# PROVIDER ROLES AND RESPONSIBILITIES

MASS ADVANTAGE
A Medicare Advantage Plan

## INTRODUCTION

Mass Advantage contracts with primary and specialty care providers, hospitals, and ancillary providers to care for our members. Mass Advantage also has an extensive network of pharmacies to service members across our service area.

Mass Advantage does not prohibit or restrict Plan providers from advising or advocating on behalf of a Plan member about:

- The Plan member's health status, medical care or treatment options (including alternative treatments that may be self-administered), including providing sufficient information to the Plan member to provide an opportunity to decide among all relevant treatment options
- The risks, benefits and consequences of treatment or non-treatment; and
- The Plan member's right to refuse treatment and express preferences about future treatment decisions.

A provider must provide information regarding treatment options in a culturally competent manner, including the option of no treatment. A provider must ensure that individuals with disabilities are presented with effective communication on making decisions regarding treatment options.

Providers may freely communicate with patients about their treatment, regardless of benefit coverage limitations. As applicable, Mass Advantage shall not prohibit the participating provider from providing inpatient services to a member in a contracted hospital if such services are determined by the participating provider to be medically necessary covered services under Mass Advantage's Medicare Contract. All providers are subject to applicable authorization and notification requirements as referenced in the Mass Advantage Prior Authorization Code List.

A provider's responsibility is to provide or arrange for Medically Necessary Covered Services for members without regard to race, ethnicity, national origin, religion, sex, age, mental or physical disability, sexual orientation, genetic information, or source of payment. A provider is further responsible to render medically necessary covered services to Mass Advantage members in the same manner, availability and in accordance with the same standards of profession as offered to the provider's other patients.

## PROVIDER AGREEMENT

The Mass Advantage Participation Agreement specifies obligations for participation in the Mass Advantage Medicare Advantage network including, but not limited to:

- Accountability
- Reporting and Disclosure Requirements
- Payment for Services covered by Mass Advantage plans
- Claims turnaround time

Unless otherwise prohibited by Federal or State laws and regulations, Mass Advantage network providers agree to refer members to other Mass Advantage network providers, whenever possible, to receive covered services. When a transfer is medically necessary, network hospitals agree to move patients to other Mass Advantage network hospitals, when possible.

Elective out-of-network services are not covered for members in Mass Advantage HMO products unless pre-authorized by the plan. Urgent and emergent services are covered as required by law.

Out-of-network services are covered for Mass Advantage PPO products at the member's out-of-network benefit levels and cost share amounts.

## NON-ACCEPTANCE AND TERMINATION

In the event a provider wishes to terminate their participation in Mass Advantage Medicare Advantage network or Mass Advantage terminates a provider for reasons other than cause, a mandatory 90-day notification is required for the termination. Please refer to your contract for specific termination requirements.

Any provider requesting termination of their participation should send written notification to the Mass Advantage Provider Relations team at Provider.Relations@MassAdvantage.com. Upon receipt of the termination request, Mass Advantage will send a written, CMS-approved notification of the termination to all affected members at least 45 calendar days before the effective date of termination, per CMS guidelines.

## SAFEGUARDING AND MAINTENANCE OF MEDICAL RECORDS

In compliance with Medicare regulations, audits, and record retention requirements, medical records and any other health/enrollment information of a member must be handled under established procedures that:

- Safeguard the privacy of any information that identifies a particular enrollee
- Maintain such records and information in a manner that is accurate and timely
- Identify when and to whom enrollee information may be disclosed

In addition to the obligation to safeguard the privacy of any information that identifies a particular enrollee, Mass Advantage and its participating providers, are obligated to abide by all Federal and State laws regarding confidentiality and disclosure for behavioral health records, medical health records, and enrollee information.

First tier and downstream providers must agree to comply with Medicare laws, regulations, and CMS instructions (422.504(I)(4)(v)), and agree to inspections, evaluations and audits by CMS and/or its designees to cooperate, assist, and provide information as requested, and maintain records a minimum of 10 years. For the purposes specified in this section, providers agree to make available provider's premises, physical facilities and equipment, records relating to Mass Advantage's covered individuals, including access to a provider's computer and electronic systems and any additional relevant information that CMS may require.

Providers acknowledge that failure to allow Health and Human Services (HHS), the Comptroller General or their designees the right to timely access under this section can subject a provider to sanction from participation in the Medicare Program or monetary penalties.

## NETWORK PARTICIPATION

Mass Advantage offers providers the opportunity to participate in the plan's network. Network providers care for Mass Advantage members and will be reimbursed for Medicare covered services at the agreed upon Medicare payment rate. Network providers sign formal agreements with Mass Advantage, agree to bill Mass Advantage for covered services provided to members, accept reimbursement as full payment minus any member required cost sharing, and receive payment directly from Mass Advantage.

## NOTIFICATION REQUIREMENTS

Notification of address, panel status, and other demographic information changes should be submitted at least 30 days in advance. You may review your practice information via Mass Advantage's online provider directory. If you need to update any information, please fill out the HCAS Form and submit to Mass Advantage Provider Relations at Provider.Relations@MassAdvantage.com.

## QUALIFICATIONS AND REQUIREMENTS FOR PROVIDER PARTICIPATION

To be included in the Mass Advantage provider network, providers must:

- Have a national provider identifier they use to submit claims to Mass Advantage (in accordance with HIPAA requirements)
- Meet all applicable licensing requirements in the state where they practice, and meet Mass Advantage credentialing requirements pertaining to licensure
- Furnish services to Mass Advantage members within the scope of their licensure or certification and in a manner consistent with professionally recognized standards of care
- Provide services that are covered by Mass Advantage and that are medically necessary by Medicare definitions
- Meet applicable Medicare approval or certification requirements
- Not have opted out of participation in the Medicare program under §1802(b) of the Social Security Act, unless providing emergency or urgently needed services

- Sign formal agreement with Mass Advantage
- Agree to bill Mass Advantage for covered services provided to Mass Advantage members and receive payments directly from Mass Advantage
- Accept Mass Advantage's reimbursement as full payment less any member cost share amounts under any condition, including plan bankruptcy
- Not be on the U.S. Department of Health and Human Services Office of Inspector General (OIG), the General Services Administration's (GSA) System for Award Management (SAM) excluded and sanctioned provider lists or the CMS Preclusion List
- Comply with all applicable Medicare and other applicable Federal health care program laws, regulations, and program instructions, including laws protecting patient privacy rights and HIPAA that apply to covered services furnished to members
- Agree to cooperate with Mass Advantage to resolve any member grievance involving the provider within the timeframe required under Federal law
- Agree to accept all Mass Advantage members unless practice is closed to all new patients

## PRIMARY CARE PROVIDER (PCP) RESPONSIBILITIES

The following is a summary of responsibilities specific to Primary Care Providers who render services to Mass Advantage members:

- Maintain accurate panel status with Mass Advantage, providing at minimum ninety (90) day notice of change submitted to Mass Advantage Provider Relations at Provider.Relations@MassAdvantage.com
- Coordinate, monitor and supervise the delivery of health care services to each member who has selected the PCP for primary care services
- Assure the availability of services to members including on-call and after-hours coverage
- Submit encounter data or claim for each visit CMS-1500 form.
- When necessary, refer members to Mass Advantage network providers. If unable to locate a participating provider for services required, contact the Mass Advantage Utilization Management department for assistance at (866) 312-8467
- Ensure members are seen for an initial office visit and assessment within the first 90 days of member's selection of provider as the PCP
- Consider member input into proposed treatment plans

## SPECIALIST RESPONSIBILITIES

Specialists are responsible for communicating with the PCP in supporting the medical care of a member. Specialists are also responsible for treating Mass Advantage plan members referred by the PCP and communicating with the PCP or Mass Advantage for authorizations. If a member is part of Mass Advantage HMO plans, these requests must be coordinated through the member's PCP.

## RESPONSIBILITIES OF ALL MASS ADVANTAGE PROVIDERS

The following is an overview of responsibilities for which all Mass Advantage providers are accountable. Please refer to your contract, policies, and this document or contact Provider Relations at Provider.Relations@MassAdvantage.com for clarification of any of the following:

- All providers must comply with the Mass Advantage Medicare Advantage plan's access to care requirements.
- Provide or coordinate health care services that meet generally recognized professional standards and the Mass Advantage guidelines in the areas of operations, clinical practice guidelines, medical quality management, customer satisfaction and fiscal responsibility.
- Use physician extenders appropriately. Advanced Practice Providers (APPs) may provide direct member care within the scope or practice established by the rules and regulations of the state where they are licensed and where services are provided and Mass Advantage guidelines.
- The sponsoring provider will assume full responsibility to the extent of the law when supervising APPs whose scope of practice should not extend beyond statutory limitations.
- APPs should clearly identify their titles to members, as well as to other health care professionals.
- A request by a member to be seen by a provider, rather than a physician extender, must be honored at all times.
- Refer Mass Advantage plan members with issues outside of their normal scope of service for consultation and/or care to appropriate specialists contracted with Mass Advantage
- Admit Mass Advantage HMO members only to participating hospitals, skilled nursing facilities, and other inpatient care facilities, except in the event of an emergency.
- Respond promptly to Mass Advantage requests for medical records to comply with regulatory requirements and plan operations including the provision of additional information about a case in which a member has filed a grievance or appeal.
- Not bill, charge, collect a deposit from, seek compensation, renumeration or reimbursement from or have any recourse against any Mass Advantage plan member, subscriber, or enrollee other than for supplemental charges, co-payments or fees for non-covered services furnished on a fee-for-service basis.

Non-covered services are defined as benefits not included or excluded by Mass Advantage, are provided by an ineligible provider, or are otherwise not eligible to be covered services, regardless of medical necessity. Prior to performing any non-covered service for a Mass Advantage member, providers are required to request an organization determination from Mass Advantage (or a coverage determination for a non-covered prescription drug) and receive a notice of denial from Mass Advantage before they may bill the member. This is required regardless of prior authorization requirements for the service. Please note that the process of submitting an Advance Beneficiary Notice of Non-coverage (ABN) is applicable for Original Medicare only and is not considered a valid form of denial notice for a Medicare Advantage member.

- Treat all member records and information confidentially, and only release such information with the written consent of the member, except as indicated herein, or as needed for compliance with State and Federal law.
- Maintain quality medical records and adhere to all Mass Advantage policies governing the content of medical records as outlined in the Mass Advantage quality improvement guidelines. All entries in the member record must identify the date and the provider of service.
- Maintain an environmentally safe office with equipment in proper working order in compliance with city, state, and federal regulations concerning safety and public hygiene.
- Communicate clinical information with treating providers timely. Communication will be monitored during medical chart review. Upon request, provide timely transfer of clinical information to Mass Advantage, the member, or the requesting party, at no charge, unless otherwise agreed to.
- Preserve member dignity and observe the rights of members to know and understand the diagnosis, prognosis and expected outcome of recommended medical, surgical, or medication regimen.
- Not discriminate in any manner between Mass Advantage members and non-Mass Advantage members.
- Fully disclose to members their treatment options and allow them to be involved in treatment planning.
- When communicating with members or prospective members concerning enrollment decisions, remain neutral and act based on an objective assessment of the needs and interests of the individual.

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