Provider Roles and Responsibilities

Introduction

This section of the Provider Manual addresses the respective responsibilities of participating providers. Our expanding network of primary care providers, as well as the growing list of specialty providers, makes it more convenient for our Medicare Advantage plan members to find health care providers in their service area.

Harvard Pilgrim Stride[SM] (HMO) does not prohibit or restrict Plan providers from advising or advocating on behalf of a Plan member about:

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

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

Practitioners may freely communicate with patients about their treatment, regardless of benefit coverage limitations. As applicable, the Plan shall not prohibit the participating provider from providing inpatient services to a member in a contracted hospital if such services are determined by the participating provider to be medically necessary covered services under the Plan, Medicare Contract. All providers are subject to applicable referral, authorization and notification requirements as outlined in Harvard Pilgrim's Stride[SM] (HMO) *Inpatient Acute Medical Admissions Payment Policy*.

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

Provider Agreement

The Provider's Agreement specifies obligations for participation in the Harvard Pilgrim Medicare Advantage HMO network including, but not limited to:

- Payment for services covered by Harvard Pilgrim Medicare Advantage plan(s)
- Reporting and disclosure requirements
- Accountability
- Claims turnaround time

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

Unless authorized or a type of care covered out of network (e.g., urgent or emergent care), out-of-network services are not covered. Contracted providers are responsible to ensure that members are referred to in-network providers and to ensure that authorizations are obtained when applicable to ensure coverage. In some instances, the referring provider may be held liable. To find a Harvard Pilgrim Medicare Advantage network provider, access the online provider directory at *www.harvardpilgrim.org/provider.* From the members section, click "Tools" > "Provider Search."

Provider Anti-Discrimination

In selecting practitioners to participate in our Medicare Advantage provider network, Harvard Pilgrim may not discriminate, in terms of participation, reimbursement or indemnification, against any health care professional acting within the scope of his or her license or certification under state law, solely on the basis of the license or certification in terms of participation, reimbursement or indemnification.

This prohibition does not preclude:

- The refusal to grant participation to health care professionals in excess of the number necessary to meet the needs of the plan's enrollees.
- The use of different reimbursement amounts for different specialties or for different practitioners in the same specialty.
- Implementation of measures designed to maintain quality and control costs consistent with Harvard Pilgrim's responsibilities.

Non-Acceptance and Termination

In the event a provider wishes to terminate his/her participation in Harvard Pilgrim's Medicare Advantage HMO network or Harvard Pilgrim terminates a provider for reasons other than cause, a mandatory 120-day notification is required for the termination. Please refer to your contract for specific termination requirements. Any provider requesting termination of his/her participation should send written notification to the Harvard Pilgrim Provider Contracting Department. Upon receipt of the termination request, Harvard Pilgrim will send a written, CMS-approved notification of the termination to all affected members at least 30 calendar days before the effective date of termination. MA organizations that suspend or terminate a contract due to deficiencies in the quality of care must give notice of that action to the licensing or disciplinary bodies.

Termination of a Provider Contract with Cause

A Medicare Advantage organization that suspends or terminates an agreement under which the health care professional provides service to the Medicare Advantage enrollees must give the affected provider written notice of the following:

- Reason for the action
- Standards and the profiling data used to evaluate the health care professional when applicable
- Mix of health care professionals the organization needs when applicable
- Affected health care professional's right to appeal the action and the process and timing for requesting a hearing

The composition of the hearing panel must ensure that the vast majority of the panel members are peers of the affected health care professional. A Medicare Advantage organization that suspends or terminates a contract with a health care professional due to deficiencies in the quality of care must give written notice of that action to licensing, disciplinary, or other appropriate authorities.

Safeguarding and Maintenance of Medical Records

In compliance with Medicare Laws, audits, and record retention requirements, medical records and other health and enrollment information of an enrollee must be handled under established procedures that:

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

In addition to the obligation to safeguard the privacy of any information that identifies a particular enrollee, Harvard Pilgrim and its participating providers, are obligated to abide by all Federal and state laws regarding confidentiality and disclosure for mental health records, medical health records, and enrollee information. First tier and downstream providers must agree to comply with Medicare laws, regulations, and CMS instructions (422.504(I)(4)(v)), and agree to inspections, evaluations and audits by CMS and/or its designees and to cooperate, assist, and provide information as requested, and maintain records a minimum of 10 years. For the purposes specified in this section, Providers agree to make available Provider's premises, physical facilities and equipment, records relating to Plan's Covered Individuals, including access to a Provider's computer and electronic systems and any additional relevant information that CMS may require. Providers

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

Network Participation

Harvard Pilgrim will offer providers the opportunity to apply for participation in the Medicare Advantage HMO network. Network providers provide care to our Medicare Advantage HMO members and will be reimbursed for Medicare covered services at the agreed upon Medicare payment rate. Network providers sign formal agreements with Harvard Pilgrim, agree to bill Harvard Pilgrim for covered services provided to our members, accept our reimbursement as full payment minus any member required cost sharing, and receive payment directly from Harvard Pilgrim.

Qualifications and Requirements for Provider Participation

To be included in Harvard Pilgrim's Medicare Advantage HMO network, providers must:

- Have a national provider identifier they use to submit paper claims or electronic transactions to Harvard Pilgrim (in accordance with HIPAA requirements)
- Hospitals, home health agencies, skilled nursing facilities, long-term acute care hospitals or comprehensive outpatient rehabilitation facilities will provide applicable member appeal notices
- Not charge the member in excess of cost sharing under any condition, including in the event of plan bankruptcy
- Meet all applicable licensure requirements in the state where they are licensed and where services are provided, and meet Harvard Pilgrim's credentialing requirements pertaining to licensure
- Furnish services to our members within the scope of their licensure or certification and in a manner consistent with professionally recognized standards of care
- Provide services that are covered by our plan and that are medically necessary by Medicare definitions
- Meet applicable Medicare approval or certification requirements
- Not have opted out of participation in the Medicare program under §1802(b) of the Social Security Act, unless providing emergency or urgently needed services
- Sign formal agreements with Harvard Pilgrim
- Agree to bill Harvard Pilgrim for covered services provided to Harvard Pilgrim Medicare Advantage members
- Accept Harvard Pilgrim's reimbursement as full payment less any member cost sharing
- Receive payment directly from Harvard Pilgrim
- Not be on the U.S. Department of Health and Human Services Office of Inspector General (OIG), the General Services Administration's (GSA) System for Award Management (SAM) excluded and sanctioned provider lists or the CMS Preclusion List
- Comply with all applicable Medicare and other applicable Federal health care program laws, regulations, and program instructions, including laws protecting patient privacy rights and HIPAA that apply to covered services furnished to members
- Agree to cooperate with Harvard Pilgrim to resolve any member grievance involving the provider within the time frame required under Federal law
- Agree to accept all Harvard Pilgrim Medicare Advantage members unless practice is closed to all new patients

Primary Care Provider (PCP) Responsibilities

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

- Coordinate, monitor and supervise the delivery of health care services to each member who has selected the PCP for primary care services.
- Assure the availability of services to members including on-call and after-hours coverage.
- Submit a report of an encounter for each visit where the Provider services the member, or the member receives a Health Plan Employer Data and Information Set (HEDIS) service. Encounters should be submitted on a CMS-1500 form.

- Ensure members utilize network Providers. If unable to locate a participating Provider for services required, contact Utilization Management for assistance.
- Ensure members are seen for an initial office visit and assessment within the first 90 days.
- A Provider will consider member input into proposed treatment plans.

Specialist Responsibilities

Specialists are responsible for communicating with the PCP in supporting the Medical Care of a member. Specialists are also responsible for treating Plan members referred to them by the PCP and communicating with the PCP or the Plan for authorizations. These requests must be coordinated through the member's PCP.

Responsibilities of All Plan Providers

The following is an overview of responsibilities for which all Plan Providers are accountable. Please refer to your contract, policies, and this Provider Manual or contact Provider Services at 888-609-0692 for clarification of any of the following:

- All providers must comply with the Harvard Pilgrim's Stride℠ (HMO) Medicare Advantage Plans access to care requirements.
- Provide or coordinate health care services that meet generally recognized professional standards and the Plan guidelines in the areas of operations, clinical practice guidelines, medical quality management, customer satisfaction and fiscal responsibility.
- Use physician extenders appropriately. Provider Assistants (PAs) may provide direct member care within the scope or practice established by the rules and regulations of the state where they are licensed and where services are provided and Plan guidelines.
- The sponsoring provider will assume full responsibility to the extent of the law when supervising PAs whose scope of practice should not extend beyond statutory limitations.
- PAs should clearly identify their titles to members, as well as to other health care professionals.
- A request by a member to be seen by a provider, rather than a physician extender, must be honored at all times.
- Refer Plan members with problems outside of his/her normal scope of service for consultation and/or care to appropriate specialists contracted with Plan (PCPs only).
- Refer members to participating providers, except when they are not available, or in an emergency. Providers should contact the Utilization Management department at 888-609-0693 in the event it is medically necessary to refer a member to a non-participating provider for continuity of care purposes or other clinical reasons.
- Admit members only to participating hospitals, skilled nursing facilities (SNFs) and other inpatient care facilities, except in an emergency.
- Respond promptly to plan requests for medical records in order to comply with regulatory requirements and Plan Operations including the provision of additional information about a case in which a member has filed a grievance or appeal.
- Not bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from or have any recourse against any Plan member, subscriber or enrollee other than for supplemental charges, co-payments or fees for non-covered services furnished on a fee-for-service basis. Non-covered services are defined as benefits not included or excluded by the Plan, are excluded by the Plan, are provided by an ineligible provider, or are otherwise not eligible to be covered services, whether or not they are medically necessary.
- Treat all member records and information confidentially, and not release such information without the written consent of the member, except as indicated herein, or as needed for compliance with State and Federal law.
- Maintain quality medical records and adhere to all Plan policies governing the content of medical records as outlined in the Plan's quality improvement guidelines. All entries in the member record must identify the date and the provider.
- Maintain an environmentally safe office with equipment in proper working order in compliance with city, state and federal regulations concerning safety and public hygiene.

- Communicate clinical information with treating providers timely. Communication will be monitored during medical/chart review. Upon request, provide timely transfer of clinical information to the Plan, the member or the requesting party, at no charge, unless otherwise agreed to.
- Preserve member dignity and observe the rights of members to know and understand the diagnosis, prognosis and expected outcome of recommended medical, and surgical medication regimen.
- Not discriminate in any manner between Plan members and non-Plan members.
- Fully disclose to members their treatment options and allow them to be involved in treatment planning.
- A Provider will consider member input into proposed treatment plans.
- When communicating with members or prospective members concerning enrollment decisions, remain neutral and act based on an objective assessment of the needs and interests of the individual.

PUBLICATION HISTORY

10/15/13	original documentation
12/15/14	reviewed; no changes
05/01/19	reviewed; added referral/authorization/notification requirements; updated out-of-network information; administrative edits
01/01/22	updated document format