Providers

Provider resources and responsibilities for Tufts Health Public Plans providers are outlined in the following sections:

- Clinical responsibilities
- Provider newsletter
- PCP responsibilities
  - Rhode Island provider responsibilities
  - Telehealth/telemedicine responsibilities
  - Covering provider
  - Leave of Absence policy
  - Providers who can serve as PCPs
  - Nurse Practitioner as PCP or specialist
- Provider access standards
- Directory accuracy and suppression of unverified provider information
- Provider inactivity and administrative termination of network providers
- Medicaid participation: Screening and mainstreaming
- Other administrative responsibilities
  - Disenrolling a member from a PCP's panel
  - Notification of practice closure
  - Benefits and covered Services
  - Summary of the credentialing process
  - Provider requirements
  - Primary hospital requirements
  - Tufts Health Public Plans requirements
  - Board-certified policy
  - Provider suspension, termination or sanction
  - Practitioners' rights and responsibilities
  - Facility credentialing
  - Hospital credentialing
  - Laboratory credentialing
  - Behavioral health facility credentialing
- Fraud and abuse policy
  - Key definitions
- Cell and gene therapy (CGT) monitoring requirement

Refer to the Tufts Health One Care chapter for specific provider responsibilities regarding Tufts Health One Care.

Clinical responsibilities

Tufts Health Public Plans providers agree to comply with all state and federal laws and regulations applicable to arranging or providing services to any member. The responsibilities of Tufts Health Public Plans' providers include, but are not limited to, the following:

- Make covered health services available to all members
- Accept and treat members in an identical manner to all other patients in the practice
- Accept and treat all members regardless of age, race, ethnicity, English proficiency, sexual orientation, gender or gender identity, health status or disability
- Make Tufts Health Public Plans patients aware of clinical management options and all care options
- Coordinate discharge planning and all follow-up activities to ensure appropriate transitions of care

- Respond to members' linguistic, cultural and other unique needs (including communicating with patients in their primary language). Help non-English-speaking patients receive interpreter services, if necessary. Members can call Tufts Health Public Plans for translation assistance:
  - Tufts Health Together and Tufts Health Direct: **888-257-1985**
  - Tufts Health One Care: **855-393-3154**
  - Tufts Health RITogether: **844-301-4093**
  - Telecommunications relay services: **711**
- Reasonably accommodate members and ensure that programs and services are equally accessible to an individual with disabilities, including diverse linguistic and cultural competence needs, as they are to an individual without disabilities.
- Utilize waiting room and exam room furniture that meet the needs of all members, including those with physical and nonphysical disabilities.
- Provide accessibility along public transportation routes and/or provide enough parking.
- Use clear signage and way finding (e.g., color and symbol signage) throughout facilities
- Have systems in place for accurately documenting:
  - Member information
  - Clinical information
  - Clinical assessments
  - Treatment plans
  - Treatment or services provided and outcomes
  - Contacts with a member's family, legal guardian or other authorized representative
  - Discharge plans
  - Members' consent for their medical and/or behavioral health providers to exchange information with each other and with us
- Notify a member's PCP about any services and/or treatment provided if you are not the member's PCP
- Agree to follow requirements and limitations in applicable federal and state regulations, government contracts and the contract with Tufts Health Public Plans when attempting to disenroll a member from the practice.
- Complete an Americans with Disabilities Act (ADA) accessibility survey
- Ensure office hours of operations for Tufts Health Together members and Tufts Health RITogether members are no more restrictive than those for your Tufts Health Direct members, Tufts Health Plan commercial members, MassHealth/Medicaid or Rhode Island Medicaid fee-for-service patients.

Tufts Health Public Plans members cannot be charged any fee for cancelling or missing an appointment. If a member misses an appointment because of transportation or any other nonmedical need, Tufts Health Public Plans' social care managers can help. Call the social care management team at **888-257-1985** (Massachusetts) or **844-301-4093** (Rhode Island). For more information about social care management, refer to the Care Management chapter.

In addition, providers agree to not charge Tufts Health Public Plans members for any service that is not medically necessary or not a covered service without providing documentation to the member communicating that they would have to pay for the service or discussing alternative services that could meet their needs. Providers agree to obtain the member's written acknowledgement of this notice.

For Tufts Health One Care members, a provider may not charge members for any service that:

- is not a medically necessary covered service or non-covered service
- for which there may be other covered services or non-covered services that are available to meet the member's needs
- that the provider did not explain the items above

Members cannot be held liable to pay for any such services in which the provider did not discuss the above. The provider must document compliance with this provision.

Provider Newsletter

Insights and Updates for Providers is a monthly newsletter for providers in the Point32Health (including Tufts Health Plan and Harvard Pilgrim Health Care) network. The newsletter is our primary vehicle for communicating 60-day notifications, policy and procedure updates, and other critical business-related information to providers.

Tufts Health Plan publishes the newsletter on the provider website. In addition, providers can opt to receive a copy by email; to do so, they must complete the online registration form.

PCP responsibilities

Members must have a PCP from whom to get regular services. Responsibilities of the PCP include, but are not limited to, the following:

- Offer coverage 24 hours a day, seven days a week, as well as back-up, on-call, after-hours, short-term and long-term leave-of-absence coverage
- Refer members to in-network specialists, if needed
  - Use the search tool or use our secure provider portal to find a network provider
- Discuss all treatment options with members, regardless of cost or benefit coverage
- Allow members to exercise their rights without having to worry about adversely affecting their treatment
- Encourage members to let you share information with their behavioral health provider, if they have one, and with us
- Verify members are in the practice's panel before seeing them. We recommend checking patient eligibility electronically through our secure portal or electronic data interface (EDI). For details — including access and registration, please refer to the Electronic Services page on the provider website. Additionally, you may check patient eligibility by contacting the Provider Service Center.

Rhode Island provider responsibilities

In addition to complying with provider requirements, Rhode Island providers must do the following:

- Enroll as a user of CurrentCare, including hospital alerts, and to assist your high-utilizing member in enrolling with CurrentCare
- Participate in Electronic Visit Verification (EVV) for in-home and community-based care services
- Ensure that family planning counseling is provided and, if appropriate, the extended family planning benefit explained during the last trimester of pregnancy and at the six-week postpartum visit.

Telehealth/telemedicine responsibilities for all Massachusetts and Rhode Island products

As we continue to navigate the evolving landscape of healthcare delivery, particularly with the increasing role of telehealth/telemedicine, we understand the need for clear guidelines on when to utilize this tool. Below are key considerations on when to use telehealth/telemedicine, underpinned by insights from the Department of Health and Human Services (HHS) and our own experiences.

- **Patient condition and complexity:** Telehealth/telemedicine can be an effective tool for chronic disease management, routine follow-ups, mental health consultations, and certain minor acute conditions. Conversely, in-person visits are essential for situations involving physical examinations, surgical procedures, complex diagnostic testing, or rapidly evolving conditions severely impacting the patient's wellbeing.
- **Non-clinical factors:** Consider your patient's comfort with technology, equipment availability, and connectivity situation. If these pose challenges, in-person visits may be preferable.
- **Access to care:** Telehealth/telemedicine can provide increased access to care for members in remote or rural areas, or those facing social barriers such as limited provider availability.
- **Appropriate telehealth/telemedicine setting:** Both the provider and the patient should be in a non-public location. Providers must be located in the state in which they are licensed to practice.

- **HIPAA compliance:** With the end of the public health emergency, it is vital to utilize HIPAA-compliant technology to share Protected Health Information (PHI).
- **Professional judgment:** As always, you, the provider, hold the responsibility to make the medically appropriate decision about the delivery method of care.
- **Identification and consent:** Before every telehealth/telemedicine appointment, providers must validate patient's identity, disclose their own credentials, review the patient's medical history, and obtain the patient's consent to receive services via telehealth/telemedicine. Patients should be informed of any relevant privacy considerations and their right to revoke their consent at any time. Additionally, providers should inform patients of their own location (i.e., distant site) and obtain the patient's location (i.e., originating site).
- **Standard of care:** Providers must ensure that they can deliver the same standard of care, comply with licensure regulations and requirements, and programmatic regulations and performance specifications using telehealth/telemedicine as applicable to in-person services.

While COVID-19 has posed significant challenges, it has also accelerated our capacity to offer remote healthcare and understand its effectiveness. We encourage you to use this knowledge to provide the highest quality, safest care in the most suitable setting.

As always, we depend on you to make the right choice between in person visits or telehealth/telemedicine visits based on your clinical assessment and the specific needs of the member. With careful consideration, telehealth/telemedicine can complement traditional modes of healthcare delivery, enhancing our ability to provide efficient, effective, and patient-centered care.

Covering provider

All Tufts Health Public Plans providers have contractually agreed to be accessible to members 24 hours a day, seven days a week. Providers who are unavailable are responsible for maintaining appropriate coverage that is acceptable to Tufts Health Public Plans. Covering providers must be contracted and credentialed by Tufts Health Public Plans.

Information regarding on-call activities must be relayed by the covering provider or the PCP to the Utilization Management (UM) Committee, for logging and tracking purposes and for continuity of care. This information includes:

- All admissions
- Member’s name, date of birth and ID number
- Instructions to members regarding follow-up care
- Instructions given or authorized services

Leave of Absence policy

Tufts Health Public Plans requires a practitioner to notify Tufts Health Public Plans when they are taking a leave of absence (LOA) for longer than 60 calendar days. At a minimum, this notification must include the dates and the general reason for the LOA (sabbatical, medical reason, etc.). Practitioners must notify Tufts Health Public Plans regarding a pending LOA as quickly as possible.

Providers who will be taking a LOA must arrange for coverage by another participating practitioner in the Tufts Health Public Plans network. All covering arrangements must be acceptable to Tufts Health Public Plans.

Arrangements for coverage by a nonparticipating practitioner (e.g., *locum tenens*) may be considered. These arrangements must have Tufts Health Public Plans’ prior approval and must be consistent with established policies and procedures.

If the LOA is scheduled for **12 months or less**, Tufts Health Public Plans will confirm the conclusion of the LOA by contacting the practitioner’s office to confirm the leave has ended. If the LOA is concluded within six months, the practitioner LOA status will be removed and will reflect their prior status.

If the LOA is scheduled for **longer than 12 months**, Tufts Health Public Plans reserves the right to terminate the practitioner from the network based upon continuity of care issues. In addition, if a practitioner's recredentialing is due during the LOA and the practitioner does not complete his or her recredentialing materials, Tufts Health Plan reserves the right to terminate the practitioner from the network based upon contractual noncompliance.

Locum Tenens policy

Tufts Health Plan requires that locum tenens providers with the potential to treat a Tufts Health Plan member be enrolled. Provider organizations wishing to enroll locum tenens providers should have the provider submit the following forms:

- HCAS enrollment form
- Release & attestation form
- IPA endorsement form
- W9 (for payment purposes)

If the locum tenens provider will be covering for Tufts Health Plan members, the provider should also include the Tufts Health Plan endorsement form. Enrollment will be valid for up to six months. If a locum tenens provider's services are required by the IPA/PHO for more than six months, the locum tenens provider may be required to execute an appropriate contract with the IPA/PHO and be fully credentialed.

Locum tenens practitioners will not be listed in the Tufts Health Plan directory and are not permitted to have a panel.

Providers who can serve as PCPs

The following types of providers can serve as a member's PCP:

- Providers with a general practice or internal medicine, pediatric, adolescent medicine or family practice specialties
- Providers credentialed in more than one specialty area
- Credentialed nurse practitioners (NPs) or physician assistants (PAs) whom we recognize as fully participating PCPs as outlined in the NPs and PAs as PCP or Specialist section below
- OB/GYNs who serve as PCPs and who maintain member panels

NPs and PAs as PCP or specialist

NPs and PAs who are credentialed with Tufts Health Public Plans may be listed as either a PCP or specialist. NPs and PAs recognized as a PCP or specialist must follow the prior authorization and referral rules as an in-network PCP or specialist. Prior authorization is not required for primary care services rendered by a NP or PA assigned as a member's PCP, a NP within the member's assigned practice who shares the same practice or tax identification number, or a covering provider.

Tufts Health Plan does not reimburse a NP or PA recognized as a PCP or specialist for services rendered (without prior authorization or referral when required) to members who are not in Tufts Health Plan's records as part of the nurse practitioner's panel, or if the nurse practitioner is not an approved covering provider. NPs and PAs cannot bill members for PCP services rendered if the NP or PA is not the member's PCP of record, part of the assigned PCP's practice, or an approved covering provider.

Provider access standards

Providers agree to make services available to members as set forth in the requirements below:

Behavioral health provider access standards are outlined in the Behavioral Health Provider Responsibilities section of the Behavioral Health chapter.

Appointment	RITogether Plan	Tufts Health One Care	All Other THPP Massachusetts Plans, except Tufts Health Direct
After-hours Care	Telephone: Available 24 hours, 7 days a week	Telephone: Available 24 hours, 7 days a week Primary care and urgent care must be available during after-hours.	Telephone: Available 24 hours, 7 days a week
Emergency Care	Immediately or referred to an emergency facility	Specialists must have an answering service available 24 hours a day, 7 days a week	Specialists must have an answering service available 24 hours a day, 7 days a week
Urgent Care Appointment	Within 24 hours of a request	Within 48 hours of a request	Within 48 hours of a request
Non-urgent, Symptomatic Care Appointment (such as headache or fatigue)	Within 10 calendar days of a request	- Within 10 calendar days of a request for PCPs - Within 30 calendar days of a request for Specialists	- Within 10 calendar days of a request for PCPs - Within 30 calendar days of a request for Specialists
Routine/Non-Symptomatic Care Appointment	Within 30 calendar days of a request	- Within 45 calendar days of a request for PCPs* - Within 60 calendar days of a request for Specialists	- Within 45 calendar days of a request for PCPs* - Within 60 calendar days of a request for Specialists
Physical Exam	Within 180 calendar days	Within 45 calendar days of a request	Within 45 calendar days of a request
EPSDT Appointment	Within 6 weeks of a request	N/A	In accordance with the schedule established by EPSDT
New Member Appointment	Within 30 calendar days of a request	Within 45 calendar days of a request	Within 45 calendar days of a request
Non-Emergent or Non-Urgent Mental Health or Substance Use Disorder Services	Within 10 calendar days of a request	Within 14 calendar days of a request	Refer to the Behavioral Health Provider's Responsibilities section.

Appointment	RITogether Plan	Tufts Health One Care	All Other THPP Massachusetts Plans, except Tufts Health Direct
Prenatal Appointment	Within 21 calendar days of a request	Prenatal visits without expressed problems shall be made available within 2 weeks after a request from a member in her first trimester, within 1 week for a member in her second trimester, and within 3 business days for a member in her third trimester. Affiliated providers shall offer hours of operation that are no less than the hours of operation offered to individuals who are not One Care members.	Within 21 calendar days of a request
Family-planning Appointment	Within 14 calendar days of a request	Within 14 calendar days of a request	Within 14 calendar days of a request
Postpartum Visit	Within 6 weeks after delivery	N/A	N/A
Department of Children and Families (MA) or Department of Youth and Families (RI) initial screening for patients in DCF/DCYF care	N/A	Within 7 calendar days of a request, and a comprehensive medical screening within 30 calendar days of a request	Within 7 calendar days of a request, and a comprehensive medical screening within 30 calendar days of a request
**If an appointment is required more quickly to ensure screenings follow the schedule established by the EPSDT Periodicity Schedule, the Provider must meet the more stringent standard.*			

Directory accuracy and suppression of unverified provider information

Introduction

Tufts Health Plan is committed to maintaining an accurate provider directory in order to provide our members with the information they need to choose and contact providers. This commitment supports requirements from the Centers for Medicare & Medicaid Services and other regulatory bodies that health plans maintain and update data in provider directories. Tufts Health Plan relies on providers to review their data and notify us of any changes as they happen to ensure that members have access to accurate information.

Notification requirements

Notification of changes to practice locations, availability to see members, including whether there is a waitlist of 4 weeks or less, and other changes that affect the content or accuracy of the Tufts Health Plan Provider Directory should be submitted **at least 30 days** prior to the change. You may review all of your practice information via Tufts Health Plan's online Provider Directory. If you need to update any information, you may do so in one of several ways. If you are an individual practitioner, you can update your information using the CAQH Provider Data Portal (formerly known as CAQH ProView), a tool offered through a partnership with HealthCare Administrative Solutions (HCAS), which offers a centralized process for providers to review and report changes to directory data. More information can be found on the HCAS website.

If you are a facility, you can utilize the Provider Attestation functionality available in the Tufts Health Plan secure Provider portal. Alternatively, you may submit your change via a Medical or Behavioral Health Provider Information Form to Provider_Information_Dept@point32health.org

Enrollment of practice locations

Practice locations that should be submitted for enrollment and inclusion in the Tufts Health Plan provider directory are locations where the provider regularly provides patient care. Locations in which a provider may occasionally render care — such as interpretation of tests or inpatient-only care — should be specified as such on the Provider Information Form (Medical or Behavioral Health) and/or in CAQH Provider Data Portal to ensure the location information is included in the provider's demographic profile, but not in the provider directory.

Practitioners who practice only in a hospital or urgent care setting should be identified as such on the Provider Information Form and/or in CAQH Provider Data Portal in order to be properly enrolled.

Suppression of unverified provider information/provider's duty to verify

Tufts Health Plan reserves the right to suppress provider information from the directory for a variety of reasons. If Tufts Health Plan becomes aware that any of the provider's information on the directory is inaccurate, we will conduct a review to validate and obtain accurate information. This review may include outreach to the provider's office. Because Tufts Health Plan is required to quickly resolve potential inaccuracies or suppress the information, it is important to respond to any inquiries in a timely manner to avoid suppression.

To assist with maintaining accurate and up-to-date data, every 90 days providers must verify and attest to the accuracy of their directory data, including practice location, practice phone, digital contact information (if applicable), availability to see members, including whether the provider has a waitlist of 4 weeks or less, etc. via the CAQH Provider Data Portal. Failure to re-attest to this directory data within this timeframe may result in your data being suppressed from our provider directory.

For any further questions, call Provider Services.

Provider inactivity and administrative termination of network providers

Introduction

Up-to-date provider data, including but not limited to the information displayed in directories, is of vital importance for health care consumers, health plans, and other providers — and Tufts Health Plan relies on providers to support maintaining information that accurately reflects network availability. Tufts Health Plan is required by the Centers for Medicare and Medicaid Services, National Committee for Quality Assurance, and federal and state laws to maintain up-to-date and accurate provider network information and provider directories.

Administrative termination of providers

We view lack of services rendered to our members by participating providers as an indicator of a potential data inaccuracy.

As a result, Tufts Health Plan systematically reviews our provider network information on an annual basis and may administratively terminate providers who have not provided services to our members for the immediate prior two years.

Prior to termination, Tufts Health Plan will use our best efforts to contact the provider and/or the provider organization the provider is affiliated with, to request confirmation of whether the provider would like to remain a participating provider despite their inactivity. If unable to verify the provider's network information, Tufts Health Plan may proceed with termination.

Ensuring renewed or continued plan participation

Please contact directory_inaccuracy_research@point32health.org if you receive a termination notice for inactivity but wish to remain a participating provider. A provider that is terminated through this process but later would like to participate in the Tufts Health Plan network may reapply to become a participating provider through our standard credentialing and enrollment process.

Medicaid participation: Screening and mainstreaming

As a participating provider in the Tufts Health Public Plans network, please be aware of the following requirements related to Medicaid.

- Pursuant to Rhode Island Law Section 210-RICR-30-05-2.13, Rhode Island Medicaid Managed Care Organizations ("MCOs"), including Point32Health, that also offer and sell commercial health insurance products in the state of Rhode Island are required to align their commercial and Medicaid MCO provider networks.
- In accordance with federal regulations under the 21st Century Cures Act, Medicaid providers must be screened or enrolled with the local State Medicaid agency to render services to Medicaid beneficiaries. Visit the Medicaid agency website for your state for additional information on requirements. For Rhode Island, visit the Rhode Island Executive Office of Health and Human Services (EOHHS) provider portal; for Massachusetts, visit the MassHealth website.

Other administrative responsibilities

In addition to needing correct provider information for contact and reporting purposes, helping Tufts Health Plan maintain proper information is required for member assignment and financial performance tracking. Providers are responsible for managing the following administrative responsibilities:

- At least every 90 days, providers (or their designee) should log into CAQH Provider Data Portal and review and verify the accuracy of their demographic data (including, but not limited to, practice location, phone number, hours of operation) displayed in our Provider Directory.

- Alternatively, providers can submit a completed Medical Provider Information Form or Behavioral Health Provider Information Change Form as soon as possible when changes occur using one of the following submission channels:
  - **Fax:** 857-304-6311
  - **Email:** Provider_Information_Dept@point32health.org
  - **Phone: 888-257-1985** (Massachusetts) or **844-301-4093** (Rhode Island)
- Meet the appropriate credentialing and recredentialing requirements as outlined in this chapter.
- Have the National Provider Identifier (NPI) and Tax ID number available when contacting Provider Services.
- Verify member eligibility the day services are rendered. We recommend checking patient eligibility electronically through our secure portal or electronic data interface (EDI). For details — including access and registration, please refer to the Electronic Services page on the provider website. Additionally, you may check patient eligibility by contacting the Provider Service Center.

Disenrolling a member from a PCP's panel

PCPs may not remove a member from their panel. If the PCP-member relationship has deteriorated to a point that the PCP is no longer comfortable seeing the member, contact Provider Services so that Tufts Health Public Plans can reach out to the member and offer them assistance finding a new PCP.

Notification of practice closure

PCPs are required to notify us as soon as reasonably possible of practice closure. We will provide written notification to each member on the PCP's panel within 30 days to the closure of the practice. This notification will describe how the member's continuing need for services shall be met.

Benefits and covered services

For information about eligibility, benefits and covered services, please use our secure portal and the provider website.

Summary of credentialing process

Tufts Health Public Plans credentials affiliated practitioners when they join the network and again at least every three years or more frequently in accordance with state, federal, regulatory and accrediting agency requirements. Credentialing standards are applied uniformly for behavioral health and non-behavioral health practitioners that are applying to the Tufts Health Public Plans network.

Provider requirements

For initial credentialing and recredentialing, each practitioner is required to comply with the Tufts Health Public Plans Credentialing Program and submit the following information to Tufts Health Public Plans via email to Provider_Information_Dept@point32health.org or to the designated credentialing verification organization for review as indicated below:

- Complete all required fields specified in CAQH Provider Data Portal and notify the Credentialing Department when the application is complete
- Sign and date the health services agreement (initial credentialing only) and any other contract documents and send to Tufts Health Public Plans via email
- Sign W-9 form (initial credentialing only) and send to Tufts Health Public Plans via email

Practitioners are notified of their recredentialing request through CAQH Provider Data Portal, allowing enough time for each practitioner to complete the information online by their recredentialing date. Tufts Health Public Plans credentials according to the birthdate cycle (practitioners born in an even year are recredentialed in the month of their birthdate every even year (e.g., 1960, 1962, etc.).

Primary hospital requirements

Each MD and DO must indicate their primary hospital on the credentialing application when applicable. For initial credentialing, Tufts Health Public Plans queries that hospital for an assessment of the practitioner's performance, as mandated by state regulation. During recredentialing, the hospital is queried again. The practitioner must notify Tufts Health Public Plans in writing of changes in primary hospital affiliation.

Tufts Health Public Plans requirements

Along with the credentialing information specified in CAQH Provider Data Portal, Tufts Health Public Plans reviews the following information prior to the final assessment of each practitioner:

- Licensure status in applicable states
- DEA/CDS certificate, if applicable
- Board certification status
- Malpractice insurance coverage, dates and amount
- Work history (initial only)
- Information obtained from the National Practitioner Data Bank
- Education and training (initial only)
- Medicare/Medicaid sanctions, suspensions, monitoring arrangement, and other corrective actions
- State disciplinary actions
- Medicare opt-out
- System of Award Management (SAM) sanctions
- Medicare Preclusion List sanctions

The Quality of Care Committee (QOCC), a board-level quality committee chaired by a Tufts Health Public Plans employed physician (or by the QOCC's designated medical director[s]) reviews practitioners who are being credentialed or recredentialed.

Providers cannot see Tufts Health Public Plans members without the following:

- Review and completion of all applicable required data by the practitioner
- The approval by the Chair of QOCC or approved Tufts Health Public Plans medical director of the practitioners' credentialing or recredentialing file

For initial credentialing applicants, practitioners are deemed in-network based upon the credentialing effective date or the contract effective date; whichever is later. Per regulations, Tufts Health Plan is not allowed to backdate credentialing effective dates.

Board-certified policy

Physicians seeking credentialing must be board-certified or in the process of receiving certification after completing requisite board education and training within a time frame set by the applicable specialty.

Board-certified physicians must maintain certification in accordance with their applicable specialty board guidelines. If physicians do not maintain board certification in at least one clinical specialty; Tufts Health Public Plans may terminate their network participation.

New physicians who are eligible but not yet certified, such as physicians who have finished the applicable training and education but have not yet obtained board certification, are exempt from the board-certification requirement. Tufts Health Public Plans will only excuse the board certification requirement provided that no more than six years or two exam cycles, whichever is greatest, have elapsed since the physician completed residency in the applicable medical specialty.

Additionally, Tufts Health Public Plans may contract with physicians who have training consistent with board eligibility, but who are not board-certified. In such circumstances, on a case-by-case basis, Tufts Health Public Plans will submit documentation describing the business need that is trying to be addressed by adding a non-board-certified physician to the network for review and approval by the Executive Office of Health and Human Services.

Provider suspension, termination or sanction

If MassHealth, Medicare, the Massachusetts Health Connector, Rhode Island Medicaid program, and/or another state's Medicaid program or other state or federal agency suspends, terminates or sanctions a provider, the Tufts Health Public Plans participating provider status will be updated to reflect the same status. When the provider resolves any outstanding issues to the satisfaction of the agency and they have changed the provider's status, the provider must notify Tufts Health Public Plans of the change in status. If the provider had been terminated, the provider will need to be initially credentialed.

The provider must notify Tufts Health Public Plans immediately of any disciplinary actions a governmental agency or licensing board takes against them or if they know of any such confirmed or pending disciplinary actions. Tufts Health Public Plans monitors the Board of Registration in Medicine (BORIM), Department of Health (DoH) licensing board, Office of Inspector General (OIG) List of Excluded Individuals/Entities (LEIE), the Medicare Exclusion Database and the Service Agreement Management System (SAM).

In the event there is a disciplinary action or evidence of serious quality issues, the credentialing committee will determine if there will be a change to the provider's credentialing status or suspend or terminate the contract. Quality issues that could cause Tufts Health Public Plans to suspend or terminate may include:

- Refusing to comply with any Tufts Health Public Plans provider contract provisions
- Failing to comply with federal, state or local clinical or administrative practice requirements or regulations
- Failing to maintain full and unrestricted licensure
- Failing to obtain or maintain board-certified status (if board certified, the provider must maintain that status)
- Failing to maintain active hospital privileges
- Failing to comply with acceptable ethical and professional standards of behavior
- Significant quality concerns

The provider must notify Tufts Health Public Plans immediately if another health plan or institution terminates for:

- Refusing to comply with any contract element that also appears in our provider contract
- Failing to comply with federal, state or local clinical or administrative practice requirements or regulations
- Failing to maintain full and unrestricted licensure
- Failing to obtain or maintain board-certified status (if board certified, the provider must maintain that status)
- Failing to maintain active hospital privileges, as applicable
- Failing to comply with acceptable ethical and professional standards of behavior
- Significant quality concerns

The provider must also notify Tufts Health Public Plans immediately about the following:

- Suspension, termination or sanctions from MassHealth, Medicare, the Massachusetts Health Connector, Rhode Island Medicaid program or another state's Medicaid program
- Any state or federal licensure action of which you are the subject
- Suspension from the Massachusetts BORIM, Rhode Island Department of health licensing board or other applicable board

If the credentialing committee decides to terminate or suspend a provider, the provider will be notified of the decision within three business days.

Practitioners' rights and responsibilities

Practitioners have the right, upon written request, to:

- Review Tufts Health Public Plans' credentialing policies and procedures
- Be informed of the status of their credentialing or recredentialing application by contacting the Credentialing Department via the following channels:
  - **Phone:** 888-257-1985 (Massachusetts) or 844-301-4093 (Rhode Island)
  - **Fax:** 617-972-9591
  - **Email:** Provider_Information_Dept@point32health.org
  - **Mail:** Tufts Health Plan
    Attn: Credentialing Department
    1 Wellness Way, Canton, MA 02021
- Review information submitted to Tufts Health Public Plans for purposes of credentialing or recredentialing, including information obtained by Tufts Health Public Plans from any outside source, such as a malpractice carrier, state license board, or the National Practitioner Data Bank (NPDB).
  - Notwithstanding the foregoing, Tufts Health Public Plans is not required to reveal the information source if the information was not obtained for the purpose of meeting Tufts Health Public Plans' credentialing requirements.
  - Providers are not entitled to review references, recommendations or information that is peer-review privileged or any information which by law Tufts Health Plan is prohibited from disclosing.
- Correct erroneous information submitted by another party, and Tufts Health Public Plans hereby notifies practitioners of their right to correct erroneous information. Tufts Health Public Plans will inform the provider how and where to submit corrections and the appropriate timeframe to do so.
- Receive notification if credentialing information obtained from sources other than the practitioner varies substantially from the credentialing information provided to Tufts Health Public Plans by the provider.

There is no right of appeal from an initial credentialing determination by the QOCC except when required by applicable state or federal law.

In the event the QOCC votes to take disciplinary action, the practitioner is entitled to notice consisting of a written statement of the reasons for the action and, if applicable, has the right to appeal such action by filing a written appeal within 30 calendar days of receipt of the statement of reasons.

The practitioner is entitled to be represented by an attorney or other representative of the practitioner's choice. If new information becomes available, the practitioner may submit new information up until the Appeals Committee meeting.

Each committee member must engage in a fair and impartial review of the practitioner's appeal. No committee member may be an economic or geographic competitor of the reviewing practitioner. The committee member should not be employed by or act in the capacity of a Tufts Health Public Plans board member or otherwise be a representative of Tufts Health Public Plans.

The decision of the Appeals Committee is final. The practitioner will be provided with written notification of the appeal decision, which contains the specific reasons for the decision.

Additional rights for Rhode Island practitioners

- The practitioner will receive a response from Tufts Health Public Plans regarding the application within 180 calendar days after receipt of the application.
- If a credentialing decision is made to deny credentials to a practitioner, the QOCC will send the practitioner written notification of all reasons for the denial within sixty (60) calendar days of receipt of the completed and verified application.

- If the QOCC votes to take disciplinary action against a practitioner, the practitioner shall have thirty (30) calendar days from the receipt of the letter from the QOCC to notify Tufts Health Plan in writing that they will appeal the QOCC decision. If the practitioner exercises their appeal right, Chair of the QOCC will arrange for a hearing before an Appeals Committee that shall review the decision of the QOCC and issue a decision prior to implementation of the disciplinary action against the practitioner. The process outlined in the Tufts Health Plan appeals process will be followed.
- If requested in writing by a practitioner whose credentials have been revoked or adversely modified, the due process outlined in the Tufts Health Plan appeals process shall be waived.

Facility credentialing

At the time of contracting, facilities are asked to complete and return the contracting package to Tufts Health Public Plans. Tufts Health Public Plans' credentialing team will review the documentation for completeness and current, valid licensure and then submit the package to the credentialing committee for review.

Tufts Health Public Plans credentials the following types of facilities:

- Acute-care and rehabilitation hospitals
- Ambulatory care centers
- Skilled nursing facilities
- Home care agencies
- Hospice agencies
- Free-standing imaging centers
- Facilities the Department of Mental Health licenses as mental health or substance-use clinics

Tufts Health Public Plans requires the following from facilities before we begin the (re)credentialing process:

- Current and valid license
- Current and valid accreditation, as applicable
- Tufts Health Public Plans Medical or Behavioral Health Provider Information Form (PIF) (initial credentialing only)
- Form W-9 (initial credentialing only)
- Completed Federally Required Disclosures Form
- Confirmation of an acceptable and timely site visit, if not accredited; if there is no recent site visit, Tufts Health Public Plans may perform one

After the credentialing committee reviews the credentialing application, facilities are contacted by Tufts Health Public Plans to inform them whether their credentials are approved.

There is no right of appeal from adverse credentialing decisions for facilities.

Facilities will be recredentialed at least every three years or more frequently as required by state, federal or accrediting agency requirements.

Hospital credentialing

Tufts Health Public Plans credentials hospitals when they join the Plan and are recredentialed every three years or more frequently as required by state, federal or accrediting agency requirements.

Requirements for initial and recredentialing

For initial and recredentialing, each hospital is assessed for quality. The hospital must be accredited by an applicable accrediting agency acceptable to Tufts Health Public Plans such as the Joint Commission, the American Osteopathic Association, or the National Integrated Accreditation for Health Care Organizations. The hospital must have a current state license. The hospital will be reviewed for Medicare and Medicaid sanctions and, for recredentialing, quality events

will be reviewed. Tufts Health Public Plans may review additional information reasonably deemed pertinent to credentialing, including a site visit.

The QOCC or its designee reviews all hospitals that are being credentialed or recredentialed and may request additional information pertinent to its credentialing of the hospital.

Laboratory credentialing

Tufts Health Public Plans credentials clinical laboratories in accordance with the federal Clinical Laboratory Improvement Amendments (CLIA). Credentialed laboratories are required to:

- Have a current, unrevoked or unsuspended certificate of waiver, registration certificate, certificate of compliance, certificate for provider-performed microscopy (PPM) procedures or certificate of accreditation issued by the U.S. Department of Health and Human Services applicable to the category of examinations or procedures performed by the laboratory, or
- Be CLIA-exempt, as defined in 42 CFR 493.2, or satisfy an exception set forth in 42 CFR 493.3(b)

There is no right of appeal from adverse credentialing decisions for laboratories.

Laboratories will be recredentialed at least every three years or more frequently as required by state, federal or accrediting agency requirements.

Behavioral health facility credentialing

In addition to the requirements outlined in this chapter, behavioral health providers must meet state and federal regulatory requirements, including but not limited to the Department of Mental Health (DMH) regulations for licensing of mental health facilities, as described in 104 CMR 27, for network inclusion. For more information about the behavioral health program, refer to the Behavioral Health chapter.

Tufts Health Public Plans uses the following criteria to credential any behavioral health facility or clinic provider:

- The provider must be licensed by the applicable state licensing agency.
- The facility may be accredited by the Joint Commission (formerly the Joint Commission on the Accreditation of Healthcare Organizations) or another Tufts Health Public Plans-recognized accreditation organization. If not accredited, other requirements apply (e.g., a recent site visit by Department of Public Health or Tufts Health Public Plans).
- The provider must have an organized and fully implemented quality management plan.
- The provider must not discriminate or restrict access on the basis of sex, race, creed, physical disability, national origin, sexual orientation or ability to pay, and must make services available to any person in the state.

Additionally, per contract requirements hospitals that provide behavioral health inpatient services must:

- Follow a human rights protocol that is consistent with DMH requirements and includes training of staff and education of patients regarding human rights
- Have a human rights officer, overseen by a human rights committee, and provide written materials to patients regarding their human rights, in accordance with DMH requirements

There is no right of appeal from adverse credentialing decisions for behavioral health facilities.

Behavioral health facilities will be recredentialed at least every three years or more frequently as required by state, federal or accrediting agency requirements.

Fraud and abuse policy

Key definitions

- **Fraud** means knowingly and intentionally misrepresenting facts to obtain or attempt to obtain payment or another benefit.
- **Waste** means overutilization of services and other actions that result in unnecessary costs to a health plan.
- **Abuse** means actions that may, directly or indirectly, result in unnecessary costs to a health plan, improper payment, and payment for services that fail to meet professionally recognized standards of care or services that are medically unnecessary.

Providers must comply with federal and state laws and regulations designed to prevent, identify and correct fraud, waste and abuse (FWA). Tufts Health Plan reserves the right to audit claims for FWA.

FWA includes any act that constitutes fraud under applicable state or federal health care fraud laws. Examples include:

- Members lending their ID cards to someone else to obtain health care or pharmacy services
- Members providing false information when applying for programs, services, enrollment and benefits
- Providers performing unnecessary tests or procedures
- Providers billing for services they are not licensed to perform
- Providers billing for services or supplies they did not deliver, or reporting incorrect diagnoses or procedures to maximize payment
- Providers charging separately for services that were part of a single procedure
- Providers prescribing medications improperly
- Providers accepting or giving either money or services for member referrals
- Violations of Tufts Health Public Plans' Payment Policies

Please note that your patients may receive a letter from us to verify that they received the services for which you billed. If you have questions, suspicions, concerns, or would like to report potential fraud and abuse involving a Tufts Health Public Plans member or provider, please call us at **888-257-1985** (Massachusetts) or **844-301-4093** (Rhode Island) or email us at fraudandabuse@point32health.org. You do not need to identify yourself. You may also call our confidential compliance hotline at **877-824-7123**, or send an anonymous letter to us at:

Tufts Health Plan
Attn: Fraud & Abuse
1 Wellness Way, Canton, MA 02021

Rhode Island providers may report concerns directly to the state of Rhode Island, by contacting the Department of Human Services at 401-574-8175 or through their fraud website.

Cell and gene therapy (CGT) monitoring requirement

To ensure efficacy and durability of response, high-cost therapies are subject to long-term monitoring. Providers must comply with long-term monitoring requirements including requests for follow-up clinical data and/or attestation of clinical outcome.

PUBLICATION HISTORY

01/01/24	Updated plan name to Tufts Health One Care
02/02/24	Added Directory Accuracy and Suppression of Unverified Provider Information; administrative edits
03/01/24	Updated email addresses
04/19/24	Updated Suppression of Unverified Provider Information/Provider's Duty to Verify section with text on availability to see members, including whether the provider has a waitlist of 4 weeks or less; administrative edits
06/05/24	Added "Medicaid Participation: Screening and Mainstreaming" section and updated phone number in the "Practitioners' Rights and Responsibilities" section
08/01/24	Added "Provider Inactivity and Administrative Termination of Network Providers" section
09/24/24	Updated "Provider Access Standards" table to include a specific column for Tufts Health One Care; added specific information to the Tufts Health One Care column for Prenatal Appointments; updated information for Non-Emergent or Non-Urgent Mental Health or Substance Use Disorder Services, Non-urgent Care Appointments (such as for headache or fatigue), Urgent Care Appointments; Routine/Non-Symptomatic Care Appointments; Physical Exam, New Member Appointments; EPSDT Appointment; administrative edits
02/14/25	Administrative edits
06/01/25	Added sentence to "Directory Accuracy and Suppression of Unverified Provider Information" section on facility attestation
07/10/25	Added bullets to "Clinical Responsibilities" section
01/01/26	Updated after-hours care information in Provider Access Standards table; updated product references; administrative edits
10/01/26	Updated language in "Provider Newsletter" section; administrative edits
11/15/26	Updated links to online resources; administrative edits; corrected Access to Care standards for Tufts Health One Care