MASS ADVANTAGE
Plan to love your plan.

PROVIDER RESPONSIBILITIES

Mass Advantage Provider Network

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. Participation in Mass Advantage in no way precludes participation in any other program with which the provider may be affiliated. To find a provider, go to www.massadvantage.com and access Mass Advantage's On-Line Provider Directory.

The following sections outline the basic guidelines for our network providers. These requirements are organized into responsibilities for all providers, for primary care physicians, for specialists, and for physician extenders. This section will be updated, as necessary, with any regulatory changes that require revisions to standard responsibilities.

TITLE VI of the Civil Rights Act of 1964

Providers are expected to comply with the Civil Rights Act of 1964. Title V of the Act pertains to discrimination on the basis of national origin or limited English proficiency. Providers are obligated to take reasonable steps to provide meaningful access to services for members with limited English proficiency, including provision of interpreter or translator services as necessary for these members.

Coverage Arrangements

All participating providers must ensure 24-hour, 7 days-a-week coverage for members. Coverage arrangements should be made with another Mass Advantage participating provider. All encounters must be billed under the name of the rendering provider, not the member's assigned primary care provider. Reimbursement will be paid directly to the participating covering provider.

Covering providers, whether participating or not, must adhere to all of Mass Advantage's administrative requirements. Additionally, covering providers must agree not to bill the member for any covered services. The covering provider should report all calls and services provided to the member's primary care provider. Participating providers will be held responsible for the actions of their non-participating coverage providers. Participating providers will not use a provider who is excluded for the Medicare program for coverage in their absence.

Primary care providers agree that, in their absence, timely scheduling of appointments for members shall be maintained.

Access Standards

Primary care providers agree to meet Mass Advantage's access standards, as follows:

REQUIREMENT	STANDARD
Wait time for Emergent Appointment	Immediately upon presentation, instructed to call 911, or directed to the nearest emergency room
Wait time for Urgent Care Appointment	Within 48 hours
Wait time for Persistent Symptoms	No later than the end of the following business day after their initial contact with the PCP site
Wait time for Routine Care Needs/Wellness Appointment	Within 30 calendar days
After Hours Care	Access to a provider 24 hours/7 days a week, 365 days a year
Waiting Time in the Waiting Room	No more than thirty (30) minutes or up to one (1) hour following appointment time when the MD encounters an unanticipated Urgent Medical Condition visit or is treating a member with a complex need

Specialty Care Providers agree to meet Mass Advantage's appointment standards, as follows:

REQUIREMENT	STANDARD
Wait time for Emergent Symptoms	Immediately upon presentation, instructed to call 911, or directed to the nearest emergency room
Wait time for Persistent Symptoms	No later than 30 calendar days after the initial contact with the specialist site
Wait time for Routine Care Needs	Within 12 weeks

Behavioral Health Providers agree to meet Mass Advantage's appointment standards, as follows:

REQUIREMENT	STANDARD
Care for non-life-threatening emergency	Within 6 hours
Urgent Care	Within 48 hours
Initial visit for routine care	Within 10 business days

A member should be seen by a provider as expeditiously as the member's condition warrants, based on the severity of symptoms. If a provider is unable to see the member within the appropriate timeframe, Mass Advantage will facilitate an appointment with a participating or non-participating provider, if necessary.

Office Hours

Office hours for all physicians should be posted and must be convenient and not discriminate against Mass Advantage members relative to:

- Other, non-Medicare members
- Members who require access to care after normal business hours (5:00 p.m. – 9:00 a.m.) for urgent medical events that require attention after hours.
- Members who are not able to take time off from work to receive their care (Medicare Working-Aged).

Provider Information Changes

Providers are required to submit sixty (60) calendar day advance written notice of any demographic or panel status changes. All changes must be submitted in writing to Mass Advantage on provider letterhead.

Patient Safety

Patient safety is the responsibility of every healthcare professional.

Providers are required to meet safety standards in accordance with the Occupational Safety and Health Administration (OSHA), Americans with Disabilities Act (ADA), Rehabilitation Act, and other federal/state regulatory requirements. This includes ensuring equipment, lab, office, restrooms, waiting area chairs and table, examination room, and medical equipment are in good working order.

Providers will establish a plan in compliance with OSHA standards regarding blood borne pathogens. In addition, provider will make the necessary provisions to minimize sources and transmission of infection in the office.

Member Confidentiality

All providers participating with Mass Advantage have agreed to abide by all policies and procedures regarding member confidentiality. Under these policies, the provider must meet the following:

Provide the highest level of protection and confidentiality of members' medical and personal information used for any purposes in accordance with federal and state laws or regulations including, but not limited to the following:

- Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 CFR Parts 160 and 164
- The Health Information Technology for Economic and Clinical Health (HITECH) Act, Title XIII of Division A and Title IV of Division B of the American Recovery and Reinvestment Act of 2009 (ARRA), Pub.L.No. 111-5 (Feb 17, 2009) and related regulations
- The HIPAA Omnibus Rule, effective 3-26-2013 with a compliance date of 9-23-2013

Mass Advantage follows the requirements of HIPAA and limits its requests to the amount of PHI that is minimally necessary to meet the payment, treatment, or operational function.

Verifying Member Eligibility

A member ID card alone does not verify a member's status or eligibility to receive benefits. In addition, all payments are subject to the terms of the contract under which the individual is eligible to receive benefits. Providers are required to take the following steps prior to administering services:

1. Verify member's eligibility with Mass Advantage. Members are eligible if:
    a. currently enrolled
    b. eligible for the requested services
    c. not exhausted his or her benefits
2. Check the authenticity of the member's ID card to avoid problems with identity theft or fraud. Be sure to ask the member for an additional form of identification such as a driver's license.
3. Make a copy of the member's ID card and make it part of the member's medical record.

All providers are responsible for the verification of member eligibility prior to rendering services to ensure reimbursement. Providers can verify eligibility through the provider eligibility verification line at 844-918-0114 (HMO), 844-915-0234 (PPO) or TTY: 711, from October 1 – March 31, seven days a week, from 8:00 a.m. – 8:00 p.m. and from April 1 – September 30, Monday through Friday, 8:00 a.m. – 8:00 p.m.

Advance Directives

As a participating provider within the Mass Advantage network, you are responsible for determining whether any member you provide services to has executed an advance directive and for providing education about advance directives when it is requested. A copy of the "Living Will" form should be maintained in the member's medical record. Providers should ask members age 21 and older whether they have executed an advance directive and document the member's response in their medical records. If a member has executed an advanced directive, it will be placed in the medical record in an area that is clearly marked "Advanced Directives". Providers requiring additional information and guidance on Advance Directives are encouraged to visit Massachusetts Medical Society: Health Care Proxies and End of Life Care (massmed.org).

Transfer of Non-Compliant Members

Primary care providers agree (a) not to discriminate in the treatment of his/her patients, or in the quality of services delivered to Mass Advantage members on the basis of race, sex, age, religion, place of residence, health status or source of payment; and (b) to observe, protect and promote the rights of members as patients. Primary care providers shall not seek to transfer a member from his/her practice based on the member's health status. However, a member whose behavior would preclude delivery of optimum medical care may be transferred from the provider's panel. Mass Advantage's goal is to accomplish the uninterrupted transfer of care for a member who cannot maintain an effective relationship with a given provider.

Should an incidence of inappropriate behavior occur, and transfer of the member is desired, the provider must send a letter requesting that the member be removed from his/her panel including the member's name, Mass Advantage ID Number, and details of the non-compliant behavior to the Mass Advantage Enrollment Department at:

Mass Advantage, PO Box 830059, Birmingham, AL 35283

The Enrollment Department notifies the requesting provider in writing when the transfer has been completed. If the member requests not to be transferred, the primary care provider is responsible for continuation of care for a minimum of 30 days until the member is assigned to a new primary care physician.

Primary care providers are required to provide emergency care for any Mass Advantage member dismissed from their practice until the member transfer has been completed.

Fraud, Waste and Abuse

Mass Advantage has a comprehensive policy for handling the prevention, detection and reporting of fraud and abuse. Mass Advantage's policy to investigate any actions by members, employees or providers affects the integrity of Mass Advantage and or the Medicare Program.

Being a participating provider with Mass Advantage requires compliance with Mass Advantage policies and procedures for the detection and prevention of fraud and abuse. Such compliance may include referral of information regarding suspected or confirmed fraud or abuse to Mass Advantage and submission of statistical and narrative reports regarding fraud and abuse detection activities.

If fraud or abuse is suspected, whether it is by a member, employee or provider, it is the provider's responsibility to immediately notify Mass Advantage at 844-569-1389 or http://massadvantage.ethicspoint.com.

All providers participating providers agree to abide Mass Advantage's Fraud, Waste, and Abuse and Reporting policy. Providers can request the Fraud, Waste and Abuse policy, which includes legal requirements stipulated in the following:

- 31 U.S.C. § 3729 (Federal False Claims Act)
- 42 U.S.C. § 1320a-7a (Civil Money Penalties Act)
- 42 U.S.C. § 1320a-7b(b) (Anti-Kickback Statute)

Providers can request the Fraud, Waste and Abuse policy.

It is Mass Advantage's policy to discharge any employee, terminate any provider or recommend any member be withdrawn from the Medicare Program who, upon investigation, has been identified or has been involved in fraudulent or abusive activities. Some common examples of fraud, waste and abuse are:

- Billing for services not rendered
- Billing for supplies not being purchased or used
- Billing more than once for the same service
- Dispensing generic drugs and billing for brand name drugs
- Falsifying records
- Performing inappropriate or unnecessary services

Access and Interpreters for Members with Disabilities

Providers are expected to address the need for interpreter services in accordance with the Americans with Disabilities Act (ADA). Each provider is expected to arrange and coordinate interpreter services to assist members who are hearing impaired. Advantage will assist providers in locating resources upon request.

Provider offices are required to adhere to the Americans with Disabilities Act guidelines, Section 504, the Rehabilitation Act of 1973 and related federal and state requirements that are enacted from time-to-time.

Providers may obtain copies of documents that explain legal requirements for translation services by contacting the Mass Advantage Provider Services Department at the following numbers. For interpreter services, please contact the Mass Advantage Member Services at the following numbers to arrange and coordinate interpreter services.

- 844-918-0114 (HMO)
- 844-915-0234 (PPO)
- TTY: 711

From October 1 to March 31, we're available 7 days a week from 8 a.m. to 8 p.m. EST. From April 1 to September 30, we're available Monday through Friday from 8 a.m. to 8 p.m. EST.

Encounters

Providers are required to report to Mass Advantage all services they provide for Mass Advantage members by submitting complete and accurate claims. All Mass Advantage providers are contractually required to submit encounters for all member visits and all charted diagnoses for each member. Billing and claims requirements are outlined in detail in the Billing and Claim sections of this manual.

Contracts/No Gag Clause

Mass Advantage supports open provider-patient communication regarding appropriate treatment alternatives without penalizing providers for discussing medically necessary or appropriate care for the patient. All Mass Advantage providers can freely communicate with patients regarding the treatment options available to them, including medication treatment options, regardless of benefit coverage limitations.

Beneficiary Financial Protections

Mass Advantage follows all necessary requirements to protect its enrollees from incurring liability (for example, as a result of an organization's insolvency or other financial difficulties) for payment of any fees that are the legal obligation of the Mass Advantage. To meet this requirement, Mass Advantage provider agreements include the following:

- Prohibit the organization's providers from holding any enrollee liable for payment of any such fees.
- Indemnify the enrollee for payment of any fees that are the legal obligation of Mass Advantage.
- Providers will accept Mass Advantage's payment as payment in full.

Health Care Disparities

Mass Advantage understands that to help improve our members' quality of life, we must consider their cultural uniqueness. For this reason, addressing disparities in health care is of high importance. We believe a strong patient-provider relationship is the key to reducing the gap in disparate health care access and health care outcomes due to cultural and language barriers.

Providers must deliver services and information regarding treatment options in a language the member understands, and in a culturally competent manner, accommodating the special needs of ethnic, cultural and the social circumstances of the patient.