Providers

Refer to this chapter for more information about:

Tufts Health Plan Contracts with CMS and EOHHS

Under its contracts with CMS and EOHHS, Tufts Health Plan receives a per member per month (PMPM) amount from the Centers for Medicare and Medicaid Services (CMS) and EOHHS. These payments to Tufts Health Plan, as a contractor, constitutes state and federal funds and, therefore, subjects Tufts Health Plan and its participating providers to all applicable laws.

Tufts Health Plan, pursuant to its contracts with CMS and EOHHS, is responsible for arranging and paying for the provision of the member's medically necessary Medicare- and Medicaid-covered health care services.

General Responsibilities

Tufts Health Plan providers agree to comply with all state or federal laws and regulations, including but not limited to, CMS and EOHHS regulatory requirements applicable to the Tufts Medicare Preferred and/or Tufts Health Plan SCO products in providing or arranging services for any member.

Providers must also comply with Tufts Health Plan's contractual obligations, including requests for information necessitated by government contracting requirements.

Telehealth Responsibilities

In accordance with state guidelines[1], providers should adhere to the following standards when delivering medically necessary care via telehealth:

- For an initial appointment with a new patient, review the patient's relevant medical history and any relevant medical records with the patient before initiating the delivery of any service
- For existing provider-patient relationships review the patient's medical history and any available medical records with the patient during the service
- Prior to each patient appointment, ensure the same services standards can be delivered as in-person care and in compliance with the provider's licensure regulations and requirements, programmatic regulations, and performance specifications related to the service (e.g., accessibility and communication access)
- If the appropriate standard of care or other requirements for providing requested care via telehealth cannot be met, make this determination prior to the delivery of treatment, notify the patient of this, and advise the patient to instead seek appropriate in-person care
- Ensure patients the same rights to confidentiality and security as provided in face-to-face services, to the extent feasible, and inform patients of any relevant privacy considerations prior to providing services via telehealth
- Follow consent and patient information protocols consistent with the protocols followed during in-person visits as well as any telehealth specific protocols
- Inform patients of the location of the provider rendering services via telehealth (i.e., distant site) and obtain the location of the patient (i.e., originating site)
- Inform the patient how to see a clinician in-person in the event of an emergency or otherwise

[1] MA DOI Bulletin 2021-04 Managed Care Practices and Continued Access to Telehealth Services and MassHealth All Provider Bulletin 327

Provider Newsletter

Insights and Updates for Providers is a monthly newsletter for providers, hospital administrators and ancillary providers in the Tufts Health Plan network. The newsletter is Tufts Health Plan's primary vehicle for communicating 60-day notifications and other critical business-related information to providers.

Tufts Health Plan distributes its the newsletter by email and via the News section of the Point32Health provider website. To receive the newsletter by email, providers must register by completing the online registration form.

This requirement applies to all contracting providers, including but not limited to, providers who are currently registered users of the secure Provider portal as well as those who have previously submitted an email address to Tufts Health Plan for any reason. Office staff and provider organization and hospital leadership can also register to receive the newsletter by email. Office staff may also register a provider on their behalf by using the provider's name, email address and NPI, and indicating the divisions of Tufts Health Plan with which the provider contracts.

Note: Providers who have registered to receive the newsletter by email but are still not receiving it must check their spam folder or check with their organization's system administrator to ensure the organization's firewall is adjusted to allow for receipt.

Confidentiality of Member Medical Records

Tufts Health Plan requires that providers comply with all applicable state and federal laws relating to the confidentiality of member medical records, including but not limited to the privacy regulations of Health Insurance Portability and Accountability Act (HIPAA).

To meet Tufts Health Plan confidentiality requirements, providers must do the following:

- Maintain medical records in a space staffed by office personnel
- Maintain medical records in a locked office when staff is not present
- Prohibit unauthorized review and/or removal of medical records
- Maintain and adhere to policies and procedures regarding patient confidentiality

Tufts Health Plan also requires that providers, upon request, provide member medical information and medical records for the following purposes:

- Administering its health benefit plans, such as claims payment, coordination of benefits, subrogation, enrollment eligibility verification, reinsurance, and audit activities
- Managing care, including but not limited to utilization management (UM) and quality improvement activities
- Carrying out member satisfaction procedures described in member benefit booklets
- Participating in bona fide medical research and in reporting on quality and utilization indicators, such as Healthcare Effectiveness Data and Information Set (HEDIS®)
- Complying with all applicable federal and state laws

Providers are responsible for obtaining any member consents or releases that are necessary beyond those that Tufts Health Plan has already acquired through the enrollment process or the member benefit booklets. Tufts Health Plan maintains and uses member medical information in accordance with Tufts Health Plan's confidentiality policies and procedures.

PCPs

PCPs are responsible for monitoring the care of their Tufts Medicare Preferred and/or Tufts Health Plan SCO members to provide quality and cost-efficient medical management.

The PCP must be able to provide integrated, accessible health care services and be accountable for addressing a large majority of personal health needs, developing a sustained partnership with members, and practicing in the context of the family and community.

The following list encompasses a common set of proficiencies for all PCPs:

- Training in a primary care discipline, or significant additional training in primary care subsequent to training in a non-primary care discipline
- Periodic assessment of the asymptomatic patient
- Screening for early disease detection
- Evaluation and management of acute illness
- Ongoing management of members with established chronic diseases
- Coordination of care among specialists, including acute hospital care and long-term care
- Assessment and either management or referral of members with more complex problems requiring the diagnostic and therapeutic tools of a specialist or other health care professional.

Note: The PCP must be an MD, DO, NP or PA who is appropriately trained and provides integrated, accessible, preventive health care services and health care services for members. The PCP must be accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of the family and the community.

Responsibilities

PCPs are responsible for providing or arranging the total care of their Tufts Medicare Preferred and/or Tufts Health Plan SCO members. This includes providing high-quality, cost-efficient medical care and/or management. The PCP's role in successfully recognizing and addressing the member's needs is key to the success and satisfaction of the member, the medical group and Tufts Health Plan PCP responsibilities include the following:

- Providing care in a manner consistent with recognized standards of health care and in a culturally-competent manner to all Tufts Medicare Preferred and/or Tufts Health Plan SCO members, including those with limited English proficiency or reading skills, diverse cultural and ethnic backgrounds and/or physical or mental disabilities. Successful medical service management and coordination ensures continuity of care and eliminates test and procedure duplication.
- Being accessible to members 24 hours a day, 7 days a week via direct contact or through PCP-arranged provider alternative, another Tufts Health Plan participating provider.
- Coordinating services that allow for continuity of care and integration of services, including:
  - Continuous patient care and quality review
  - An initial assessment of the member's health care needs within 90 days of the member's initial enrollment
  - Systems to address barriers to the member's compliance with the practitioner's prescribed treatments or regimens
  - Procedures to ensure that members are informed by providers of specific health care needs that require follow-up care and receive care/treatment as appropriate
  - Training in self-care and other measures members should take to promote their health.
- Arranging for the continuation of benefits in the event of plan contract termination, non-renewal, or insolvency through the end of the period for which the Tufts Medicare Preferred and/or Tufts Health Plan SCO member's premium is paid or hospital discharge date by the following:
  - Honoring all open authorizations for care
  - Placing outbound calls to affected Tufts Medicare Preferred and/or Tufts Health Plan SCO members who are scheduled for services and undergoing treatment plans to coordinate continuation of care
  - Providing an opportunity for members undergoing a treatment plan to continue to see providers who are no longer in the network due to the group insolvency
  - Providing standard and expedited organization determinations in accordance with the requirements described in the Member Appeals and Grievances chapter.

Specialty Care Referrals

Referrals for specialty services are required for Tufts Medicare Preferred HMO and Tufts Health Plan SCO members. Summaries from all specialist consultations and all procedures should be routed to the PCP for review prior to requesting additional services. Tufts Medicare Preferred PPO members are not required to obtain a referral for in- or out-of-network services.

Members cannot be held financially responsible for services rendered without a referral or prior authorization unless the member received prior notice that the item or service would only be covered if further action is taken by the member.

If a member believes that Tufts Health Plan should pay for a service that is considered noncovered, that constitutes a request for an organization determination according to the Medicare Managed Care Manual, Chapter 4, Section 160: "Beneficiary Protections Related to Plan-Directed Care."

Refer to the Referrals, Prior Authorizations and Notifications chapter for more information on organization determinations.

PCP Eligibility Report and List

Tufts Health Plan provides each medical group with a monthly eligibility listing report that identifies all new and existing members who have selected a provider within the group as their PCP.

Eligibility Listing Report	
Report Heading	**Description**
C	-An indicator noted before a member's name if the practitioner is the member's current PCP. -No indicator will be noted for a member who has changed PCPs.
Member	Member's name (last, first and middle initial)
Member Number	Tufts Medicare Preferred/Tufts Health Plan SCO Member ID number
PN	Person number
DOB	Member's date of birth
Age	Member's age
Sex	Member's gender
Sp St	Special status, if appropriate, noted by indicator: • M (Medicaid) • I (Institutionalized) • H (Hospice) • T (Medicaid and institutionalized)
WA	Working Aged, noted if member is working and has other insurance
Elig Eff Date	The date the member began coverage through Tufts Health Plan (or the date of the member's most recent internal plan change)
Plan	The benefit plan chosen by the member
Member Address	Member's current street, city, state and zip code
Member phone	Member's current phone number
Term Dt	Term date, noted only in the TERM MEMBERS section with a date of member's termination from the plan or internal plan change.
Termination Reason	Reason for termination, noted only in the TERM MEMBERS section for a member who has disenrolled or terminated from the plan. A member still on the plan who has an internal plan change (such as changing pharmacy, standard plan, address, phone, or special status) will not show a reason.

Eligibility Listing Report	
Report Heading	**Description**
ACTIVE MEMBERS	-Members who are new or currently on the plan. -New members are also listed in the NEW MEMBERS section.
NEW MEMBERS	New members who are also listed in the ACTIVE MEMBERS section.
TERM MEMBERS	Members who: • Have left the plan and have a termination date and reason, or • Have had an internal plan change and have a termination date but no reason (these members will be listed in the ACTIVE MEMBERS section and the effective date will change to the month the internal change was made).

Access Standards

Timeliness of Care

- Urgently needed services or emergency: immediately
- Services that are not emergency or urgently needed, but the enrollee requires medical attention: within 7 business days
- Routine and preventive care: within 30 business days

Telephone Callbacks

During Office Hours

The office determines if the member's call is urgent and the following procedures are followed:

- Urgent calls will be returned within one hour
- Nonurgent calls will be returned on the same day

After Office Hours

Members are expected to exercise appropriate judgment about urgent needs for service when contacting their providers outside normal office hours.

An answering service or machine answers telephones after hours. For urgent problems, an answering service offers to contact the provider or a covering provider, as necessary. An answering machine provides a number through which a provider can be contacted for urgent problems. Providers normally return urgent calls within one hour.

If a provider uses a triage service for telephone screening after hours, the provider must instruct the nursing staff to identify themselves as a nurse who is covering for a provider. The nurse must also communicate to the member that during a life-threatening situation, the member must hang up and either call 911 or go to the nearest emergency department (ED), as appropriate. At the completion of the call, the nurse must verify that the member is comfortable with the nurse's advice and tell the member of their right to speak to the covering provider. All providers used for covering purposes must be licensed as required by law.

Note: Routine use of an ED to supply after-hours care is not an acceptable coverage arrangement.

Office Waiting Time

In most situations, members should not have to wait more than 30 minutes past their appointment time to be seen. If a longer wait is anticipated, office staff should explain the reason for the delay and offer to book the member for another appointment.

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. Harvard Pilgrim 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.

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 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), 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 at 800-279-9022.

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.

Closing and Opening a Panel

PCPs may close their practices to new members for reasons such as maternity leave, research leave, or for capacity reasons. However, the PCP shall not close a panel for selected plans; closing a panel pertains to all Tufts Medicare Preferred and/or Tufts Health Plan SCO members.

PCPs must submit written notification to the Network Management department at least 90 days prior to closing their panels or as otherwise specified in their contract with Tufts Health Plan. During the 90-day transition period, members will still be allowed to select the provider as their PCP. After the 90-day period, neither Tufts Health Plan enrollment representative nor the sales representative will direct any prospective members to select this PCP.

To reopen the panel, the provider must notify the Tufts Health Plan Associate Contract Specialist in writing and must include the date the panel will reopen.

Providers are also responsible for reviewing and verifying the accuracy of their demographic data (including, but not limited to, specialty information, practice location, phone number, hours of operation and availability to see members, including whether the provider has a waitlist of 4 weeks or less). Providers may log into CAQH Provider Data Portal or fill out the Provider Information Form and submit the completed form to the appropriate email, as noted on the form.

Temporary Transfer of Responsibility

Provider agreements obligate PCPs to establish and maintain coverage 24 hours a day, 7 days a week. However, personal illness, sabbatical or maternity leave are examples of situations in which briefly withdrawing from your practice and temporary transfer of this responsibility may be necessary.

If the intended interruption will exceed 60 calendar days, Tufts Health Plan requires the PCP to provide written notice to Tufts Health Plan. At a minimum, this notification must include the dates and general reasons for the temporary transfer

of responsibility. Tufts Health Plan can then close the panel since absence beyond two months does not allow for direct patient management.

Leave of Absence

Tufts Health Plan requires prior notification from providers if they are going on 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.). Tufts Health Plan must be notified of a pending LOA as soon as possible.

Providers taking a LOA must arrange for coverage by another participating practitioner in the member's network. All covering arrangements must be acceptable to Tufts Health Plan.

Arrangements for coverage by a nonparticipating practitioner (i.e., locum tenens) may be considered. These arrangements must have Tufts Health Plan's prior approval and must be consistent with established policies and procedures.

If the LOA is scheduled for **six months or less,** Tufts Health Plan 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 LOA status will be removed and will reflect the provider's prior status.

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

Covering Practitioner

All contracted Tufts Health Plan providers have contractually agreed to be accessible to Tufts Medicare Preferred and/or Tufts Health Plan SCO members 24 hours a day, seven days a week, either directly or through a covering practitioner. If a contracted provider is not available, they are responsible for maintaining appropriate coverage that is acceptable to Tufts Health Plan. Covering providers must also be credentialed by Tufts Health Plan.

Information regarding on-call activities must be relayed by the covering practitioner 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

Locum Tenens Policy

If coverage will be rendered by a locum tenens provider, the provider must be credentialed by Tufts Health Plan.

Credentialing of Locum Tenens Providers

When notice is given by an independent practice association (IPA) or practice office that a practitioner will be joining under a locum tenens status, the locum tenens provider(s) must submit the following forms to the Tufts Health Plan Credentialing Department:

- HCAS enrollment form
- Release & attestation form
- IPA endorsement form
- W-9 form (for payment purposes)

If a practitioner does not have a primary hospital affiliation, they must submit the name of the practitioner who will be admitting on their behalf.

Tufts Health Plan's credentialing staff will:

- Obtain primary verification of hospital privileges and confirmation that the hospital has credentialed the practitioner pursuant to appropriate state and/or federal regulations, as applicable
- Collect information from the National Practitioner Databank

Changing PCPs

Tufts Medicare Preferred and/or Tufts Health Plan SCO members or their authorized representatives may request to change their selected PCP to a PCP within the Tufts Health Plan service area. Tufts Health Plan must receive the member's request either by phone or in writing by 4 p.m. of the last business day of the month for the transfer to be effective the first day of the following month. Transfers are normally effective on the first day of the following month. Tufts Health Plan providers should make efforts to ensure that the member's records are transferred to the new PCP in a timely manner to ensure continuity of care.

Each Tufts Medicare Preferred and/or Tufts Health Plan SCO member selects a PCP and at times during this practitioner/patient relationship situations arise where the PCP and member do not agree. These disagreements can usually be discussed to develop an action plan agreed upon by both parties. For instance, members may disagree with the PCP suggested treatments or may opt for no treatment for some medical issues. These issues usually do not cause alarm or grave concern for the member's health.

In some cases, members select PCPs but choose not to participate in annual visits. This is the member's choice and is not considered a valid reason to discharge a member from a PCP panel. Providers may request the member's care manager reach out to the member to determine if there are barriers that may be preventing the member from visiting the PCP's office. If so, transportation services, nurse practitioner home visits, or other benefits that address such barriers should be taken into consideration by the provider.

In rare circumstances, a member's behavior may interfere with the member's treatment plan initiated by the PCP. The PCP must discuss their concerns with the member and document it in the member's medical record. If the member's behavior continues to interfere with the treatment plan, the PCP may issue a non-compliance with the treatment plan notice to the member documenting their discussion and any actions agreed upon. The notice should describe instances in which the member's behavior has impaired the physician's ability to furnish services and for which the PCP has given the member opportunity to explain their behavior.

A second notice may be issued if the member has not taken action to correct the noncompliance issue. If the noncompliance of treatment persists despite discussions with the member and sending two written notices, both parties may come to an agreement that the member would best be served by arranging to change their PCP. If the member has not taken action to change their behavior and does not want to change their PCP, the PCP should contact Senior Products Provider Relations for assistance with ongoing management of the member's care. The PCP may not discharge a Tufts Medicare Preferred HMO or Tufts Health Plan SCO member; however, the member may voluntarily make a PCP change.

In extremely rare circumstances, inappropriate disruptive behavior on the part of the member may impair the provider's ability to furnish quality medical services. A PCP is expected to contact Tufts Health Plan if they feel a member has displayed true disruptive behavior. This disruptive behavior is behavior that will substantially impair the PCP's ability to arrange for or provide services to either that particular member or other Tufts Medicare Preferred HMO and/or Tufts Health Plan SCO members. In these cases of behavioral concern, the PCP must discuss the case with Tufts Health Plan, who will investigate the case details and determine if further actions up to and including requesting disenrollment will be initiated.

In the event a provider believes they have a disruptive member, the provider should contact Provider Relations and notify the member's care manager.

Notes:

Tufts Health Plan requires the following:

- Documentation that the provider has discussed with the member (or authorized representative) the issues that are affecting the member's medical treatment.
- The PCP must send the Noncompliance of Practitioner Treatment Plan letter(s) to the member, with copies to Tufts Health Plan for the member's file.
- The letter must provide specific description of the concern with specific practitioner orders, dates of noncompliance and provider recommendations.
- The notice should include how the member may comply with the treatment plan and should be sent to the member on two separate occasions, allowing a reasonable time for the member to demonstrate compliance with the treatment plan.
- Examples of when PCPs may use this letter include situations such as when the member's treatment plan involves appointments with the PCP every other week to evaluate a wound status and wound care regimen, but the member has failed to keep the last two appointments although the PCP's office staff has called in advance to remind the member of each appointment.

Provider Terminations and Network Changes

A provider must notify Tufts Health Plan with at least 90 calendar days' written notice prior to the effective date of a PCP or behavioral health provider termination from the network, subject to any notice requirements as may be found in the provider's contract.

Tufts Health Plan must notify members with at least 45 calendar days' written notice and one telephonic notice prior to the effective termination date of their PCP or behavioral health provider. Notification will be sent to all impacted members who are currently assigned to that PCP and who have been a patient of that primary care or behavioral health provider within the past three years.

For specialty providers other than PCP and behavioral health, Tufts Health Plan must provide written notice to impacted members with at least 30 calendar days prior to the termination effective date. Notification will be sent to all members who are patients seen on a regular basis by the provider, whose contract is terminating, or who are currently or have received care from such provider within the past three months.

Specialists

Specialists within the Tufts Health Plan network are expected to provide quality, cost-efficient health care to Tufts Medicare Preferred and/or Tufts Health Plan SCO members. Contracted providers must provide care in a culturally competent manner to all Tufts Medicare Preferred and/or Tufts Health Plan SCO members, including those with limited English proficiency or reading skills, diverse cultural and ethnic backgrounds, and physical or mental disabilities.

The specialist's primary responsibility is to provide authorized medical treatment to Tufts Medicare Preferred and/or Tufts Health Plan SCO members who have an electronic or written referral from their PCP. Services rendered without authorization or referral from their PCP, are only covered if the member received prior notice that such services will be covered. Such prior notice of coverage is the issuance of an organizational determination. Tufts Medicare Preferred PPO members do not need a referral to see a specialist (in- or out-of-network).

Refer to the Referrals, Prior Authorizations and Notifications chapter for more information on Organizational Determinations.

If a specialist feels that additional care beyond that which has been authorized on the referral is necessary, the specialist must contact the PCP prior to rendering services that have not been expressly authorized on the referral form. If a specialist feels that additional treatment is required and cannot provide these services, the specialist must contact the member's PCP and suggest that the PCP provide that member with an alternative referral. Tufts Health Plan will not pay

for additional specialist services/treatments that are not approved by Tufts Health Plan. Refer to the Referrals, Prior Authorizations and Notifications chapter for more information.

Specialists are also responsible for submitting a summary report to the member's PCP following the member's appointment prior to requesting additional services.

Contracted specialists are required to provide 90 calendar days prior notice of termination of their participation with Tufts Health Plan to members who have been/are under their ongoing care.

Nurse Practitioners and Physician Assistants

Nurse practitioners (NPs) and physician assistants (PAs) may elect to bill under their supervising or collaborating physician. NPs and PAs who are working under the auspices of a licensed practitioner, as permitted by state law, and for whom the provider and/or facility (e.g., hospital) have met all applicable requirements, may bill for those covered services under the supervising provider's identification number.

A provider organization may, in its discretion, include NPs and PAs in their contracts through the signature pages attached to the contract to provide or arrange for health services pursuant to the contract. Once contracted and credentialed by Tufts Health Plan, NPs and PAs may be listed in directories and may hold a panel as a PCP or serve as a specialist and are subject to the terms as set forth in the relevant contract's financial exhibit(s).

For additional information, refer to the Nurse Practitioner and Physician Assistant Professional Payment Policy.

Use of Nurse Triage Service

If a practitioner uses a nurse triage service for telephone screening after hours, the practitioner must instruct the nursing staff to identify themselves as nurses covering for a practitioner. This service also includes the following:

- Communication to members that if they are in an emergency situation, they should hang up and call 911 or go to the nearest emergency department
- At the completion of the call, verification that the member is comfortable with the advice received and notice of the members of their right to speak to the covering provider

Note: All practitioners used for covering purposes must be licensed as required by law.

Aging Services Access Points and Geriatric Support Services Coordinators

To provide home- and community-based services (HCBS) for the geriatric population, Tufts Health Plan contracts with aging services access points (ASAPs) and geriatric support services coordinators (GSSC) to manage these services for Tufts Health Plan SCO members. Refer to the ASAP/LTSS chapter for more information.

Credentialing

Summary of Credentialing Process

Tufts Health Plan credentials affiliated providers when they join the plan, and again at least every three years in accordance with state and federal regulatory and accrediting agency requirements. All contracting providers must be eligible for and accepting payment under Medicare.

The credentialing process involves collecting documents from providers and direct verification through various outside agencies, all in accordance with the standards of Centers for Medicare and Medicaid Services (CMS) and as required by state and federal laws.

Provider Requirements

For initial credentialing and recredentialing, each provider is required to comply with Tufts Health Plan's Credentialing Program and to submit the following information for review:

- Complete all required fields specified in CAQH ProView™ 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 Plan via email
- Sign W-9 form (initial credentialing only) and send to Tufts Health Plan via email
- Current malpractice insurance information and send to Tufts Health Plan via email

Practitioners are notified of their recredentialing request through CAQH ProView, allowing enough time for each practitioner to complete the information online by his or her recredentialing date. Tufts Health Plan credentials according to the birthdate cycle (people 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 in the application when applicable. For initial credentialing, Tufts Health Plan queries that hospital for an assessment of the practitioner's performance, as mandated by the Joint Commission or other accrediting agency acceptable to CMS and/or EOHHS and Tufts Health Plan. During recredentialing, the hospital is queried again. The practitioner must notify Tufts Health Plan in writing of changes in primary hospital affiliation.

Tufts Health Plan Requirements

Along with the credentialing information specified in CAQH ProView, Tufts Health Plan 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 arrangements, and other corrective actions
- State disciplinary actions
- Medicare opt-out
- System of Award Management (SAM) sanctions
- Medicare Preclusion sanctions

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

Practitioners cannot see Tufts Health Plan 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 Plan medical director of the practitioners' credentialing or recredentialing file

Note: 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.

If the contract provides for credentialing activities by a first-tier or downstream entity, the first-tier or downstream entity must meet all applicable Tufts Health Plan credentialing requirements, including Tufts Health Plan either reviewing the credentials of medical professionals or reviewing, preapproving and auditing the credentialing process.

Practitioners' Rights and Responsibilities

Practitioners have the right, upon written request, to:

- Review Tufts Health Plan's credentialing policies and procedures
- Be informed of the status of their credentialing or recredentialing application by contacting the Credentialing Department via the following:

  Phone: 800-279-9022
  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 Plan for purposes of credentialing or recredentialing, including information obtained by Tufts Health Plan from any outside source, such as a malpractice carrier, state license board, or the National Practitioner Data Bank (NPDB).
  - Notwithstanding the foregoing, Tufts Health Plan is not required to reveal the information source if the information was not obtained for the purpose of meeting Tufts Health Plan's 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 Plan hereby notifies practitioners of their right to correct erroneous information. Tufts Health Plan will inform the provider how and where to submit corrections.
- Receive notification if credentialing information obtained from sources other than the practitioner varies substantially from the credentialing information provided to Tufts Health Plan by the practitioner.

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. In the event that 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 Plan board member or otherwise be a representative of Tufts Health Plan.

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.

Hospital Credentialing

Tufts Health Plan credentials hospitals when they join the Plan and are recredentialed every three years in accordance with National Committee for Quality Assurance (NCQA) standards.

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 Plan 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 Plan 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.

Contracting Requirements

Health care providers and plans must abide by specific contracting requirements, including, but not limited to the following:

Privacy, Confidentiality and Accuracy

Providers and subcontractors must:

- Safeguard member privacy and confidentiality
- Assure the accuracy of member health records
- Comply with all federal and state laws regarding the privacy, security and disclosure of member information (including HIPAA), as amended

Availability of Health Services

Practitioners must provide access to health services 24 hours a day, 7 days a week, or arrange for coverage that is reasonably acceptable to Tufts Health Plan.

Cultural Competency

Providers must offer covered benefits in a culturally competent manner consistent with professionally recognized standards of health care and in a culturally competent manner, and, if possible, provide interpreters/translator services for those who are deaf or hearing-impaired.

Providers must provide health services in way that is responsive to the linguistic, cultural, ethnic, or other unique needs of members of minority groups, homeless individuals, disabled individuals and other special populations served under this program.

Urgently Needed Care

Tufts Health Plan must pay for and providers may not bill or require members to receive prior authorization for emergency and urgently needed care. This information is defined in the Referrals, Prior Authorizations and Notifications chapter.

Data Submission

Providers must submit to Tufts Health Plan all data (including medical records) that are necessary to characterize the content/purpose of each visit with a member. Providers must also certify that any data resulting from a visit or any other information submitted to Tufts Health Plan will be complete, accurate and truthful.

Data must be in a format that is compatible with Tufts Health Plan systems and should include the management, clinical data, utilization and cost data needed to administer the product.

Fraud, Waste and Abuse

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.

If a practitioner becomes aware of a questionable practice by a Tufts Health Plan provider or member that may indicate possible health care fraud, Tufts Health Plan has a Hotline for reporting concerns. The Hotline was established to help Tufts Health Plan's members, providers and vendors who have questions, concerns and/or complaints related to possible wasteful, fraudulent or abusive activity.

Providers may call the Tufts Health Plan Compliance and Fraud Hotline to report concerns 24 hours a day, 7 days a week at 877-824-7123. Callers may self-identify or choose to remain anonymous.

Providers who care for Tufts Medicare Preferred and/or Tufts Health Plan SCO members are required to comply with CMS certification requirements. For additional educational materials about FWA, including web-based training, refer to CMS.

Disclosure of Relevant Information

Providers must disclose to Tufts Health Plan, CMS, and EOHHS all information necessary to establish and facilitate a process for current and prospective enrollees to exercise choice in obtaining Medicare and Medicaid covered services.

Inspections and Audits

First tier and downstream entities must:

- Comply with Medicare laws, regulations and CMS instructions (422.504(i)(4)(v)), as well as Medicaid laws
- Agree to audits and inspection by CMS and EOHHS, and/or its designees and to cooperate, assist, provide information as requested, and maintain records for a minimum of ten years
- Agree to comply with all state and federal confidentiality requirements, including those established by the Tufts Health Plan, the Medicare Advantage program and the SCO program.
- Comply with all federal and state laws and regulations concerning the privacy and confidentiality of member information, including HIPAA.

Responsibilities of Administrative Services Providers

The contract must clearly state the responsibilities of the administrative services provider and its reporting arrangements.

Advance Directives

If a member has a signed advance directive, providers must document this information in a noticeable place in the member's medical record.

Outreach

Tufts Health Plan will not contact a prospective member without a direct request from that individual or that individual's representative or as permitted, under applicable CMS and EOHHS requirements. If an individual is interested in learning about a Tufts Medicare Preferred or Tufts Health Plan SCO plan, they can call Senior Products Member Services.

Additional outreach methods include the following:

- A provider can request assistance from Tufts Health Plan to mail a letter to current patients
- Additionally, a representative is available to conduct informational sessions at provider practice locations. For additional information, contact the Sales department at 855-670-5938.

CMS guidelines associated with provider marketing activities and additional information may be found in CMS' Medicare Communications and Marketing Guidelines.

Treatment Plan

Providers must:

- Educate members regarding their unique heath care needs

- Inform members of follow-up care or provide training in self-care as necessary
- Share the findings of medical history and physical examinations
- Discuss potential treatment options, including alternative medications, side effect of treatment and management of symptoms
- Recognize that the member generally has the right to choose the final course of action among clinically acceptable choices regardless of any coverage limitations or exclusions
- PCPs must make best efforts to conduct or arrange an initial health needs assessment of each member in their panel within 90 days of the member's date of enrollment

Communication of Clinical Information

Appropriate and confidential exchange of information among providers should occur such that:

- A provider making a referral transmits necessary information to the provider supplying the referral service
- A provider supplying a referral service reports appropriate information to the referring provider
- Providers request information from treating providers as needed to furnish care

Discrimination Prohibited

Tufts Health Plan may not limit, deny, or condition the coverage of benefits to individuals eligible to enroll in a Medicare Advantage or SCO Plan on the basis of any factor that is related to health status, including but not limited to:

- Medical condition
- Claims experience
- Receipt of health care
- Medical history
- Genetic information
- Evidence of insurability, including conditions arising out of acts of domestic violence and disability

Exceptions include an individual who:

- Lives inpatient in a chronic or rehabilitation hospital
- Resides in an intermediate care facility for the intellectually disabled

Provider Compliance

Tufts Health Plan participating providers agree to comply with all applicable state or federal laws and regulations. Providers must cooperate in a timely manner with plan policies and procedures and its activities to comply with these laws and regulations, and with plan contractual obligations, such as requests for information necessitated by CMS and/or EOHHS contracting requirements, as applicable.

All Tufts Medicare Preferred network providers must be eligible for and accept payment under Medicare. All Tufts Health Plan SCO network providers must be eligible for and accept payment under Medicare and MassHealth or be known to MassHealth as a managed care entity provider.

Provider Rights

Federal regulations require Tufts Health Plan to maintain procedures relating to the rights of participating providers.

Contracting Rights

All participating providers must be furnished with plan participation rules and notice of material changes in participation rules.

If Tufts Health Plan decides not to include individuals or groups of providers in its provider network after an application has been submitted, the affected providers will be given written notice of the reason for this decision.

In some cases, providers may appeal adverse participation decisions. In the case of termination or suspension of a provider contract by Tufts Health Plan, the provider must be given written notice of the reasons for such action and notification of appeal rights, if applicable, including the process and timing for a hearing request, if any, as required by law.

Providers who have not been notified of the suspension or termination of an existing contract with Tufts Health Plan may be allowed to appeal adverse participation decisions.

Provider Marketing Activities

Tufts Health Plan requires that any contracting provider (and its subcontractors) or agent (or its subcontractors) performing functions on behalf of Tufts Health Plan related to the administration of the benefit, including all activities related to assisting in enrollment and education, agrees to the same restrictions and conditions that apply to Tufts Health Plan through its contract(s) with CMS, and prohibits providers from steering, or attempting to steer, an undecided potential enrollee toward a plan, or limited number of plans, offered either by Tufts Health Plan or another plan sponsor, based on the financial interest of the provider or agent (or their subcontractors). Providers that have entered into co-branding relationships with Tufts Health Plan must also follow this guidance.

Guidelines associated with provider marketing activities and additional information can be found in CMS' Regulatory Resources.

MassHealth

Current and potential members who inquire about MassHealth eligibility should be referred to EOHHS about enrollment.

Eligibility Verification Process

EOHHS designed a web-based and telephonic eligibility verification system (EVS). Providers must use this system to verify eligibility and available third-party liability information about members.

All Tufts Health Plan SCO network providers must verify membership and eligibility prior to providing any service. For emergency services, providers should verify eligibility as soon as possible following the date of the service. Eligibility information can be accessed by using the Virtual Gateway/EVS. Access may also be available through Change Healthcare™.

Providers may also call Senior Products Member Services to verify member eligibility. For additional information regarding eligibility verification, refer to the public Provider website.

Provider Education

To ensure knowledge and understanding of the health care needs of members, Tufts Health Plan provides continuing education programs for provider networks, including primary care teams, specialists, behavioral health providers, and long-term care providers. This education describes the responsibilities involved in integrating and coordinating services.

Provider education consists of training curriculum, flow charts and other written material. Delivery may include printed instructional material, face-to-face training, as well as web and audio/visual conferencing. Topics include but are not limited to:

- Quality management activities and requirements
- Information regarding providers' integration and coordination of covered services
- Information regarding procedures and time frames for enrollee complaints and appeals
- Coordination of care within the provider network, including instructions regarding policies and procedures to maintain the Centralized Enrollee Record (CER)

- Identification and management of depression, alcohol abuse and Alzheimer's disease
- Identification and treatment of incontinence
- Prevention of falls
- Identifying and Reporting Elder Abuse and Neglect
- Influenza and pneumonia immunization
- Recognition of change in conditions and early intervention
- Delirium, depression and dementia
- Assessment and management of proactive congestive heart failure (CHF)
- Prevention of unnecessary hospitalization
- For Tufts Health Plan SCO providers:
  - Annual Model of Care training: This required training provides annual updates on Tufts Health Plan SCO's care management program and care coordination policies and procedures.
  - Continuity of Care requirements for new Tufts Health Plan SCO members to the plan

Other instructions for providers will include the process to verify each member's EOHHS eligibility from the EVS, which must be done prior to providing services, except for services for emergency conditions. (An emergency condition is a medical condition that manifests itself by acute symptoms of sufficient severity (including severe pain) such that a "prudent layperson", who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in: 1) placing the health of the individual in serious jeopardy; 2) serious impairment to bodily functions; or 3) serious dysfunction of any bodily organ or part.)

Provider Education Tracking

Tufts Health Plan will track the completion of provider program training. Tracking may be in the form of attendee lists, results of testing, web-based attendance confirmation and/or electronic training records. Tufts Health Plan will maintain an action plan and take appropriate steps, should the required training not be completed in a timely fashion.

Health Promotion and Wellness Activities Performance

Providers must comply with Tufts Health Plan's evaluation process, as well as any other corrective measures that are identified as being relevant to the provider.

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.

Provider Advice and Advocacy

Tufts Health Plan does not prohibit or otherwise restrict providers, acting within the lawful scope of their practice, from advising or advocating on behalf of an individual who is a Plan member. This includes informing members on:

- Their medical status, care or treatment options for the member's health condition or disease (including any alternative treatments that may be self-administered). Providers should always share sufficient information with the member so that the member has an opportunity to decide among all relevant treatment options, regardless of any coverage limitations, exclusions, or the cost of the treatment.
- The risks, benefits and consequences of any medical treatment or non-treatment options involved in the member's health condition or disease. Of note, the provider must tell the member in advance if any proposed medical care or treatment is part of a research experiment. The member has the right to refuse any experimental treatments.

- The member's right to participate in decisions about their medical care and treatment, including the opportunity for the member to refuse treatment and to express preferences about future treatment decisions regardless of whether the Plan provides coverage for such medical care or treatment. This includes the right of a member to request to leave a hospital or other medical facility and/or the right to stop taking medication, even when the provider advises or advocates against the decision.

Providers must (1) explain the member's medical condition, care and treatment choices in a way the member understands; (2) provide information about the options in a culturally competent manner, including the option to refuse treatment, and (3) ensure that members with disabilities have the appropriate access to communications with their Health Care Team, and others involved in their health care, so that they may make informed decisions about the treatment options for their health condition or disease.

PUBLICATION HISTORY

01/01/24	Updated timeliness of care and provider termination sections to align with CMS final rule CY 2024
02/02/24	Added Directory and Suppression of Unverified Provider Information; administrative edits
03/01/24	Updated email addresses
03/20/24	Updated email address
04/19/24	Updated Notification Requirements section in the Directory and Suppression of Unverified Provider Information with text on availability to see members, including whether the provider has a waitlist of 4 weeks or less, also inserted this text into the Closing and Opening a Panel section; administrative edits.
04/30/24	Added Provider Advice and Advocacy section; administrative edits
06/01/24	Updated Provider Education section
08/01/24	Added "Provider Inactivity and Administrative Termination of Network Providers" section
05/01/25	Updated "Provider Terminations and Network Changes" section to note 90 days' written notice prior to the effective date of a PCP or behavioral health provider termination from the network; administrative edits