email	Website/Portal
Vision (Routine) Benefit Administrator: VSP				
Claims processing • Member eligibility • Covered services • Provider Services • Appeals and grievances • Vision Provider Manual In-network providers Vision Service Plan Attention: Claim Services PO Box 385020 Birmingham, AL 35238-5020 Out-of-network providers Vision Service Plan Attention: Claim Services PO Box 385018 Birmingham, AL 35238-5018	800-615-1883			Portal: vspproviderhub.com
Silver & Fit Fitness Benefit				
SCO ONLY • Claims processing • Member eligibility • Provider Relations • Gym Assignment American Specialty Health Fitness, Inc. PO Box 509117 San Diego, CA 92150-9117				

Contact	Telephone	Fax	Email	Website/Portal
Compliance				
Concerns and reporting • Fraud, waste, and abuse and compliance concerns	866-457-4953 Compliance Hotline **anonymous**			CCA Electronic submission form
Third-Party Liability				
COB, third party, Q&A	617-426-0600 Ext. 5-1221		Email: tplcoordinator@commonwealthcare.org	
Interpreter Services				
Providers may contact the CCA Provider Services department, along with the member, to be connected to the appropriate interpreter telephonically. Please have member's name and ID number available. Provider Services is available during the hours of 8 am to 6 pm, Monday–Friday. For assistance after business hours and weekends, please call CCA Member Services. Member Services is available during the hours of 8 am to 8 pm, Monday–Friday, and 8 am to 6 pm, Saturday and Sunday, to assist members with interpreter services.	Provider Services: 866-420-9332 Member Services: 866-610-2273		Email: providerservices@commonwealthcare.org Email: memberservices@commonwealthcare.org	

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 healthcare to its members.

What is Commonwealth Care Alliance?

Commonwealth Care Alliance® (CCA) is a mission-driven healthcare services organization that offers high-quality health plans and care delivery programs designed for individuals with the most significant needs. CCA delivers comprehensive, integrated, and person-centered care by coordinating the services of local staff, provider partners, and community organizations. CCA's unique model of *uncommon care*® has achieved an unparalleled track record of improved health and quality outcomes and lower costs of care.

Our mission is to improve the health and well-being of people with the most 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 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
- 24/7 personalized continuity in all care settings
- Selective comprehensive primary care networks and selective networks of physician specialists, healthcare 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

CCA Senior Care Options (HMO D-SNP) Eligibility Requirements

Commonwealth Care Alliance Senior Care Options is for elders who:

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

*** Note:** The Senior Care Options 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)

CCA One Care (Medicare-Medicaid Plan) 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 Senior Care Options and One Care. Please see example cards below.

CCA Senior Care Options (HMO D-SNP)

Please refer to page 23 for the claims submission address.

CCA One Care (Medicare-Medicaid Plan

Please refer to page 23 for the claims submission address.

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 the CCA Provider Services department at 866-420-9332 and they will be connected to the appropriate interpreter telephonically.

- Please have the member's name and CCA ID number available.

Provider Services is available during the hours of 8 am to 6 pm, Monday–Friday. For assistance after business hours and weekends, please call CCA Member Services at 866-610-2273.

Member Services is available during the hours of 8 am to 8 pm, Monday–Friday, and 8 am to 6 pm, Saturday and Sunday, to assist members with interpreter services.

Member Rights and Responsibilities

Commonwealth Care Alliance members deserve the best service and health care possible. CCA is committed to maintaining a mutually respectful relationship with its members.

Clearly outlined member rights and responsibilities help foster cooperation among members, practitioners and CCA. Member rights and responsibilities are updated annually. You can find the most up to date versions of the member rights and responsibilities by following the links below.

- Member Rights and Responsibilities
    - CCA One Care (Medicare-Medicaid Plan)
    - CCA Senior Care Options (HMO D-SNP)

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, public assistance, or place of residence. 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, public assistance, or place of residence.

All CCA providers must:

1. Provide all medically necessary covered services to members
2. Provide services without resulting in unlawful discrimination against members
3. Assist non-English-speaking members with interpreter services if needed (providers can call CCA Provider Services for translation services at 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 10 calendar days, and specialty care office visits must be available within thirty (30) days of the member's request for non-urgent symptomatic care.

Urgent Care and Symptomatic Office Visits

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

Non-symptomatic Office Visits

All non-symptomatic office visits must be available to members within 30 calendar days. Examples of non-symptomatic office visits include, but are not limited to, well and preventive care visits for covered services, such as annual physical examinations or immunizations.

Behavioral health providers access and availability time frames can be found in Section 11 of this Provider Manual.

Member 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 a post service member appeal or grievances on behalf of a member. A pre-service appeal will not be delayed for receipt of the AOR from a provider only; others will need to submit the AOR, prior to beginning a member appeal or grievance.

An AOR form can be printed from the following link: cms.gov/medicare/cms-forms/cms-forms/downloads/cms1696.pdf. The form must be completed and signed by the member and the provider within 44 days of receipt of the appeal request.

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

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

Member Appeals

Appeals are procedures that deal with the review of adverse initial determinations made by Commonwealth Care Alliance regarding healthcare services or medication. Appeals processed by CCA are called Level 1 appeals. Depending on whether the service or drug is covered by Medicare or Medicaid or both, there are additional levels of appeals available, including: Independent Review Entity (IRE) or Board or Hearing (BOH), Administrative Law Judge (ALJ), Medicare Appeal Counsel (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 for pre-service requests. 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 and Grievances department at 857-453-4517 or via mail at the address listed above.

A participating provider does not need to be the representative to initiate a pre-service appeal but is required to submit an appointment of representative form (AOR) for post-service member appeals prior to the end of the appeal time frame. CCA includes as parties to the appeal the member and the appeal representative, or the legal representative of a deceased member's estate. Participating providers filing a dispute regarding how a claim was processed must utilize the Provider Payment Disputes and Appeals process found in Section 6.

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

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

*Pre-service appeal requests that are not entirely pre-service will be split, addressing pre-service appeals and post-service claim appeals separately. If an appeal request is post-service but pre-claim, this request will be dismissed until the claim organization determination has been made for the date of service (e.g., claim is processed). Participating providers filing a dispute regarding how a claim was processed must utilize the Provider Payment Disputes and Appeals process found in Section 6.

Pre-service 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 member or the member's ability to regain maximum function (the physician does not have to use these exact words), the plan will process the appeal as expedited.

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

Appeals decided by a Medical director during the utilization review will be reviewed on appeal by another medical director who has not been involved in the initial level of review and does not report to the individual who made the initial determination. Appeals will be reviewed by a physician with the same or similar specialty as the appealing provider. Providers and members may submit supporting evidence for the appeal at any point during the appeal time frame. Upon decision, the member and provider are notified in writing. For expedited appeals, the member and provider will also receive verbal notification of the decision.

If an appeal is approved, authorization will be entered within the appeal time frame. If an appeal is denied, there are additional levels of review available. CCA requires that members and their appeal representative exhaust the CCA internal appeals process before filing a Level 2 (external) appeal.

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 for a Level 2 review with the Board of Hearing (BOH). For services covered by both Medicare and Medicaid, both processes may be used and the decision most favorable to the member is effectuated (See External Appeals table below).

External Appeals

CCA ensures that members have access to all Medicare Appeal processes.

Level	Type	Entity
1	Internal	CCA
2	External	The Independent Review Entity (IRE) (Medicare); Board of Hearing (Medicaid)
3	External	Administrative Law Judge (ALJ)
4	External	Medicare Appeals Council (MAC)
5	External	Federal District Court

Grievances

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

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 appointed representative.

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 CCA One Care (Medicare-Medicaid Plan) grievances that are received orally, and all other cases are responded to in writing. Grievances about quality of care are always responded to in writing.

Grievance Resolution Time Frames	
Standard	30 days, plus extension up to 14 days, when applicable
Expedited	24 hours

Grievances are handled according to the standard time frame 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: Prior Authorization Requirements

In accordance with the member's Evidence of Coverage, certain services performed by contracted providers require prior authorization before being rendered. The Commonwealth Care Alliance Authorization and Utilization Management department is responsible for reviewing prior authorization service requests from providers. All requests, except behavioral health and inpatient/observation admissions—must be faxed to **855-341-0720** using the Standardized Prior Authorization Request form along with the necessary clinical documentation to support the request. Use the Standard Prior Authorization 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.
- Inpatient/observation admissions authorization service requests must be faxed to **855-811-3467** using the standard prior authorization form for the service requested along with the necessary clinical documentation to support the request.
    - Download the Standard Prior Authorization Form
- CCA utilizes Patient Ping, a secure, third party admission and discharge notification software system.
    - CCA will create the admission authorization once notified of the member's admission for facilities who contract and participate in the use of Patient Ping, preventing late authorizations.
        - If you do not contract with patient ping, admission notification is required within 24-48 hours of facility admission
- CCA Massachusetts does not require submission of clinical information for those facilities which have granted electronic medical record (EMR) access to CCA staff for medical necessity (MN) review (except for members who have restricted EMR access. Clinical submission is still required for these members.)
    - Providers must review their contracts to determine EMR agreements.
    - All facilities which have not granted CCA EMR access are required to submit clinical information timely for MN review.
- Please go to CCA's provider portal to check the status of your authorization request; CCA Provider Portal.
    - For more information, please refer to section six, claims and billing procedures.
- Contracted acute care facilities of CMS are required to issue the Medicare Outpatient Observation Notice (MOON), Form CMS10611-MOON to CCA members who receive hospital outpatient observation services. CCA members are not responsible for any cost share and therefore cannot be billed, though they are still expected to receive and sign the MOON when they receive observation services.
    - Providers may access instructions and the MOON forms (English and Spanish) on the CMS website at https://www.cms.gov/Medicare/Medicare-General-Information/BNI/MOON.

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 **866-420-9332** for clarification.

- Prior Authorization Requirements Table

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 One Care and Senior Care Options.

Utilization Determination Time Frames

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

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

Category of utilization management decision	Review and determination time frame
Standard	Determination and notification within 14 calendar days after receipt of request, and as quickly as needed based on the member's health condition
Standard Extension	Up to 14 additional calendar days (not to exceed 28 calendar days) after receipt of the original request
Expedited	Determination and notification as quickly as the member's health condition requires, but no later than 72 hours after receipt of the request
Expedited Extension	Up to 14 additional calendar days (not to exceed 17 calendar days) after receipt of the original request
Concurrent	Determination and notification as soon as medically indicated; usually within 72 hours of request
Medicare Part B Standard request	Determinations are made no later than 72 hours of request
Medicare Part B Expedited request	Determinations are made within 24 hours of request

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

Clinical Decision Making

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

We use InterQual® criteria to review certain services (such as imaging, DME, and inpatient). We make these criteria available, upon request, to members and providers impacted by a denial decision.

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.

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

About Medical Criteria Request

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

Discharge Notification and Planning

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

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

- Requests for facility stay extensions (Note: Contact must be made prior to the expiration of the approved days)
- Requests to move members to a different level of care
- Discharge plans that include any of the following:
    - Home health services or specialized durable medical equipment
    - Multiple medications
    - Programs for lifestyle changes like weight management, nutrition, smoking cessation, exercise, diabetes education, or stress management
- Facilities are requested to submit all discharge documentation within 24 hours of members discharge; including medication list, after visit summary, and completed discharge summary if available to the Transitions of Care Department via fax 855-811-3467.

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 by qualified hospital personnel for all individuals who seek care in a provider's emergency department. A provider will either provide stabilizing treatment for that individual or arrange for another qualified provider to do so. Nothing shall impede or obstruct a provider from rendering emergency medical care to an individual.

Referrals

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

Continuity of Care

Out-of-network providers: CCA will honor covered services provided by an out-of-network provider during the continuity of Care period. Please refer to our Out-of-Network Provider Payment Policy.

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

SECTION 5: Centralized Enrollee Record

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

In order to ensure the highest-quality, most effective healthcare 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 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 the Commonwealth Care Alliance 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 their 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. For detailed instructions for completing both the CMS HCFA 1500 and UB-04 claim forms, please use the links below.

- CMS HCFA 1500
- CMS UB-04 claim

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

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

Commonwealth Care Alliance (CCA) partnered with Cognizant to implement the new Facets claims platform, which went into effect on April 1, 2023. We have modified this section to include pre- and post- implementation guidance for ease of access.

Contact Information for Provider Claims, Billing Support, and EDI Support	
For Dates of Service: Through March 31, 2023	**For Dates of Service: April 1, 2023 – Onward**
Claims Customer Service at 800-306-0732 Available M–F, 8:30 am – 5 pm	CCA Provider Services at 866-420-9332 Available M–F, 8 am – 6 pm
EDI support: ccaedisupport@pcgus.com	EDI Support: Availity Client Services at 800-Availity (800-282-4548) M–F, 8 am – 8 pm
EZNET Online Claims Web Portal	Availity Essentials Provider Portal To register click on the registration button in the upper right corner and follow the instructions.

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, review Section 4 of this manual, or contact Commonwealth Care Alliance Provider Services 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 prior authorization covers a long period.

Eligibility may be confirmed by:	
For Dates of Service: Through March 31, 2023	**For Dates of Service: April 1, 2023 – Onward**
Logging in to the CCA Provider Portal	Using the Availity Essentials Provider Portal*
Logging in to the EZNET Online Claims Web Portal	Logging in to the CCA Provider Portal
Using the MassHealth Provider Online Service Center	Using the MassHealth Provider Online Service Center
Using the NEHEN Provider Portal*	Using the NEHEN Provider Portal*
Contacting CCA Provider Services at 866-420-9332	Contacting CCA Provider Services at 866-420-9332

**Supports batch Eligibility transactions*

Claims Submission

Commonwealth Care Alliance accepts submissions of properly coded claims from providers by means of Electronic Data Interchange (EDI) or industry-standard paper claims. The provider acknowledges and agrees that each claim submitted for reimbursement reflects the performance of a covered service that is fully and accurately documented in the member's medical record prior to the initial submission of any claim. No reimbursement or compensation is due should there be a failure in such documentation. 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, review Section 4 of this manual, or contact the Commonwealth Care Alliance 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.

Minimum Requirements for EDI Claims:

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

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Companion Guide and Training Manual	Companion Guide and Training Manual
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 use the secure EZNET Online Claims Web Portal for all other claim inquiries.	To register with the Availity Essentials Provider Portal, click on the registration button in the upper right corner and follow the instructions. If you have additional questions or need assistance, please contact Availity Client Services at 800-Availity (800-282-4548), M–F, 8 – 8 pm ET.
Initial EDI Setup 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.	**Initial EDI Setup** In order to view member eligibility, claims status and submit claims electronically to Commonwealth Care Alliance, providers must register with the Availity Essentials Provider Portal

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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 the Commonwealth Care Alliance 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 EZNET 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 our secure web portal. Alternatively, providers who submit non-batch 837 files may opt to enroll in one of various ways that clearinghouse Change Healthcare can accept claims. There are multiple options that providers may use, including ConnectCenter and APIs. Please click here to determine what might fit your office needs. **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.	**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 the Commonwealth Care Alliance payer ID number, **A2793**. This PIN is the identifier at the Clearinghouse to route claims directly to the Claims Operation department. ***Option Two*** **Direct Submitters** This option is for those entities that choose to create their own 837 file and submit that file directly to the Availity Essentials Provider Portal with the CCA payer ID number **A2793**. 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 register to access information. Once you are a registered user, please click here to access the Availity Essentials Provider Portal. ***Option Three*** **Single Claims Submitters** Single claims submissions are for industry standard claim forms. Providers are required to register with the Availity Essentials Provider Portal for claims submission and to validate member eligibility and claim status. **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.

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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 Providers may submit corrected claims electronically or by mailing a corrected paper claim to correct a claim that was previously submitted and paid or denied. Corrected claim submissions do not apply to an original or first-time submission. Please click here to obtain the Request for Claim Review form. Mail corrected paper claims to: Commonwealth Care Alliance P.O. Box 548 Greenland, NH 03840-0548	**Reprocessing EDI Claims** Providers may submit corrected claims electronically or by mailing a corrected paper claim to correct a claim that was previously submitted and paid or denied. Corrected claim submissions do not apply to an original or first-time submission. Please click here to obtain the Request for Claim Review form. Mail corrected paper claims to: Commonwealth Care Alliance Claims P.O. Box 3085 Scranton, PA 18505

Electronic Funds Transfer (EFT)

Commonwealth Care Alliance (in partnership with Payspan) has implemented an enhanced online provider registration process for electronic funds transfer 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
- EFT is HIPAA compliant (ASC X12 835 Health Care Payment and Remittance Advice or subsequent standard)

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

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

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 workflow management options to manage your payments and remittances.

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

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

Paper Claims

All providers are encouraged to submit claims to 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 a provider does submit paper claim forms, the following forms are acceptable.

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

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

- CMS HCFA 1500
- CMS UB-04 claim

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

For Dates of Service: Through March 31, 2023	For Dates of Service: April 1, 2023 – Onward
Mail all paper claims to: Commonwealth Care Alliance P.O. Box 548 Greenland, NH 03840-0548	**Mail all paper claims to:** Commonwealth Care Alliance Claims P.O. Box 3085 Scranton, PA 18505
Please note: While Commonwealth Care Alliance accepts paper claim submissions, electronic billing and electronic funds transfer 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 EZNET Online Claims Web Portal.	Please note: While Commonwealth Care Alliance accepts paper claim submissions, electronic billing and electronic funds transfer are preferred. Please register with the Availity Essentials Provider Portal. If providers utilize billing agencies to manage their account receivables, please grant them access to Payspan.
Use of 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 Invoices** CCA will **no longer accept** spreadsheets as a claim submission. Invoice submitters will be required to register with Availity Essentials Provider Portal and follow the single claim submitter process. Availity has many online resources to assist your practice with this transition. https://apps.availity.com/availity/Demos/QSG_AE_PayerImplementations.pdf

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 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 in a timely manner:

- 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
    - Commonwealth Care Alliance product name or line of business

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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 may call Claims Customer Service at 800-306-0732.	**Checking Claim Status** Once you are a registered user, providers may check claims status, member eligibility, and provider status through the Availity Essentials Provider Portal. All other providers requesting information on the status of a claim, including clarification of any Explanation of Payment may call CCA Provider Service at 866-420-9332.
Web Portal Commonwealth Care Alliance offers two secure web portals where providers can obtain access to claim status, member eligibility, and other options. **CCA Provider Portal:** CCA offers a secure Provider Portal, where active and participating providers,	**Web Portal** Commonwealth Care Alliance offers two secure web portals where providers can obtain access to claim status, member eligibility, and other options. **CCA Provider Portal:** CCA offers a secure Provider Portal, where active and participating providers, provider groups,

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provider groups, hospitals, and ancillaries may register to obtain access to member eligibility and authorization status; to access and download CCA documentation, forms, and templates; to access the EZNet Online Claims Web Portal; and to access Explanation of Payments. To access the CCA Provider Portal, you will need to create a new account. Be sure to have the most recent CCA Explanation of Payment (EOP) available, along with "check number" and corresponding "payment amount" to assist in the validation process. Please click the CCA Provider Portal and follow the additional steps required for access. **EZNET Online Claims Web Portal:** The easy-to-navigate claims web portal requires authorized billers and providers to obtain a login to access this information. To request online access, please email ccaedisupport@pcgus.com. If providers utilize billing agencies to manage their account receivables, please grant them access to Payspan and to the secure EZNET Online Claims Web Portal.	hospitals, and ancillaries may register to obtain access to member eligibility and authorization status; to access and download CCA documentation, forms, and templates; ro access the claims portal; and to access Explanation of Payments. To access the CCA Provider Portal, you will need to create a new account. Be sure to have the most recent CCA Explanation of Payment (EOP) available, along with "check number" and corresponding "payment amount" to assist in the validation process. Please click the CCA Provider Portal and follow the additional steps required for access. **Availity Essentials Provider Portal:** The easy-to-navigate claims Availity Essentials Provider Portal requires authorized billers and providers to register. If providers utilize billing agencies to manage their account receivables, please grant them access to Payspan.

Corrected Claims

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

How to Submit a Corrected Claim

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

A Request for Claim Review form must accompany each paper corrected claim. For detailed instructions for completing both the CMS HCFA 1500 and UB-04 claim forms, please use the links below.

- CMS HCFA 1500
- CMS UB-04 claim

A paper 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 UB-04 paper claim form with the corrections
   - No handwritten changes
   - No correction fluid on form
3. Any required supporting documentation

Submission Requirements

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

For Dates of Service: Through March 31, 2023	**For Dates of Service: April 1, 2023 – Onward**
Provider must submit their paper corrected claim requests to the address below: Commonwealth Care Alliance, P.O. Box 548, Greenland, NH 03840-0548	**Provider must submit their paper corrected claim requests to the address below:** Commonwealth Care Alliance, Claims P.O. Box 3085, Scranton, PA 18505
Rejected Claims If Commonwealth Care Alliance returns/rejects a claim due to missing or incomplete information, it is the provider's responsibility to resubmit a clean claim within original filing limits. **Mail all paper claims to:** 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 resubmit a clean claim within original filing limits. **Mail all paper claims to:** Commonwealth Care Alliance, Claims P.O. Box 3085, Scranton, PA 18505

Provider Payment Disputes and Appeals

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

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

Provider Payment Disputes Do Not Include:

- Seeking resolution of a contractual issue payment disputes, wherein the provider believes CCA is paying an amount different than was contractually agreed. Please direct these concerns to ccacontracting@commonwealthcare.org.
- An appeal made by a provider on behalf of a specific member. These should be directed to the CCA 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 the CCA Request for Claim Review form.

All Provider Payment Disputes Must Include:

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

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

Payment Dispute Submission Requirements for Contracted Providers

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

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

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

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.

For Dates of Service: Through March 31, 2023	For Dates of Service: April 1, 2023 – Onward
Provider Payment Disputes and Appeals: Contracted and non-contracted Providers must submit their request to the address below: Commonwealth Care Alliance Attn: Payment Disputes and Appeals P.O. Box 548 Greenland, NH 03840-0548 For additional questions on provider payment disputes or appeals, please contact the Claims Customer Service department at 800-306-0732.	**Provider Payment Disputes and Appeals:** Contracted and non-contracted Providers must submit their request to the address below: Commonwealth Care Alliance Attn: Payment Disputes and Appeals P.O. Box 3566 Scranton, PA 18505 For additional questions on provider payment disputes or appeals, please contact CCA Provider Services at 866-420-9332.

Hospice

Senior Care Options: Commonwealth Care Alliance's participation in the hospice pilot program ended December 31, 2021. Beginning January 1, 2022, Original Medicare is the payer for dually eligible Senior Care Options members who elect hospice on or after January 1, 2022. MassHealth Only Senior Care Options members remain with CCA as they payer.

One Care: Services rendered to CCA One Care 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: Payment Policies.

National Drug Coverage

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

Revenue Code	Description
Rev Code 192	Sub-acute level of care—short-term, goal-oriented treatment plan requiring nursing care or rehabilitation at a high intensity level; lower intensity than acute care
Rev Code 191	Skilled nursing level of care—short-term, goal-oriented treatment plan while the member cannot be treated in a community-based setting; lower intensity than sub-acute
Rev Code 100	Custodial 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 policy regarding reimbursement.

Degree	License and/or certification	Modifier	Commonwealth Care Alliance Policy
Physician	MD, DO	U6	May provide/bill for direct services
Physician Assistant	PA	SA	May provide/bill for direct services
Psychologist: Ph.D., Psy.D., Ed.D.	LP	AH	May provide/bill for direct services
Advanced Practice Nurse; Clinical Nurse Specialist	APRN, RNCS	SA	May provide/bill for direct services
Nurse Practitioner	NP	SA	May provide/bill for direct services
Licensed Independent Clinical Social Worker	LICSW	AJ	May provide/bill for direct services
Licensed Independent Clinical Social Worker, Licensed Mental Health Counselor; Licensed Marriage and Family Therapist, Licensed Social Worker	LICSW, LMHC, LMFT, LCSW	HO	May provide/bill for direct services
Master's in social work, Counseling, and Clinical Psychology	MSW, MA, MS, M. Ed	HL	May provide/bill for direct services only under the direct personal supervision of an independently licensed clinician.
Licensed Alcohol and Drug Counselor, Certified Alcohol and Drug Counselor – Advanced	LADC I, CADC II	HO	May provide/bill for direct services
Certified Alcoholism Counselor, Certified Alcohol and Drug Counselor,	CAC, CADC	HL	May provide direct services only under the direct personal supervision of an independently licensed clinician.
Registered Nurse	RN	TD	May provide/bill for direct service medical services
Bachelor's	None	HN	May provide/bill for community support program, collateral contact, and opioid counseling only

Significant Events with Reimbursement Impact

Serious Reportable Events

According to the National Quality Forum (NQF), serious reportable adverse events (SREs)—commonly referred to as "never events"—are errors in medical care that are clearly identifiable, preventable, and serious in their consequences for patients, and that indicate a real problem in the safety and credibility of a healthcare facility. 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 “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 recoup 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 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 Massachusetts Executive Office of Health and Human Services (EOHHS), to identify, report, analyze, and prevent PPCs.

When a provider is required to provide notification of a PPC, the provider shall provide notification to 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 members going to Medicaid-certified nursing facilities be given a preliminary assessment to determine whether they might have serious mental illness (SMI) or intellectual disability (ID).

This is called a "Level I screen." Those members who test positive at Level I are then evaluated in depth, called "Level II," or PASRR. The results of this evaluation outline a determination of need, determination of appropriate setting, and a set of recommendations for services to inform the member's plan of care. It is a requirement and the responsibility of the facility to ensure that every Commonwealth Care Alliance member 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 ensure compliance with the PASRR. In addition to the audit, if it is then determined that there is no evidence of a completed PASRR on file for any admitted Commonwealth Care Alliance member, 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 members do not have a financial obligation in this matter and will not be subject to any balance-billing from the facility; for any balance-billing attempts, the facility may be in breach of its contract with 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
   - Assesses relevant symptoms and physical examination findings at time of visit
   - Only contains diagnoses that are active or chronic (which must be identified as such)
   - Lists and addresses all past and recent diagnosis if they are active and of medical significance
2. A **status** for each diagnosis to indicate progress or lack thereof; for example:
   - Stable, progressing or worsening, improving
   - Not responding to treatment or intervention
3. A **treatment plan** for each diagnosis; for example:
   - Observation or monitoring for exacerbation, responses to treatment, etc.
   - Referrals to specialists or services (e.g., cardiologist or PT)
   - 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 the Commonwealth Care Alliance Clinical Documentation team to request education about coding and documentation compliance. Please email: rahub@commonwealthcare.org.

Behavioral Health Screening Compliance

In collaboration with EOHHS, Commonwealth Care Alliance requires all of its 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 manual. How to make a behavioral health specialty care referral can be found in Section 14, Provider Credentialing.

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 AUDIT, or DAST screening tools to assess the use of alcohol and other drug abuse and dependence. These tools are not diagnostic but can identify the existence of alcohol or other drug problems.

In addition, CCA recommends that providers conduct a mental status exam to further evaluate 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 assessed and documented during a face-to-face encounter at least once per calendar year for the diagnoses to count for risk adjustment purposes.

Annual Assessment Process

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 to monitor the quality, access, and cost-effectiveness of their services and identify and address opportunities for improvement on an ongoing basis. Providers may be required to submit clinical data and/or clinical documentation to 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 insurance policy and serves to determine which insurance is primarily responsible for payment to ensure claims are paid correctly. An example coverage is an employer-sponsored plan. COB is administered by Commonwealth Care Alliance based on the member's benefit plan and applicable law.

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.

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

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, the workers' compensation insurer is primary, and Commonwealth Care Alliance is the secondary payer of coverage. 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 the Commonwealth Care Alliance Third-Party Liability Claims Investigation Analyst at tplcoordinator@commonwealthcare.org or call 617-426-0600 (ext. 5-1221).

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

Commonwealth Care Alliance has contracted with Navitus Health Solutions, a national pharmacy benefits management company, to administer the pharmacy benefit on behalf of Commonwealth Care Alliance. 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 primary care providers have established relationships and members can access easily. In addition to many smaller independent pharmacies, the Commonwealth Care Alliance pharmacy network includes CVS, Stop and Shop, Walgreens, and many others. For a complete and up-to-date listing of contracted pharmacies, use the link below to access the online directory:

CCA Pharmacy Directory

Formulary

Commonwealth Care Alliance has established a formulary that aims to provide prescribing clinicians with 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 if they are medically necessary. Use the links below to access the formulary list on our web site:

Senior Care Options Formulary
One Care Formulary

The CCA formulary is updated monthly and posted on our website. CCA covers both Abbott and LifeScan diabetic testing supplies. Please refer to our website for a complete list of the supplies covered.

Prior Authorization

Certain medications require prior authorization (prior approval) before a pharmacy can fill the prescription. Clinicians may request prior authorization by calling 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 submit a prior authorization form online. If a 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).

Part D Medications

Medications covered under the pharmacy benefit can be oral, injectable, infusible, or topical medications such as creams and lotions. Prescription drugs under the pharmacy benefit are subject to formulary tiers and may require authorization.

View the list of drugs and prior authorization requirements by plan.

Part B Medications

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

View the list of office administered part B medications that do not require authorization.

Please note: Requests for outpatient part B medical pharmacy drugs (J-Codes) are reviewed by the Utilization Management department.

For medications not addressed in this document, refer to the Medicare Coverage Database to search for applicable coverage policies (national coverage determinations, local coverage determinations, and local coverage articles).

Part B versus D

Medicare medical insurance or part B also covers other selected medications. Some of these medications include:

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

View the list and billing determination forms for part B vs D drugs.

Where to Submit a Prior Authorization

1. Medications that are processed under the pharmacy benefit, and filled at retail pharmacies as well as self-administered specialty medications should be submitted to Navitus:

Phone	866-270-3877
Fax	855-668-8552
Mail	Navitus Health Solutions PO Box 1039 Appleton, WI 54912-1039

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

2. Medications that are processed under the medical benefit and administered by healthcare professionals in the physician office setting should be faxed to the Utilization Department at 855-341-0720. For your convenience, the standard prior authorization request form used for submitting requests for outpatient part B medical pharmacy drugs (J-Codes) can be found here.

Where to Submit an Appeal

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

Phone 1-866-610-2273

Fax 1-857-453-4517

Mail Commonwealth Care Alliance
Appeals and Grievances Department
30 Winter Street, Boston, MA 02108

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

Phone 866-610-2273

Fax 857-453-4517

Mail Commonwealth Care Alliance
Appeals and Grievances Department
30 Winter Street, Boston, MA 02108

Avoid delays

Completing and submitting the correct PA form will ensure there is sufficient information for processing your request. This will prevent delays and unnecessary denials.

Please be sure to include:

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

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

Step Therapy Program

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

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

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

Senior Care Options: Senior Care Options Covered Drugs | Commonwealth Care Alliance MA

One Care: CCA One Care Covered Drugs | Commonwealth Care Alliance MA

Extended Day Supply

Commonwealth Care Alliance members can get an extended day supply (up to 100 days) at contracted community pharmacies for medications that are used for the treatment or management of chronic conditions. This is in addition to members being able to receive extended day supply through mail order. Whether members choose to get their extended day supply through a community pharmacy or mail order, members 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 a high annual drug cost. 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. The review includes prescription, non-prescription, and over-the-counter medications along with 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 and 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 the designated Commonwealth Care Alliance 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 4 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. Sub-acute/skilled days shall be limited to 100 days per benefit period
- Skilled nursing level of care—short-term, goal-oriented treatment plan while the member cannot be treated in a community-based setting, lower intensity than sub-acute. Sub-acute/skilled days shall be limited to 100 days per benefit period
- Custodial level of care—absent of a defined treatment goal, yet the member's functional (ADL) or cognitive status requires the support of a facility setting
- Medical leave of absence (MLOA) days—a bed is guaranteed for the member if he or she returns to the facility during the 1st day through the 20th day after transferring out of the facility. If the member returns after this period, his or her admission shall be accommodated upon the availability of a bed, unless otherwise arranged
- Non-medical leave of absence (NMLOA)—a bed is guaranteed for the member if he or she returns to the facility during the 1st day through the 10th day after transferring out of the facility. If the member returns after this period, his/her admission shall be accommodated upon the availability of a bed, unless otherwise arranged
- Inpatient rehabilitation—intensive rehabilitation program for members. Members who are admitted must be able to tolerate an intensive level of rehabilitation services and benefit from a team approach
- Long-term acute care facility services—treatment of patients with serious medical conditions that require care on an ongoing basis but no longer require intensive care or extensive diagnostic procedures

Level-of-Care Determinations

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

Conditions and criteria for **Skilled Nursing Facility (SNF) Services Under Medicare Part A** are determined in the Medical Necessity Guidelines found here: https://www.commonwealthcarealliance.org/ma/providers/medical-policies/medical-necessity-guidelines/.

Conditions and criteria for **Determination and Documentation of Medical Necessity in an Inpatient Rehabilitation Facility** are determined in the Medical Necessity Guidelines found here: https://www.commonwealthcarealliance.org/ma/providers/medical-policies/medical-necessity-guidelines/.

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

Rehabilitative Services in a Skilled Nursing Facility

Rehabilitation services provided intermittently while at the custodial level of care. Intermittent therapy cannot exceed 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 on behalf of CCA no later than 2 days before a member's covered services end in accordance with Medicare requirements. The extended care facility shall provide CCA with a copy of the notice within the same timeframe as the member for monitoring and documentation purposes.

Service Specification of Extended Care Facilities

1. Maintain 24 hours a day, 7 days a week availability to provide extended care facility services in accordance with state and federal regulations, and be accessible by phone, directly, at all times.
2. Upon request, provide admission for extended care facility services within 24 hours of the request subject to bed availability and with the prior authorization of CCA nursing staff and/or those designated and authorized by CCA to direct patient care.
3. Maintain and respect the rights of members at all times
4. Inform CCA nursing staff and/or those designated and authorized by CCA to direct patient care as to the availability of beds upon their request.
5. Ensure that personnel providing services under this agreement meet current applicable federal, state, and local licensing standards for the provision of healthcare services, and are fully MA state credentialed healthcare providers, as described in Section 14, Provider Credentialing. The extended care facility agrees to notify CCA of changes in provider(s) status that would disqualify provider(s) from meeting above standards.
6. Before or during admission, a full written transfer summary with appropriate physician's orders signed by the PCP will be provided to the facility by the member's PCP or designee.
7. Provide extended care facility services to members in conformance and full cooperation with the treatment plan developed by the PCP or primary care team (PCT). Facility agrees to allow the member's PCP or designee to continue as the member's physician of record.
8. Contact the PCP/PCT immediately, upon notice of significant changes and/or relevant findings in regard to the status of the member.
9. Agree to meet with PCT clinical staff as needed.
10. **A) Skilled Nursing Facility**. Conform to CCA's protocols for timely updates and submissions of SC1, MDS, and Medications List forms upon CCA request; provide the PCT and/or CCA with timely clinical updates appropriate to the member's status in a mutually agreed upon format and frequency. Additionally, the quarterly submission of facility care plans is required to be sent to the Transitions of Care Department via fax to 855-811-3467.

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

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

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

Status Change Form (SC-1) for CCA Members

Facilities are required to submit a Status Change form (SC-1) to Commonwealth Care Alliance and the appropriate Medicaid member enrollment center for certain triggering events; "Commonwealth Care Alliance Member" must be clearly indicated on the SC-1 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 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 " Senior Care Options member" or "One Care member" clearly written on form. Appropriate boxes on form should be checked and a physician's signature is required.	a) MassHealth Enrollment Center 45–47 Spruce Street Chelsea, MA 02150 Fax 617-889-3285 Also fax a copy to Commonwealth Care Alliance at 617-830-0534
	b) MDS 3.0	b) Electronic submission of MDS 3.0 to MassHealth and fax a copy to clinical coordinator at Commonwealth Care Alliance Transitions of Care at 855-811-3467
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 "Senior Care Options member" or "One Care 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 Also fax a copy to Commonwealth Care Alliance at 617-830-0534

Event Triggers	Approvals and/or Forms	Where to Send Information
Long-Term Stays		
If the admission is long-term (more than 6 months)	a) Status Change Form (SC-1) indicating long-term status with " Senior Care Options member" or "One Care member" clearly written on form. Appropriate boxes on form should be checked. **Note:** When the 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 MassHealth forms as LTC supplement.	a) Submit to MassHealth Enrollment Center where the nursing facility is located and fax a copy to Commonwealth Care Alliance at 617-830-0534
	b) MDS 3.0 In compliance with state and federal regulations	b) Submit MDS 3.0 to clinical coordinator via fax to Commonwealth Care Alliance Transitions of Care team at 855-811-3467
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 "Senior Care Options member" or "One Care member" clearly written on form. Appropriate boxes on form should be checked. **Note:** When the 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 at 617-830-0534
At the end of the third month	**MDS 3.0 - needs to be posted at the end of the third calendar month.	Electronic submission of MDS 3.0 to MassHealth and fax a copy to clinical coordinator at Commonwealth Care Alliance Transitions of Care at 855-811-3467

Event Triggers	Approvals and/or Forms	Where to Send Information
Long-Term Discharges		
Upon discharge of long-term stay more than 6 months	Status Change Form (SC-1) indicating member is long term with "Senior Care Options member" or "One Care member" clearly written on form. Appropriate boxes on form should be checked and a physician's signature is required.	MassHealth Enrollment Center 45–47 Spruce Street Chelsea, MA 02150 Fax 617-889-3285 Also fax a copy to Commonwealth Care Alliance at 617-830-0534
Status Changes		
E.g., when a member meets the MDS significant change criteria or member is changing from short-term to long-term status	a) MDS 3.0	a) Electronic submission of MDS 3.0 to MassHealth and fax a copy to clinical coordinator at Commonwealth Care Alliance Transitions of Care at 855-811-3467

*MDS's are also required as determined by MassHealth.

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

Member Enrollment Centers (MEC)
Chelsea 80 Everett Avenue Chelsea, MA 02170 Toll-free: 800-841-2900 Fax: 617-887-8777 When submitting or inquiring about a long-term care applicant residing in a nursing facility serviced by the Chelsea MEC, please use this fax number: 617-889-3285.
Springfield 88 Industry Avenue, Suite D Springfield, MA 01104-3259 Toll-free: 800-841-2900
Taunton 21 Spring Street, Suite 4 Taunton, MA 02780 Toll-free: 800-841-2900
Tewksbury 367 East Street Tewksbury, MA 01876 Toll-free: 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 of time; and (d) appropriate for home use. DME services includes, but are not limited to, the purchase of medical equipment, replacement parts, and repairs for such items such as canes, crutches, wheelchairs (manual, motorized, custom fitted, and rentals), walkers, commodes, 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

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

Prior Authorization

All services provided must be deemed appropriate by the member's 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:	
For Dates of Service: Through March 31, 2023	**For Dates of Service: April 1, 2023 – Onward**
Logging in to the CCA Provider Portal	Use the Availity Essentials Provider Portal*
Logging in to the EZNET Online Claims Web Portal	Logging in to the CCA Provider Portal
Using the MassHealth Provider Online Service Center	Using the MassHealth Provider Online Service Center
Using the NEHEN Provider Portal*	Using the NEHEN Provider Portal*
Contacting CCA Provider Services at 866-420-9332	Contacting CCA Provider Services at 866-420-9332

**Supports batch Eligibility transactions*

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 for which malfunctions or absence presents an immediate life-threatening situation to the member, including, but not limited to, oxygen and respiratory services and equipment
- Provide all other needed supplies, services, or equipment, including wheelchairs and wheelchair repairs, within 24 hours of receiving request, and notify the 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 the 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.”

For additional information, please review the Durable Medical Equipment (DME) payment policy.

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 (lifts, walkers, oxygen concentrators, etc.)
- Remove any rental items within 48 hours of notification

Note: Emergently needed services or equipment shall include that for which malfunctions or absence presents an immediate life-threatening situation to the member, including, but not limited to, oxygen and respiratory services and equipment.

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 include, but are not limited to, disposable items, purchases, rentals, order changes, replacement items, or when 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) and includes, but is not limited to, the member's name, description of item(s), quantity, and date delivered.

Dental

Commonwealth Care Alliance (CCA) uses Skygen for preventive and comprehensive dental services. Skygen's provider line is 855-434-9243. Medical dental services, such as emergency care, should be billed through CCA's medical claims. Please refer to Key Contact information section for claims information.

Skygen Portal**:** pwp.sciondental.com

Skygen**:**
Electronic submission payer ID "SCION"
Paper claim via current ADA Dental Claim form, sent via postal mail:
CCA Claims
PO Box 508
Milwaukee WI 53201

Vision

Commonwealth Care Alliance (CCA) is pleased to announce that we have partnered with VSP for routine vision benefits as of 4/1/2023. For ease of access, we have modified this section to include pre- and post-implementation guidance.

	For Dates of Service: April 1, 2023 – Onward
CCA uses our own contracted network providers for routine eye care and eyewear. Routine and non-routine vision services should be billed through CCA claims. Please refer to the Key Contact section for claims information.	CCA uses Vision Service Plan (VSP) for routine eye care and eyewear. VSP's provider line is 800-615-1883. **Non-routine vision** services, such as emergency care, must be billed through CCA's medical claims.

	As of 4/1/2023, all routine vision claims for dates of service on or after 4/1/2023, must be billed to VSP. Please refer to the Key Contact information section for claims information. Vision Service Plan Portal: https://www.vspproviderhub.com/ **In-network provider claims address:** Vision Service Plan Attention: Claim Services PO Box 385020 Birmingham, AL 35238-5020 **Out-of-network providers claims address:** Vision Service Plan Attention: Claim Services PO Box 385018 Birmingham, AL 35238-5018

Hearing

CCA uses NationsHearing for routine hearing services, including hearing exams and hearing aids. NationsHearing's provider line is 800-921-4559. Medical hearing services, such as emergency care, should be billed through CCA medical claims. Please refer to the Key Contact section for claims information.

NationsHearing Provider Portal: providers.nationshearing.com

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

SECTION 11: Behavioral Health Services Providers

Philosophy and Components of Service

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

Commonwealth Care Alliance is committed to full integration of behavioral health (BH) services that include our members' self-directed components of care team members as noted above. We hold both our internal and external our providers to the highest standard of care and expect that contracted behavioral health providers will work closely with our CCA care teams, PCPs and LTSC and GSSC support coordinators as well as any specialty 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 -15-mile, 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.

Behavioral Health Performance Specifications

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

- Covered services
- Components of treatment/provider responsibilities
- Training, inclusive language, culturally responsive care, and trauma-informed care
- Staffing requirements
- Assessments, treatment planning, and documentation
- Collateral and care coordination
- Discharge planning, aftercare, and collateral linkages
- Quality management

Behavioral Health Clinical Provider Engagement Department (BH PE):

BH PE is responsible for building collaborative relationships with providers and driving provider performance through the use of data and education. The team utilizes data to help support community relations with providers as well as support clinical improvement in the care delivered to CCA members. Provider Engagement works to educate providers about the CCA mission and vision and the value that each provider is delivering to CCA members, including a focus on creating linkages between all behavioral health and substance use levels of care, from psychiatric inpatient to community-based services, for improved transitions of care. 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 supports provider activities consistent with provider and CCA priorities, including but not limited to, Healthcare Effectiveness Data and Information Set (HEDIS®) metrics, discharge planning, readmissions, and community tenure.

Provider Concerns

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

Health Record Maintenance

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

Adverse Incident Protocol

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

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

- Death
- Injuries/accidents
- Absence without authorization
- Any sexual assault, or alleged sexual assault, to or by members
- Serious injury/medical emergency requiring transport and admission to an acute care facility (whether the care rendered is ambulatory or requires admission for treatment)
- Violations, or alleged violations, of DMH restraint and/or seclusion regulations
- Any physical assault, or alleged physical assault, to or by members
- Unscheduled event that results in the evacuation of the program

- Public health hazard (including, but not limited to food contamination and, lice or bedbug infestation)
- Medication errors or incidents, including but not limited to missed medication administration, administration of the wrong medication, member medication refusal, and member sharing/distributing their prescribed medication with/to others.
- Riot

All adverse incidents and/or serious reportable events (SRE) should be reported to the Commonwealth Care Alliance Serious Reportable Events (SRE) team by faxing a copy of the mass.gov incident report form (https://www.mass.gov/doc/adverse-incident-report/download) with CCA specified as the managed care entity, to CCA Senior Quality of Care Specialist at 857-317-8405 within 24 hours

Levels of Care

Behavioral Health Services That Require Prior Authorization or Notification of Admission

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

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

Behavioral Health Services That Require a Prior Authorization (PA) or Notification of Admission (NOA)							
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:	Medically Managed Intensive Inpatient Services ASAM Level 4		PA not required for admission. Notification of admission is required within 48 hours	Admitting facility required to notify CCA BH UM within 48 hours of admission at 866-420-9332	No authorization required. Medical necessity determination is made by the provider	No continued authorization required. Medical necessity determination is made by the provider	Not applicable
Inpatient Services	Psychiatric Inpatient Level of Care		Emergency admissions: PA not required for admission. Notification of admission is required prior to bed placement	AMCIs are required to provide notification by calling CCA BH UM Team at 866-420-9332 before bed placement	Emergency admissions: See notification process	Admitting facility calls CCA BH UM Team on the last covered day. Continued stay review process is conducted by phone and medical necessity is determined for continued authorization	Emergency admissions: Verbal notification confirming receipt of notification of admission within 30 minutes; written notification within 24 hours
Inpatient Services	Observation/Holding beds		PA not required for admission Notification is required within 24 hours	See process for medical	No authorization or medical necessity review process required	No continued authorization required	Not applicable
Inpatient Services:	Administrative Necessary Days AND		Prior authorization is required	Not applicable	Requesting provider calls BH UM team at 866-420-9332 to request AND	Requesting provider calls CCA BH UM team on the last covered day to request AND	Within 72 hours
Diversionary Services	Acute Treatment Service (ATS): ASAM Level 3.7 (including Enhanced ATS/E-ATS/Individualized Treatment Services)		PA not required for admission Notification of admission is required within 48 hours	Admitting facility required to notify CCA BH UM within 48 hours of admission at 866-420-9332	No authorization required. Medical necessity determination is made by the provider	No continued authorization required. Medical necessity determination is made by the provider	Not applicable
Diversionary Services	Clinical Stabilization Services for Substance Use (CSS) ASAM Level 3.5		PA not required for admission Notification of admission required within 48 hours	Admitting facility required to notify CCA BH UM team within 48 hours of admission at 866-420-9332	No authorization required. Medical necessity determination is made by the provider	No continued authorization required. Medical necessity determination is made by the provider	

Diversionary Services	Residential Eating Disorder Treatment Services		Prior authorization is required for admission	Call CCA BH UM team at 866--420-9332	BH UM will review request for medical necessity	Same as prior authorization process	Within 14 calendar days
Behavioral Health Special Procedures	rTMS Services	PA Form – RTMS	Prior authorization is required	Provider faxes form to 855-341-0720	BH UM team will review request for medical necessity	Same as prior authorization process	Within 14 calendar days
Behavioral Health Special Procedures	Esketamine for Treatment-Resistant Depression	Standard Prior Authorization Form	Prior authorization is required	Provider faxes form to 855--341--0720	BH UM team will review request for medical necessity	Same as prior authorization process	Within 14 calendar days
Behavioral Health Special Procedures	Specialing		Prior authorization is required		Requesting provider calls BH UM team at 866-420-9332	Same as prior authorization process	Within 72 hours

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

Diversionary Services:

- Partial Hospitalization Program (PHP)
- Intensive Outpatient Programs (IOP)
- Psychiatric Day Treatment
- Community Support Program (CSP)
- Community Support Program for Homeless Individuals (CSP-HI)
- Community Support Program for Tenancy Preservation Program (CSP-TPP)
- Community Support Program for Justice Involved Individuals (CSP-JI)
- Residential rehab services for SUD (RRS): ASAM Level 3.1

Community behavioral health centers (CBHC) services

Behavioral Health Emergency Service:

- Adult Mobile Crisis Intervention—risk management and safety planning (AMCI)
- Medication management crisis
- Diagnostic evaluation
- Emergency department visit

Outpatient Services:

- Behavioral health outpatient treatment
- Acupuncture for withdrawal management
- Ambulatory Withdrawal Services (AWS)Diagnostic evaluation
- Bridge consultations inpatient/outpatient
- Case consultation
- Consultations in the ED
- Dialectical Behavioral Therapy (DBT)
- Electroconvulsive Therapy (ECT)
- Medication management
- Medication assisted treatment
- Methadone maintenance
- Neuropsychological/Psychological (Testing)
- Office-based opioid treatment (OBOT)
- Opioid replacement therapy (ORT)
- Recovery coach
- Recovery support navigator
- Structured outpatient addiction programs (SOAP)
- Urgent outpatient: (UOS)

Behavioral Health Inpatient Covered Services

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

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

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

In addition to our contracted network, CCA-licensed behavioral health 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.

Medically Managed Intensive Inpatient Services ASAM Level 4: Provides a planned substance use treatment program offering 24-hour, medically managed evaluation and treatment for individuals who are experiencing severe withdrawal symptoms and/or acute biomedical complications as a result of substance use. Level IV services are rendered in a hospital that can provide life support in addition to 24-hour physician and nursing care. Daily individual physician contact is required for this level of care. A 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): Provides the most intensive level of psychiatric care, which is delivered in a general hospital with a psychiatric unit licensed by the Department of Mental Health (DMH), or a private psychiatric hospital licensed by the DMH. Multidisciplinary assessments and multimodal interventions are provided in a 24-hour, locked, secure and protected, medically staffed, and psychiatrically supervised treatment environment. 24-hour skilled nursing care, daily medical care, and a structured treatment milieu are required. The goal of acute inpatient care is to stabilize members who display acute psychiatric conditions associated with either a sudden onset and a short, severe course, or a marked exacerbation of symptoms associated with a more persistent, recurring condition. Typically, the member poses a significant danger to self or others, and/or displays severe psychosocial dysfunction. 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 (AMCI) provider, regardless of the availability of capacity or clinical presentation. Providers are expected to collaborate and communicate with the CCA BH Transitions of Care team within one business day after admission, and then every three business days throughout the duration of the admission, to collaborate on discharge planning for our members admitted to the inpatient psychiatric unit.

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

Community Behavioral Health Centers

Community Behavioral Health Centers (CBHC): Comprehensive community behavioral health providers that offer substance use disorder and mental health services, care coordination, peer supports, and screening and coordination with primary care. A CBHC provider (the provider) is required to provide behavioral health urgent care services, including access to same-day or next-day services, and expanded hours with evening and weekend services. Providers contracted for this service are expected to comply with all requirements of these service-specific performance specifications. Additionally, CBHCs are held accountable to outpatient performance specifications and all CCA general performance specifications. The requirements outlined within these service-specific performance specifications take precedence over those in the general performance specifications. The core outpatient and urgent services provided by the CBHC will be paid as a bundled flat rate per encounter. An encounter is only billable when a covered clinical service is provided and may only be billed once per member per day. CBHCs must provide Adult Community-Based Mobile Crisis Intervention (AMCI), Emergency Services Program (ESP) services for adult members, and Mobile Crisis Intervention (MCI) services. AMCI is co-located at the CBHC site. CBHCs must also provide Adult Community Crisis Stabilization (Adult CCS) services. A CBHC shall be a legal entity with the capacity to contract and meet all provider enrollment qualifications. Multiple providers may partner to form a CBHC, or the CBHC may subcontract to other providers for the delivery of required services. However, the CBHC as the primary entity shall be solely accountable for ensuring all adult, AMCI, and Adult CCS services are delivered in compliance with these specifications and all other applicable laws, regulations, and standards. The CBHC must be a licensed Massachusetts Department of Public Health (DPH) clinic with a mental health service designation, or a DPH-licensed hospital satellite that provides outpatient mental health and substance use disorder services and be a Medicare-participating provider. The CBHC must either (1) be licensed by the DPH Bureau of Substance Addiction Services (BSAS) or (2) have a substance use disorder service designation on their DPH clinic license and a BSAS Certificate of Approval or be a DPH-licensed hospital that provides substance use disorder services. The CBHC must have a Clinical Laboratory Improvement Amendments (CLIA) certificate of waiver and the appropriate state and federal controlled substance registrations.

Behavioral Health Diversionary Covered Services

Diversionary services for mental health and substance use treatment are provided as clinically appropriate alternatives to behavioral health inpatient services, or to support a member returning to the community 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 providers of BH diversionary services are expected to collaborate with the CCA BH UM, giving notice within 48 hours of admission so that the CCA Transitions of Care and care teams can coordinate discharge planning and aftercare.

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

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

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

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

Clinical Stabilization Services (CSS) ASAM Level 3.5: Provides 24-hour, clinically managed detoxification services that are provided in a non-medical setting. These services, which usually follow Acute Treatment Services (ATS), include supervision, observation, support, intensive education, counseling regarding the nature of addiction and its consequences, relapse prevention, outreach to families and significant others, and aftercare planning for members beginning to engage in recovery.

CSS provides 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 diagnosis that is manageable at this level. Members may be admitted to CSS directly from the community or as a transition from inpatient services.

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

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

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

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

Psychiatric Day Treatment: Provides a coordinated set of individualized, integrated, and therapeutic supportive services to members with psychiatric diagnosis, who need more active or inclusive treatment than is typically available through traditional outpatient mental health services.

While less intensive than partial hospitalization, psychiatric day treatment is an intensive, clinical program that includes diagnostic, medical, psychiatric, psychosocial, and adjunctive treatment modalities in a structured setting. Psychiatric day treatment programs provide rehabilitative, pre-vocational, educational, and life-skill services to promote recovery and attain adequate community functioning, with focus on peer socialization and group support.

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

In general, a member who can benefit from CSP services has a mental health, substance use, and/or co-occurring diagnosis that has required psychiatric hospitalization or the use of another 24-hour level of care or has resulted in serious impairment with a risk of admission. CSP services are used to prevent hospitalization. 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 (ADLs) so they can perform ADL more independently or access services to support them in doing so
- Providing service coordination and linkage including:
    - Assistance with transportation to essential medical and behavioral health appointments
    - Assisting with obtaining benefits, housing, and healthcare
    - Collaborating with emergency services programs/mobile crisis intervention (AMCIs) and/or outpatient providers; including working with AMCI's to develop, revise and/or utilize member crisis prevention plans and/or safety plans as part of the crisis planning tools for youth
    - Fostering empowerment, recovery, and wellness, including linkages to recovery-oriented peer support and/or self-help supports and services

Community Support Program for Homeless Individuals (CSP-CH, formerly CSP-CHI & C-SPECH): Community Support Program for Homeless Individuals (CSP-HI) is a specialized CSP service to address the health-related social needs of members who: (1) Are experiencing homelessness and are frequent users of acute health services (2) Are experiencing chronic homelessness, as defined by the US Department of Housing and Urban Development, (3) Have identified a Permanent Supportive Housing (PSH) housing opportunity. Once housing is imminent (members moving within 120 days), members receiving CSP may receive CSP-HI services. CSP-HI includes assistance from specialized professionals who, based on their unique skills, education, or lived experience, have the ability to engage and support individuals experiencing chronic homelessness. Their support includes helping members in searching for permanent supportive housing, 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.

Community Support Program for Tenancy Preservation Program (CSP-TPP): CSP-TPP is a specialized CSP service to address the health-related social needs of members who are at risk of homelessness and facing eviction because of behavior related to a disability. CSP-TPP works with the member, the Housing Court, and the member's landlord to preserve tenancies by connecting the member to community-based services to address the underlying issues causing the lease violation. To qualify for participation as a CSP-TPP provider, a provider must have an active contract with the Department of Housing and Community Development or Mass Housing to provide tenancy preservation program services. CSP-TPP providers are not required to be licensed by DPH. CSP-TPP includes help from specialized professionals who have the education and/or lived experience required, and who can engage and support members facing eviction by:

• Assessing the underlying causes of the member's eviction, and identifying services to address both the lease violation and the underlying causes

• Developing a service plan to maintain the tenancy

• Providing clinical consultation services as well as short term, intensive case management and stabilization services to members

• Making regular reports to all parties involved in the eviction until the member's housing situation stabilizes

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

Behavioral Health Emergency Service Programs (AMCIs)

Adult Mobile Crisis Intervention Program—Risk Management/Safety Planning Service (AMCI): 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 AMCI is to respond rapidly, assess effectively, and deliver a course of treatment intended to promote recovery, ensure safety, and stabilize the crisis in a way that allows a member to receive medically necessary services in the community, or if medically necessary, in an inpatient or 24-hour diversionary level of care. In all encounters with a member in crisis, the AMCI provides a core service, including:

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

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

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

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

ACMI services also include the following components:

- Medication management crisis
- Diagnostic evaluation
- Safety planning
- Emergency department visit
- Specializing services

Behavioral Health Outpatient Covered Services

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

CCA is committed to providing convenient access and availability of behavioral health services that support the needs of each CCA member and support each member's care plan. Excluding emergency services (AMCI) and urgent care, behavioral health office visits will be made available within the following time frames 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 behavioral health 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: BH outpatient treatment should result in positive outcomes within a reasonable time frame for specific diagnosis symptoms and/or problems. The evaluation of goals and treatment should be based on the member's diagnosis, symptoms, and level of functioning. Treatment should be targeted to specific SMART goals that have been mutually negotiated between the provider and the member. Goals of initial and extended outpatient therapy may include crisis resolution, symptom reduction, stabilization, improvement in adaptation, and/or recovery from addiction. Treatment modality, frequency, and length of treatment should be individualized for each member. Most clinical situations can be effectively managed using a short-term and/or intermittent model of treatment with varying modalities and frequency of contact as needed.

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

Diagnostic Evaluation: A 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): DBT is an evidence-based, clinician directed, outpatient treatment modality that combines strategies from behavioral, cognitive, and other supportive psychotherapies for members with a diagnosis of borderline personality who exhibit chronic parasuicidal behaviors, as well as members with other diagnoses who struggle with safely managing incidences of emotional dysregulation. DBT includes individual therapy, DBT skills groups, therapeutic consultation to the member on the telephone or telehealth, and the therapist/therapists' internal consultation 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 that is grounded in a dialectical approach of support and

confrontation. Providers of this service must consult with the member's care team to discuss the clinical appropriateness of this treatment. CCA prefers DBT-certified clinicians as providers of this service, but exceptions can be made pending discussion with the CCA clinical team.

Urgent Outpatient Services (UOS): 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 provides 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 not intended to replace or be interchangeable with emergency services program/mobile crisis intervention services. UOS are ideally provided on the same day as the request and no later than within 24 hours or one business day. These services focus on clinical assessment, brief crisis intervention, stabilization of the crisis, and the alleviation of immediate symptoms that are interfering with the member's functioning. The goal of UOS is to stabilize the member and make the needed aftercare arrangements to transition 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 family consultation is 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.

Case Consultation: A 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, or revise the treatment plan. Case consultation shall not include clinical supervision or consultation with other clinicians within the same provider organization.

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

Consultation in the ED: A consultation in the ED is 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: 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 medication side effects. Psychiatric medication prescribers are expected to coordinate care with other mental health, medical, and substance use providers. Telehealth services are available for members with specific geographic, cultural, linguistic, or special needs that cannot be met in their community. Telehealth can be provided using a combination of interactive video and audio. Medication visits may consist specifically of a psychopharmacological evaluation, prescription, review, and/or monitoring by the prescriber. Visits may also include counseling and/or coordination of care with other physicians or other qualified healthcare professionals or agencies.

Behavioral Health Covered Outpatient Services for Substance Use

Ambulatory Withdrawal Services (also known as ambulatory detoxification) ASAM Level 2.D: Ambulatory withdrawal services are provided in an outpatient clinical setting, under the direction of a physician, and are designed to stabilize the medical condition of an individual experiencing an episode of substance use or withdrawal complications. Ambulatory withdrawal services are indicated when 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): SOAP consists of short-term, clinically intensive, structured, day and/or evening substance use services. These programs are used as a transition service in the continuum of care for members being discharged from community-based acute treatment services (ATS) for substance use ASAM level 3.7, and members being stepped down from clinical stabilization services (CSS) for substance use ASAM level 3.5. SOAP provides multi-disciplinary treatment to address the sub-acute needs of members with addictions and/or co-occurring diagnosis, while allowing them to maintain participation in the community, work or school, and involvement in family life. SOAP services are only provided in Department of Public Health (DPH)–licensed, freestanding facilities skilled in addiction recovery treatment, outpatient departments in acute-care hospitals, or licensed outpatient clinics and facilities.

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

Opioid Replacement Therapy (ORT): ORT is the medically monitored administration of methadone, buprenorphine, or other U.S. Food and Drug Administration (FDA)–approved medications to treat opioid use , in conformance with FDA and Drug Enforcement Administration (DEA) regulations. This service combines medical and pharmacological interventions with counseling, educational, and vocational services and is offered on a short-term (detoxification) and long-term (maintenance) basis.

- **Opioid Treatment Program/Methadone Maintenance (OTP):** 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 –approved medications to treat opioid use as a medication-assisted treatment (MAT), as well as for pain management. This service combines medical and pharmacological interventions with counseling, educational, and vocational services and is offered on a short-term (withdrawal management) and long-term (maintenance) basis. An opioid treatment program is provided under a defined set of policies and procedures, including admission, continued stay, and discharge criteria stipulated by Massachusetts state regulations and 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):** OBOT 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: Acupuncture for withdrawal management is a treatment program providing acupuncture services for individuals experiencing side effects from the use of alcohol and/or other drugs. An acupuncturist is defined as an individual licensed by the Board of Registration in Medicine in accordance with M.G.L. c. 112, §§ 150 through 156.

Recovery Coaches (RC): RCs are individuals currently in recovery who have lived experience with addiction and/or co-occurring mental health diagnosis 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 RCs 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.

RCs are employed by an organization that is licensed by the DPH to offer RC services and that 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. RCs can be deployed to any setting in the community.

Recovery Support Navigator/Community Support Program (RSN): RSN services are provided by paraprofessionals who provide care management and system navigation supports to members with a diagnosis of substance use and/or co-occurring mental health diagnosis. 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.

RSN services are appropriate for members with substance use and/or co-occurring mental health conditions 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 diagnosis. 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 Covered Special Procedures

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

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

Repetitive Transcranial Magnetic Stimulation (rTMS): Repetitive Transcranial Magnetic Stimulation (rTMS) is a multisession treatment that uses magnetic fields to stimulate nerve cells associated with mood control and depression. rTMS is a noninvasive procedure, and serious side effects are rare. rTMS temporarily modulates cerebral cortical function and changes the level of neuronal activity in key regions of the brain related to higher-level cognitive function and is used to treat medication-resistant major depression; however, there is also emerging evidence of its efficacy in treating PTSD. The treatment has been approved by the FDA since 2008 for the treatment of refractory major depressive disorder (MDD), defined as less than a 50% response to medication and outpatient therapy trials. rTMS is approved for re-administration if a member has had a successful outcome on an initial trial of rTMS. The procedure takes place in an outpatient setting, is non-invasive, and does not require anesthesia. The procedure is generally administered daily, 5 days a week, over a four- to seven-week period but could be shorter depending on rating scale assessment results. Tapering occurs following the active treatment phase and lasts approximately 3 weeks. Side effects include lightheadedness and mild headaches. Seizures constitute a rare side effect. Medications can be continued but should not be changed during treatment and members are encouraged to continue with outpatient therapy. Providers and members should conduct a risk/benefit assessment when determining if rTMS is an appropriate treatment.

Esketamine for Treatment-Resistant Depression: 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 a healthcare provider, and patients are required to be monitored by a healthcare provider for at least two hours. Esketamine is only part of the treatment for a person with depression. To date, it has only been shown to be effective when taken in combination with an oral antidepressant. For these reasons, esketamine is not considered a first-line treatment option for depression. It's only prescribed for people who have 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 (LTSS), and of behavioral health (BH), in addition to the medical service needs identified for each member. Accordingly, we provide a wide range of LTSS and BH services for all Commonwealth Care Alliance members.

Long-Term Services and Supports

Long-term services and supports (LTSS) are covered for Commonwealth Care Alliance members. LTSS are considered covered services when (a) delivered consistent with provider regulation, 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 service authorization policies.

LTSS include certain services the member receives in their home and/or community.

Examples of LTSS received in the community include:

Adult Day Health (ADH): ADH programs are community-based, non-residential service that supports members with physical, cognitive, complex medical, and/or behavioral health impairments by providing nursing care, supervision, and health related support services in a structured, program setting. The programs typically operate up to six hours per day and can provide transportation to and from the program site. ADH not only supports members who attend the day program but supports families and other caregivers by providing them with respite while the member attends the program.

Day Habilitation (DH): DH is a community-based, non-residential service that supports members with developmental or intellectual disabilities to help them achieve their optimal level of physical, cognitive, psychosocial, and occupational capabilities in a structured, program setting. The program helps each member set realistic and measurable goals and establishes individually designed activities and therapies necessary to reach those goals. The programs typically operate up to six hours per day and CCA can provide transportation to and from a member's program.

Supportive Day Programs: These programs help participants who have an assessed need for increased social integration and/or structured day activities in a group setting. The services include social services and 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. The programs typically operate up to six hours per day

Examples of LTSS typically received in the home include:

Adult Foster Care (AFC): AFC is a personal care service delivered to a member in their home or in the home of the AFC caregiver that includes daily assistance with activities of daily living (ADLs) and instrumental activities of daily living (IADLs). AFC services are provided by a live-in caregiver who is employed or contracted by an AFC agency provider. The caregiver may be a relative, as long as they are not the spouse or a legally responsible relative. In addition to the ADL and IADL assistance, AFC services include care management and nursing oversight of the provided personal care.

Doula: A qualified professional who provides non-medical emotional, informational, and physical support to individuals and families during pregnancy, delivery, and the post-pregnancy period.

Doula Group Practice: An entity that is not part of a hospital, other group practice, or other healthcare facility and that possesses its own legal identity, maintains its own patient records, administers its own budget and personnel, and is organized primarily for the purpose of rendering doula services

Group Adult Foster Care (GAFC): GAFC is a personal care service delivered to a member who requires daily assistance with activities of daily living (ADLs) and instrumental activities of daily living (IADLs). The GAFC direct care aide comes to

the member's home or residence for approximately two hours per day to provide support. In addition to the ADL and IADL assistance, GAFC services include care management and nursing oversight of the provided personal care.

Home Care Services: Members have several types of in-home support options to promote independence and self-determination, including assistance with and/or skills training in, general household tasks, personal care, personal finance, health, shopping, use of community resources, community safety, and other social and adaptive skills to live in the community.

A worker or support person performs general household tasks such as preparing meals, doing laundry, and routine housekeeping, and/or to provide companionship to the member, In addition the worker might., provide a range of personal support and assistance to enable an member to continue to live as independently as possible. Personal care support could include 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 member to perform a task.

Home care services also can include chore services, grocery shopping and delivery, and home-delivered meals. The full range of supports include:

- Chores
- Companion services
- Grocery & shopping
- Home health aide
- Homemaking services
- Laundry
- Personal care
- Supportive home care aide

Self-Directed Care: Personal Care Attendant (PCA): The Personal Care Attendant (PCA) program is a program that helps members with permanent or chronic disabilities maintain their independence, stay in the community, and manage their own personal care. The member, also known as the PCA consumer (the person receiving PCA services), is the employer of the PCA, unless managed by a surrogate, and is fully responsible for recruiting, hiring, scheduling, training, and, if necessary, firing PCAs. PCAs provide authorized and scheduled services to assist a member with activities of daily living (ADLs) and instrumental activities of daily living (IADLs). PCA assessors complete a functional assessment to confirm eligibility for PCA, as well as the number of weekly personal care hours needed to support the member. Personal Care Management (PCM) agencies also work to support the member by providing them with skills training on how to be an employer of their PCA(s), determine whether a member may need a surrogate to support the member with certain employer functions, and generally support members in employing and directing their own PCA.

Below is a listing of additional services that require prior authorization and are available if appropriate for members' individual circumstances:

Home Delivered Meals (HDM) and Medically Tailored Meals (MTM): Home-delivered meals (HDM) and medically tailored meals (MTM) are food delivery programs that are used to supplement nutrient intake and facilitate access to quality foods. HDM programs provide non-tailored foods to individuals who have limitations in their ability to procure and prepare food due to illness, disability, isolation, or food insecurity. The program can offer special therapeutic (e.g., low sodium, pureed, etc.) and culturally appropriate meals. MTM are home-delivered meals that are prepared or chosen by registered dietitian nutritionists or other qualified health professionals as part of a treatment plan.

Home Modifications: Physical adaptations in a member's private residence, such as widening of doorways, installation of ramps, and 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. This 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: Provided to enable the member to access community services, activities, and resources.

Peer Support Services: 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 any time duration in a member's home, or as a short-term stay in an overnight facility.

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

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

- Likelihood that the member 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 service and supports coordinator (LTSC) to assist with coordination of their LTSS needs. LTSCs provide expertise in community supports to the member and his/her care team, advocate for the member's LTSS needs, and participate as a member of the interdisciplinary care team (ICT), all at the member's discretion. Most aging services access points (ASAPs), some independent living centers (ILCs), and some recovery learning centers (RLCs) provide LTSS coordination services.

Geriatric Support Services Coordinator (GSSC)

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

SECTION 13: Quality Improvement Program

Commonwealth Care Alliance is committed to providing the highest-quality, most effective healthcare to its members. In pursuance of this, the Commonwealth Care Alliance framework for quality improvement is designed to integrate quality assessment and performance improvement activities throughout all levels of its care delivery system. As an organization governed by "consumer experience," the Commonwealth Care Alliance Quality Program is structured to ensure that the members' perspective is built into all elements of its quality improvement activities. An underlying tenet of the program is 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 experience 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, member, and provider 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. This includes incorporating a health equity framework into our quality program and actively working to identify and improve disparities that exist in the healthcare system
- 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 composed 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 the Commonwealth Care Alliance annual Quality Program
- Recommendations related to Commonwealth Care Alliance quality assessment and performance improvement activities

The board of directors delegate's responsibility for the development and oversight of the Commonwealth Care Alliance Quality Program to the Chief Executive Officer/Chief Medical Officer, who delegate 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 the CCA Quality Program to ensure the quality of CCA 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: (1) the CCA Quality Strategy, (2) the CCA's annual Quality Improvement Work Plan, and (3) reviewing progress toward achievement of CCA's quality strategic objectives as measured by key quality indicators. The Quality Committee is composed 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.

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 related to implementation of quality improvement initiatives annually and as needed

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 the Commonwealth Care Alliance 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 of the Utilization Committee 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, identifying, and reducing disparities, and addressing unmet social needs

- Understand the needs, expectations, and satisfaction of members 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 member input from across the network
- Improve clinical and service quality by identifying and disseminating best practices

Annual Quality Improvement Plan

Commonwealth Care Alliance selects activities annually that facilitate the organization's achievement of its quality improvement goals. Activities are tracked in the Commonwealth Care Alliance Annual Quality Improvement Plan, Work Plan, and annual evaluation.

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

- Alignment with the Commonwealth Care Alliance 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 provider/provider experience
- Scope and urgency

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

Program Monitoring and Evaluation

The board of directors, Board Quality Committee, and the Management Quality Committee assesses the annual Quality Improvement Work Plan through a formalized quality improvement annual evaluation, which assesses the results of the plan. This evaluation guides the next steps and 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 contracted providers is critical to Improvement Plan development, execution, and evaluation. Commonwealth Care Alliance collaborates with contracted providers to identify opportunities for improvement. To this end, CCA has established a Provider Advisory Council, a group of in-network, contracted healthcare providers practicing in primary care and behavioral health to engage with CCA leadership to facilitate the open exchange of ideas and promote collaboration and mutual accountability between CCA and the network.

Prioritized Quality Initiatives

Though they may change over time, Commonwealth Care Alliance 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 2024 include:

- Social determinants of health
- Life Choices: palliative and end-of-life care
- Diabetes disease management
- Behavioral health integration
- Vaccination rate improvement

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 several ongoing data submissions, including but not limited to:

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

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

With HEDIS, Commonwealth Care Alliance is assessed on six domains of care:

- Effectiveness of care
- Access/availability of care
- Experience of care
- Utilization and risk adjusted utilization
- Health plan descriptive information
- Measures reported using electronic clinical data systems

Specifications for 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 is used to calculate the Commonwealth Care Alliance Medicare star rating.

Consumer Assessment of Healthcare Providers and Systems (CAHPS®)

In addition to HEDIS, Commonwealth Care Alliance participates in 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 members each spring. A subset of CAHPS results is used to calculate the Commonwealth Care Alliance Medicare star rating.

Health Outcomes Survey (HOS)

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

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

Quality-of-Care Concerns

Commonwealth Care Alliance is committed to providing the highest-quality, most effective healthcare 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 the Commonwealth Care Alliance confidentiality policy, which is compliant with HIPAA rules and regulations. Results of improvement activities and reports do not contain any identified patient information and, when necessary, are coded or reported in aggregate. All information generated by improvement activities is protected by applicable state and federal laws and regulations.

SECTION 14: Provider Credentialing

The Commonwealth Care Alliance Credentialing Committee oversees the credentialing and re-credentialing 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. If you have any questions, please contact the Credentialing department at credentialing@commonwealthcare.org.

Credentialing and Re-credentialing Process

Types of Providers Credentialed

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

- Acupuncturists
- Audiologists
- Chiropractors
- Hearing instrument specialists
- Optometrists
- Alcohol and drug addiction counselors (CADC-II and LADC-I)
- Licensed marriage and family therapists (LMFT)
- Licensed mental health counselors (LMHC)
- Licensed independent clinical social workers (LICSW)
- Nurses—nurse practitioners and other advanced practice nurses (ARNP, CNS, CRNP, NP, PNMHCS, RNCS)
- Oral surgeons
- Physicians (MD and DO)
- Physician assistants
- Podiatrists
- Psychologists (Ed.D., 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 (i.e., HCAS, CAQH) that includes supporting documents, work history, education and training, attestation, authorization and release, professional liability insurance information, malpractice history, disciplinary action information, board certification status, primary hospital, and names of all other hospitals where you have privileges.

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

For behavioral health providers treating substance use disorders, providers need to report on continuing education 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 re-credentialed 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 time frame you have to do so. We will document receipt of your response.

Your Right to Be Informed

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

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

Notice to Practitioners

All applicants granted initial credentialing are notified in writing of the approval no later than 45 calendar days from the approval date. Any initial applicant who is denied credentialing, or a participating practitioner whose credentials are

approved with conditions or terminated, is notified in writing of the action, and the reasons therefore, within 45 calendar days from the Committee's decision. Practitioners who are re-credentialed in the ordinary course do not receive written notice.

Notice to Members

If a 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/Re-credentialing Criteria

Practitioners are credentialed and re-credentialed 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 MCSR/CDS certification: Practitioner must have DEA or MCSR/CDS certification, as applicable.
- Professional liability insurance: Practitioner must maintain professional liability insurance no less than $1,000,000 per claim/$3,000,000 annual aggregate, or higher if required by the Commonwealth of Massachusetts, or be covered under the Federal Tort Claims Act (FTCA). (Applicants who meet the professional liability requirements because they are covered under the FTCA and are credentialed by 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 the Commonwealth Care Alliance 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 at 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 re-credentialing.) 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: Practitioner must not be currently excluded, terminated, or suspended from participation in Medicare, Medicaid, or any other federal or state healthcare program
- Criminal proceedings: Practitioner must not have been involved in any criminal proceedings that may be grounds for suspension or termination of your license to practice
- Compliance with legal standards: Practitioner must be in compliance with all applicable legal requirements relating to the practice of your profession, including meeting all continuing education requirements
- Quality care and service:
    - Based on all the information collected as part of the credentialing process, practitioner must reasonably be expected to provide quality and cost-effective clinical care and services to plan members
    - Practitioner must not have engaged in behavior which may adversely impact member care or service, including but not limited to: behavior which negatively impacts the ability of other participating providers to work cooperatively with you; reflects a lack of good faith and fair dealing in your dealings with 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 managed care policies and procedures; indicates a lack of cooperation with the Commonwealth Care Alliance Quality Improvement or Utilization Management Programs; or constitutes unlawful discrimination against a member under any state or federal law or regulation. Provider shall not discriminate by product and shall maintain access and hours equally for all CCA members
    - Practitioner must not have engaged in any behavior which could harm other healthcare professionals, patients, or Commonwealth Care Alliance employees. Such behaviors include, but are not limited to, acts of violence committed within or outside the practitioner's practice, whether or not directed toward other healthcare professionals, patients, or Commonwealth Care Alliance employees, and must be judged by the Credentialing Committee to create a significant risk to other healthcare 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, at its discretion, Commonwealth Care Alliance network access and availability needs

You are not entitled to be credentialed or re-credentialed on the basis that you are licensed by the state to practice a particular health profession, or that you are certified by any clinical board or have clinical privileges in a Commonwealth Care Alliance contracted entity. Commonwealth Care Alliance, in its sole discretion, credentials and re-credentials practitioners based on its 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 participan t 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.

Re-credentialing

You will be required to update and re-attest to your information every three years. If a practitioner does not keep his or her information current, or re-attest to information to ensure it is available for re-credentialing, termination may result, in which case the practitioner 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, the Office of Inspector General, and internal sources, such as member grievances and adverse clinical events. This information is routinely included in practitioner file reviews during re-credentialing cycles, but it may also be reviewed by a medical director or the Credentialing Committee at any time between re-credentialing cycles. After review, the Committee may take no action, may continue the practitioner's credentials with conditions, may require the practitioner to complete a full off-cycle credentialing application and review, or may terminate the practitioner from Commonwealth Care Alliance programs.

If information is received through the monitoring process that causes the Commonwealth Care Alliance Medical Director or the Chief Medical Officer to believe that a practitioner has placed or is at substantial risk for placing a member in imminent danger and that failure to summarily suspend credentials is contrary to the immediate best interests of member care, he or she may summarily suspend a practitioner's credentials. In such event, the practitioner is notified in writing immediately, including the reasons for the action, and the subsequent procedure to be followed by 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 the Commonwealth Care Alliance Credentialing Policies, you are entitled to appeal the disciplinary action. A disciplinary action is an adverse action taken by the Commonwealth Care Alliance 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 the practitioner's 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 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 30-calendar-day period. You have a right to be represented in an appeal by another person of your choice (including an attorney). Your appeal should include any supporting documentation you wish to submit.

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

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

Credentialing Committee Reconsideration

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

Appeals Panel Hearing and Notice

The appeals panel is a medical peer-review committee that is appointed by 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 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 the sole discretion of Commonwealth Care Alliance, 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, at its sole discretion, deems a shorter period to be appropriate.

Role of the Credentialed Primary Care Provider (PCP)

A PCP is responsible for supervising, coordinating, and providing initial and basic care of members who have selected that provider for general healthcare services. The PCP also initiates referrals for specialty care and assessments needed by a member and maintains overall continuity of a member's care. Examples of specialty care services may include medical, behavioral, and long-term support services. The referral process may include PCPs utilizing the CCA directory of contracted providers wherever possible and a review of the prior authorization requirements, found in Section 4 of this Provider Manual. The PCP provides coverage for members 24 hours a day, 7 days a week. 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 (NPs) may also function as CPs, 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.

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

- Acute care hospitals
- Addiction disorder facilities
- Adult day health
- Adult foster care
- Ambulatory surgery centers
- Assisted living facilities
- Certified home health agencies
- Community-based organizations
- Community health centers
- Community mental health centers
- Durable medical equipment suppliers
- Freestanding diagnostic radiology centers
- Freestanding outpatient dialysis centers
- Freestanding laboratories
- Hospices
- Inpatient psychiatric facilities
- Intermediate care facilities for the mentally disabled
- Long-term acute care hospitals (LTACs)
- Long-term service and support providers
- Nursing facilities (NFs)
- Outpatient behavioral health clinics
- Rehabilitation hospitals
- Residential treatment centers for psychiatric and addiction disorders
- Skilled nursing facilities (SNFs)

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

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

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

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

Re-credentialing of Organizational Providers

All contracted organizational providers are re-credentialed every 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 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, 5th Floor
Boston, MA 02111
credentialing@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 member 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 members should a member 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 members 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 members to select them as their provider
- Offer incentives to persuade members to enroll in a particular plan or organization
- Conduct health screening as a marketing activity
- Accept compensation directly or indirectly from the plan for enrollment activities
- Distribute materials/applications in an exam room

Contracted providers may:

- Provide the names of plans/Part D sponsors with which they contract or participate
- Provide information and assistance in applying for the low-income subsidy (LIS)
- Make available or distribute plan marketing materials and enrollment forms in common areas
- Refer their patients to other sources of information, such as SHIPs, Commonwealth Care Alliance marketing representatives, their state Medicaid office, local Social Security Office, the CMS website www.medicare.gov/, or

1-800-MEDICARE

- Share information with patients from the CMS website, including the Medicare and You Handbook or Medicare Plan Finder at www.medicare.gov/plan-compare, or other documents that were written by or previously approved by CMS
- Share information with patients from the MassHealth Senior Care Options website, www.mass.gov/senior-care-options-sco
- Share information with patients from MassHealth's One Care website, www.mass.gov/one-care

Provider Affiliation Information

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

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

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

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 CCA lines of business. The CCA compliance commitment includes its internal business operations, as well as its oversight and monitoring responsibilities related to its first-tier, downstream and related entities (FDR).

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

The CCA Compliance Program contains the following core elements, including measures to prevent, detect, and correct 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

The CCA Compliance Program is developed to:

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

The Commonwealth Care Alliance's Fraud, Waste and Abuse (FWA) 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 the CCA FWA Program is to assist in protecting the integrity of CCA, and 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 the CCA 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:

- Fill out a Compliance Incident Report
- Report to the CCA Compliance Hotline at 866-457-4953 (may be reported anonymously)
- Contact the interim CCA Chief Compliance Officer
  Elizabeth (Steffen) West
  Email: esteffen@commonwealthcare.org
  Phone: 617-426-0600 (ext. 52376)
- Email cca_compliance@commonwealthcare.org
- 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 healthcare benefit program; or to obtain, by means of false or fraudulent pretenses, representations, or promises, any money or property owned by or under the custody or control of any healthcare benefit program. Examples of fraud include but are not limited to: a provider billing for services or supplies that were not provided; or a member knowingly sharing their CCA ID card with a non- member of CCA in order to obtain services.
- Waste is defined as the overutilization of services, or other practices that directly or indirectly result in unnecessary costs. Waste is generally not considered to be caused by criminally negligent actions but rather the misuse of resources. Examples of waste include but are not limited to: a mail-order pharmacy sending medications to members without first confirming the member still needs them; or a physician ordering excessive diagnostic tests.
- Abuse involves payment for items or services when there is no legal entitlement to that payment even when the provider has not knowingly and/or intentionally misrepresented facts to obtain payment. Examples of abuse include but are not limited to: a medical professional providing treatment to a patient that is inconsistent with the diagnosis; or misusing codes and modifiers on a claim such as upcoding or unbundling codes.

The CCA 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 applicable state False Claims Acts, 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 healthcare 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. Additionally, the Massachusetts False Claims law and the Rhode Island False Claims Act allow for State prosecution of companies and individuals who mislead or defraud state or municipal entities through the use of false or fraudulent claims, records, or statements.

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. Learn more at https://www.whistleblowers.gov/know_your_rights.

Click here to access CCA compliance and FWA resources information on the CCA website.

Regulations

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

General Compliance and Fraud, Waste and Abuse Training

All providers contracted with CCA are required to complete general compliance and 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 & Medicaid Services (CMS) has developed a Medicare Parts C and D General Compliance Training program 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 via one of the following methods:

- Call the CCA Interim Chief Compliance Officer at 617-426-0600 (ext. 52376)
- Call the CCA Compliance Hotline at 866-457-4953. The Compliance Hotline is a confidential and anonymous avenue for reporting a compliance concern such as a suspected fraud, waste, or abuse case
- Submit a Compliance Incident Report
- Email cca_compliance@commonwealthcare.org. Please note that this is not an anonymous method

Policies and Procedures

CCA maintains compliance and FWA policies, including the following relevant topics:

- Compliance Training and Education
- Fraud, Waste, and Abuse
- Reporting, Investigating, and Externally Reporting a Compliance Concern
- Compliance Monitoring
- Compliance Auditing
- Whistleblower Protections, False Claims Act, and Deficit Reduction Act
- Anti-Kickback Statute and Stark Law

SECTION 17: Provider Training

Training and shared learning among our contracted providers is a key element of our strategy for communicating best practices and assuring the quality and integration of services delivered to Commonwealth Care Alliance 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 offer 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, or designate, a human rights officer and 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 healthcare quality through person-centered coordinated care.

Additionally, the three Massachusetts One Care plans have worked with MassHealth and its contractor, 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 healthcare 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 the Commonwealth Care Alliance 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, LTSS coordination, and care transitions
- Wellness
- MDS, assessment, and care planning

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

1. Care planning and care teams
2. Overview of behavioral health topics
3. Overview of motivational interviewing

SECTION 18: Forms

All forms below may be accessed utilizing this link: Download the forms.

Appointment of Representative (Form CMS-1696)*

Notice of Privacy Practices

Prior Authorization Form – Massachusetts Medication Requests

Standard Prior Authorization Request Form

Prior Authorization Form – Repetitive Transcranial Magnetic Stimulation Request

Out of Network Prior Authorization Form – Psychological and Neuropsychological Assessment

CCA Esketamine Prior Authorization Request

CCA Out of Network ECT Authorization Request

Provider Referral Form: Senior Care Options

Provider Referral Form: One Care

The Patient Health Questionnaire 2 Overview (PHQ 2)

The Patient Health Questionnaire (PHQ 9)

Mental Status Exam

CAGE Questionnaire