MEMBERS

The following topics are covered in this chapter:

New Members

Under most circumstances, members who enroll in Tufts Health Plan must complete a Member Enrollment Form.

To confirm a member's eligibility status, providers and their office staff are required to use self-service channels to verify effective dates and copayments prior to initiating services. However, please note that the information on file may be subject to retroactive reporting of disenrollment (e.g., by the member's employer).

Members receive an identification card as well as benefit materials that contain information on plan benefits, cost-sharing amounts, exclusions, and plan policies and procedures, including the evidence of coverage (EOC), which is made available to the member upon enrollment and annually thereafter.

Depending on plan structure, members may be required to choose a primary care provider (PCP) to arrange for transfer of their medical records, and to arrange for an initial visit as appropriate. To be eligible for any and all covered services, HMO members are required to select a PCP. Without a PCP assignment, HMO members are covered only for emergency services. Refer to the Guides and Resources section of the Provider website for more specific information on working with Commercial plans.

PCPs receive a monthly report that reflects their membership, including new members. PCPs may elect to proactively contact new members appearing on this list who have not yet contacted their offices. Once a member has chosen a PCP, the provider must be prepared to address all the member's medical needs. In some cases, members require care before they have introduced themselves to the PCP's practice.

Review the member's rights and responsibilities, as they are useful when explaining to members their responsibility for adhering to certain Tufts Health Plan policies, such as not requesting unwarranted out-of-plan referrals. Member's rights and responsibilities from the member's perspective are outlined below. These apply to all products and are outlined in the member's Evidence of Coverage (EOC) or equivalent document.

Members' Rights and Responsibilities

Tufts Health Plan distributes a Members' Rights and Responsibilities statement to members. There are separate benefit documents for HMO, Point of Service (POS), and Preferred Provider Organization (PPO) members. This reflects the different benefit options among the plans. At their own discretion, POS and PPO members may receive care from an out-of-plan provider and be covered at an unauthorized/out-of-network benefit payment level that includes any applicable deductible and coinsurance. PPO members may seek services outside the Tufts Health Plan network that will be subject to a deductible and coinsurance. In-network services may have an in-network deductible and coinsurance depending on the member's particular plan. For more information, refer to Our Plans.

Know the Member's Rights and Responsibilities

As part of our strong commitment to quality care and customer service, Tufts Health Plan wants members to

remain informed about their rights and responsibilities as Tufts Health Plan members. We developed the following list to help members get the most out of their memberships. Additional information about the grievance process, policies, procedures, and member records can be found in members' EOCs.

Member Rights

Members have the right to:

- Receive information about Tufts Health Plan including its services, health plan staff and their qualifications, contractual relationships, benefits, member rights and responsibilities, healthcare providers, policies, and procedures
- Be informed by their physician or other healthcare provider regarding their diagnosis, treatment, and prognosis in terms that are understandable
- Receive sufficient information from their healthcare providers to enable them to give informed consent before beginning any medical procedure or treatment
- Have a candid discussion of appropriate or medically necessary treatment options for their condition, regardless of cost or benefit coverage
- Participate with practitioners in decisions regarding their healthcare
- Be treated courteously, respectfully and with recognition of their dignity and need for privacy
- Refuse treatment, drugs or other procedures recommended by Tufts Health Plan providers to the extent permitted by law and to be informed of the potential medical consequences of refusing treatment
- Be covered for emergency services in cases where a prudent layperson, acting reasonably, would believe that an emergency medical condition exists
- Have reasonable access to essential medical services
- Decline participation in or disenroll from services offered by Tufts Health Plan
- Expect that all communications and records pertaining to their healthcare are treated as confidential in accordance with Tufts Health Plan's Notice of Privacy Practices
- Select a doctor from Tufts Health Plan's directory of healthcare providers who is accepting new patients and expect the physician to provide covered healthcare services
- Obtain a copy of their medical records from their providers, in accordance with the law
- Use the Tufts Health Plan member satisfaction process described in their benefit document (which include timeliness for responding to and resolving complaints and quality issues) to voice a concern or complaint about the organization or the care it arranges and to appeal coverage decisions
- Make recommendations regarding the organization's members' rights and responsibilities policy

Member Responsibilities

Members have a responsibility to:

- Treat network providers and their staff with the same respect and courtesy that members expect for themselves
- Ask questions and seek clarification to understand their illness or treatment
- Cooperate with Tufts Health Plan so that we may administer member benefits in accordance with their benefit document
- Obtain services from an in-network provider except in a medical emergency, (e.g., a serious injury, or onset of a serious condition that prevents them from calling their PCP in advance)
  Note: This applies to HMO and EPO members as well as POS and PPO members seeking coverage at the authorized level of benefits.
- Follow plans and instructions for care that they have agreed to with their practitioners
- Obtain appropriate authorization(s) from their Tufts Health Plan PCP before seeking care, except in the case of urgent/emergency care
  Note: This applies to HMO and EPO members, as well as POS members seeking coverage at the authorized level of benefits
- Keep scheduled appointments with healthcare providers or give adequate cancellation notice
- Express concerns or complaints through the Tufts Health Plan member satisfaction process described in their benefit document

- Familiarize themselves with their Tufts Health Plan benefits, policies and procedures by reading distributed materials and by calling Member Services with any questions
- Supply, to the extent possible, information needed by their healthcare providers and Tufts Health Plan and to the practitioners who provide their care
- Participate in understanding their health problems and developing mutually agreed-upon treatment goals, to the degree possible

Confidentiality of Protected Health Information

Tufts Health Plan follows federal and state privacy regulations, including the Health Insurance Portability and Accountability Act of 1996 (HIPAA), to safeguard the privacy of members' protected health information (PHI). Tufts Health Plan's Notice of Privacy Practices outlines member privacy rights and describes how Tufts Health Plan collects, uses, and discloses PHI. Refer to the Legal, Security, and Privacy Practices section of our website for more information.

Patient Self Determination Act

The Federal Patient Self Determination Act requires certain facilities, including HMOs, to document whether or not a member has executed an advance directive. An advance directive is a written instruction relating to the provision of healthcare when the member is unable to communicate their wishes regarding medical treatment. This document is sometimes called a living will, healthcare proxy, or durable power of attorney for healthcare.

To ensure Tufts Health Plan's compliance with the provisions of the Patient Self Determination Act, Tufts Health Plan requests that the following language be added to, or used with, the member's standard intake sheet:

Have you executed an advance directive/healthcare proxy? Yes ☐ No ☐
To be completed by office staff: Advance directive/healthcare proxy on file? Yes ☐ No ☐ Healthcare agent named in advance directive/healthcare proxy: Name: _____ Address: _____ Telephone: _____

Member Appeals Process

Tufts Health Plan provides its members, authorized representatives, and treating providers with a process to appeal decisions concerning coverage of healthcare services. Through this process, members, authorized representatives or treating providers can request a review of decisions concerning benefits and coverage. Benefit documents provide specific information on how to access this process.

Note: Member appeals may be related to availability of benefits or a claim or part of the utilization management process. Therefore, response is required within the timeframe requested (which may be from one to five business days, depending on the urgency of the appeal) to any requests for additional information that may arise in the course of reviewing an appeal.

Members are initially referred to the Member Services Department, where a member specialist attempts to identify and resolve their concerns. If not satisfied, a member, a member's authorized representative, or provider on behalf of a member, may request an appeal verbally or in writing, and send it to the Appeals and Grievances Department.

Members, a member's authorized representative, or providers submitting an appeal on behalf of a member, may also file a verbal appeal with a member specialist, who forwards the information regarding the appeal to the Appeals and Grievances Department. If an authorized representative is acting on behalf of the member, Tufts Health Plan must receive written or verbal authorization from the member prior to initiation of the

grievance. An Appeals and Grievances specialist sends a letter acknowledging the receipt of the appeal to the member and requesting provider, and also requests any necessary medical documentation to ensure a thorough review. The Appeals and Grievances specialist coordinates the investigation of the appeal and notifies the member and requesting provider in writing of the determination. A member's PCP may be copied on the correspondence. In addition, prior to a decision being rendered, the Appeals and Grievances specialist will provide the requester with a copy of the appeal file, which will consist of all information gathered for the appeal, including but not limited to, medical records and consultations, benefit language pertaining to the coverage request and relevant claim information.

If a member of a fully-insured Massachusetts plan is not satisfied with the determination, their case could be eligible for external review by an external review agency contracted with the Health Policy Commission Office of Patient Protection, or, for certain self-insured employer groups, by an Independent Review Organization through a process coordinated by Tufts Health Plan.

A member with a fully insured Rhode Island plan may have their appeal processed under rules set by the Rhode Island Office of the Health Insurance Commissioner (RI OHIC). If the member is dissatisfied with the determination, their case could be eligible for review by the external agency approved by RI OHIC, as applicable.

Member Grievance (Complaint) Process

Tufts Health Plan has established a forum for members to express concerns regarding their experiences with healthcare providers or Tufts Health Plan itself. The member grievance process, developed as part of Tufts Health Plan's Quality Improvement Program, allows for the documentation and investigation of member complaints. It is the member's responsibility to notify Tufts Health Plan of their concerns about their healthcare services. It is the responsibility of all network providers to participate in the quality of care review process.

If an authorized representative is acting on behalf of the member, Tufts Health Plan must receive written or verbal authorization from the member prior to initiation of the grievance. Upon receipt of a verbal or written member grievance, the member is notified in writing that the complaint has been filed and is being reviewed, stating that it will be processed within 30 calendar days (unless an extension is needed and agreed to by the member).

Complaints related to clinical encounters are sent to the Appeals and Grievances Department for review and follow-up. Grievances related to specific clinical interactions or treatment interventions are addressed directly with the provider. Concerns about the office staff or services (e.g., appointment access, timeliness of processing referrals) are generally addressed with the provider's office manager.

Upon receipt of the provider's response, the grievance review team evaluates the information. All clinical grievances are reviewed by a Tufts Health Plan RN specialist and/or a Tufts Health Plan Medical Affairs Department physician. After being reviewed, the grievance is assigned a rating for degree of severity and preventability of the issue of concern. The provider is notified of the results of the review.

All clinical grievances and their respective ratings are entered into Tufts Health Plan's secured quality database for tracking and trending purposes. This data becomes part of the provider's credentialing file and is reviewed periodically.

To enable the completion of the grievance review within the specified time frame, providers are expected to respond to requests for information within five business days, as it is standard for providers to respond to Tufts Health Plan's request for information in investigating member grievances. This response time ensures that Tufts Health Plan meets its regulatory and accreditation requirements to the member and remains compliant with all state and federal requirements.

Some communication between providers and Tufts Health Plan representatives concerning the clinical review of a grievance are considered peer review-privileged information and may not be shared with members. However, members are notified in writing when the review of their grievance has been completed.