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## INTRODUCTION

### Purpose of Manual

This manual provides Senior Products (Tufts Medicare Preferred HMO and Tufts Health Plan Senior Care Options [SCO]) network providers and their office staff with details on the structure, policies and procedures of Tufts Health Plan. Providers and their office staff are required to read, abide by, and reference this manual as necessary.

For more information on Tufts Health Plan Commercial Products or Tufts Health Public Plans policies and procedures, refer to the 2020 [Commercial](#) or [Tufts Health Public Plans](#) provider manuals.

**Note:** The information contained in this Manual is subject to change and may be periodically updated throughout the year to reflect information, including, but not limited to, changes in law, rule, regulation, and/or requirement of any applicable state or federal agency, industry updates, or other business decisions that may affect how providers do business with Tufts Health Plan. Providers should also refer to their contracts for specific compensation provisions and may contact Senior Products Provider Relations at 800.279.9022 with specific questions.

### Overview of Tufts Medicare Preferred HMO

Tufts Associated Health Plans, Inc., which does business under the name Tufts Health Plan, is a Medicare Advantage Organization (MAO) that has entered into a Medicare risk contract with the Centers for Medicare and Medicaid Services (CMS). Tufts Health Plan's Medicare Advantage product is known as Tufts Medicare Preferred HMO.

CMS pays Tufts Health Plan a "per member per month" (PMPM) amount to cover the cost of approved services. CMS issues regulations to implement the various statutes on which the Medicare Advantage Program is based. CMS also publishes various manuals, memoranda and statements necessary to administer the programs. Each MAO with a Medicare Advantage contract with CMS must comply with these requirements. CMS conducts routine regulatory audits to review the MAO's procedures and to ensure compliance by the MAO as well as providers under contract to the MAO with federal requirements.

Tufts Medicare Preferred HMO members are Medicare beneficiaries and effectively assign their Medicare benefits to Tufts Health Plan upon enrollment. Tufts Health Plan arranges coverage for covered health care needs of its members. In addition to services covered by Medicare, Tufts Medicare Preferred HMO also provides other specific benefits.

### Overview of Tufts Health Plan SCO

Tufts Health Plan SCO consists of two comprehensive health plan offerings:

- The **Tufts Health Plan SCO-Special Needs Plan (SNP)** plan is offered to individuals aged 65 and over who are dual-eligible and live in the plan service area. This plan, which operates as both a Medicare Advantage HMO-SNP and a MassHealth SCO plan, covers all Medicare and MassHealth reimbursable services through a network of contracted providers.
- The **Tufts Health Plan SCO Medi** plan is also offered to individuals aged 65 and over who are eligible for MassHealth Standard only (Medicaid only). This plan, which operates as a MassHealth SCO plan, covers all MassHealth-reimbursable services through a network of contracted providers.

**Note:** The SCO-SNP plan is regulated by the Centers for Medicare and Medicaid Services (CMS) and the Massachusetts Executive Office of Health and Human Services (EOHHS). The SCO Medicaid-only plan is regulated only by EOHHS.

Tufts Health Plan SCO offers seniors aged 65 or older the opportunity to receive quality health care coverage combined with social support services. By coordinating care, specialized geriatric support services, and respite care for families and caregivers, Tufts Health Plan SCO provides eligible members with important advantages over traditional fee-for-service care that has no structured care coordination model. These advantages include, but are not limited to:

- A primary care team (PCT) comprised of the member's primary care physician (PCP), nurses, specialists and a geriatric support services coordinator (GSSC) who work with the member (and family)

members or caregivers, if applicable) to develop an individualized plan of care to specifically address the needs of the member

- Access to and coordination with other providers as needed
- Benefits that include Medicare and Medicaid covered services (or Medicaid-only for individuals not eligible for Medicare)
- Flexibility to provide services that specifically meet the needs of the member
- A network of community providers, including aging services access points (ASAPs)
- 24-hour access to an on-call health care professional and active involvement of the member in decisions concerning their health care

## Primary Care Physicians

Tufts Medicare Preferred HMO and Tufts Health Plan SCO members are required to choose a primary care physician (PCP) participating in the Tufts Medicare Preferred HMO and/or Tufts Health Plan SCO network, as applicable. Appropriately authorized, medically necessary services are paid based on the terms in the applicable provider contract..

**Note:** There is no cost-sharing amount for covered services for Tufts Health Plan SCO members.

Referrals from the member’s PCP are required for coverage of specialty care services and members must be informed of their potential liability for payment of unauthorized services. Inpatient notification is required for all inpatient admissions, but is not required for ambulatory surgical day care or observation services.

Refer to the [payment policies](#) on the Provider website for more information on referral and/or authorization requirements for specific services.

## Department Directory

When contacting Tufts Health Plan, use the directory below to identify the most appropriate department, phone and fax contact numbers, and individual role responsibilities. The Provider Relations and Provider Information Department manage Tufts Medicare Preferred HMO/Health Plan SCO provider information.

DEPARTMENT	CONTACT	RESPONSIBILITY
<b>Care Management</b>		
Care Management	888.766.9818	<ul style="list-style-type: none"> <li>• Concurrently reviews members hospitalized at an in-plan facility</li> <li>• Coordinates discharge planning, including rehabilitation, SNF, or chronic hospital placement, home health care, home therapies and DME</li> <li>• Coordinates care for high-risk members in the community (Tufts Health Plan SCO only)</li> </ul>
<b>Network Management and Contracting</b>		
Allied Health Contracting	617.972.9411	<ul style="list-style-type: none"> <li>• Negotiates and administers contracts for all ancillary services, including but not limited to skilled nursing facilities (SNFs), inpatient rehabilitation facilities and home care services</li> <li>• Evaluates prospective ancillary providers and assesses need for additions and changes to the provider network</li> <li>• Monitors contract compliance and performs utilization review of contracts</li> </ul>

DEPARTMENT	CONTACT	RESPONSIBILITY
Network Contracting and Performance Management (NCPM)	888.880.8699, ext. 52169	<ul style="list-style-type: none"> <li>Negotiates and executes contracts medical groups, providers and hospitals</li> <li>Processes operational changes</li> <li>Fosters and maintains medical group relationships</li> <li>Ensures contracts are implemented in the appropriate Tufts Health Plan systems</li> </ul>
Provider Credentialing	617.972.9495	Maintains practitioner credentialing/ recredentialing process
Provider Information	888.306.6307	Facilitates change of provider, practice or payment information
<b>Pharmacy Utilization Management</b>		
Pharmacy Utilization Management (UM)	617.673.0956 (fax)	Reviews and processes the initial pharmacy prior authorization request for coverage determinations and exceptions (CDE)
<b>Precertification Operations Department</b>		
Intake coordinator (Inpatient Admissions)	800.843.3553 (fax) 617.972.9590 (fax)	Processes inpatient admission notifications
Precertification Operations - Outpatient	617.972.9409 (fax)	Reviews preservice organization determination requests for medical services requiring prior authorization <b>Note:</b> All pharmacy requests should be directed to the Pharmacy Utilization Management (UM) Department
<b>Provider Education</b>		
Provider Education Specialist	<a href="mailto:Provider_Education@tufts-health.com">Provider_Education@tufts-health.com</a> 888.306.6307, Option 7	<ul style="list-style-type: none"> <li>Helps providers learn about policies and procedures, products and online self-service tools. Offers the following educational programs: <ul style="list-style-type: none"> <li>Training videos</li> <li>Webinars</li> <li>In-person and live-streamed presentations</li> </ul> </li> </ul>
<b>Provider Relations</b>		
Provider Specialist	800.279.9022	<ul style="list-style-type: none"> <li>Addresses inquiries regarding covered benefits, claims and explanations of payment</li> <li>Confirms member eligibility</li> <li>Answers general and specific provider questions</li> </ul>

## MEMBERS

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.

Members are required to choose a primary care provider (PCP) and are expected to transfer their medical records (if the elected PCP is not their current PCP). If the member does not choose a PCP upon enrollment, Tufts Health Plan will assign a PCP to the member. If new members are receiving ongoing medical care, they are advised to contact their new PCP as soon as their membership becomes effective with Tufts Health Plan. Any new members who are not receiving ongoing care are advised to call their PCP to schedule a routine physical examination. New members are encouraged to receive an initial health assessment within 90 days of the effective date of enrollment. Tufts Health Plan provides each medical group with a monthly eligibility listing report that identifies both new and existing members who have a provider within the group designated as their PCP. The PCP may elect to contact new members who appear on the eligibility listing report.

All Tufts Health Plan SCO members who are eligible for both Medicare and MassHealth are covered for services grunder both programs. For those Tufts Health Plan SCO members who are eligible for Medicaid-benefits only, they are covered under the MassHealth program. Regardless of whether Tufts Health Plan SCO members are dual-eligible or MassHealth-only eligible, they have no cost share (i.e., copays, coinsurance, deductibles) or other out-of-pocket costs for covered services.

**Note:** Members may choose to receive their elected pharmacy benefits through Tufts Health Plan.

Members receive dental benefits from providers in the Tufts Health Plan DentaQuest network, and routine eye care from providers in the Tufts Health Plan EyeMed network. Pharmacy, dental and vision care providers are listed in the [provider directories](#).

## Coverage Options

### Tufts Medicare Preferred HMO

Tufts Medicare Preferred HMO offers various medical and prescription drug coverage options for its members.

Tufts Medicare Preferred HMO offers the following medical coverage options:

- **Tufts Medicare Preferred HMO Value** costs less in monthly plan premiums but has higher out-of-pocket costs.
- **Tufts Medicare Preferred HMO Prime** costs more in monthly plan premiums, but has lower out-of-pocket costs.
- **Tufts Medicare Preferred HMO Basic** has minimal or no costs in monthly plan premiums but has higher out-of-pocket costs.
- **Tufts Medicare Preferred HMO Saver Rx** includes prescription drug coverage, has no monthly plan premium, but the highest out-of-pocket costs.

Plan premiums vary by county for all plans. All plans cover all Medicare benefits, and members who join Tufts Medicare Preferred HMO Prime, Tufts Medicare Preferred HMO Value, or Tufts Medicare Preferred HMO Basic plans may also purchase Part D prescription drug coverage. Tufts Medicare Preferred HMO offers two prescription drug coverage options:

- **Rx option** has a lower monthly premium but has higher cost-sharing amounts and does not offer any coverage in the coverage gap.
- **Rx Plus** option has a higher monthly premium but has lower cost-sharing amounts and offers coverage for all Tier-1 drugs in the coverage gap. This option is only available with the HMO Prime medical coverage.

Any member who joins Tufts Medicare Preferred HMO Value, Tufts Medicare Preferred HMO Prime, or Tufts Medicare Preferred HMO Basic may also choose to purchase one of the prescription drug coverage options listed above. Individuals may not purchase prescription drug coverage without medical coverage.

Members may also purchase the [Delta Dental](#) option in addition to their Tufts Medicare Preferred HMO medical coverage for an additional monthly premium (**Note:** certain Medicare-covered services performed by a dentist

or oral surgeon are included in the member's medical coverage).

Tufts Health Plan covers all services that the member currently receives under Medicare and/or MassHealth, as applicable. Limitations may apply to some services. Additional information can be found in the member's EOC.

**Note:** Changes to covered services are communicated in writing to network providers and members.

### Tufts Health Plan SCO

Tufts Health Plan SCO covers all services that the member currently receives under MassHealth and Medicare (or MassHealth only if the member does not have Medicare Part A and Part B). Limitations may apply to some services. For more information, refer to the Tufts Health Plan SCO [EOC](#).

**Note:** Changes to covered services are communicated in writing to network providers and members.

## Eligibility

### Tufts Medicare Preferred HMO

Individuals joining Tufts Medicare Preferred HMO must meet specific requirements, as outlined in 42 CFR 422.50 and outlined in Chapter 2 of the Medicare Managed Care Manual, Chapter 2 – [Medicare Advantage Enrollment and Disenrollment](#).

#### **End Stage Renal Disease (ESRD)**

An individual who elects a Medicare Advantage Plan and who is medically determined to first have ESRD after the date on which the enrollment form is signed (or receipt date stamp if no date is on the form), or the election is made by alternate means provided by CMS, but before the effective date of coverage under the plan, is still eligible to elect Tufts Medicare Preferred HMO.

An individual who develops ESRD while enrolled in a Medicare Advantage Plan may continue to be enrolled in the Medicare Advantage plan. Once enrolled in a Medicare Advantage Plan, an individual who has ESRD may elect other Medicare Advantage Plans in the same Medicare Advantage Organization (MAO) during allowable election periods. However, the member would not be eligible to elect a Medicare Advantage Plan in a different MAO, or a plan in the same Medicare Advantage Organization in a different state (with exceptions).

An individual with ESRD whose enrollment in a Medicare Advantage Plan was terminated on or after December 31, 1998 (as a result of a contract termination, nonrenewal, or service area reduction) can make one election into a new Medicare Advantage plan. An individual must meet all other Medicare Advantage eligibility requirements and must enroll during a Medicare Advantage election period. An individual who has exhausted their one election will not be permitted to join another Medicare Advantage Plan unless the new plan is terminated.

An individual who develops ESRD while a member of a health plan offered by a Medicare Advantage Plan in the same organization as their health plan (within the same state, with exceptions) during the initial coverage election period is eligible to elect the plan. An individual must meet all other Medicare Advantage Plan eligibility requirements and must fill out an election form to complete an alternate enrollment election to join the Medicare Advantage Plan.

### Tufts Health Plan SCO

Enrollment in Tufts Health Plan SCO is voluntary and open to individuals who meet all of the following requirements:

- Age 65 or older
- Live at home or in a long-term care facility
- Eligible for MassHealth Standard (to enroll in the Tufts Health Plan SCO Medicaid-only plan)  
Note: Members who wish to enroll in the Tufts Health Plan SCO (HMO-SNP) plan must also have Medicare.
- Must not be diagnosed with end-stage renal disease (ESRD) at the time of enrollment
- Must reside within the Tufts Health Plan SCO service area

Individuals who meet any of the following criteria are not eligible to join Tufts Health Plan SCO:

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- Have been diagnosed with ESRD at the time of enrollment
- Are subject to a six-month deductible period under MassHealth regulations
- Are residents of an intermediate care facility (ICF) for the intellectually disabled
- Are inpatient in a chronic or rehabilitation hospital

## Enrollment

### Tufts Medicare Preferred HMO

Members [enrolling](#) in Tufts Medicare Preferred HMO may use one of the following methods:

- [Online enrollment tool](#)
- Mail or fax a completed enrollment form to Tufts Health Plan
- Call Tufts Health Plan at 800.890.6600 (TTY 711) Monday–Friday, 8 a.m.–8 p.m.
- Attend a local [informational meeting](#) with a licensed Medicare Agent
- Enroll through Medicare by calling 1.800.MEDICARE (1.800.633.4227) (TTY 1.877.486.2048) 24 hours a day, 7 days a week or online via the CMS [Medicare Online Enrollment Center](#)

Completed election forms received by Tufts Health Plan on or before the last day of the month will generally be effective the first day of the next calendar month.

### **Enrollment Rules**

Tufts Medicare Preferred HMO includes limits on when and how often individuals can change the way they obtain Medicare for the HMO plan, in accordance with CMS' Medicare Managed Care Manual, Chapter 2 – [Medicare Advantage Enrollment and Disenrollment](#). Switching from one plan to another plan Tufts Health Plan offers, or to a plan offered by another MAO, is considered a change.

### **Enrollment Periods and Effective Dates**

**Initial Coverage Election Period (ICEP):** The time during which an individual who is newly eligible for Medicare Advantage can make an initial election to enroll in a Medicare Advantage Plan. This period begins 3 months before the individual's first entitlement to both Medicare Part A and Part B, and ends on the last day of the month preceding entitlement to both Part A and Part B, or the last day of the individual's Part B enrollment period (whichever date is later).

The initial enrollment period for Part B is the 7-month period that begins 3 months before the month that an individual meets the eligibility requirements for Part B and ends 3 months after the month of eligibility.

**Initial Enrollment Period for Part D (IEP for Part D):** The time during which an individual is first eligible to enroll in a Part D plan. Generally an individual is eligible to enroll in a Part D plan when the individual is entitled to Part A or the individual is enrolled in Part B and permanently resides in the service area of a Part D plan.

**Annual Enrollment Period (AEP):** The time from October 15 through December 7 each year when individuals enrolled in Medicare will have an opportunity to change the way they participate in Medicare and to add or drop Medicare prescription drug coverage effective January 1st.

**Medicare Advantage Open Enrollment Period (MA OEP):** From January 1 through March 31 each year, anyone enrolled in a Medicare Advantage Plan (except a Medicare Savings Account (MSA) or other Medicare health plan type) may enroll in another MA plan or disenroll from their current plan and return to Original Medicare. MA OEP also applies to new Medicare beneficiaries who are enrolled in a MA plan during their ICEP; this MA OEP occurs during the month of entitlement to Part A and Part B to the last day of the 3<sup>rd</sup> month of entitlement. Individuals may make only one election during the MA OEP. Individuals may add or drop Part D coverage during the MA OEP. Individuals enrolled in either MA-PD or MA-only plans can switch to: MA-PD, MA-only or Original Medicare (with or without stand-alone Part D plan).

The effective date for an MA OEP election is the first of the month following receipt of the enrollment request. The MA OEP does not provide an opportunity for an individual enrolled in Original Medicare to join a MA plan, nor does it allow for Part D changes for individuals enrolled in Original Medicare, including those enrolled in stand-alone Part D plans. If individuals join a Medicare Prescription Drug Plan, they will be automatically disenrolled from Tufts Medicare Preferred HMO and returned to Original Medicare.

**Note:** Generally, individuals cannot make any other changes during the year unless they meet special exceptions

(e.g., if a member moves out of the plan's service area or has both Medicare and Medicaid coverage). If a member has Medicare and Medicaid coverage, they may change to another plan at any time. If a member lives in a long-term care facility (such as a nursing home) they can also change to another plan at any time. If an individual joins another Medicare plan, including a Medicare Prescription Drug Plan, they will be disenrolled from Tufts Medicare Preferred HMO when enrollment in the new plan begins.

If a member leaves their current plan and does not join a plan that offers Medicare Prescription Drug Coverage or a Medicare Prescription Drug Plan, and they do not have prescription drug coverage that offers the same or better benefits as the basic Medicare Prescription Drug Coverage, the member may have to pay a Medicare Part D late enrollment penalty (LEP) if they decide to join later, resulting in a higher monthly premium.

## Tufts Health Plan SCO

A qualified individual may voluntarily enroll in Tufts Health Plan SCO at any time during the year. Membership is effective on the first calendar day of the month following the approval of the member's enrollment and renewal occurs on the anniversary of the member's effective date.

## Disenrollment

### Tufts Medicare Preferred HMO

Tufts Health Plan may not, either orally or in writing or by any action or inaction, request or encourage any Tufts Medicare Preferred HMO member to disenroll. While a MAO may contact members to determine the reason for disenrollment, the MAO may not discourage members from disenrolling after they indicate their desire to do so. The MAO must apply disenrollment policies in a consistent manner for similar members in similar circumstances.

#### ***Voluntary Disenrollment by Member***

Tufts Medicare Preferred HMO members may voluntarily disenroll in accordance with the approved election periods noted in the enrollment rules. To disenroll from a plan, members must do one of the following:

- Hand-deliver, mail or fax a signed written [form](#) to Tufts Health Plan
- Call 1.800.MEDICARE for disenrollment from Tufts Health Plan (TTY: 877.486.2048)
- Join another Medicare Advantage PDP or Prescription Drug Plan during a valid enrollment period to be automatically disenrolled from Tufts Medicare Preferred HMO coverage.

**Note:** If a Tufts Medicare Preferred HMO member verbally requests to disenroll, Tufts Health Plan must instruct the member to make the request through one of the methods described above.

#### ***Required Involuntary Disenrollment***

Tufts Health Plan must disenroll a Tufts Medicare Preferred HMO member in the following situations:

- The member has a change in residence (including incarceration) that makes them ineligible to be a member of Tufts Medicare Preferred HMO. An HMO member disenrolled under this provision has a special election period to elect a different Medicare Advantage Plan or to return to Original Medicare. A member who fails to make an election will be deemed to have elected Original Medicare.
- The member loses entitlement to either Medicare Part A or Part B
- The member dies
- The Tufts Medicare Preferred HMO contract is terminated, or if the member resides in an area where the plan is no longer offered. A Tufts Medicare Preferred HMO member disenrolled under this provision has a special election period to elect a different Medicare Advantage Plan or to return to Original Medicare. A member who fails to make an election is deemed to have elected Original Medicare.
- The member fails to pay their Part D-IRMAA and CMS notifies the plan to effectuate the disenrollment
- The member is not lawfully present in the United States.

#### ***Optional Involuntary Disenrollment***

Tufts Health Plan must disenroll a Tufts Medicare Preferred HMO member from a Medicare Advantage Plan in the following situations:

- Premiums are not paid on a timely basis
  - The member engages in disruptive behavior
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- The member provides fraudulent information on an election form, permits abuse of a Tufts Medicare Preferred HMO enrollment card, or the member engages in other fraudulent conduct with respect to the program.

**Disenrollment Procedures for Employer Group Health Plans**

When an employer group terminates its contract with an MAO, or determines that an enrollee in its program is no longer eligible to participate in the employer group plan, Tufts Medicare Preferred HMO may disenroll beneficiaries by following the procedure in either Option 1 or Option 2:

- **Option 1:** Enroll the individual in another Medicare Advantage Plan (i.e., individual plan) offered by the same MAO unless the beneficiary makes another choice. The individual must be eligible to enroll in this plan, including residing in the plan’s service area. The individual plan selected for this option must be the same type of plan.
- **Option 2:** Disenroll the individual from the employer/union-sponsored Medicare Advantage Plan to Original Medicare following prospective notice.

Tufts Health Plan SCO

**Voluntary Disenrollment**

Members can voluntarily disenroll at any time for any reason. Disenrollment is effective on the first calendar day of the month following the month in which the notice is received. To voluntarily disenroll from the plan, members must do one of the following:

- Hand-deliver, mail or fax a signed written notice to Tufts Health Plan
  - Call 1.800.MEDICARE (1.800.633.4227) (if individual is Medicare-eligible)
  - Join another SCO plan from another Medicare Advantage Organization
- Note:** If a member verbally requests to disenroll, Tufts Health Plan will instruct the member to make the request in writing.

**Involuntary Disenrollment**

Occasionally, it is necessary for Tufts Health Plan to involuntarily disenroll a Tufts Health Plan SCO member. Reasons for involuntary disenrollment may include:

- Loss of MassHealth eligibility. Tufts Health Plan can help members apply to regain their eligibility by contacting the applicable MassHealth Enrollment Center.
- Member remains outside the service area for more than six consecutive months

**Note:** Membership cannot be cancelled due to the status of the member’s health.

**Member Education**

Tufts Health Plan’s member education outreach includes literature that helps certain prospective and active members understand how to use the health plan. All members have access to the EOC and summary of benefits. These documents provide important information about Tufts Health Plan plan benefits, policies and procedures.

**Member Identification Cards**

Members are encouraged to carry their Tufts Medicare Preferred HMO or Tufts Health Plan SCO ID card at all times. If a member has enrolled but has not received their ID card, the pink copy of the election form may be used as temporary identification. The ID cards include the following information:

Tufts Medicare Preferred HMO

Front of Card	
PCP	Primary care provider name
RxBIN RxPCN RxGRP	Prescription drug references

Plan	Tufts Medicare Preferred HMO's identification number
ID	Member's identification number
Name	Member's name
PCP OV Spec OV ER	Office visit (OV) and emergency room (ER) cost-sharing amount information
Issued	Date ID card was generated
CMS-H2256-xxx CMS-S0655-xxx	CMS tracking number based on Member's selected coverage Tufts Medicare Preferred HMO (H2256) Tufts Medicare Preferred Prescription Drug Plan (S0655)
<b>Back of Card</b>	
<ul style="list-style-type: none"> <li>• Claim submission address and contact information</li> <li>• Contact phone numbers and website</li> </ul>	

## Tufts Health Plan SCO

<b>Front of Card</b>	
Plan Name	Tufts Health Plan SCO Tufts Health Plan SCO (HMO-SNP)
PCP	PCP's name
ID	Member ID number
Name	Member name
Issue Date	Effective date of coverage
<b>Back of Card</b>	
Customer service number	Provider Relations: 800.279.9022 Customer Relations: 800.701.9000 TDD/TTY: 800.208.9562
Hours of Operations	Monday–Friday, 8 a.m. to 8 p.m.
Dental Subcontractor	Delta Dental (if elected)
Pharmacy Subcontractor	CVS/Specialty
Claims	Submission address for dental, medical and pharmacy claims
URL	Website address

## Health Risk Appraisal

As part of the Health Risk Appraisal program, newly enrolled members are provided a Health Needs Questionnaire within the first two weeks of their effective date. Completing the questionnaire is voluntary. The purpose of the program is to profile members' health risk status at enrollment and provide information regarding member risk to the PCP. Tufts Health Plan ultimately expects the sharing of information to lead to better management of care, which will result in improved health outcomes.

A Health Needs Summary Report is sent to the member's PCP and group care manager. If requested by the provider, a copy is sent to a central group contact. This report includes the following information:

- Member rating of health and social status
- Notification if the member has not scheduled an initial appointment
- Hospitalization or emergency department visits reported within the past year
- A list of diagnoses, symptoms experienced and medications, as reported by the member
- Tobacco and alcohol use
- Preventive care services for which the member is due

Members who self-identify as being in fair or poor health, or who identify as having a chronic condition such as Chronic Obstructive Pulmonary Disease (COPD), are screened for eligibility for additional care management services.

**Note:** Tufts Health Plan sends each PCP a Nonresponder Report that lists each member who did not fill out the

questionnaire.

## Advance Directives

The federal Patient Self-Determination Act requires certain facilities, including MAOs, to document whether or not a member has executed an advance directive. An advance directive is a written instruction relating to the provision of health care 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. A sample [appointment of representative \(AOR\)](#) form is distributed to new Tufts Health Plan members.

Tufts Health Plan maintains written policies and procedures that provide for community education regarding advance directives. Members receive educational materials upon enrollment that define advance directives, emphasizing that advance directives are designed to enhance an incapacitated individual's control over medical treatment decisions. Applicable state law concerning advance directives is also included in the materials.

To ensure compliance with the provisions of the federal Patient Self-Determination Act, Tufts Health Plan requires that providers document whether a member has executed an advance directive and that the advance directive must be a prominent part of the member's medical record.

## Member Rights and Responsibilities

Tufts Health Plan makes a Member Rights and Responsibilities Statement available to its members. This document explains the member's responsibility to adhere to Tufts Health Plan policies and informs members that they have certain rights regarding their care, such as access to care and participation in decisions about their care. Members may refer to their [Evidence of Coverage \(EOCs\)](#) or contact Senior Products Customer Relations at 800.701.9000 for additional information on this statement.

## Member Appeals and Grievances

Members have the right to file a complaint if they have concerns or problems related to their coverage or care. Appeals and grievances are two different types of member complaints. CMS defines appeals and grievances in the [Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance](#).

Tufts Health Plan and its contracting providers must not treat members unfairly or discriminate against them because they initiate a complaint. Refer to the [Member Appeals and Grievances](#) chapter for more information on member appeals.

## PROVIDERS

### 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 HMO and/or Tufts Health Plan SCO products in providing or arranging for services to any member.

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

### Provider Update

*Provider Update* is Tufts Health Plan's quarterly newsletter for providers, hospital administrators and ancillary providers in the Tufts Health Plan network. *Provider Update* 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 *Provider Update* newsletter by email. To receive *Provider Update* by email, providers must register by completing the [online registration form](#), available in the [News](#)<sup>1</sup> section of the public Provider website. Providers who routinely visit the public Provider website for updates and who prefer not to receive *Provider Update* by email will have the opportunity to indicate that preference on 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 website 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 *Provider Update* 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.

Individuals who register to receive *Provider Update* by email are responsible for keeping their email addresses and contact information updated. To update information that was previously submitted through the online registration form, providers should resubmit the form with updated information.

**Note:** Providers who have registered to receive *Provider Update* 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 (sender: [providerupdate@email-tuftshealth.com](mailto:providerupdate@email-tuftshealth.com)).

Current and recent past issues, as well as the articles featured in *Provider Update* are available in the [News](#) section of the public Provider website.

### 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

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<sup>1</sup> Providers who do not register to receive *Provider Update* by email can be mailed copies of the full issue upon request by calling Senior Products Provider Relations at 800.279.9022.

- 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.

## Primary Care Providers (PCPs)

PCPs are responsible for monitoring the care of their Tufts Medicare Preferred HMO 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 HMO 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 HMO 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 HMO 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 HMO 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.

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 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, 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 HMO 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: <b>M</b> = Medicaid <b>I</b> = Institutionalized <b>E</b> = ESRD <b>H</b> = Hospice

Report Heading	Description
	<b>T</b> = Medicaid and institutionalized <b>Q</b> = Medicaid and ESRD
WA	Working Aged, noted if member is working and has other insurance
Elig Eff Date	The date the member began coverage through Tufts Medicare Preferred HMO (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.
ACTIVE MEMBERS	Members of Tufts Medicare Preferred HMO who are new or currently on the plan. New members are also listed in the NEW MEMBERS section.
NEW MEMBERS	New members of Tufts Medicare Preferred HMO who are also listed in the ACTIVE MEMBERS section.
TERM MEMBERS	Members who: <ul style="list-style-type: none"> <li>• Have left the plan and have a termination date and reason, <b>or</b></li> <li>• 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).</li> </ul>

### Closing and Opening a Panel

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

PCPs must submit written notification to their Tufts Health Plan Associate Contract Specialist 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.

### 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 recertification is due during the LOA and the practitioner does not complete their recertification materials, Tufts Health Plan reserves the right to terminate the provider from the network based on contractual noncompliance.

### Covering Practitioner

All Tufts Health Plan providers have contractually agreed to be accessible to Tufts Medicare Preferred HMO and/or Tufts Health Plan SCO members 24 hours a day, seven days a week, either directly or through a covering practitioner. If a provider is not available, they are responsible for maintaining appropriate coverage that is acceptable to Tufts Health Plan. Covering providers must 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 appropriate documents to the Tufts Health Plan Credentialing Department. 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 [243 CMR 3.05](#) or other regulation, as applicable
- Collect information from the National Practitioner Databank.



**Locum Tenens Sample Letter**

<<Date>>

RE: *Locum Tenens*

Dear Provider:

Tufts Health Plan has received your request to become a *locum tenens* provider. Please review practitioner rights in the Tufts Medicare Preferred HMO/Tufts Health Plan SCO Provider Manual. Please provide us with the following information so that we may initiate our *locum tenens* credentialing process:

- Credentialing Application through <https://proview.caqh.org/>
- IPA/PHO Endorsement for Locum Tenens Practitioners Form
- Tufts Health Plan Endorsement for Locum Tenens Practitioners Form
- Completed and signed W-9 form

To expedite your application, please indicate if you have or will have hospital privileges.

Please call the Credentialing Department with any questions at 617.972.9495. Select option 1 and ask to speak to a Credentialing Specialist. Please reference the IPA/PHO you are joining when calling. Thank you for your anticipated cooperation.

Sincerely,

Contract Specialist

## Changing PCPs

Tufts Medicare Preferred HMO 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 HMO 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 [Noncompliance of Practitioner 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 provide Tufts Health Plan with at least 60 calendar days' written notice when a PCP or specialist is terminating, subject to any notice requirements and deadlines as may be found in the provider's contract.

Tufts Health Plan will make a good-faith effort to provide written notice of the termination of a contracted provider at least 30 calendar days prior to the termination effective date to all members who are seen on a regular basis by the provider whose contract is terminating, irrespective of whether the termination was for cause or without cause. When a contract termination involves a PCP, all of that PCP's members must be notified.

## Specialists

Specialists within the Tufts Health Plan network are expected to provide quality, cost-efficient health care to Tufts Medicare Preferred HMO and/or Tufts Health Plan SCO members. Contracted providers must provide care in a culturally competent manner to all Tufts Medicare Preferred HMO 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 HMO 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.

Refer to the [Referrals, 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, 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.

Contracting specialists are required to provide 90 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:

- Signed and completed credentialing/recredentialing application through [CAQH ProView™](#)
- Current malpractice insurance information
- Signed health services agreement (initial credentialing only) and appropriate contract documents
- Signed W-9 form (initial credentialing only)

### Primary Hospital Requirements

Each practitioner must indicate their primary admitting hospital in the application. Tufts Health Plan, on behalf of Tufts Health Plan sends a request to the primary hospital confirming that it has assessed the practitioner's performance, as mandated by the Joint Commission or other accrediting agency acceptable to CMS and/or EOHHS and Tufts Health Plan. The hospital is queried again during recredentialing. Appointment verification is then sent by the primary admitting hospital for each practitioner. The practitioner must notify Tufts Health Plan in writing of changes in primary hospital affiliation.

### Credentialing Requirements

In addition to verification of certain credentialing elements, Tufts Health Plan must obtain and review the following information prior to the final assessment of each provider:

- Board certification status
- Information obtained from the National Practitioner Data Bank (NPDB)
- Medicare/Medicaid sanctions
- System award management sanctions
- State disciplinary actions

The Quality of Care Committee (QOCC), chaired by a Tufts Health Plan medical director, meets monthly to review and discuss providers who are being credentialed or recredentialed. No provider will be authorized to provide services to members unless the following criteria are met:

- Review of all data requirements from the provider
- Approval by a designated medical director or by the QOCC

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.

### 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, 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). 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 HMO or Tufts Health Plan SCO plan, they can call Senior Products Member Relations at 800.890.6600 (711 TTY).

Additional outreach methods include the following:

- A provider can request assistance from Tufts Health Plan to mail a CMS-approved 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 health 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:

- Has been medically determined to have ESRD
- 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 HMO 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.

## 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.

### Credentialing Rights

Participating providers may appeal certain adverse credentialing decisions. In the case of termination or suspension of a provider for quality reasons by Tufts Health Plan, the provider must be given written notice of the reasons for such action and informed of their right to appeal the action, including the process and timing for a hearing request, as required by law. There is no right of appeal an initial application decision.

Providers have the right to review information submitted to Tufts Health Plan for purposes of credentialing or recredentialing the provider, including information obtained by Tufts Health Plan from any outside primary source, (e.g., malpractice carrier, state license board or the NPDB). Tufts Health Plan shall notify the provider of the right to review such information.

Notwithstanding the foregoing, Tufts Health Plan is not required to reveal the source of information if the information was not obtained for the purpose of meeting Tufts Health Plan 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.

Tufts Health Plan shall notify providers in the event that credentialing information, which is obtained from sources other than the provider, varies substantially from credentialing information provided to Tufts Health Plan by the provider.

Providers have the right to correct erroneous information submitted by another party and Tufts Health Plan shall notify providers of their right to correct erroneous information.

If the QOCC votes to take disciplinary action, the provider is entitled to a 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 days of receipt of the statement of reasons.

Providers have the right to be informed of the status of their credentialing or recredentialing application upon request.

## 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' [Medicare Marketing Guidelines](#).

## 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 Provider Relations at 800.279.9022 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
- Identification of abuse and neglect of elderly individuals



- 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 and hospitalization

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.

## REFERRALS, AUTHORIZATIONS AND NOTIFICATIONS

### Referrals

A referral verifies that the member's PCP has approved the member's request to receive services from a specialist provider. It is the responsibility of the PCP to ensure that the member is directed to the appropriate specialist. Referrals should be coordinated prior to services being rendered.

To ensure that appropriate specialty care is provided, the PCP initiates and coordinates the referral management process for Tufts Medicare Preferred HMO and/or Tufts Health Plan SCO members according to the following list:

- The PCP may approve a referral to a specialist in or out of the Tufts Medicare Preferred HMO or Tufts Health Plan SCO networks, indicating the specific services and number of visits to be provided to the member, when:
  - The PCP decides that such a referral is medically necessary
  - The specialist agrees to a treatment plan and provides the PCP with all necessary clinical and administrative information on a regular basis
  - The health care services to be provided are consistent with the terms of the member's plan benefits
- Specialists must submit a summary report on a timely basis to the medical group following the member's appointment.
- Any questions or problems regarding referrals should be directed to Senior Products Provider Relations at 800.279.9022.
- PCPs should not generate referrals for urgent/emergent services and should instead contact the Tufts Medicare Preferred HMO or Tufts Health Plan SCO care manager to notify of urgent/emergency care. Providers should contact Senior Products Provider Relations to identify the care manager assigned to the member. All PCP urgent/emergent admissions are reported to the group care manager on a daily basis on the Day of Admission report.
- Tufts Health Plan is financially responsible for any nonurgent/nonemergent outpatient care authorized by Tufts Health Plan that is provided outside the network; if authorized by the medical group that provides services (rather than Tufts Health Plan), the care is the financial responsibility of the medical group.
- If a contracting specialist provides a service without a referral from the member's PCP, the claim will be sent to the PCP's medical organization through a "10-day report" for review. If the PCP or group representative agrees with the service provided, the claim will be released for adjudication. If the PCP disagrees with the services provided, the claim will deny and the contracting specialist will be held financially liable and the member cannot be billed.

Refer to the [Referral, Authorization and Notification Policy](#) for additional information.

### Completing the Paper Referral Form

The paper referral form requires information about the PCP, the member, and the consulting provider. To order paper referral forms, providers may fill out the [W.B. Mason Provider Forms Requisition](#) and fax it to W.B. Mason at 800.738.3272 or email it to [tuftshealthplan@wbmason.com](mailto:tuftshealthplan@wbmason.com).

The PCP must complete the referral form. If any required fields are left blank, the referral form will be returned to the PCP requesting additional information. Upon receipt, the Tufts Health Plan Claims Department enters the referral in the system.

Claim reviewers verify the date range on the referral matches the date of service on the claim. If no matching referral is found, the claim will pend for AUREQ (authorization/referral expired).

Member name, ID number, and date of birth are required for claim payment. Member information may be obtained from the following sources:

- Member ID card
- Individual Election Form
- Monthly Eligibility Listing Report
- Eligibility Inquiry on the secure Provider [website](#)
- Change Healthcare™

- Integrated voice response (IVR) system at 800.279.9022

### Electronic Referral Exclusions

Tufts Health Plan referral policies apply to electronic referrals. However, certain services and/or coverage for certain specialties do not require referrals or may have alternative prior authorization or inpatient notification requirements, as applicable. Refer to the [Referral, Authorization and Notification Policy](#) as well as the Senior Products [payment policies](#) for specific authorization requirements, as applicable. Refer to the Tufts Medicare Preferred HMO [Prior Authorization and Inpatient Notification List](#) or the Tufts Health Plan SCO [prior authorization](#) and [notification](#) lists for specific procedures, items, and/or services that fall under these requirements.

### Out-of-Area Services

Tufts Medicare Preferred HMO/Tufts Health Plan SCO may provide coverage outside the service area to members in certain circumstances, including but not limited to the following:

- Urgently needed or emergency care (including post-stabilization services provided after an emergency)
- Kidney dialysis services provided by a Medicare-certified dialysis facility
- Medically necessary care that cannot be obtained from an in-network provider (e.g., a provider whose specialty is not contracted with Tufts Health Plan)

Providers may contact [Senior Products Provider Relations](#) to verify benefit coverage when the member is outside the service area.

### Referral Inquiry

Providers may check the status of an existing referral by using **Referral Status Inquiry** on the Tufts Health Plan secure Provider [website](#). The referral status inquiry tool provides the status of referrals submitted to Tufts Health Plan, regardless of how the referral was initially submitted.

### Referral Adjustments

To request an adjustment to a referral that is already in the Tufts Health Plan system, the PCP must contact [Senior Products Provider Relations](#) for assistance. Tufts Health Plan cannot adjust referrals based on the specialist's request. If the specialist would like to request an adjustment to a referral, the specialist should follow up directly with the member's PCP.

### Prior Authorizations

A prior authorization (PA) may be required to determine medical necessity and appropriateness of certain health care services. Services that may require prior authorization include surgical services, durable medical equipment (DME), and/or [prescription drugs](#). Additional prior authorization information may be found in the [Referral, Authorization and Notification Policy](#).

### Medical Coverage Prior Authorization Requests

To obtain authorization for a medical service, device or equipment requiring prior authorization through the Precertification Operations Department, the provider must submit the appropriate clinical documentation for review. As a condition of payment, the treating/ordering provider is required to submit documentation of medical necessity for services requiring authorization. Documentation should detail:

- The member's diagnosis
- Planned treatment, including medical rationale for the service requested
- All pertinent medical information available for review.

Prior authorization requests should be faxed to the Precertification Operations Department at 617.972.9409. When the use of an InterQual SmartSheet is required, it may be submitted without additional supporting documentation, unless otherwise indicated.

Refer to the [Tufts Medicare Preferred HMO](#) and [Tufts Health Plan SCO](#) prior authorization lists for specific nonpharmacy services, items and supplies that require PA.

## Prescription Drugs Prior Authorization Requests

Certain prescription medications require prior authorization through Tufts Health Plan. For Part D drugs covered under the pharmacy benefit, providers must submit the [Request For Medicare Prescription Drug Coverage Determination Form](#). For Part B drugs covered under the medical benefit, providers must submit the [Request for Medicare Part B Prescription Drug Organization Determination Form](#).

Requests for coverage determinations and exceptions may be submitted to the Pharmacy Utilization Management Department via the following:

Fax: 617.673.0956  
Mail: Tufts Health Plan  
Attn: Pharmacy Utilization Management Department  
705 Mount Auburn Street  
Watertown, MA 02472

**Note:** Providers may also submit electronic prior authorizations (ePA) through their EMR system or through a third party ePA vendor for review by Tufts Health Plan.

### **Exception Requests**

All formulary exception requests require a supporting statement from the prescribing provider. The provider may submit the request using the [Request for Medicare Prescription Drug Coverage Determination Form](#). This form requests information regarding diagnoses, what other drugs (if any) have been prescribed for the diagnoses and why they have not worked. The provider may submit either form via the ePA, fax or mail options listed above. Providers may also provide an oral supporting statement by calling Senior Products Provider Relations at 800.279.9022 (TTY 711), Monday through Friday, 8 a.m.–8 p.m.

All **standard** coverage determination and exception requests will be made within **72 hours** after receipt of the request, but can be up to six days if supporting information is needed from the requesting provider.

All **expedited** coverage determination and exception requests will be made within **24 hours** after receipt of the request, but can be up to four days if supporting information is needed from the requesting provider.

**Note:** Coverage determinations may not exceed 14 calendar days from the date the request is received.

### **Formulary**

A formulary is a list of covered drugs selected for Tufts Health Plan in consultation with a team of health care providers. This list represents the prescription therapies believed to be a necessary part of a quality treatment program. Tufts Health Plan will cover drugs listed in the Tufts Medicare Preferred HMO and Tufts Health Plan SCO [formularies](#) as long as the drug is medically necessary, the prescription is filled at a network pharmacy, and all other plan rules are followed. If approved, the member will be covered for the drug. If denied, members and providers may follow the appeal process outlined in the [Member Appeals and Grievances](#) chapter.

**Note:** Some Part D drugs obtained at out-of-network pharmacies are covered by Tufts Medicare Preferred HMO and Tufts Health Plan SCO, as required by CMS and federal regulations (Medicare Prescription Drug Benefit Manual, Chapter 6, Section 10.2: "[Part D Drugs and Formulary Requirements](#)," in accordance with 42CFR §423.124)

**Note:** The Tufts Health Plan comprehensive formulary includes the Part D formulary approved by CMS.

### **Medicare Part D Transition**

Tufts Health Plan may offer a temporary 30-day supply of prescription drugs that were either not on the previous year's formulary or that may have been restricted in some way. Members may receive this "transition fill" during the first 90 calendar days of new membership or the first 90 calendar days of the calendar year for existing members. If the member receives a transition fill, Tufts Health Plan will send a letter to the practitioner and the member detailing the nature of the temporary supply.

### **Medications Covered by Original Medicare Part B**

Tufts Health Plan provides coverage for most drugs and biologicals that are covered by Original Medicare Part B.

**Note:** Medications covered by Original Medicare Part B are not part of the member's Part D prescription drug benefit. Refer to the [Coverage Determination and Prior Authorization Request Form: Medicare "Part B versus Part D" Drugs](#) for more information.

Original Medicare-covered Part B medications include the following:

- Drugs billed by providers and typically provided in an office setting
- Drugs billed by pharmacy suppliers and administered through DME (e.g., respiratory drugs given through a nebulizer)
- Some drugs filled by the pharmacy (e.g., some immunosuppressant drugs depending upon use and some oral chemotherapy drugs)
- Some end-stage renal disease (ESRD) drugs

### ***Vaccines***

Some vaccines are covered under the member's medical benefit (Part B) while others are covered under the pharmacy benefit (Part D). When vaccines are covered under Part D, the administration costs will be reimbursed under Medicare Part D. Refer to the [Immunization Payment Policy](#) for more information.

## Pharmacy Plan Management Programs

### ***Prior Authorization (PA)***

The PA process encourages rational prescribing of drug products with significant safety and/or financial concerns. A provider can submit a request for coverage based on a member's medical need for a particular drug.

### ***Quantity Limit (QL)***

Because of potential safety and utilization concerns, Tufts Health Plan has placed dispensing limitations on certain prescription drugs. Pharmacies may only dispense a certain quantity of these drugs within a given time period. These quantities are based on recognized standards of care, such as FDA recommendations for use. If a member needs a quantity greater than the program limitation, their prescribing provider may submit a formulary exception request for coverage under the medical review process.

### ***Step Therapy Prior Authorization (STPA)***

Step therapy is an automated form of PA that uses claims history for approval of a drug at the point of sale. STPA programs help encourage the clinically proven use of first-line therapies and are designed to ensure the utilization of the most therapeutically appropriate and cost-effective agents first, before other treatments may be covered. Members who are currently on drugs that meet the initial STPA criteria will automatically be able to fill their prescriptions for a stepped medication. If the member does not meet the initial STPA criteria, the prescription will deny at the point of sale with a message indicating that PA is required.

## Medication Therapy Management (MTM) Program

Tufts Medicare Preferred HMO and Tufts Health Plan SCO members may be eligible for the Medication Therapy Management (MTM) Program. Eligible members are automatically enrolled in the program and are offered a one-to-one telephone consultation with a clinical pharmacist. Information gathered during this process, along with pharmacy claims and clinical notes from the provider (when made available), are used to develop clinical recommendations where appropriate. Pharmacist recommendations are faxed to the provider for consideration. Members will receive an individualized written summary of the consultation and comprehensive medication review (CMR) by mail. CMRs are offered at least once a year.

In addition, targeted medication reviews (TMRs) are done to assess medication use, monitor unresolved issues, and identify new drug therapy problems. These TMRs are performed on a quarterly basis with any recommendations sent to the provider via fax. Participation in the program is voluntary and a member can disenroll at any time.

For additional information on program eligibility criteria, refer to the [MTM Program](#) page.

## Appeals and Grievances for Pharmacy Benefits

Timelines for appeals and/or grievances for pharmacy benefits may differ from those surrounding preservice

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coverage determinations (also known as organization determinations). For more information regarding appeals and grievances, refer to the [Member Appeals and Grievances](#) chapter.

## Organization Determinations

The term “organization determination” is a CMS term used to describe preservice coverage decisions made by Tufts Health Plan. Tufts Health Plan’s processes may include prior authorization requests for services addressed in this chapter and other coverage decisions, such as benefit exhaustions.

Preservice organization determinations may be requested for any Medicare procedure, service, or supply, regardless of whether or not that service requires prior authorization. If the member disagrees with a treatment decision or plan of care, an organization determination may be initiated by the member, the member’s authorized representative, or the provider on the member’s behalf.

Once an organization determination is requested, Tufts Health Plan will:

- Validate that the requestor is approved to make a request
- Determine whether the request is expedited or standard, as defined by CMS
- Collect and review the applicable coverage documents (e.g., Medicare regulations, member evidence of coverage [EOC], or supporting medical necessity documentation)
- Ensure that the member and provider are notified of coverage decisions within the required time frames

### **Organization Determination Time Frames**

Requests may be expedited if either the member or provider believes that waiting for a decision under the standard timeframe could place the member’s life, health or ability to regain maximum function in serious jeopardy.

Tufts Health Plan follows CMS and EOHHS regulations regarding decision and notification time frames for organization determinations and expects contracting providers to be in compliance with these regulations. Providers may contact Provider Relations at 800.279.9022 with additional questions regarding the organization determination process.

Tufts Health Plan must notify the member of the determination as expeditiously as the member’s condition requires but not later than the expiration of the time frames below:

- For standard requests, the member must be notified of the decision no later than 14 calendar days from the time of the request
- For expedited requests, the member must be notified of the decision no later than 72 hours from the time of the request

An extension to the above time frames may be requested under certain limited circumstances, as defined by CMS. Refer to the Tufts Health Plan [Utilization Review Determination Time Frames](#) for more information.

### **Organization Determination Process**

In order to process an organization determination, Tufts Health Plan must collect and review all necessary supporting documentation to make a decision. Documentation may include, but not be limited to, the member’s EOC, Medicare regulations (including LCD/NCDs) and clinical documentation submitted by the provider.

It is expected that all Medicare-certified providers be familiar with the coverage regulations related to the services that they order and/or provide. Providers must participate in discussions with Tufts Health Plan medical directors and clinicians as needed to discuss coverage requests. Tufts Medicare Preferred HMO and Tufts Health Plan SCO providers are expected to submit all organization determination requests with sufficient clinical documentation for Tufts Health Plan to make a timely decision.

If a request is received with insufficient clinical information to make a decision, Tufts Health Plan will fax a request for more information (RFMI) letter to the provider (or call the provider in expedited cases). The RFMI letter includes the specific clinical information being requested, submission options, and a due date by which the information must be received by Tufts Health Plan in order to process the request within regulatory requirements.

In general, providers are asked to respond to these requests by the end of the next business day. If there is no timely response from the provider to the RFMI request, follow-up outreach calls to the provider office and group

medical director or integrated delivery networks (IDN) leader will be made.

**Note:** RFMI letters will be directed to the treating provider, except for out-of-plan and/or out-of-referral circle services that require a referral. These requests will be directed to the centralized contact specified by each medical group for such requests instead of the PCP.

Once all the necessary documentation is on hand, Tufts Health Plan will make an organization determination. The member and provider will be notified verbally and in writing of the decision, according to regulations.

In the event of an adverse determination (denial), the decision may be appealed (reconsideration). Medicare does not allow for a peer-to-peer discussion of the decision in lieu of filing an appeal. Refer to the [Member Appeals and Grievances](#) chapter for additional information about the appeal process.

Refer to the [Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance](#) for complete information about the organization determination requirements under Medicare.

### ***Member-Initiated Requests for Organization Determinations***

If there is a disagreement between the member and provider with a provider's decision to deny a service or course of treatment, in whole or part, the provider must inform the member of the right to contact Tufts Health Plan and request an organization determination. The same organization determination timeframe, notice and process requirements are in effect for all member initiated requests as those described above.

Although it is encouraged, members are not required to discuss their request with their provider before contacting Tufts Health Plan. Members who have not discussed the requested coverage with their provider will be educated about the member's plan design and the benefit of discussing treatment options with their PCP who is familiar with their health condition.

Once a member requests an organization determination, the Precertification Operations Department will fax an RFMI letter to the group medical director or IDN leader explaining the member's request, the specific information being requested to complete the review, and the deadline by which the information must be returned to Tufts Health Plan, unless sufficient information can be provided directly by the member at the time of the request. Responding by the deadline is expected so Tufts Health Plan can make a timely decision in compliance with CMS regulations. Phone calls will also be made in expedited cases.

### **Benefit Exhaustions (Tufts Medicare Preferred HMO members)**

Certain services, such as skilled nursing facility, inpatient rehabilitation and long-term acute care hospital may have benefit limitations for Tufts Health Plan Tufts Medicare Preferred HMO members. Members receiving these services must be notified in writing that their benefit will be exhausted as of a certain date prior to the exhaustion of their benefit.

Tufts Health Plan must be notified by the provider in advance of the benefit exhaustion so a letter can be generated and the member may be notified, in accordance with CMS requirements. In order for the member to receive timely notice, the letter will be written by Tufts Health Plan and must be delivered to the member in the facility, or to their authorized representative.

If a member is exhausting their SNF, acute inpatient rehabilitation, or long-term acute care hospital benefit, the care manager must notify the member/member's authorized representative and the facility of the impending benefit exhaustion **15 calendar days prior** to the date the coverage will end. The care manager is also required to complete and fax an [Extended Care Exhaustion of Benefit Notification Form](#) to the Precertification Operations Department at 617.673.0955. Instructions and additional information regarding this process may be found [here](#).

After receiving the form, the Precertification Operations Department uses the information to generate the Notice of Denial of Medical Coverage and Payment (NDMCP) and then faxes it to the facility to be delivered to the member. In addition to serving as Tufts Health Plan's formal notification of benefit exhaustion to the member, the NDMCP also provides the member with their appeal rights and the process to request an organization determination if the member disagrees with the benefit exhaustion.

Refer to the [Member Appeals and Grievances](#) chapter for additional information on appeals and grievances.

## **Notifications**

Inpatient notification is a process that makes Tufts Health Plan aware of all inpatient admissions and/or

transfers to another facility. Inpatient notification should be completed by the facility where the member is scheduled to be admitted or may be completed by the specialist.

Inpatient notification is required for the following services, in accordance with the notification lists for [Tufts Medicare Preferred HMO](#) and [Tufts Health Plan SCO](#):

- Inpatient acute hospital admissions, including acute rehabilitation and long-term acute care
- Inpatient behavioral health and substance use disorder admissions and partial hospitalization services (PHP)  
**Note:** There is a 190-day lifetime limit under Medicare for inpatient BH/SUD services provided in a private psychiatric hospital. This limit does not apply to inpatient BH/SUD services provided in a general hospital.
- Skilled nursing facility (SNF) admissions
- Institutional long-term care and other services provided to members while at a custodial level of care

### Prior Authorizations

Prior authorization may be required for certain items, procedures, and services **in addition to** inpatient notifications. For a complete listing of services requiring prior authorization, refer to the [Tufts Medicare Preferred HMO](#) and [Tufts Health Plan SCO](#) prior authorization lists. Refer to the [Referrals, Authorizations and Notifications](#) chapter for more information on obtaining and verifying prior authorizations.

### Inpatient Notification Process

Inpatient notification is a notification to Tufts Health Plan of utilization of inpatient services. Inpatient notification is required for all elective, urgent, and emergent hospital admissions, as well as acute rehabilitation and skilled nursing facility (SNF) admissions.

When an admission is reported, the inpatient notification process does the following:

- Verifies member eligibility (subject to retroactive reporting of disenrollment)
- Screens for coverage/benefit exclusions
- Identifies the facility as an in-network facility
- Verifies authorization for inpatient services outside of the Medicare Preferred HMO network.
- Identifies the facility as Medicare-approved, for services that must be performed in a Medicare-approved facility. Refer to the [Tufts Medicare Preferred HMO](#) and [Tufts Health Plan SCO](#) Medicare-approved Facilities lists for more information.

Tufts Health Plan verifies that covered services are directed by the PCP and/or the care manager. The Tufts Medicare Preferred HMO or Tufts Health Plan SCO clinical team will also be notified so they can identify and intervene in any potential transition planning and/or discharge needs for the member. When the inpatient notification process is completed, an inpatient notification reference number is assigned and is used as a reference for adjudication of claims associated with a particular episode.

### Inpatient Notification Requirements

Notification verifies that covered services are directed by the PCP and have appropriate approvals by the medical group. The care manager is also notified so they can initiate concurrent review using Medicare coverage guidelines and InterQual® criteria and can identify and intervene in any potential discharge needs for the member. InterQual criteria are used for screening purposes only and are not used for medical necessity determinations.

Admitting providers and hospital admitting departments share the responsibility of notifying Tufts Health Plan in accordance with the following timelines:

- Elective admissions must be reported no later than **five business days** prior to admission (**Note:** SNF and LTAC admissions are not subject to this time frame)
- Urgent or emergent admissions must be reported by 5 p.m. the **next business day** following admission. This includes admissions that occur after hours, on weekends, or on holidays.

If a previously submitted inpatient notification of admission is cancelled, the Precertification Operations Department must be notified of that cancellation and the reschedule date, if applicable. If an admission changes from outpatient or emergency to inpatient, the provider must notify the Precertification Operations Department



within one business day.

### Submission Channels

Registered providers may submit inpatient notification 24 hours a day, 7 days a week using the Tufts Health Plan secure Provider website or New England Healthcare EDI Network (NEHEN), and will receive a notification number upon submission in most cases.

Providers may also fax a completed [Inpatient Notification Form](#) to the Precertification Operations Department at 617.972.9409 or 800.843.3553 (Tufts Medicare Preferred HMO) or 617.673.0705 (Tufts Health Plan SCO), 24 hours a day, 7 days a week. No other forms will be accepted. Incomplete forms will be returned to the submitting provider for completion and resubmission. Processing of the request will be delayed until all required information is submitted.

### **Confirmation of Inpatient Notification**

Notifications submitted via the web will be confirmed on entry. Notifications submitted via fax are confirmed via the Provider Inquiry screen on the secure Provider website.

If a provider wants to obtain an inpatient notification number after submitting a notification request via fax, they may access this information via the Provider Inquiry screen or contact [Senior Product Provider Relations](#).

### Payment

Inpatient admissions for which an inpatient notification has been submitted according to the foregoing requirements are eligible for claim adjudication by Tufts Health Plan, as long as all other requirements have been met.

An inpatient notification number or the report of an admission does not guarantee payment. Denial of payment for late inpatient notification or lack of notification applies to the hospital claims. Tufts Medicare Preferred HMO or Tufts Health Plan SCO network providers who are denied payment for late notification or lack of notification may not bill the member. To dispute a denial or request a claim review in writing, refer to the instructions outlined in the [Provider Payment Dispute Policy](#).

### Medicare-Approved Facility Requirement

Medicare has issued several National Coverage Determinations (NCDs) providing coverage for services and procedures of a complex nature, with the stipulation that the facilities providing these services meet certain criteria. These criteria usually require, in part, that the facilities meet minimum standards to ensure the safety of beneficiaries receiving these services. Certification as a Medicare-approved facility is required for performing the following procedures. For coverage criteria, refer to the [Medicare National Coverage Determination Manual](#) (NCD manual):

- Lung volume reduction surgery (LVRS): [NCD manual, Section 240.1](#)
- Carotid artery stenting (CAS) : [NCD manual, Section 20.7](#)

**Note:** This requirement does not apply to CAS performed in a Medicare-covered Category B IDE study or postapproval study.

- Ventricular assist device (VAD) destination therapy: [NCD manual, Section 20.9](#)
- Certain oncologic positron emission tomography (PET) scans in Medicare-specified studies: [NCD Manual, Section 220.6.17](#)

In addition to these procedures, there is also a long-standing requirement that all heart, heart-lung, liver, intestinal/multivisceral, kidney, and pancreas transplants be performed at a Medicare-approved facility. The transplant work-up evaluation must also be performed in a Medicare-approved transplant facility. For more information regarding transplants, refer to the [Transplant Facility Payment Policy](#).

To determine if a facility is Medicare-approved to perform a particular service, refer to the List of CMS-Approved Organ Transplant Programs available on the Quality, Certification and Oversight Reports (QCOR) [website](#).

Not all in-network providers who perform these services are Medicare-approved. Tufts Health Plan will not compensate for services rendered at a non-Medicare-approved facility and network providers cannot hold the member liable for these services. Refer to the [Tufts Medicare Preferred HMO](#) and [Tufts Health Plan SCO](#) Medicare-

approved facilities lists to identify facilities that are also contracting with Tufts Health Plan.

In addition to the Medicare-approved facility requirement, all plan inpatient notification, prior authorization, and in-network and out-of-network plan rules apply. Providers must be sure members are referred only to Medicare-approved facilities for these services. To the extent a medical group/PCP is involved in referring a member to a non-Medicare-approved facility, the provider will be financially liable for the associated costs. Because these services must be provided in a Medicare-approved facility to be covered, the costs of services in a non-Medicare-approved facility cannot be paid using Medicare funds.

# CLAIM REQUIREMENTS, COORDINATION OF BENEFITS AND PAYMENT DISPUTES

## General Guidelines

Tufts Health Plan processes completed claims that meet the conditions of payment and that are submitted within the time frame identified in the provider’s contract with Tufts Health Plan. Completed claims are claims submitted in industry-standard electronic format or on industry-standard forms with all fields completed accurately (refer to the [Claim Specifications](#) section in this chapter).

Claims must be submitted within the contracted filing deadline according to the date of service, date of discharge, or date of the primary insurance carrier’s explanation of benefits (EOB). Tufts Health Plan will deny claims submitted after the filing deadline, and the member may not be held responsible for payment. Refer to the [Filing Deadline](#) section of this chapter for more information.

Additional guidelines, payment policies, and clinical coverage criteria for specific services are available on the Tufts Health Plan Provider website. To ensure accurate claims processing, providers must follow the [payment policies](#) on the Tufts Health Plan website. For initial claims submission and additional information, refer to the [Avoiding Administrative Claim Denials](#) document.

## Electronic Data Interchange Claims

Tufts Health Plan encourages direct electronic submission to the plan, but also accepts claims submitted via a clearinghouse or [ABILITY<sup>2</sup>](#). To be accepted, claims submitted directly to Tufts Health Plan must be in HIPAA-compliant standard 837 format and include all required information. Refer to the [837 Companion Guide](#) for additional information. All methods of electronic data interchange (EDI) claim submission produce claim reports that can be accessed electronically. These reports are used to confirm the receipt of claims, as well as to follow up on rejected claims.

When required information is missing, Tufts Health Plan or the clearinghouse will reject the claim. If an electronic claim is rejected, a clean electronic claim must be resubmitted no later than 60 days from the date of service. For additional information, refer to the [Avoiding EDI Claim Rejections](#) document.

For more information about submitting electronic transactions, contact Tufts Health Plan’s EDI Operations Department via email at [EDI\\_operations@tufts-health.com](mailto:EDI_operations@tufts-health.com) or by phone at 888.880.8699, ext. 54042 for a setup request. Visit the [Electronic Services](#) section of the Provider website to download a setup form and companion documents to submit claims electronically directly to Tufts Health Plan.

## EDI Referrals, Eligibility and Claim Status Inquiry

EDI submission commonly refers to claims, referral and eligibility transactions, but can be applied to other transaction types as well. Tufts Health Plan offers options for electronic referrals, online eligibility inquiries and claim status information, as follows:

Referral	<ul style="list-style-type: none"> <li>• Web-based referral inquiry via the secure Provider <a href="#">website</a></li> <li>• ANSI 278: Request for review and response for outpatient referrals — standardized referral submission format, currently available through New England Healthcare EDI Network (NEHEN)</li> </ul>
Eligibility	<ul style="list-style-type: none"> <li>• Web-based eligibility status via the secure Provider <a href="#">website</a></li> <li>• NEHEN eligibility inquiry and response</li> <li>• Integrated voice response (IVR) at 800.279.9022</li> </ul>
Claim Status Inquiry	<ul style="list-style-type: none"> <li>• Web-based claims inquiry via the secure Provider <a href="#">website</a></li> <li>• NEHEN</li> </ul>

<sup>2</sup> Professional claims only.

## Multiple Payees

For providers billing through EDI, Tufts Health Plan cannot accommodate payment to multiple payees at multiple payment addresses. Payment will be sent to the address listed as the primary provider's office location in the Tufts Health Plan provider database. Any address changes or primary vendor/payee changes should be submitted in writing to the Tufts Health Plan Provider Information Department or by contacting them at 888.306.6307.

## Paper Claims

Some claims cannot be submitted electronically. Claims that must be submitted on industry-standard paper forms include:

- Claims requiring additional supporting documentation, such as operative or medical notes
- Claims for provider payment disputes
- Services with a zero amount billed (except ambulatory surgical claims)
- Unlisted procedure codes that require explanations or descriptions

## Paper Claim Submission Requirements

All paper CMS-1500 and UB-04 claims must be submitted on standard red claim forms. Black and white versions of these forms, including photocopied versions, faxed versions and resized representations of the form that do not replicate the scale and color of the form required for accurate OCR scanning will not be accepted and will be returned with a request to submit on the proper claim form.

To avoid a filing deadline denial, rejected paper claims must be received by Tufts Health Plan within 60 days from the date of service for professional or outpatient services or within 60 days from the date of discharge.

Submitted paper claim forms should include all mandatory fields, as noted in the [Claim Specifications](#) section of this chapter. Paper claim forms deemed incomplete will be rejected and returned to the submitter. The rejected claim will be returned to the submitter along with a letter stating the reason for the rejection, and a new claim with the required information must be resubmitted for processing.

- Industry-standard codes should be submitted on all paper claims.
- Diagnosis codes must be entered in priority order (primary, secondary condition) for proper adjudication. Up to 12 diagnosis codes will be accepted on the CMS-1500 form.
- Paper claims will be rejected and returned to the submitter if required information is missing or invalid. Common omissions and errors include, but are not limited to, the following:
  - Illegible claim forms
  - Member ID number
  - Date of service or admission date
  - Physician's signature (CMS-1500 Box 31)
  - Place of service

Paper claims should be mailed to

**Tufts Medicare Preferred HMO or Tufts Health Plan SCO**  
**P.O. Box 9183**  
**Watertown, MA 02471-9183**

## Claims Payment

### Clean Claims

Medicare defines a clean claim as a claim that does not require the Medicare contractor to investigate or develop prior to adjudication. Clean claims must be filed within the filing period. For information about the forms to use for submitting claims, refer to the [Claim Specifications](#) section in this chapter.

To qualify for payment, clean claims must also meet the following conditions of payment:

- The billed services must be:

- Covered in accordance with the applicable benefit document provided to members who meet eligibility criteria and who are members on the date of service
  - Furnished by a provider eligible for payment under Medicare and/or Medicaid, as applicable
  - Provided or authorized by the member's PCP or the PCP's covering provider in accordance with the applicable benefit document, or as identified elsewhere in the provider's contract with Tufts Health Plan (if applicable)
  - Provided in the member's evidence of coverage document
  - Medically necessary as defined in the Medicare and/or Medicaid coverage guidelines, as applicable
- Tufts Health Plan received the claim within 60 days of the date of service (or date of discharge if the member was inpatient), or date of the primary insurance carrier's EOB.
  - The services were preregistered and/or prior authorized in accordance with Tufts Health Plan's inpatient notification and inpatient notification procedures as outlined in the [Referral, Authorization and Notification Policy](#).
  - The services were billed using the appropriate procedure codes
  - In the case of professional services billed by the hospital, services were billed electronically according to the HIPAA standard or on CMS-1500 and/or UB-04 forms with a valid CPT code and/or HCPCS code.

All services rendered to Tufts Medicare Preferred HMO and/or Tufts Health Plan SCO members must be reported to Tufts Health Plan as encounter or claims data. An encounter is a billing form submitted by capitated providers for tracking purposes. Claim forms are submitted by noncapitated providers for both payment and tracking purposes.

## Explanation of Payment

The Tufts Health Plan explanation of payment (EOP) is a weekly report of all claims that have been paid, pending, or denied to that provider. The EOP will also include a summary of claims in process. This summary indicates the claims that Tufts Health Plan has received, however, may require additional review or information before being finalized in the system. The EOP for capitated providers shows zero dollars paid, and the pay code indicates that services were prepaid under the capitation agreement. The EOP for noncapitated providers indicates the amount paid, denied or pending, with a message code indicating the claim status.

EOPs may be viewed electronically by logging on to the [PaySpan Health](#) website and electronic versions of EOPs are available for download and printing on the PaySpan Health website.

## Summary of Claims in Process

Tufts Health Plan generates a weekly Summary of Claims in Process report that shows all claims received to date and pending for payment. The Summary of Claims in Process reports is similar to the EOP report, except "Summary of Claims in Process" appears at the top of the barred section and pay codes display a pending message, rather than a payment or denial message. Once adjudicated, all entries on the Summary of Claims in Process report appear on the EOP.

## Electronic Remittance Advice

Tufts Health Plan now offers the 835 Health Care Claim Payment Advice through PaySpan Health. This electronic remittance advice (ERA) includes paid and denied claims submitted either via EDI or on paper forms and uses HIPAA-standard reason codes.

All registration and support questions for retrieving an 835 from PaySpan Health and for ongoing support is handled by PaySpan Health Provider Support Team via their [website](#) or phone by dialing 877.331.7154, option 1. Provider Support Team specialists are available to assist Monday through Friday from 8 a.m. to 8 p.m., EST.

## Claims Reports

Tufts Health Plan sends the following reports to medical groups regarding claims for members in their group:

1. A **weekly referral report** includes claims for which Tufts Health Plan has not received a referral. The report gives the PCP an opportunity to authorize or deny the payment of billed services. The group has 10 business days from the date of the letter that accompanies the report to respond with a pay or deny response. The Notice of Attestation of Authorization and Denial of Payment must accompany the

returned report and must include a valid reason for a denial. The form must be signed and dated by the Member's PCP, a covering provider, or the medical director. Note that a stamped signature is not appropriate. After 10 business days, any claims for which a response is not received are considered authorized.

2. The biweekly **adjusted claims report** includes claims that Tufts Health Plan has retracted and reprocessed. Medical groups can then review claims that have been adjusted for denial or payment.
3. Two **paid claims reports** are generated biweekly and show claims processed from the Medical Services Fund and those processed from the Hospital Services Fund. These reports allow the medical group to review claims processed from each service fund.

## Retroactive Denials (Tufts Health Plan SCO)

Effective for behavioral health claims received on or after July 1, 2019, Tufts Health Plan may reprocess claims in accordance with our adjudication guidelines to ensure appropriate payment for services rendered. In accordance with [state law](#) governing Massachusetts Medicaid plans, Tufts Health Plan sends notification to behavioral health providers in Massachusetts and allows 30 days for a response prior to retroactively denying or adjusting claims to reduce payment for behavioral health services. If communication is not received from the provider within 30 days (15 days for coordination of benefits or worker's compensation claims), the claim will be readjusted and processed.

## Corrected Claims and Disputes

Tufts Health Plan accepts both electronic and paper corrected claims, in accordance with guidelines of the National Uniform Claim Committee (NUCC), Medicare Managed Care Manual and HIPAA EDI standards for Tufts Health Plan claims.

### Online Adjustment Requests

Registered providers may submit corrected claims or dispute a claim using Tufts Health Plan's secure provider [website](#). Follow the instructions when submitting online claim adjustments. After the transaction has been completed, providers will receive a tracking number as confirmation the adjustment has been received. Refer to the [Provider Payment Dispute Policy](#) for more information on corrected claims and disputes.

Provider Services is unable to process claim adjustment requests. Registered providers may submit claim adjustments using the secure provider website. If you are not a registered user of our website, go to our secure Provider website and follow the instructions.

**Note:** Some claims may not be adjustable online. If a claim cannot be adjusted online, a message will appear indicating the claim is not adjustable. In this instance, claim adjustments may be submitted on paper.

### EDI Submissions

To submit a corrected facility or professional claim via EDI:

- Enter the frequency code (third digit of the bill type for institutional claims; separate code for professional claims) in **Loop 2300, CLM05-3** as one of the following:
  - **7** (corrected claim)
  - **5** (late charges)
  - **8** (void or cancel a prior claim)
- Enter the last 8 digits of the original claim number in Loop 2300, REF segment with an F8 qualifier. For example, for claim #000123456789, enter **REF\*F8\*23456789**.

**Note:** Provider payment disputes that require additional documentation **must** be submitted on paper.

### Paper Submissions

Disputes (not corrected claims) must include a completed [Request for Claim Review Form \(v1.1\)](#). Both corrected claims and disputes, however, should be mailed to the address on the form.

**Facility claims**

On the UB-04 (CMS-1450) form, enter either **7** (corrected claim), **5** (late charges), or **8** (void or cancel a prior claim) as the third digit in Box 4 (Type of Bill), and enter the original claim number in Box 64 (Document Control Number).

**Professional claims**

In Box 22 on the CMS-1500 form, enter the frequency code **7** under "Code" and the original claim number in the same box under "Original Ref No."

**Filing Deadline**

Claims for professional or outpatient services must be received by Tufts Health Plan within 60 days of the date of service, or within 60 days of the date of hospital discharge for inpatient or institutional services. When a member has multiple insurance plans, the filing deadline for claims submission is 60 days from the date of the primary insurer's EOB.

**Filing Deadline Adjustments**

To be considered for review, requests for review and adjustment for a claim received over the filing deadline must be submitted within 120 calendar days of the EOP date on which the claim originally denied. Disputes received after 120 calendar days will not be considered.

If the initial claim submission is after the filing deadline and the circumstances for the late submission are beyond the provider's control, the provider may submit a payment dispute for reconsideration by sending a letter documenting the reason(s) why the claim could not be submitted within the contracted filing deadline and any supporting documentation.

Documented proof of timely submission must be submitted with any request for review and payment of a claim previously denied due to the filing deadline. A completed [Provider Request for Claim Review Form \(v1.1\)](#) must also be sent with the request.

For paper claim submissions, the following are considered acceptable proof of timely submission:

- Copy of patient ledger that shows the date the claim was submitted to Tufts Health Plan
- Copy of EOB from the primary insurer that shows timely submission from the date that carrier processed the claim
- Copy of EOB as proof that the member or another carrier had been billed, if the member did not identify him/herself as a Tufts Health Plan member at the time of service

For EDI claim submissions, the following are considered acceptable proof of timely submission:

- For claims submitted through a clearinghouse or MD On-Line, a copy of the transmission report and rejection report showing that the claim did not reject at the clearinghouse or at Tufts Health Plan (two separate reports)
- For claims submitted directly to Tufts Health Plan, the corresponding report showing that the claim did not reject at Tufts Health Plan
- Copy of EOB from the primary insurer that shows timely submission from the date that carrier processed the claim
- Copy of EOB as proof that the member or another carrier had been billed, if the member did not identify him/herself as a Tufts Medicare Preferred HMO/Health Plan SCO member at the time of service

The following are not considered to be valid proof of timely submission:

- Copy of original claim form
- Copy of transmission report without matching rejection/error reports (EDI)
- Verbal requests

Requests for filing deadline adjustments should be sent to the following address:

Tufts Medicare Preferred or Tufts Health Plan SCO  
P.O. Box 9162  
Watertown, MA 02471-9162

## Provider Disputes

Providers who disagree with the reimbursement, adjudication or denial of a claim may submit a payment dispute to the following address:

Tufts Medicare Preferred or Tufts Health Plan SCO  
P.O. Box 9162  
Watertown, MA 02471-9162

Payment disputes must include a copy of the EOP, appropriate documentation and a completed [Request for Claim Review Form \(v1.1\)](#). Refer to the [Provider Payment Dispute Policy](#) for more information on the dispute process.

**Note:** Payment disputes cannot be submitted via EDI; however, corrected claims may be submitted via EDI using the appropriate frequency code.

## Coordination of Benefits

Regardless of whether Tufts Health Plan is the primary or secondary insurer, members must follow plan procedures to receive benefits. For additional information, refer to the [Coordination of Benefits Policy](#).

## Motor Vehicle Accidents (MVA)

Tufts Health Plan coordinates with auto insurance coverage, including personal injury protection (PIP) and/or Medical Payment (MedPay) on claims for services rendered as a result of an MVA.

The auto insurance coverage is primary for the full PIP coverage and/or any available MedPay coverage until all benefits are exhausted. Providers should bill the motor vehicle carrier directly. Members should not be billed or required to pay up front for services as a result of an MVA, other than applicable cost-sharing amounts.

If further payment is requested after receiving the insurer's statement or check, providers must submit a copy of the auto carrier's documents (i.e., PIP exhaust or benefit denial letter) along with the claim(s) to Tufts Health Plan within the 60-calendar day filing deadline date from the date the statement or check was issued.

**Note:** Tufts Health Plan does not accept PIP notification or claim forms from any entities other than the member's motor vehicle insurer and contracting providers of Tufts Medicare Preferred HMO and Tufts Health Plan SCO.

Under the provider's Tufts Health Plan contract, after the member's PIP and MedPay benefits are exhausted, the member cannot be balance-billed or have a lien filed against their third-party settlement or judgment. Do not bill the member or the member's attorney directly, even if requested by either of them. If a provider chooses to bill the member or attorney directly, it is done so at the provider's own risk.

The following applies to claims for services rendered as a result of a motor vehicle accident:

- Claims should be submitted to the motor vehicle insurer first to expedite adjudication
- Claims should not be submitted beyond the filing deadline from the date on the auto insurer's notification of benefit payment, denial, or exhaustion
- Claims should be submitted with dated notification from the auto insurer that benefits have been paid, denied or exhausted
- Inpatient notification procedures for any inpatient admissions resulting from an MVA, regardless of whether or not Tufts Health Plan is the primary or secondary insurer. Refer to the Referrals, Authorizations and Notifications chapter for additional information.

**Note:** Tufts Health Plan does not routinely compensate conditional bills.

## Subrogation

Subrogation is a liability recovery activity in which medical costs that are the result of actions or omissions of a third party are recovered from the third party (and/or their insurer).

Tufts Health Plan has outsourced subrogation recovery services to the Rawlings Company in Louisville, Kentucky. Providers may receive correspondence from Rawlings related to duplicate claim payments (e.g., Tufts Health Plan and a motor vehicle carrier). Inquiries relating to correspondence received by the provider must be directed



to the Rawlings Company. All other subrogation questions should be directed to Provider Services at 800.279.9022.

## Claim Specifications

### Completing the UB-04 Form

Use the UB-04 form to complete a Medicare claim for institutional services. To complete this form, refer to the [UB-04 Claim Form Specifications](#). Field information is required unless otherwise noted. This form may be prepared according to Medicare guidelines as long as all required fields are completed.

### Completing the CMS-1500 (02/12) Form

Use the CMS-1500 form to submit a Medicare claim for noninstitutional services. All providers, including internal medicine, gynecology and psychiatry, should use ICD-CM diagnosis codes and HCPCS/CPT procedure codes. Oral surgeons may use CDT-3 codes, and dentists may use the ADA procedure codes and ADA form. To complete this form, refer to the [CMS-1500 Claim Form Specifications](#).

**Note:** Unlisted or miscellaneous codes require notes and/or a description of services rendered to be submitted with the claim. Using unlisted or miscellaneous codes will delay claims adjudication and should be avoided whenever possible. Claims received with unlisted or miscellaneous codes that have no supporting documentation may result in a claim denial and the member may not be held liable for payment.

### UB-04 Claim Form Specifications

Box	Field Name	Type	Description
1	Untitled	M	Name and address of the hospital/provider
2	Untitled	M	Address of payee (if different from the address in box 1)
3a-b	Patient control number	O	3a: Patient account number 3b: Medical record number
4	Type of bill	M	3-digit code to indicate the type of bill. Claim will be returned if the type of bill is missing
5	Federal tax number	M	Hospital/provider federal tax ID. Claim will be returned if federal tax ID is not on the claim.
6	Statement covers period	M	Beginning and ending service dates of the period covered by this bill (MMDDYY). These dates are necessary on all claims. For services received on a single day, both the "from" and "through" dates will be the same If the "from" and "through" dates differ, then these services must be itemized by date of service (see Box #45)
7	Untitled	N/A	
8a	Patient ID and name	M	8a: Member ID number 8b: Member's last name, first name and middle initial, if any, as shown on the member's ID card.
9a-e	Patient address	M	Member's mailing address from the patient record
10	Birth date	M	Member's date of birth (MMDDYYYY)
11	Sex	M	Indicate (M)ale or (F)emale
12	Admission date	M	Date of admission/visit
13	Admission hour	M	Time (hour: 00-23) of admission/visit
14	Admission type	M	Code indicating the type of admission/visit
15	Source of admission (SRC)	M	Code indicating the source of admission/visit
16	Discharge hour	M	Time (hour: 00-23) the member was discharged

Box	Field Name	Type	Description
17	STAT (Patient discharge status)	M	Indicates the status of the member as of the through date on bill (interim billing is not allowed and the member's status cannot be 'member')
18-28	Condition codes	O	Code used to identify conditions relating to this bill (can affect payer processing)
29	Accident state	M	Enter the state in which accident occurred
30	Untitled	N/A	
31-34	Occurrence codes and dates	M (if applicable)	Enter the code and associated date defining a significant event relating to this bill that can affect payer processing. <b>Note:</b> Tufts Health Plan requires all accident-related occurrence codes to be reported.
35-36	Occurrence span code and dates	O	Code and related dates that identify an event that relates to the payment of the claim
37	Untitled	N/A	
38	Untitled	N/A	
39-41	Value codes and amounts	N/A	
42	Revenue code	M	Most current industry standard revenue codes
43	Revenue description	M	Narrative description of services/procedures rendered. Use CPT-4/HCPCS definitions whenever possible
44	HCPCS/rates	M	Use CPT/HCPCS Level II codes for outpatient procedures, services, and supplies Do not use unlisted codes. If an unlisted code is used, supporting documentation must accompany the claim Do not indicate rates
45	Service date	M	Date the indicated service was provided
46	Units of service	M	Units of service rendered per procedure
47	Total charges	M	Enter the charge amount for each reported line item. A negative amount will not be accepted.
48	Noncovered charges	O	Enter any noncovered charges for the primary payer pertaining to the revenue code.
49	Untitled	N/A	
50 A-C	Payer	M	All other health insurance carriers on file (attach EOB from other carrier, if applicable)
51	Health plan ID	O	Provider number assigned by health insurance carrier
52	Rel. info (release of information)	N/A	
53	Asg ben (assignment of benefits)	N/A	
54	Prior payments (payer and patient)	M	Report all prior payment for claim (attach EOB from other carrier, if applicable) A negative amount will not be accepted
55	Est. amount due	N/A	
56	NPI	M	Valid NPI number of the servicing provider
57a-c	Other Prv ID (other provider ID)	N/A	
58a-c	Insured's name	M	Name of the individual who is carrying the insurance
59	P. rel (patient's relationship to insured)	M	Code indicating the relationship of the member to the identified insured/subscriber

Box	Field Name	Type	Description
60a-c	Insured's unique ID (health insurance claim/identification #)	M	Member's ID number, as shown on the Tufts Health Plan ID card
61a-c	Group name	M	Name of the group or plan through which the insurance is proved to the insured
62a-c	Insurance group number	M	Identification number, control number, or code assigned by the carrier or administrator to identify the group under which the individual is covered
63a-c	Treatment authorization code	O	Tufts Health Plan referral/authorization number for outpatient surgical day care services
64a-c	Document control number	N/A	
65a-c	Employer name	M (if applicable)	Name of the employer for the individual identified in box 58
66	DX version qualifier	N/A	
67a-q	Principal diagnosis code	M	ICD-CM code describing the principal diagnosis chiefly responsible for causing admission/visit. The code must be to the appropriate digit specification, if applicable. If the diagnosis is accident related, then an occurrence code and accident date are required. Present on admission (POA) indicator should be entered as the 8th character
68	Other diagnosis codes	M (if applicable)	ICD-CM codes corresponding to additional conditions that coexist at the time of admission or develop subsequently. The code must be to the appropriate digit specification, if applicable.
69	Admit DX	M	ICD-CM code provided at the time of admission as stated by the provider
70	Patient reason DX	O	
71	PPS code (Prospective Payment System)	O	
72	ECI (external cause of injury code)	M (if applicable)	ICD-CM code for the external cause of an injury, poisoning or adverse effect
73	Untitled	N/A	
74a-e	Principal procedure code (code and date)	M	Most current ICD-CM code to the appropriate digit specification, if applicable, to describe the principal procedure performed for this service billed. Also, enter the date the procedure was performed. Date must be recorded as month and day (MMDD)
75	Unlisted	N/A	
76	Attending physician	M	Ordering physicians NPI, physician's last name, first name and middle initial
77	Operating physician	M (if applicable)	Name and NPI number of the physician who performed the principal procedure
78-79	Other provider types	O	Optional
80	Remarks	O	Examples: "COB-related" or "billing for denial purposes only"
81a-d	ICC	O	Optional

**CMS-1500 Form Specifications**

Box	Field Name	Type	Instructions
1	Type of insurance coverage	O	Check the appropriate box to show health insurance coverage applicable to this claim. This field is optional. If the Other box is checked, complete Box #9.
1a	Insured's ID number	M	Enter the member's current identification number exactly as it appears on the member's Tufts Medicare Preferred HMO ID card, including the alpha prefix and number suffix. Inaccurate or incomplete ID numbers will delay processing the claim and can result in a denial.
2	Patient's name	M	Member's last name, first name and middle initial, if any, as shown on the member's ID card.
3	Patient's birth date and sex	M	Member's date of birth and sex.
4	Insured's name	M	If the insured and the member are the same person, enter SAME. If the insured and the member are not the same person, enter the name of the insured (last name, first name and middle initial).
5	Patient's address	M	member's permanent mailing address and telephone number: 2nd line: street address, city and state 3rd line: zip code and telephone number
6	Patient relationship to insured	M	Member's relationship to the insured (i.e., self)
7	Insured's address	M	If the insured's address is the same as member's address, enter SAME. If the insured's address is different than the member's address, enter insured's permanent mailing address (street number and name, city, state, zip code) and telephone number, if available.
8	Reserved for NUCC use	O	
9	Other insured's name	M	If the insured is the same as the person in Box #4, enter SAME. If the insured is not the same as the person in Box #4, enter name of the other insured (last name, first name and middle initial).
9a	Other insured's policy or group number	M	If the other insured is covered under another health benefit plan, enter the other insured's policy or group number.
9b	Reserved for NUCC use	O	
9c	Reserved for NUCC use	O	
9d	Insurance plan name or program name	M	Other insured's insurance plan name or program name and attach the other insurer's EOB to the claim.

Box	Field Name	Type	Instructions
10a-c	Is patient's condition related to:	M	For each category (Employment, Auto Accident, Other Accident), check either YES or NO. When applicable, attach an EOB or letter from the auto carrier indicating that personal injury protection (PIP) benefits have been exhausted. State postal code where the auto accident occurred
10d	Claim codes	O	Up to 4 claim condition codes may be entered
11	Insured's policy group or FECA number	M	If the insured has other insurance, indicate the insured's policy or group number.
11a	Insured's date of birth and sex	M	Insured's date of birth and sex if different from the information in Box #3.
11b	Other claim ID	O	Enter 2-character qualifier found in 837 electronic claim to the left of the dotted line. Enter claim number from other insured's plan to the right of the dotted line
11c	Insurance plan name or program name	M	Insurance plan or program name, if applicable (this field is used to determine if supplemental or other insurance is involved)
11d	Is there another health benefit plan?	M	Check YES or NO to indicate if there is another primary health benefit plan. For example, a member may be covered under insurance held by a spouse, parent, or other person
12	Patient's or authorized person's signature	M	If the signature is not on file, the member or authorized representative must sign and date this box If the signature is on file, enter Signature on File If an authorized representative signs, indicate this person's relationship to the member
13	Insured's or authorized person's signature	M	If the signature is not on file, the insured or authorized representative must sign this block to authorize payment of benefits to the participating practitioner or supplier If the signature is on file, enter Signature on File
14	Date of current illness, injury or pregnancy (LMP)	O	Date of current illness, injury or pregnancy in the designated MMDDYY space Qualifier found in the 837 electronic claim to the right of the QUAL dotted line
15	Other date	O	Qualifier found in the 837 electronic claim between the dotted lines to the right of QUAL Date in the designated MMDDYY space
16	Dates patient unable to work in current occupation	O	Enter dates if the member is unable to work in current occupation. An entry in this box could indicate employment-related insurance coverage

Box	Field Name	Type	Instructions
17	Name of referring provider or other source	O	Enter 2-character qualifier found in 837 electronic claim to the left of the dotted line Enter the name of the referring and/or ordering practitioner or other source if the member: <ul style="list-style-type: none"> <li>Was referred to the performing practitioner for consultation or treatment</li> <li>Was referred to an entity, such as clinical laboratory, for a service</li> <li>Obtained a practitioner's order for an item or service from an entity, such as a DME supplier</li> </ul>
17a-b	ID number of referring physician	O	NPI-assigned practitioner ID number of the referring or ordering practitioner Referring practitioner information is required if another practitioner referred the member to the performing practitioner for consultation or treatment Ordering practitioner information is required if a physician ordered the diagnostic services, test or equipment
18	Hospitalization dates related to current services	M	Admission and discharge dates when a medical service was furnished as a result of, or subsequent to, a related hospitalization
19	Additional claim information (designated by NUCC)	O	Additional claim information
20	Outside lab	O	Check YES or NO to indicate if laboratory work was performed outside the practitioner's office
21	Diagnoses	M	Up to 12 ICD-CM 12 codes in priority order (primary, secondary condition) may be entered. Codes are arrayed across the box.
22	Resubmission code	O	Identifies a resubmission code
23	Prior authorization/referral number	O	If applicable, enter the inpatient notification or prior authorization number
24a	Date(s) of service	M	Dates for each procedure in MMDDYY format, omitting any punctuation Itemize each date of service. Do not use a date range
24b	Place of service	M	Appropriate place of service code
24c	EMG	N/A	Check this item if the service was rendered in a hospital or emergency room
24d	Procedures, services, or supplies	M	Valid CPT/HCPCS procedure codes and any modifiers
24e	Diagnosis pointer	M	Diagnosis reference letter for up to 4 ICD-CM codes, as shown in box #21, to relate the date of service and the procedures performed to the appropriate diagnosis. Maximum of 4 letters that refer to four diagnosis codes. If multiple services are being performed, enter the diagnosis codes warranting each service.
24f	\$ Charges	M	Charges for each listed service

Box	Field Name	Type	Instructions
24g	Days or units	M	Days or units of service rendered for the procedures reported in Box 24d
24h	EPSDT family plan	O	Check only if EPSDT or family planning services were used
24i	ID QUAL	O	Check only if the service was rendered in a hospital emergency room <b>Note:</b> If this box is checked, the place of service code in Field #24b should match.
24j	Rendering provider ID #	M	rendering practitioner's NPI number (if different from billing practitioner)
25	Federal Tax ID number	M	Practitioner/supplier's federal tax ID, employer ID number, or Social Security number
26	Patient's account number	O	Member's account number assigned by the physician's/supplier's accounting system <b>Note:</b> This is an optional field to enhance member identification by the practitioner or supplier.
27	Accept assignment?	M	Indicate if the practitioner accepts assignment for the claim (by checking yes, the practitioner agrees to accept the amount paid by Medicare or CHAMPUS as payment in full for the encounter)
28	Total charge	M	Total charges for the services (total of all charges in Box 24f).
29	Amount paid	M	Total amount paid by any other carrier/entity for the submitted charges in Box 28 Attach supporting documentation of any payments (e.g., EOB, EOP or a copy of a cancelled check, if applicable)
30	Reserved for NUCC use	O	
31	Signature of physician or supplier including degrees or credentials	M	If the signature is not on file, have the physician/supplier or authorized representative sign and date this block. If the signature is on file, enter Signature on File.
32, 32a-b	Service facility location information	M	If other than home or office, enter the name and address of the facility where services were rendered to the member, enter NPI number for the facility (or other ID number, if applicable)
33, 33a	Billing provider info and phone	M	33: Name and payment address of the entity receiving payment (this must match the Tax ID and name on file with the IRS) 33a: NPI number for the entity receiving payment

## MEMBER APPEALS AND GRIEVANCES

Members have the right to file a complaint if they have concerns or problems related to their coverage or care. Appeals and grievances are two different types of member complaints, as defined in the [Parts C & D Enrollee Grievances, Organization/Determinations, and Appeals Guidance](#). Appeals are intended to review an adverse organization determination for health care services and/or an adverse coverage determination for drugs that the member feels they are entitled to. Grievances are intended to address concerns or problems members have with their coverage or care.

- [Appeals](#)
- [Grievances](#)

### Quality Improvement Organizations

Quality improvement organizations (QIOs) are groups of health care professionals that monitor the quality of care provided to Medicare members enrolled in Medicare Advantage products with CMS, including Tufts Medicare Preferred HMO/Tufts Health Plan SCO members. The KEPRO review process is designed to help prevent any improper practices. This process is separate and distinct from the Tufts Health Plan grievance process.

KEPRO Beneficiary and Family-Centered Care is the QIO (BFCC-QIO) for Massachusetts. Tufts Medicare Preferred HMO and Tufts Health Plan SCO members concerned about the quality of care received may also file a complaint with KEPRO at 888.319.8452.

In accordance with the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985, as amended by the Omnibus Budget Reconciliation Act (OBRA) of 1986, Tufts Health Plan participates in external reviews of its QI program for members enrolled in Tufts Medicare Preferred HMO or Tufts Health Plan SCO plans. The responsibilities of each organization that conducts the external review of Tufts Medicare Preferred HMO/Tufts Health Plan SCO are delineated in Tufts Health Plan's agreement with KEPRO.

### KEPRO Contact Information

KEPRO  
BFCC-QIO Program  
5700 Lombardo Center Dr., Suite 100  
Seven Hills, OH 44131

Phone: 888.319.8452  
TTY: 855.843.4776  
Fax: 833.868.4055  
Web: [kepro.com](http://kepro.com)

### KEPRO Reviews

KEPRO maintains a review system to ensure that services provided to Medicare beneficiaries enrolled in Medicare health plans are of adequate quality across all settings. This review system addresses the following issues:

- Appropriateness of treatment
- Potential for under-utilization of services
- Accessibility to services
- Potential for premature discharge of patients
- Timeliness of services provided
- Appropriateness of the setting for the provision of services
- Appropriateness of the Medicare health plan's activities to coordinate care (e.g., adequacy of discharge planning and follow-up of abnormal diagnostic studies)

KEPRO will notify Tufts Health Plan regarding issues that include results of KEPRO review activities, unless otherwise specified in KEPRO's agreement with CMS. These issues will be identified as quality of care concerns or documentation concerns.

Tufts Health Plan will be notified when a KEPRO review indicates a quality problem regarding an out-of-plan emergency or urgently needed care that an out-of-plan hospital, SNF, or other health care facility provided to a



member, and the problem is attributable to the institution. However, the quality problem identified with respect to these services will be attributed to the out-of-plan provider/practitioner, rather than to Tufts Health Plan.

## Appeals

As defined in 42 CFR 422.561 and 423.560, appeals are procedures that deal with the review of adverse initial determinations made by Tufts Health Plan regarding health care services or benefits under Part C or D that the member believes they are entitled to receive, including a delay in providing, arranging for, or approving the health care services or drug coverage (when a delay would adversely affect the health of the member) or on any amounts the member must pay for a service or drug defined in 42 CFR 422.566(b) and 423.566(b). These appeal procedures include the following:

- Tufts Health Plan reconsideration or redetermination (also referred to as a level 1 appeal)
- Reconsideration by an independent review entity (IRE)
- Adjudication by an Administrative Law Judge (ALJ) or attorney adjudicator
- Review by the Medicare Appeals Council (Council)
- Judicial review

Under Part C, a reconsideration is the first level in the appeals process, which involves the review of an adverse organization determination by Tufts Health Plan, the evidence and findings upon which it was based, and any other evidence submitted by a party to the organization determination, Tufts Health Plan or CMS.

Under Part D, a redetermination is the first level in the Part D appeal process in which the plan sponsor reviews an adverse Part D coverage determination, including the findings upon which the decision was based and any other evidence submitted or obtained.

**Note:** Tufts Health Plan and its network providers must not treat members unfairly or discriminate against them because they initiate a complaint.

### Executive Office of Health and Human Services Board of Hearings (EOHHS BOH)

Upon receipt of a written notice of Tufts Health Plan's decision to deny, terminate, or reduce services, both Tufts Health Plan SCO dual members and Medicaid-only members may file an internal appeal. If the internal appeal decision upholds the original service denial, members may request an external review by the BOH. The BOH will render a final decision within the time limits specified under MassHealth's Fair Hearing Rules ([130 CMR 610.015\[D\]](#)). Pursuant to 130 CMR 610.016, if a member elects a provider to be their appeal representative, the provider may request a BOH review of Tufts Health Plan's internal appeal decision to uphold the initial decision to deny, terminate, suspend, or reduce services.

The member must submit a request for a BOH appeal, in writing, no later than 120 calendar days from the date of mailing of Tufts Health Plan's internal appeal decision.

A member can choose to continue receiving requested services from Tufts Health Plan during the BOH appeal process. If the member wants to receive such continuing services, the member or their authorized appeal representative must submit the BOH appeal request within ten calendar days from the date of the internal appeal denial letter and indicate that they want to continue to get these services.

If the BOH decides in the member's favor, Tufts Health Plan must authorize or provide the service in dispute as expeditiously as the member's health condition requires but no later than 72 hours from the date Tufts Health Plan receives the notice of the BOH decision. If the outcome of the BOH external review upholds Tufts Health Plan decision, the member will not be financially responsible for the services provided during the review period. If Tufts Health Plan or the member disagrees with the BOH decision, there are further levels of appeal available, including judicial review of the decision under M.G.L. c. 30A. Tufts Health Plan must comply with any final decision upon judicial review.

### Fast-Track Appeals

A fast-track appeal is appropriate when the member disagrees with the coverage termination decision from a skilled nursing facility (SNF), home health agency (HHA), or comprehensive outpatient rehabilitation facility (CORF), or upon notification of discharge for an inpatient hospital stay.

To initiate a fast-track review, the member must submit a fast-track appeal request within the required time frame to KEPRO. Once an appeal is filed, beneficiaries remain entitled to continuation of coverage for their

inpatient hospital stay, SNFs, HHAs, or CORFs until KEPRO renders a decision. KEPRO may be contacted by the member (or member's representative), attorney, or court-appointed guardian. KEPRO is authorized by Medicare to review the services noted above provided to Tufts Medicare Preferred HMO/Tufts Health Plan SCO members.

The provider must submit a copy of the important message (IM) or [Notice of Medicare Noncoverage \(NOMNC\)](#) and documentation from the medical record supporting the member's discharge from services to KEPRO. Submission of these documents is a condition of payment and failure to submit these upon request may result in a claim denial.

The following documentation supporting the member's discharge from the current level of services is required:

1. Valid IM/NOMNC
2. At a minimum, the medical record must include **all of the following**:
  - a. An attending practitioner's (e.g., MD or NP) progress note, written within two calendar days of delivery of IM/NOMNC and including **all of the following**:
    - i. A statement that the member's current condition is stable and they are ready for discharge
    - ii. A statement that the member no longer requires or will benefit from current level of services
    - iii. An outline of the member's discharge plan: where member will be discharged to and what the transition of care plan is
    - iv. A statement that addresses any open medical issues and how they will be managed
  - b. Attending practitioner's order to discharge member from the current level of services, documented in the medical record by the date that the IM/NOMNC is issued.
  - c. A progress note from each applicable rehabilitation service (physical, occupational, and/or speech therapy) describing the member's current functional level, stability of their medical condition and a description of the discharge plan including any treatments to be carried out after discharge

If KEPRO agrees with the member and overturns the decision to discharge, the member will be reinstated. The process recommences if/when the member is ready to be discharged again.

Tufts Health Plan monitors compliance with the time frame associated with KEPRO hospital discharge appeals.

If the member misses the KEPRO deadline (up until noon on the day of discharge), they have the right to call Senior Products Provider Relations at 800.701.9000 to request an expedited appeal. Tufts Health Plan generally makes a decision within 72 hours. During the fast-track appeals process, the member may not be held financially responsible for coverage of the requested services until an appeal determination has been made by KEPRO.

### Standard and Expedited Appeals

A member (or provider acting on the member's behalf) may appeal any adverse organization determinations or coverage determinations they believe they are entitled to receive, including delay in providing, arranging for, or approving the health care services (such that a delay would adversely affect the health of the member), or any amounts the member must pay for. These appeals can include hospital discharge decisions, as well as SNF/HHA/CORF discharge decisions if the member missed the QIO (KEPRO) deadline.

The following procedures apply to both Tufts Health Plan SCO dual eligible members and Medicaid-only members, with a few exceptions. The additional levels of appeal available to Tufts Health Plan SCO members include the independent review entity reconsideration.

**Note:** The ALJ hearing, MAC review and the judicial review are only available to dual eligible members, but not available to the Medicaid-only members. For Medicaid covered services, members have an additional right to appeal to the MassHealth Board of Hearings (see above).

The following procedures include reconsideration by Tufts Health Plan and, if necessary, the IRE, (MAXIMUS Federal Services, Inc.), hearings before a Social Security Administration ALJ, review by the MAC, and judicial review, as well as hearings at the MassHealth Board of Hearings.

### **Standard Member Appeals**

In most cases, the organization determination and coverage determinations are final unless a member contacts Tufts Health Plan within 60 calendar days of receiving the determination (or longer if there is a reason for a good cause extension). If a member requests reconsideration (appeal) of a denial, Tufts Health Plan follows the standard member appeals procedure below. The appeal procedure takes place after the adverse organization determination has been issued by Tufts Health Plan.

### **Appeals Procedure for Part C Services**

1. The member submits a written request for reconsideration to the Appeals and Grievances Department or a verbal request through the Senior Products Member Relations Department. For preservice requests, the treating provider may also request an appeal verbally or in writing without being appointed as the member's representative as long as the provider notifies the member the provider is filing the appeal. For post-service requests, the provider must be appointed as the member's representative.
  - a. The Appeals and Grievances Department receives and reviews the appeal and, if needed, will request additional documentation.
  - b. The member can identify an [Appointment of Representative \(AOR\)](#) as an authorized representative to act on their behalf during the appeal process. If the member does have an AOR or activated health care proxy, all correspondence regarding the appeal must be sent to the AOR and a copy may be sent to the member.
  - c. For a request for a medical item or service, the Appeals and Grievances Department consults with other Tufts Health Plan departments, when appropriate, and completes the investigation and notifies the member as expeditiously as the member's health condition requires, not exceeding 30 calendar days (preservice requests) from the date the reconsideration request was received (or no later than upon expiration of a 14 calendar-day extension), regardless of whether or not the organization determination was overturned.
    - i. If the request is for a Medicare Part B prescription drug, the Appeals and Grievances Department will complete the investigation and notify the member as expeditiously as the member's health condition requires, but not exceeding **seven calendar days** (preservice requests) from the date the request was received. The review time frame for Part B drug requests will not be extended. Post service requests will be resolved within 60 calendar days from the date the reconsideration request was received.
  - d. For Tufts Health Plan SCO members, the Appeals and Grievances Department completes the investigation and notifies the member as expeditiously as the member's health condition requires, not exceeding 30 calendar days for either preservice or post-service requests from the date the reconsideration request was received (or no later than upon expiration of a 14 calendar-day extension), regardless of whether or not the organization determination was overturned.
2. Tufts Health Plan may extend a preservice review time frame up to 14 calendar days if the extension is requested by the member, or if Tufts Health Plan determines that additional information is necessary and the delay is in the best interest of the member (e.g., additional diagnostic testing or consultation with medical specialists). Lack of availability of plan provider medical records is not considered an acceptable reason for delay. The review time frame for requests for Medicare Part B prescription drugs will not be extended. Tufts Health Plan may extend the SCO pre- and post-service review time frame up to 14 calendar days for the reasons stated above.
3. If the organization determination was not overturned, the notice informs the member that all relevant information was forwarded to the CMS reconsideration contractor, MAXIMUS Federal Services, Inc.

**Note:** Forwarding an appeal to MAXIMUS Federal Services, Inc. does not apply to Medicaid-only members or to SCO Dual members (dually eligible for both Medicare and Medicaid) requesting Medicaid-only covered services.

### **Appeals Procedure for Part D Services**

1. The member sends a written request for reconsideration to the Appeals and Grievances Department or a verbal request through Senior Products Member Relations at 800.701.9000. For preservice requests, the prescribing provider may also request an appeal verbally or in writing without being appointed as the member's representative, as long as the provider notifies the member that they are filing the appeal on the member's behalf.
  - a. The Appeals and Grievances Department receives and reviews the appeal and, if needed, requests additional documentation.
  - b. The member may identify an AOR to act on their behalf during the appeal process. If the member does have an AOR or activated health care proxy, all correspondence regarding the appeal must be sent to the AOR and a copy may be sent to the member.
  - c. The Appeals and Grievances Department consults with other Tufts Health Plan departments when appropriate, and completes the investigation as expeditiously as the member's health condition requires, not exceeding seven calendar days from the date the redetermination

- request was received for pre-service requests. Requests for reimbursement are completed within 14 calendar days from the date the redetermination request was received.
2. Tufts Health Plan may not extend the review time frame beyond **seven calendar days** for Part D appeals or requests for a Medicare Part B prescription drug.
  3. If the coverage determination was not overturned, the notice informs the member of the right to submit a reconsideration request to MAXIMUS Federal Services, Inc. Included with the decision notice is a Request for Reconsideration notice for the member to send to the MAXIMUS Federal Services, Inc.

### ***Independent Review Entity (IRE) Review and Additional Appeal Levels***

1. MAXIMUS Federal Services, Inc. is the IRE that reviews the information provided by Tufts Health Plan and requests any additional documentation needed from either Tufts Health Plan or the member. MAXIMUS Federal Services, Inc. is a separate entity from KEPRO.
2. MAXIMUS Federal Services, Inc.'s reconsideration determination is final and binding, unless a request for a hearing before an ALJ is filed within 60 calendar days of receiving the reconsideration notice.
3. Any member may request a judicial review (after notifying other parties) of an ALJ decision, if the amount in controversy meets the appropriate threshold (new thresholds are published by CMS every fall) and the Medicare Appeals Council (MAC) has denied the member's request for review.
4. Any decision by Tufts Health Plan, MAXIMUS Federal Services, Inc., the ALJ, or the MAC may be reopened within 12 months or within four years for good cause. Once a revised determination or decision is issued, any party may file an appeal.

### Expedited Appeals

An expedited appeal is a review of a time-sensitive adverse organization determination or coverage determination that a member believes that they are entitled to receive, including:

- Any delay in providing, arranging for, or approving health care services/medications that would adversely affect the health of the member
  - Reduction or stoppage of treatment or services that would adversely affect the member's health
- Note:** Time-sensitive is defined as a situation in which applying the standard decision time frame could seriously jeopardize a member's life, health, or ability to regain maximum function.

Members, their representatives, or any treating or prescribing physician (regardless of whether the provider is affiliated with Tufts Health Plan) can request an expedited appeal. Verbal and written requests for expedited appeals are accepted. If the request meets the necessary time-sensitive criteria, a decision will be made within 72 hours of receipt of the request, unless an extension is needed. Extensions of up to 14 calendar days can be granted if in the best interest of the member.

**Note:** Extensions are not allowed for expedited Part D appeals or requests for a Medicare Part B prescription drug.

Providers may access appeals information on the CMS [website](#) as well as at the following links:

- [Medicare Managed Care Appeals and Grievances](#)
- [Beneficiary Notices Initiative \(BNI\)](#)
- [Advance Notice Form Instructions](#)

### Grievances

A grievance is an expression of dissatisfaction with any aspect of the operations, activities, or behavior of a plan or its delegated entity in the provision of health care items, services, or prescription drugs, regardless of whether remedial action is requested or can be taken. A grievance does not include, and is distinct from, a dispute of the appeal of an organization determination or coverage determination or an LEP determination.

In addition, grievances may include complaints regarding the timeliness, appropriateness, access to, and/or setting of a provided health service, procedure or item. Grievance issues may also include complaints that a covered health service procedure or item during a course of treatment did not meet accepted standards for delivery of health care.

## Grievance Procedure

Per regulatory guidelines, Tufts Health Plan has established a forum for members or authorized representatives to express concerns regarding their experiences with health care providers. The member grievance procedure, allows for the documentation and review of member complaints, as follows:

1. Upon receipt of a verbal or written complaint, the grievance specialist/intake coordinator acknowledges either verbally or in writing that the complaint was received and will be reviewed within 30 calendar days (or within 24 hours if the grievance is expedited). All grievances pertaining to clinical care and/or services issues are reviewed within the Quality Management (QM) Department. All grievances pertaining to provider billing, along with operations and activities of Tufts Health Plan are reviewed within the Appeals and Grievances or QM departments. The QM and Appeals and Grievances departments can accept any information or evidence concerning the grievance orally or in writing.
2. In most instances, providers or their office managers (depending on the specific situation) are notified either verbally or in writing about the complaint and asked for input.
3. If the complaint pertains to a quality of care issue (clinical grievance), the QM RN Specialist evaluates the information. The clinical grievance is assigned a severity and preventability rating related to the issue or concern. The provider is notified of the results of the quality review. All grievances and their respective ratings are entered into our secured quality database for tracking and trending purposes. This data becomes part of the provider's credentialing file and is reviewed periodically.

It is the member's responsibility to notify Tufts Health Plan of concerns about their health care services. It is the responsibility of all network providers to participate in our grievance review process.

Providers are expected to respond to a request for information within five business days, as it is standard for providers to respond to the plan's request for information in investigating member grievances. This turnaround time is required to ensure that the plan meets its regulatory and accreditation requirements to the member and remains compliant with all state and federal requirements.

## FINANCIAL PROGRAMS

### Risk Adjustment

Under a Medicare Advantage contract, Tufts Health Plan receives revenue from CMS each month. This payment to Tufts Health Plan, as a contractor, constitutes federal funds and therefore subjects Tufts Health Plan and its participating providers to applicable laws.

The CMS payment amount is based solely upon a risk adjustment methodology used to adjust payments based on the care required to treat a condition. Each year, a member is given a risk score based on their historical diseases and demographic characteristics that impact their costs/payments for that year. Documentation for conditions must be submitted to CMS annually, particularly documentation for chronic conditions. The risk score may also be adjusted from year to year to reflect changes to the risk score model as determined by CMS.

The risk adjustment model is a lagged model, meaning that current year revenue is based on the previous year's risk scores. The Tufts Health Plan Risk Adjustment Department oversees multiple programs aimed at capturing a more accurate depiction of a member's risk score. These include but are not limited to chart reviews, comprehensive health assessments, and prospective assessment forms, and other point of care coding improvement campaigns. Administrative costs incurred and additional revenue realized from these programs are shared with participating groups based on their contract arrangements.

### Reimbursement

#### Hospital Service Fund (HSF)

Through a contractual arrangement with CMS, an HSF is established for each medical group. Each month, a percentage of the PMPM amount received from CMS is credited to the HSF for a member who has selected a PCP from that medical group. The HSF is included in a [Summary of Fund](#) Services table. This summary is not all-inclusive.

#### PCP Payments

A specified per member per month (PMPM) payment may be paid to the medical group based on the number of Tufts Medicare Preferred HMO members who have selected providers participating through the medical group as their PCPs. The predetermined PMPM amount is paid to the medical group for certain services that the medical group PCPs provide directly to its Tufts Medicare Preferred HMO members. This type of payment arrangement, i.e., capitation, is made to the medical group monthly.

The balance of the medical services fund is held by Tufts Health Plan to pay specialty and other services for which the medical group is financially responsible. Tufts Health Plan is responsible for general program administration and management.

#### Specialists

Tufts Health Plan makes payments to specialists and other providers. The amount paid is debited against the medical group's medical services fund. Tufts Health Plan administers payment amounts and methodologies, such as fee for service and capitation, according to the specialist's contract. Noncontracting providers are paid according to Medicare regulations.

#### Out-of-Area Services

Tufts Medicare Preferred HMO's out-of-area benefit covers urgent and emergent events occurring when a member is 30 miles or more from their home hospital (as identified by their PCP selection). A Tufts Medicare Preferred HMO Care Manager manages out-of-area services for both internally and externally managed groups. When a group or PCP (rather than Tufts Health Plan) authorizes out-of-area care in advance of the service or at time of service, the care is the responsibility of the medical group. For additional information, refer to the [Referrals, Authorizations and Notifications](#) chapter.

## Medical Group Financial Responsibility

Any out-of-area services prospectively authorized by the medical group are the medical group's financial responsibility.

Tufts Health Plan sends a weekly referral report to medical groups regarding claims for members in their group. This report includes claims for which Tufts Health Plan has not received a referral and provides the PCP an opportunity to authorize or deny payment of billed services. If the report is returned authorizing any service, claims for the service will be paid from the medical group's fund. If the report is not reviewed, the claims will be paid from the medical groups' fund per CMS regulations.

Medicare Advantage regulation requires that Medicare Advantage plans pay for medically necessary dialysis services from any qualified provider chosen by a member when the member is temporarily outside the plan's service area. Furthermore, Medicare Advantage regulation states that Medicare Advantage plans cannot require prior authorization or advance notification for dialysis services as a condition of coverage when a member is temporarily outside the service area.

Because chronic renal dialysis is considered anticipated, regularly scheduled care and the payment of out-of-area routine care for chronic dialysis is the responsibility of the medical group.

## Services Received under Contracts

Tufts Medicare Preferred HMO is a Medicare Advantage plan, as such, Tufts Health Plan may not compensate, directly or indirectly, for services furnished to a Medicare enrollee by a provider or other health care practitioner who has filed with the local Medicare carrier an affidavit promising to furnish Medicare-covered services to Medicare beneficiaries only through private contracts.

## Pharmacy Services

All Medicare beneficiaries are eligible to enroll in the Medicare Part D prescription drug plan. Tufts Medicare Preferred HMO members may voluntarily choose an option without pharmacy coverage or with pharmacy coverage. Monthly pharmacy premiums vary by plan design.

## Stop Loss Reinsurance

### Medical

Medical stop-loss is a reinsurance program that may be purchased by the medical group from Tufts Health Plan in conjunction with hospital stop-loss and aggregate stop-loss to cover the costs of medical services that exceed a specified cost-sharing amount per member per calendar year. Under this program, a certain percentage of the cost in excess of the cost-sharing amount is credited back to the MSF at the time of settlement of the fund.

### Hospital

Hospital stop-loss is a reinsurance program that may be purchased by the medical group from Tufts Health Plan in conjunction with medical stop-loss. The hospital stop-loss covers the costs of hospital services that exceed a specified cost-sharing amount per member per calendar year. Under this program, a certain percentage of the cost in excess of the cost-sharing amount is credited back to the hospital service fund (HSF) at the time of settlement of the fund.

### Aggregate

Aggregate stop-loss is a reinsurance program made available by Tufts Health Plan in conjunction with medical stop-loss and hospital stop-loss. The aggregate stop-loss provides additional protection to the medical group and its providers against the medical group's share of any deficit in the MSF and HSF.

## Reinsurance Coverage

Tufts Health Plan may adjust stop-loss limits and coverage, aggregate or individual, or require the medical group to adjust its own stop-loss and coverage, applicable to services provided to Tufts Medicare Preferred HMO

members to comply with state or federal law or regulations or contractual obligations imposed by government entities.

Applicable coverage limits (aggregate or individual) and capitation adjustments are determined by Tufts Health Plan based on information disclosed to Tufts Health Plan by its participating providers. In certain circumstances, upon approval in advance from Tufts Health Plan, the medical group may purchase reinsurance from an outside vendor as an alternative to the stop-loss coverage offered by Tufts Health Plan.

All risk arrangements with providers must meet applicable federal regulations regarding placing providers at substantial financial risk. This may be accomplished by participation in Tufts Health Plan’s reinsurance program or by purchase of reinsurance from an outside vendor. Any reinsurance purchased from an outside vendor must meet Tufts Health Plan’s requirements in effect from time to time, including compliance with all state and federal regulations.

A summary of the services covered in each fund is listed in the following table. This summary is intended to be illustrative and is not all-inclusive. Refer to the provider’s contract with Tufts Health Plan for specific services related to your arrangement.

### Summary of Fund Services

<b>Hospital Services Fund (including ancillary services)</b>
<ul style="list-style-type: none"> <li>• Inpatient hospital care, including behavioral health/substance use disorder (BH/SUD) day treatment</li> <li>• Skilled nursing facilities (SNFs)</li> <li>• Hospital-based provider services</li> <li>• Ambulance transportation</li> <li>• In-area emergency department (ED)</li> <li>• Home health care</li> <li>• Ambulatory surgery, including hospital/surgical</li> <li>• Dialysis for end-stage renal disease (ESRD)</li> <li>• Other services including, but not limited to surgical devices, chemotherapy, drugs and radiation therapy</li> </ul>
<b>Medical Services Fund (MSF)</b>
<ul style="list-style-type: none"> <li>• In-area inpatient and outpatient provider services</li> <li>• Out-of-area provider services if authorized by the group</li> <li>• Outpatient pathology, radiology and diagnostics, including preventive screening</li> <li>• Outpatient BH/SUD</li> <li>• Outpatient speech, physical and occupational therapies</li> <li>• Durable medical equipment (DME)</li> <li>• Health education and preventive services. Tufts Medicare Preferred HMO must provide coverage to a member for renal dialysis services provided by noncontracting providers while the member is temporarily outside the service area</li> </ul>
<b>Health Plan Fund</b>
<ul style="list-style-type: none"> <li>• All nonelective (primary care and specialty) out-of-area services not authorized by the group</li> <li>• Vision, fitness, wellness, and weight-loss programs</li> <li>• Marketing and customer service</li> <li>• Provider group support programs</li> </ul>

## Settlement of Funds

### Medical Services

The MSF is settled according to contract terms to determine the relationship between credits and expenses. The MSF capitation credit, inclusive of any applicable coordination of benefits and subrogation and any credits relating to the MSF reinsurance coverage, will be compared to the MSF expenses, inclusive of estimated incurred but not yet reported claims.

If the MSF capitation credit exceeds the MSF expenses, the surplus is paid to the medical group. If the MSF



expenses exceed the MSF capitation credit, the medical group will be invoiced for the deficit. Future month's capitation payments to the medical group may be adjusted to balance an actual or projected deficit.

### Hospital Services

The HSF is periodically settled according to the contract terms to determine the relationship between credits and expenses. The HSF capitation credit, inclusive of any applicable coordination of benefits and subrogation and any credits relating to the HSF reinsurance coverage, will be compared to the HSF expenses, inclusive of the value of the services rendered and estimated incurred but not yet reported claims.

If the HSF capitation credit exceeds the HSF expenses, the surplus is paid to the hospital. If the HSF expenses exceed the HSF capitation credit, the hospital will be invoiced for the deficit. The medical group shares financial risk with the hospital for any deficit or surplus as defined in the group contract. The medical group's share of the hospital surplus or deficit is combined with the settlement of the medical group's MSF.

### Pharmacy

Part D requires Medicare Advantage plans to share risk directly with CMS. The medical group is not at risk.

## Special Member Status

### Hospice Election

Members certified as terminally ill by their PCP or attending provider may elect the hospice benefit. The hospice obtains a copy of the certification and the beneficiary-election document from Medicare directly. The beneficiary election document identifies the effective date and the beneficiary's acknowledgment that certain services are waived, such as the right to therapeutic services in favor of palliative care.

Once a Tufts Medicare Preferred HMO member has elected the hospice benefit, CMS pays Tufts Health Plan a reduced capitation for each Tufts Medicare Preferred HMO member. This reduced capitation is allocated for supplemental benefits (such as routine vision) that Tufts Health Plan offers to each Tufts Medicare Preferred HMO member. A copy of the beneficiary election document should be obtained for Tufts Medicare Preferred HMO records if possible.

For further information about hospice election, refer to the [Hospice Payment Policy](#) and the [Medicare Managed Care Manual](#), Chapter 2 - Medicare + Choice Enrollment and Disenrollment, Section 20.7, Eligibility and the Hospice Benefit.

#### **Note:**

- Members who have elected hospice may revoke hospice election at any time, but claims will continue to be paid by fee-for-service contractors (carrier/fiscal intermediary), as if the beneficiary were a fee-for-service beneficiary, until the first day of the month following the month in which hospice was revoked.
- Therefore, providers need to bill the carrier/fiscal intermediary, and Tufts Health Plan will pay the cost-sharing amount not paid by the carrier/fiscal intermediary.
- Tufts Medicare Preferred HMO remains responsible for providing its members who have elected hospice with the following benefits:
  - All cost-sharing amounts for Medicare-covered services that are not related to the patient's hospice status
  - Any nonhospice services that are not Medicare-covered but are supplemental benefits provided under the plan

### **Hospice Billing Guidelines**

Billing guidelines for hospice members is included in the following sections of the Medicare Managed Care Manual:

- Chapter 7: [Risk Adjustment](#)
- Chapter 9, Section 20.2: [Election, Revocation, and Discharge](#)

## Additional Benefits Billing Guidelines

Tufts Medicare Preferred HMO covers additional benefits that are not covered by Medicare. These are referred to as supplemental benefits. The provider must bill Tufts Health Plan directly for any Tufts Medicare Preferred HMO covered services which Medicare does not cover and which are not related to terminal illness. Tufts Health Plan will make payment directly to the provider of services.

## End-Stage Renal Disease

Tufts Health Plan and a capitated medical group receive additional capitation from CMS for reported ESRD members.

The attending provider at the dialysis center completes the [ESRD Medical Evidence Report Medicare Entitlement and/or Patient Registration](#). The dialysis center sends this form to the Social Security District Office and to the ESRD network.

The medical group must obtain a completed ESRD form from the center providing dialysis treatment and forward a copy to Tufts Health Plan. The additional capitation for ESRD is not paid without verification from CMS.

Tufts Health Plan must provide coverage to a Tufts Medicare Preferred HMO member for renal dialysis services provided by noncontracting providers while the member is temporarily outside Tufts Health Plan's service area. Additional capitation may not be applied to the medical group without appropriate reporting to Tufts Health Plan.

## General Guidance on Dual Eligibility

"Dual eligible" are persons who are entitled to Medicare (Part A and/or Part B) and who are also eligible for Medicaid.

There are several categories of dual eligibility, each having specific income requirements and providing different levels of financial assistance to those who qualify at that level.

To view these categories and additional information about dual eligibility, see the following:

- Medicare Managed Care Manual, Chapter 3: [Medicare Marketing Guidelines](#)
- [Medicaid: Dual Eligibles](#)

## **Member Benefit Coverage**

Tufts Medicare Preferred HMO dual-eligible members continue to be entitled to all Tufts Medicare Preferred HMO and MassHealth benefits, and their Medicare coverage will remain the same. However, all MassHealth benefits will be provided within the fee-for-service sector.

According to federal regulation, the providers who receive the additional monies must waive all office visit cost-sharing amounts for the Division of Medical Assistance (DMA)-approved dual-eligible members. Members will not be responsible for cost-sharing amounts for most services and will continue to receive their prescription drug coverage from MassHealth. Whenever they receive covered services, members must present both their MassHealth and Tufts Medicare Preferred HMO ID cards to all health care providers.

## Provider Reimbursement

Tufts Health Plan will continue to reimburse providers minus the cost-sharing amount for all Tufts Medicare Preferred HMO covered services. To obtain payment for the cost-sharing amount and services, providers must submit the appropriate invoice to MassHealth, DMA's claims-processing contractor. The DMA has compiled a manual that details the billing procedures for MassHealth providers.

To be eligible for payment from MassHealth for services provided to the dual-eligible population, in addition to being a Medicare provider, you must also be a MassHealth or Qualified Medicare Beneficiary (QMB)-only provider. To become a MassHealth provider, the provider must contact the MassHealth Provider Enrollment and Credentialing department at [providersupport@mahealth.net](mailto:providersupport@mahealth.net) or 800.841.2900.

When submitting an invoice for reimbursement for MassHealth-covered medical and provider services, the provider must attach a copy of their Tufts Medicare Preferred HMO explanation of payment (EOP). To receive training or to set up an individual consultation concerning questions about billing from MassHealth services, providers can contact MassHealth at 800.841.2900.

## PCP Capitation Report

Tufts Health Plan provides a PCP capitation report that provides member capitation listings for a designated PCP. The report includes the following information:

- Names, addresses, and identification numbers for vendors, PCPs and members
- 100 percent CMS blended payment
- MSF budget cap
- MSF cash cap

## MEDICAL MANAGEMENT

### Medical Management Program

The goal of the medical management program is to monitor and manage the delivery of health care services to ensure that all services meet Centers for Medicare and Medicaid Services (CMS) and/or MassHealth Standard (Medicaid) coverage criteria, as applicable. The Tufts Medicare Preferred HMO or Tufts Health Plan SCO care manager is an integral part of the Tufts Health Plan medical management program. Physicians and other providers are responsible for:

- Sharing clinical information (including, but not limited to, discharge summaries, test results and medication records) in a timely manner to facilitate coordination and continuity of care
- Abiding by plan inpatient notification policies providing timely notification of acute inpatient and skilled nursing facility (SNF) admissions
- Collaborating with the Tufts Medicare Preferred HMO or Tufts Health Plan SCO care manager to coordinate and oversee the delivery of each member's medical services
- Responding promptly to quality of care concerns raised either concurrently or retrospectively
- Participating fully with the primary care team (PCT) and Tufts Health Plan SCO care manager to share clinical information concerning members under their care (for Tufts Health Plan SCO members)
- Collaborating with the Tufts Health Plan SCO care manager to review, approve, and help manage the individualized plan of care (IPC) for Tufts Health Plan SCO members

The medical management program's scope encompasses all health care delivery activities across the continuum of care, including inpatient admissions to hospitals, acute rehabilitation facilities and SNF, home care services, outpatient care and office visits.

### Tufts Medicare Preferred HMO Medical Management

For Tufts Medicare Preferred HMO, the medical group and their associated health care team facilitate the medical management of members assigned to their group. Each medical group is responsible for developing their individual group's medical management program.

#### Roles and Responsibilities

##### **Health Care Team**

The health care team consists of a group of health care professionals including:

- The group's medical director
- Primary care providers (PCPs) and their office staff
- All other providers associated with the medical group, including specialists, preferred SNF and home health care providers
- The Tufts Medicare Preferred HMO Care Manager

##### **Care Management**

Tufts Medicare Preferred HMO care managers may be internally or externally managed (i.e., by the PCP's medical group); Tufts Health Plan SCO care managers are internally managed. The care manager collaborates with the medical group to provide a standardized, integrated care management experience.

The Tufts Medicare Preferred HMO care manager works with the PCP/attending provider/Tufts Health Plan medical director to coordinate and oversee the delivery of a member's medical services, following the Case Management Society of America's [Standards of Practice for Case Management](#).

For more information on how Tufts Health Plan works with medical groups, refer to the Tufts Medicare Preferred HMO [Care Management Resource Guide](#).

### Medical Management Program Activities

The medical group organizes and conducts ongoing medical management meetings, and the care manager is an integral part of these meetings. The care manager and medical management team are instructed to consult

Medicare coverage guidelines as well as the member's evidence of coverage (EOC) when determining coverage of benefits, and MassHealth coverage guidelines (where appropriate) for SCO members.

The care manager, in collaboration with the health care team, ensures that the member receives appropriate care and services in a timely, cost-effective manner by conducting concurrent and retrospective review for the following services:

- Acute inpatient hospitalization, utilizing InterQual® criteria
- Acute inpatient rehabilitation
- Extended care and skilled nursing services
- Home care services
- Hospice care
- Community-based services

### Medical Management Meetings

Medical management meetings are held weekly as a means for the medical group and care managers to regularly discuss member care, with the goal being ongoing communication between the group medical director, PCP and care manager to provide updates and discuss individual issues. In addition, the group medical director is responsible for communicating with PCPs as necessary.

Committee members include the medical group's medical director, PCPs, as well as office staff and Tufts Health Plan care managers. Other attendees may include hospitalists, SNF rounders (physicians/nurse practitioners) and other Tufts Health Plan staff, as appropriate.

Medical Management meetings intend to:

- Develop concurrent plans of care that use a team approach to manage specific high-risk members
- Identify obstacles to effective care and developing mitigation strategies
- Provide clinical input for individual member-centric plan of care
- Improve process and outcome of care
- Monitor group performance
- Identify opportunities for improvement
- Develop strategies to work with preferred SNFs and homecare agencies
- Provide information regarding regulatory changes, provider updates, and topics from Tufts Health Plan Medical Directors meetings
- Integrate quality metrics, monitoring and reporting

### Utilization Review

Federal and state regulatory agencies and accrediting bodies establish regulations and standards that govern utilization management (UM) functions. When utilization review is conducted, the decision time frame and notifications must adhere to the requirements outlined in the [Utilization Review Determination Time Frames](#) for Senior Products members.

This resource for staff engaged in the UM decision-making process outlines the required time frame for rendering coverage decisions and providing verbal and written notifications to the member and provider. Tufts Health Plan UM policies and plan documents assist the care manager, physicians and other providers in planning and managing care with efficiency and high quality standards.

The process for conducting initial utilization review determinations for requests for coverage applies to all individuals performing utilization review. This process will be followed when reviewing prospective, concurrent and retrospective coverage of inpatient and outpatient services. All initial utilization review should be conducted on a case-by-case basis.

### Urgent and Emergency Care

Although prior authorization is not required, both inpatient and outpatient urgent or emergency care involves coordination by the PCP/medical group/care manager. Emergencies and urgent care that occur out of the service area should be reported to the Clinical Nurse Liaison (CNL) or care manager.

## Urgent Care

“Urgently needed services” are nonemergency but unforeseen medical illnesses, injuries or conditions that require immediate medical care. Urgently needed services may be provided by network providers, or by out-of-network providers when network providers are temporarily unavailable or inaccessible (e.g., if the member is temporarily outside of the plan’s service area).

### ***Urgent Care inside the Service Area***

Members should try to obtain urgently needed care from their PCP or specialists within their network when in the Tufts Medicare Preferred HMO or Tufts Health Plan SCO service area. If a member believes they require urgently needed care, they should first contact their PCP. Hearing or speech-impaired members with TTY/TDD do machines may also call the Massachusetts Relay Service at 800.439.0183 (TTY/TDD 800.439.2370) for assistance contacting their PCP after hours.

In the event that providers are temporarily unavailable and it is not reasonable for the member to wait until the provider becomes available, Tufts Health Plan will provide coverage for the member to obtain urgently needed care from providers who are outside the member’s network.

### ***Urgent Care Outside of the Service Area***

Authorization is not required for urgently needed care outside the Tufts Medicare Preferred HMO or Tufts Health Plan SCO service area. If the member is treated for an urgent care condition while out of the service area, Tufts Health Plan prefers that they return to the service area to receive follow-up care through their PCP. However, Tufts Health Plan will cover follow-up care provided from out-of-network providers outside the Tufts Medicare Preferred HMO or Tufts Health Plan SCO service area as long as the care the member is getting still meets the definition of “urgently needed care.”

Urgently needed care may be rendered in any Medicare-certified (or Medicaid-certified if services are rendered to Tufts Health Plan SCO members) clinical setting (e.g., a provider’s office or outpatient clinic). Tufts Health Plan will refer members to their PCPs if they call requesting clinical guidance prior to receiving urgent or nonurgent out-of-area care.

Urgent care that occurs outside the service area should be reported to the Clinical Nurse Liaison (CNL) or care manager, who will follow urgent cases that occur outside the service area (i.e., the 30-mile radius from the PCP’s home hospital<sup>3</sup>) while the member remains inpatient and when receiving follow-up care services within 14 calendar days of an urgent/emergent episode. Members who call with questions regarding follow-up care more than two weeks after receiving urgent care will be referred back to their PCP.

## Emergency Services

Emergency care that occurs outside the service area should be reported to the Clinical Nurse Liaison (CNL) or care manager, who will follow all emergency cases that occur outside the service area within the first two weeks of the member receiving emergent or urgent out of area care. Refer to the [Emergency Services](#) payment policies in the Provider Resource Center for more information.

## Poststabilization Care

Poststabilization services are covered services that are related to an emergency medical condition and that are provided after a member is stabilized, and provided either to maintain the stabilized condition, or under certain circumstances, to improve or resolve the member’s condition. Tufts Health Plan must cover poststabilization care services in accordance with Chapter 4, Section 20.5 of the [Medicare Managed Care Manual](#).

## InterQual Criteria

InterQual criteria are applied to all medical and surgical acute inpatient admissions and subsequent inpatient days. The criteria may be applied to assist in determining the most appropriate level of care for Tufts Medicare Preferred HMO and Tufts Health Plan SCO members.

These criteria are based on the use of the severity of illness and/or the intensity of service being provided. In

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<sup>3</sup> Some medical groups may have an alternative arrangement.

general, the severity of illness criteria are used for the day of admission and the intensity of service criteria are applied to continued stay days. However, both sets of criteria are flexible and can be used at any point during an acute stay.

InterQual criteria are used to facilitate communication with the provider about a member's health status for the coordination of care. These criteria do **not** replace Medicare or Medicaid coverage guidelines. Where available, Medicare and or Medicaid coverage guidelines must be used when making coverage determinations. InterQual criteria are also used for medical necessity determinations.

## Coverage Resources

Tufts Health Plan provides coverage for all services and items covered by Original Medicare for Tufts Medicare Preferred HMO members; additional coverage for all services and items covered by Masshealth Standard is provided to Tufts Health Plan SCO members. When making coverage determinations for services, providers should refer to the applicable CMS and/or EOHHS coverage guidelines.

There are additional services covered for members that are not covered under traditional Medicare and/or Medicaid. To determine which services/items are covered as supplemental benefits, providers should also refer to the most current version of the member's Summary of Benefits and Evidence of Coverage.

### Medicare Coverage Guidelines

At a minimum, Tufts Health Plan provides coverage for all services and items covered by Medicare.

Tufts Health Plan uses Local Coverage Determinations (LCDs), National Coverage Determinations (NCDs), and Medicare interpretive manuals (e.g., the Medicare Benefit Policy Manual) to make coverage determinations for Tufts Health Plan members.

Tufts Health Plan medical necessity guidelines do not replace Medicare coverage guidelines, unless specifically indicated by Tufts Health Plan, and are not to be used by providers when making coverage determinations, except for services that are covered by Tufts Medicare Preferred HMO as a supplemental benefit. If the benefit is not a Medicare benefit or a Medicare-approved supplemental benefit, the [MassHealth Guidelines for Medical Necessity Determinations](#) should be followed.

### **Local Coverage Determinations (LCDs)**

An LCD is a decision issued by a carrier or fiscal intermediary to cover (or not cover) a particular service on an intermediary-wide or carrier-wide basis.

#### **Note:**

- LCDs cannot restrict or conflict with NCDs or coverage provisions in interpretive manuals
- LCDs are binding on Medicare Advantage Organizations (MAOs)
- LCDs are accessible through the [Medicare Coverage Database](#)

Providers must adhere to the LCDs associated with the following contractors that have jurisdiction in Massachusetts:

- Durable Medical Equipment (DME MAC): NHIC as of 7/1/06; [DME MAC LCDs](#)
- Part B carrier: [National Government Services](#)
- Part A fiscal intermediary: jurisdiction is dictated by which contractor the hospital bills for fee-for-service

### **National Coverage Determinations (NCDs)**

National Coverage Determinations (NCDs) are developed by CMS to describe the circumstances for Medicare coverage nationwide for a specific medical service, procedure or device. NCDs are binding on all Medicare Advantage plans as well as other Medicare contractors (such as carriers and fiscal intermediaries).

NCDs are contained in the Medicare [NCD Manual](#), which is updated via [NCD Transmittals](#). NCDs are also accessible through the [Medicare Coverage Database](#).

### **Interpretive Manuals**

Coverage provisions in interpretive manuals are instructions that are used to further define when and under which circumstances services may be covered (or not covered). Coverage information may be found in the

following [CMS](#) interpretive manuals:

- [Medicare Benefit Policy Manual](#)
- [Medicare Claims Processing Manual](#)
- [Medicare Program Integrity Manual](#)
- [Medicare Managed Care Manual](#)

### ***Case-by-Case Review***

If there is no national policy or the national policy is purposefully vague and the applicable contractor does not have an LCD, providers or Tufts Health Plan staff should review the case on an individual case basis using Medicare's existing national guidance and any other LCDs in Massachusetts, if available. If there are no other LCDs in Massachusetts, contact the Medical Policy Department, who will contact the applicable contractor for input.

### [MassHealth Guidelines for Medical Necessity Determinations for Tufts Health Plan SCO Members](#)

The MassHealth Guidelines for Medical Necessity Determination contains clinical information recommended by MassHealth to determine medical necessity for certain products and services that require prior authorization. MassHealth developed these guidelines and the associated forms using an ongoing process that includes a rigorous review of the most current evidence-based literature and input from clinical and program staff, as well as frequent input from external clinical experts.

Tufts Health Plan SCO uses these guidelines to clarify specific medical information that MassHealth requires to determine medical necessity. The Tufts Health Plan SCO care manager works with the PCP to recommend services that are covered under these guidelines.



## QUALITY ADMINISTRATIVE GUIDELINES

### Quality Improvement Program

Tufts Health Plan's Corporate Quality Improvement (QI) Program addresses the quality of care in all settings in which care is delivered to members. This program has five primary components:

- Ongoing monitoring and evaluation
- Continuous quality improvement
- Customer satisfaction
- Practitioner/provider credentialing
- Utilization management

The goals of the program are to:

- Continuously improve the quality of clinical care and service that members receive from participating health care providers who are contracting with Tufts Health Plan
- Increase member satisfaction
- Improve the quality of service that providers receive from Tufts Health Plan
- Increase provider satisfaction
- Improve the health of identified segments of the member community

A Board of Directors has overall responsibility for the QI program. A Care Management Committee (CMC) is responsible for overseeing the implementation of the QI program (including the annual QI Work Plan) and for determining that funding is adequate to support program activities and goals. An annual summary of the QI work plan may be found [here](#).

Specific positions, committees and organizational units play a significant role in QM activities, including:

- Quality Management Committee (QMC)
- Quality of Care Committee (QOCC)
- Quality Performance Improvement Team (QPIT)
- QI work groups
- QI project teams (providers offer input into the QM program by participating in committees such as QOCC and MSPAC)

### Medical Care Access Goals for Primary Care

Access to medical care is a key component of health care quality. Members must have access to their providers, although in a life-threatening situation members are expected to obtain care at the nearest medical facility.

Tufts Health Plan recognizes the diversity with which providers handle member calls, arrange urgent care, and schedule routine care. Tufts Health Plan expects that members will be heard and their medical needs met in a manner that is reasonable and provides quality medical care.

Emergencies and episodic increases in the demand for services at times may overwhelm the ability of an individual office to meet the expectations for medical care access. However, in the normal course of providing medical care, provider offices should regularly meet these expectations. Tufts Health Plan has developed medical care access goals that all provider offices are expected to adopt and review with their office staff. The goals include suggestions for PCPs to provide better service to their patients. Many providers may have already included these suggestions in their telephone triage system.

Members may periodically contact Tufts Health Plan regarding concerns about office waiting times, appointment availability, and similar issues. Tufts Health Plan uses these guidelines to determine whether member concerns are reasonable and provides feedback to the members and providers, as necessary.

All medical care access goals are evaluated at least annually by Tufts Health Plan and revised, as necessary, based on the results of access surveys and provider input. Provider office hours for Tufts Health Plan SCO members should be in parity with office hours for Commercial and Medicaid fee-for-service members.

### Office Visit Appointments

- Emergency care: Appointments are scheduled on the same day with an available clinician

- Urgent care: Appointments are scheduled within 24 hours with an available clinician; if the office has more urgent cases than it can handle, the staff arranges for urgent care at another site
  - Nonurgent symptomatic care: Appointments are scheduled within 48 hours with an available clinician for nonurgent episodic illness
  - Preventive care: For history and physical checkups with no acute illness, the practitioner or other appropriately licensed clinician sees the member within 30 calendar days from the date of the request
- Note:** Members are covered for one routine physical exam per year

## 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.

## Credentialing Site Visit Requirements

Provider site visits may be conducted for any of the following reasons:

- When more than one complaint/grievance is received about a provider's office regarding physical accessibility, physical appearance or the adequacy of waiting and examining room space within six months
- Member satisfaction results indicate an office site may not meet Tufts Health Plan standards
- employee reports, other concerning data and information is received from a member or provider indicating a site may not meet Tufts Health Plan standards
- Other data is required for quality improvement purposes and cannot be reasonably collected using alternative methods
- Other circumstances, as deemed necessary

Tufts Health Plan personnel or a designated representative with the appropriate training will perform the site visit within two weeks of Tufts Health Plan's determination that a site visit is warranted.

Of the 32 components, at least 28 must be present to obtain a passing score (85%). Select components may be considered not applicable for some types of offices.

Site visits resulting in deficiencies requiring corrective action will require the practitioner to submit a corrective

action plan within 30 days to the Quality Management (QM) Department. All sites receiving a failing score will be subject to a follow-up site visit within six months of the visit.

If the site still does not receive a passing score or does not demonstrate adequate improvements in the deficient areas from the previous visit, the results will be documented and the site will continue to be visited every six months until the deficiencies are remedied, or the site receives a passing score, or if it is determined that further action is required by Tufts Health Plan.

Tufts Health Plan participating providers must comply with Tufts Health Plan medical policies, the Quality Administrative program, and medical management programs that are developed in consultation with participating providers.

Practice guidelines and utilization management guidelines:

- Are based on reasonable medical evidence or a consensus of health care professionals in a particular field
- Consider the needs of the enrolled population
- Are developed in consultation with contracting health professionals
- Are reviewed and updated periodically
- The guidelines are communicated to providers and, as appropriate, to members.
- Decisions with respect to utilization management, member education, coverage of services, and other areas in which the guidelines apply are consistent with the guidelines.

For additional information, refer to the sample credentialing site visit checklist:

Provider name: _____ Address: _____ Telephone: _____ THP ID: _____ Date and time of site visit: _____	Provider unit: _____ Other providers at same site (attach additional sheet if necessary): _____ Office contact: _____
<b>Physical accessibility</b> Handicapped accessible with signage      Y <input type="checkbox"/> N <input type="checkbox"/> Ramp from parking into building            Y <input type="checkbox"/> N <input type="checkbox"/> Elevator (if office is not on 1 <sup>st</sup> floor)      Y <input type="checkbox"/> N <input type="checkbox"/> Doorknobs are pull-down                      Y <input type="checkbox"/> N <input type="checkbox"/> Doorways are at least 3.5 feet wide        Y <input type="checkbox"/> N <input type="checkbox"/> At least one bathroom has adequate space for a wheelchair or assistant      Y <input type="checkbox"/> N <input type="checkbox"/> Entrance is safely accessible (e.g., free of snow and ice)      Y <input type="checkbox"/> N <input type="checkbox"/> Stairs have handrails                          Y <input type="checkbox"/> N <input type="checkbox"/> At least one examining room has adequate space for a wheelchair      Y <input type="checkbox"/> N <input type="checkbox"/>	<b>Physical appearance</b> Visual cleanliness                              Y <input type="checkbox"/> N <input type="checkbox"/> Adequate lighting                                Y <input type="checkbox"/> N <input type="checkbox"/> Free of odor                                        Y <input type="checkbox"/> N <input type="checkbox"/> Refuse disposal available                      Y <input type="checkbox"/> N <input type="checkbox"/> Office hours posted                              Y <input type="checkbox"/> N <input type="checkbox"/> Exit signs readily visible                      Y <input type="checkbox"/> N <input type="checkbox"/> Policies/procedures for patient confidentiality available      Y <input type="checkbox"/> N <input type="checkbox"/> Adequate seating                                Y <input type="checkbox"/> N <input type="checkbox"/> Smoke detectors present                      Y <input type="checkbox"/> N <input type="checkbox"/>
<b>Adequacy of medical/treatment record keeping</b> Staff has immediate access to key health information/data (e.g., diagnoses, allergies, test results, treatments, medications)      Y <input type="checkbox"/> N <input type="checkbox"/> Office has a scheduling system(s) for booking appointments and record keeping is orderly      Y <input type="checkbox"/> N <input type="checkbox"/> Office utilizes a reminder system(s) to prompt and alert the staff to ensure regular screenings and preventative practices      Y <input type="checkbox"/> N <input type="checkbox"/> File area locked when unattended            Y <input type="checkbox"/> N <input type="checkbox"/> Legible file markers                              Y <input type="checkbox"/> N <input type="checkbox"/> Legible documentation                        Y <input type="checkbox"/> N <input type="checkbox"/>	<b>Adequacy of appointments</b> Routine office visit within 1 week of request with an available clinician      Y <input type="checkbox"/> N <input type="checkbox"/> Urgent care within 24 hours with an available clinician      Y <input type="checkbox"/> N <input type="checkbox"/> 24-hour coverage                                Y <input type="checkbox"/> N <input type="checkbox"/>
<b>Adequacy of waiting and examining room space</b> Sharps disposal                                Y <input type="checkbox"/> N <input type="checkbox"/> Biohazard waste disposal                      Y <input type="checkbox"/> N <input type="checkbox"/> Provisions for universal precautions (wearing gloves, masks, hand washing)      Y <input type="checkbox"/> N <input type="checkbox"/> Medications and prescription pads locked/restricted access      Y <input type="checkbox"/> N <input type="checkbox"/> Use of clean linen and/or paper on exam tables      Y <input type="checkbox"/> N <input type="checkbox"/>	<b>Score of 32 = %</b> (Score of 85% or greater is passing)

## Medical Record Maintenance Procedures and Review

Tufts Health Plan requires medical records to be maintained in a manner that is current, detailed, complete, accurate, and organized, and permits effective and confidential patient care and quality review. As a Medicare Advantage Organization, Tufts Health Plan agrees to do the following:

- Maintain records for at least 10 years from the end of the final contract period or completion of audit, whichever is later, unless there is a special need to retain longer
- Provide medical record access to federal entities, such as the Department of Health and Human Services (HHS) and the Comptroller General, which is head of the Government Accountability Office (GAO), or their designees
- The medical record, whether electronic or paper, communicates the member's past medical treatment, past and current health status, and treatment plans for future health care. Well-documented medical records facilitate communication and the coordination and continuity of care while promoting efficiency and effectiveness of treatment.

Tufts Health Plan considers all records to be confidential and requires that all Tufts Health Plan providers 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
- Permit review or removal of medical records only with Member's authorization
- Release medical and behavioral health records, other member health information and other member information regarding Tufts Health Plan members, only in accordance with state and federal laws regarding confidentiality and disclosure

In addition, Tufts Health Plan participates in QM activities as directed by the contracting agency. These activities often involve medical record reviews. Tufts Health Plan requires that providers provide access to medical records when requested as part of QM activities and maintain confidentiality during medical record review.

## Outpatient Behavioral Health/Substance Use Disorder Treatment Access Standards

All contracting inpatient and outpatient behavioral health and substance use disorder providers are expected to meet the standards described below.

### Temporal Access

Emergency care will be made available to all Tufts Health Plan members at any Tufts Health Plan contracting facility with emergency services available. Emergency care must be available 24 hours a day, 7 days a week at each Tufts Health Plan BH/SUD facility.

A member with life-threatening needs must be seen immediately. A member with nonlife-threatening needs must be seen within six hours. Each facility is a licensed hospital with a full-time specific BH/SUD emergency and triage team. Tufts Health Plan also covers emergency BH/SUD care at any licensed facility when medically necessary.

Urgent care must be available within 48 hours of a member's request and may be provided by any Tufts Health Plan behavioral health provider. Nonurgent care must be available within 10 business days of a member's request.

### Geographical Access

Most outpatient BH/SUD care is available within 30 miles of the member's home or workplace. For certain areas of subspecialty care, a greater distance may be required.

## Transplants

Medicare-covered transplants do not require prior authorization from Tufts Health Plan or from the PCP/medical group. Members may be referred for evaluation of appropriateness for transplant by either the PCP, or by a specialist to whom the PCP initially referred the member.

**Note:** The PCP must supply a referral for the transplant center specialist for proper claims adjudication.

Once a member is deemed to be appropriate for a transplant, the inpatient notification process must be performed according to the Tufts Health Plan's timeframe guidelines. Refer to the prior authorization lists for [Tufts Medicare Preferred HMO](#) and [Tufts Health Plan SCO](#) for more information.

All solid organ heart, lung, heart-lung, liver, intestinal, kidney, and pancreas transplants must be performed at a Medicare-approved facility. Tufts Health Plan will not compensate services rendered at a non-Medicare-approved facility. Refer to the Medicare-approved facilities lists for [Tufts Medicare Preferred HMO](#) and [Tufts Health Plan SCO](#) to determine which facilities are Medicare-approved.

For more information regarding transplants, refer to the [Transplant Facility Payment Policy](#).

In addition to the preventive health and disease management programs described above, Tufts Health Plan also works on several other quality initiatives specific to preventable hospital admissions, discharge planning, appropriate nursing facility institutionalization, and identification of abuse/neglect.

## Serious Reportable Events

**Never Events:** Serious reportable events (SREs), serious reportable adverse events (SRAEs), and provider preventable conditions (PPCs)

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The National Quality Forum (NQF) defines serious reportable events (“never events”) as “errors in medical care that are of concern to both the public and health care professionals and providers, clearly identifiable and measurable, and of a nature such that the risk of occurrence is significantly influenced by the policies and procedures of the health care organization.” Tufts Health Plan considers the following types of events as never events:

- **SREs and SRAEs:** Unambiguous, serious, preventable adverse incidents involving death or serious harm to a patient resulting from a lapse or error in a healthcare facility. SREs are developed and endorsed by the NQF. SRAEs are defined by CMS.
- **PPCs:** Conditions that meet the definition of a “health care acquired condition (HCAC)” or a “provider preventable condition (PPC)” as defined by CMS in federal regulations at [42 CFR 447.26\(b\)](#).

### Nonpayment for SREs, SRAEs and PPCs

Tufts Health Plan’s policy and regulatory obligation is to deny or retract payment for services related to care that meets the definition of SREs, SRAEs and/or PPCs once they have been identified. Tufts Health Plan will not compensate providers or permit providers to bill members for services related to the occurrence of a SRE, SRAEs and/or PPCs.

Providers are required to notify Tufts Health Plan of SREs, SRAEs and PPCs that occur when providing services to Tufts Health Plan members.

### Reporting SREs, SRAEs, and PPCs

To report a SRE, SRAEs or PPCs to Tufts Health Plan, providers should fax their report to the QM Department at 617.673.0973.

Tufts Health Plan works directly with the involved provider to review the event, identify opportunities for quality improvement and determine how the nonpayment issue will be resolved.

Reference sources:

- Refer to the [National Quality Forum](#) and to the CMS [Medicare Part C Reporting Requirements](#) for information on reporting SREs and SRAEs
- Refer to the Medicaid [website](#) and the following link for information on reporting Provider Preventable Conditions (PPCs):
  - CMS: [Hospital-Acquired Conditions](#)

Refer to the [SRE, SRAE and PPC Payment Policy](#) for more information.

## UTILIZATION REVIEW DETERMINATION TIME FRAMES

The purpose of this chart is to reference utilization review (UR) determination time frames for organizational determinations (ODs), in accordance with the time frames referenced in [Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance](#).

Organization determinations (ODs) are managed by Tufts Health Plan exclusively. For additional information regarding the OD process, refer to the [Referrals, Authorizations and Notifications](#) chapter.

Written notice of authorization will be sent to members and/or providers upon request. In all instances, Tufts Health Plan strives to conduct utilization review determinations and provide notice of these determinations within a reasonable period of time, appropriate to the medical circumstances.

**Note:** A provider is defined as a health care professional/practitioner, facility or vendor.

**Note:** For the purposes of this document, verbal and written notices to providers and members must occur as expeditiously as the member’s health requires, but no longer than the time frames specified below.

### Review Type: Whether to Expedite a Request for a Determination

Any request for coverage for medical care or treatment with respect to which the member or a provider believes applying standard organization timeframes could seriously jeopardize the member’s life, health or ability to regain maximum function.

<b>Decision Timeframe</b>	A decision must be made within 24 hours whether or not to expedite. Tufts Health Plan must automatically expedite the determination if a provider makes or supports the request. Requests for cases that only involve claims for payment of services the member has already received cannot be expedited.
<b>Extension Rules</b>	N/A
<b>Notice of Authorization Determination</b>	N/A
<b>Notice of Denial Determination</b>	<p>If Tufts Health Plan denies the request for an expedited determination/OD, it must automatically transfer the request to the standard time frame. the member will be given prompt oral notice of the denial, including member rights to appeal and subsequently deliver written notice within 3 calendar days of the notice of denial determination that:</p> <ul style="list-style-type: none"> <li>• Explains that the organization will automatically transfer and process the request using the 14 days standard time frame</li> <li>• Informs the member of the right to file and expedited grievance if they disagree</li> <li>• Provides instructions about the expedited grievance process and its timeframes</li> <li>• Informs the member of the right to resubmit a request for an expedited determination and that if the member gets physician support applying standard organizational time frames could seriously jeopardize the member’s life, health or ability to regain maximum function, the request will automatically be expedited.</li> </ul>

### Review Type: Part B Drug Prospective and Concurrent Expedited (Urgent)

UR performed prior to a course of treatment for a Part B drug in which the application of the time period for making nonurgent determinations could seriously jeopardize the member’s life, health or ability to regain maximum function.

**Note:** This applies to Tufts Medicare Preferred HMO member requests only.

<b>Decision Timeframe</b>	Determination and notification must occur within 24 hours of receipt of the request. This time frame cannot be extended.
<b>Notice of Authorization Determination</b>	Notification must occur within 24 hours of receipt of request. The time and date of notification, name of staff communicating the determination and the name of the person notified must be documented.
<b>Notice of</b>	Notification must occur to the requesting provider within 24 hours of receipt of request.

<b>Denial Determination</b>	The time and date of notification, name of staff communicating the determination and the name of the person notified must be documented.
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### Review Type: Non-Drug Prospective and Concurrent Expedited (Urgent)

UR performed prior to an admission or other course of treatment in which the application of the time period for making nonurgent determinations could seriously jeopardize the member's life, health or ability to regain maximum function.

<b>Decision Timeframe</b>	Determination and notification must occur within 72 hours of receipt of the request. Total time including decision on whether to expedite a request is 72 hours.
<b>Extension Rules</b>	<p>The time frame may be extended up to 14 calendar days if:</p> <ul style="list-style-type: none"> <li>• The enrollee requests the extension; or</li> <li>• The extension is justified, in the enrollee's interest, and additional medical evidence from a non-contracted provider is needed in order to make a decision favorable to the enrollee (i.e., the MA plan should not extend the timeframe to get evidence to deny the coverage request); or</li> <li>• The extension is justified due to extraordinary, exigent or other non-routine circumstances and is in the enrollee's interest</li> </ul> <p>If extended, the enrollee must be notified in writing of the reasons for the delay and inform the enrollee of the right to file an expedited grievance if they disagree with the MA plan's decision to grant an extension.</p>
<b>Notice of Authorization Determination</b>	Verbal notification must occur within 72 hours of receipt of request (or an additional 48 hours if an extension was granted). The time and date of notification, name of staff communicating the determination and the name of the person notified must be documented.
<b>Notice of Denial Determination</b>	Notification must occur to the requesting provider within 72 hours of receipt of request (or an additional 48 hours if an extension was granted). The time and date of notification, name of staff communicating the determination and the name of the person notified must be documented.

### Review Type: Concurrent Expedited (Urgent)

UR that is performed during a hospital stay or other course of treatment in which the application of the time period for making non-urgent determinations could seriously jeopardize the member's life, health or ability to regain maximum function.

<b>Decision Timeframe</b>	Within 24 hours of the receipt of request
<b>Extension Rules</b>	N/A
<b>Notice of Authorization Determination</b>	<p>Verbal notification must occur within 24 hours of receipt of request.</p> <p>The time and date of notification, name of staff communicating the determination and the name of the person notified must be documented.</p> <p>Written notification must be sent to the member and the requesting provider within 24 hours of the receipt of request.</p>
<b>Notice of Denial Determination</b>	<p>Verbal notification to the requesting provider must occur within 24 hours of receipt of request. The time and date of notification, name of staff communicating the determination and the name of the person notified must be documented.</p> <p>Written notification must be sent to the member and the requesting provider no later than 24 hours after receipt of request (or an additional 48 hours if an extension was granted). Simply mailing the letter within the time frame is insufficient.</p>

### Review Type: Part B Drug Standard Prospective and Concurrent (Nonurgent)

Prospective nonurgent is UR that is performed prior to a course of treatment for a Part B Drug. Concurrent



nonurgent is UR that is performed during a hospital stay or other course of treatment.

**Note:** This applies to Tufts Medicare Preferred HMO member requests only.

<b>Decision Timeframe</b>	Determination and notification must be completed as expeditiously as the member's health condition requires, but no later than 72 hours after receipt of request. This time frame cannot be extended.
<b>Notice of Authorization Determination</b>	<ul style="list-style-type: none"> <li>• Verbal notice must occur within 72 hours after receipt of request</li> <li>• The time and date of notification, name of staff communicating the determination and the name of the person notified must be documented.</li> <li>• Written notification must be sent to the member within 72 hours after receipt of request.</li> </ul>
<b>Notice of Denial Determination</b>	<ul style="list-style-type: none"> <li>• Notification must occur to the requesting provider within 72 hours after the receipt of request</li> <li>• The time and date of notification, name of staff communicating the determination and the name of the person notified must be documented.</li> <li>• Written notification must be sent to the member within 72 hours after the receipt of request.</li> </ul>

### Review Type: Non-Part B Drug Standard Prospective and Concurrent (Nonurgent)

Standard prospective UR is performed prior to an admission or other course of treatment. Concurrent nonurgent UR is performed during a hospital stay or other course of treatment.

<b>Decision Timeframe</b>	Determination and notification must be completed as expeditiously as the member's health condition requires, but no later than 14 calendar days after receipt of request.
<b>Extension Rules</b>	The time frame may be extended up to 14 calendar days from the receipt of the request for coverage only in extreme circumstances. The member must then be notified of the extension in writing using a CMS-approved template.
<b>Notice of Authorization Determination</b>	<p>Notification must occur within 14 calendar days after receipt of request (or an additional 14 days if an extension was granted). The time and date of notification, name of staff communicating the determination and the name of the person notified must be documented.</p> <p>Written notification must be sent to the member as expeditiously as required but no later than 14 calendar days after receipt of request (or an additional 14 days if an extension was granted*).</p>
<b>Notice of Denial Determination</b>	Notification must occur within 14 calendar days after receipt of request (or an additional 14 days if an extension was granted). The time and date of notification, name of staff communicating the determination and the name of the person notified must be documented.

\*Only applicable in extreme circumstances.

### Review Type: Retrospective Review

UR of services after they have been provided to the member.

<b>Decision Timeframe</b>	Determination and notification must be made within 30 calendar days of the receipt of request.
<b>Extension Rules</b>	<p>An extension may be granted once for 15 calendar days due to lack of information. If the information received within 30 calendar days is inadequate, a written notice must be sent to the member and provider with the information required to complete the coverage determination, specifying that additional information is needed within 45 calendar days.</p> <p>The time frame for making the determination is suspended from the date of written noticed until the earlier of:</p> <ol style="list-style-type: none"> <li>1. Date response received</li> <li>2. Date established for furnishing requested information</li> </ol> <p>Once the information is received (or the 45 days expire) the review determination must be completed within 15 calendar days.</p>

<b>Notice of Authorization Determination</b>	An optional written notification may be sent to the provider and member within 60 calendar days of the request (or an additional 15 calendar days if an extension was granted).
<b>Notice of Denial Determination</b>	Written notification denials must be sent to the provider and member within 60 calendar days of the request, unless an extension was granted.

## OBSERVATION PROGRAM

Tufts Health Plan's observation program was introduced to ensure that medically necessary care is provided in the most appropriate setting. Utilization experience has shown that inpatient admissions often may be avoided in cases where short-term, intensive outpatient management interrupts the progression of an illness, successfully stabilizes and improves the member's conditions, and permits the member to return home.

Tufts Health Plan does not expect observation services to be used as a replacement for medically appropriate inpatient admissions, as noted in the following CMS definition:

"Observation care is a well-defined set of specific, clinically appropriate services, which include ongoing short-term treatment, assessment and reassessment that are furnished while a decision is being made regarding whether members will require further treatment as hospital inpatients or if they are able to be discharged from the hospital. Observation status is commonly assigned to patients who present to the emergency department and who then require a significant period of treatment or monitoring before a decision is made concerning their admission or discharge."

Observation services are covered only when provided on the order of a physician or another individual authorized under state law and hospital staff bylaws to admit members to the hospital or to order outpatient tests. Observation services must also be reasonable and necessary to be covered by Medicare. Reasonable and necessary outpatient services span more than 48 hours only in rare and exceptional cases. In the majority of cases, the decision whether to discharge a member from the hospital following resolution of the reason for the observation care or to admit the member as an inpatient can be made in less than 48 hours, usually in less than 24 hours.

The following information highlights important points of this program:

- When medically appropriate, observation care is an option for members whose problems are reasonably expected to be resolved within 24 to 48 hours. Members must generally be released or admitted by the 49th hour of observation care.
- Hospitals must follow the inpatient notification procedures outlined in the [Referrals, Authorizations and Notifications](#) chapter for members admitted to inpatient status after receiving observation services
- Behavioral health and substance use disorder (BH/SUD) observation services must be provided or coordinated by a member's designated BH facility, or by Tufts Health Plan's Behavioral Health Department Program Manager
- Upon notification, the member's primary care team (PCT) will assist with discharge planning and care coordination services<sup>4</sup>
- Tufts Health Plan may retrospectively review observation services for medical necessity to ensure compliance with Tufts Health Plan guidelines, which are consistent with Medicare guidelines
- Hospitals will no longer be reimbursed at the contracted rate for both observation care and an inpatient admission if a decision is made that results in an inpatient admission from the observation stay. If the observation services and admissions commence on the same calendar day, Tufts Health Plan will only pay for the admission.
- When other outpatient services are provided, all reasonable and necessary observation services are packaged in the ambulatory payment classification (APC) payment for the procedure or visit with which it was furnished. Separate APC payments made only for outpatient observation services involving three specific conditions (chest pain, asthma, and congestive heart failure) will not apply. However, hospitals may receive payment for "direct admission" to observation services in accordance with Medicare guidelines. Refer to the CMS Medicare Claims Processing Manual, [Chapter 4](#), §290 for additional payment criteria.
- As required by CMS and the Notice of Observation Treatment and Implication for Care Eligibility (NOTICE) Act, hospitals must provide written notification and a verbal explanation to individuals receiving observation services in an outpatient setting for more than 24 hours. This notice must be issued using the standard CMS [Medicare Outpatient Observation Notice \(MOON\)](#) form to provide notification to affected individuals. Providers must submit the form no later than 36 hours after observation services are initiated and the notification must be signed by the individual or proxy to acknowledge receipt. For more information about the NOTICE Act and for the current version of the MOON form, refer to [CMS](#).

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<sup>4</sup> Applies to Tufts Health Plan SCO members only.

**Note:** As outlined in the Moon notice, certain portions do not apply to Tufts Medicare Preferred HMO or Tufts Health Plan SCO members; members are instead covered in accordance with their member benefit documents. Providers should include this information in their verbal explanations to members receiving observation services for more than 24 hours and advise members to contact Senior Products Customer Relations at 800.701.9000 with any coverage-related questions:

- Members are not required to meet the 3-day minimum inpatient stay for admission to a skilled nursing facility (SNF)
- Member cost-sharing amounts may apply but are capped (Note: Member cost-sharing does not apply to Tufts Health Plan SCO members)

For additional information on observation services and payment criteria, refer to the [Observation Facility Payment Policy](#).

## CARE MODEL FOR TUFTS HEALTH PLAN SENIOR CARE OPTIONS

The overarching construct for the Tufts Health Plan Senior Care Options (HMO-SNP) is to improve access to medical, behavioral health and social services for all enrolled members. The Tufts Health Plan SCO care model is based on the below core principles and practices, which Tufts Health Plan believes form the foundation for measurable cost savings and improved health outcomes.

**Affordability:** Tufts Health Plan SCO is designed to minimize cost sharing on the part of the member to improve access to affordable care.

**Handle all aspects of the member's needs holistically:** medical, behavioral, social and community: The SCO model of care integrates the member's Medicaid and Medicare benefits into one benefit package, allowing the primary care team (PCT) to coordinate medical and social/community benefits in an integrated way.

**"High-touch" model with a consistent, primary point of contact:** The Tufts Health Plan SCO model of care is intended to be a high-touch model that provides frequent contact (via telephone or in person) between plan staff and members to educate members on their condition, address their concerns, proactively monitor health status and identify health care needs.

A care manager with appropriate language skills are assigned to each member and serve as the primary point of contact, whenever feasible. When a care manager with appropriate language skills is not available, a medically trained interpreter is used. Other members of the care team with specialized skills may need to contact the member as well; however, they are introduced through the trusted relationship between the member and the care manager.

**Member engagement and education:** The PCT creates an individualized plan of care (IPC) for all SCO members. The IPC is actively managed and updated as the member's situation changes. Members, their families and caregivers are all critical to the care management process and are engaged to the greatest extent possible.

**Identify high-risk members and provide care coordination and case management services:** All SCO members are evaluated for care coordination needs through initial and ongoing clinical assessments and other health risk assessment tools. All SCO members will receive some level of care coordination, and members with more acute and complex needs are provided more intensive case management through their PCT.

**Primary care focused:** Tufts Health Plan believes that a well-executed primary care strategy is critical to the success of managing the dual eligible population. The care management model is structured to support a partnership between the primary care provider (PCP) and the member through a supportive "safety net" team approach.

**Managing transitions of care:** Tufts Health Plan places great importance on continuity of care between settings to reduce inefficiencies and duplication of services and to help ensure that the member is being cared for in the setting that best meets their needs. Tufts Health Plan's model is built around actively coordinating transitions of care to or from acute settings, skilled nursing facilities (SNF), long-term care settings and the member's place of residence.

**Information systems support and centralized communication tool:** Tufts Health Plan uses a secure, web-based care management application that houses a summary record of each member's medical information and care plan. The PCT has access to the care management application 24 hours a day, seven days a week.

Tufts Health Plan is founded on the following core principles:

- Integrate and manage all components of a member's needs (medical, behavioral and social) to promote independent functioning in the most appropriate, least restrictive environment.
- Provide timely access to necessary services and preventive care.
- Assign each member a care manager to coordinate all aspects of care. The type of care manager and the intensity of the care management that the member receives will differ depending on the member's clinical complexity and level of need.
- As part of the comprehensive initial assessment, the care manager creates and manages an IPC. The IPC is unique to each member and focuses on the scope, duration and frequency of home- and community-based services (HCBS), taking into account the availability of caregiver and other informal supports.

- Perform routine follow-up assessments thereafter to facilitate early identification of changes in condition, while IPCs are adjusted accordingly.
- Provide support to the care manager, as needed, through a team of clinical experts that includes, but is not limited to, behavioral health clinicians, registered nurses (RNs) and nurse practitioners (NPs)
- Ensure the use of individualized goal-setting to engage members and caregivers while focusing on stabilization, self-management and autonomy. Members, families and caregivers are considered critical to care planning and should be engaged to the greatest extent possible.
- Coordinate safe transitions of care to ensure that the member is being cared for in a setting that best meets their needs and preferences.

## Primary Care Team

The PCT consists of a group of Tufts Health Plan SCO network providers, including at least a PCP, a care coordinator, a geriatric support services coordinator (GSSC) and a Tufts Health Plan RN or BH care manager. The PCT works to help ensure effective coordination and delivery of covered services to all SCO members. The PCT roles and responsibilities are described below.

### Primary Care Providers (PCPs)

When enrolling, every Tufts Health Plan SCO member must select a PCP. The role of the PCP is to provide primary care and participate in the development of each member's IPC. PCT meetings are organized to discuss the status and plan of care for each member of the PCP's panel that is enrolled in Tufts Health Plan SCO. The frequency of these meetings depends on the member's acuity and level of need.

Key tasks of the PCP include the following:

- Providing overall clinical direction and serve as the central point for integration and coordination of all covered services
- Providing primary medical services, including acute and preventive care
- Participating in PCT meetings, during which changes to complex member's IPC are reviewed and approved
- Promoting independent functioning of the member in the most appropriate, least restrictive environment with the proper supports in place
- Assisting in the designation of a health care proxy, if the member wants one
- Communicating with the member and member's caregiver/s about their medical, social and psychological needs

### Care Coordinators

The care coordinator is responsible for the following:

- Facilitate mailing of the welcome letter and completion of the orientation call
- Serve as the care manager for a subset of the non-complex Tufts Health Plan SCO membership
- Coordinate execution of the IPC for the non-complex members they manage and consult other members of the PCT as needed
- Schedule PCT meetings
- Act as a support to the RN care managers in the field to assist with administrative duties

Tufts Health Plan attempts to provide members with care coordinators based on relevant language skills.

### Geriatric Support Services Coordinators

The geriatric support services coordinator (GSSC) is employed by an aging services access point (ASAP) and is part of the PCT. Organized under Massachusetts law, ASAPs are local agencies that manage the home health care program and perform various services for and on behalf of elderly residents in Massachusetts. ASAPs also arrange for HCBS (e.g., Meals on Wheels, adult day health) through subcontractors.

In turn, ASAPs use GSSCs to provide services to members. The GSSC is responsible for:

- Performing, arranging and/or participating in ongoing assessments of the health and functional status of members and developing community-based care plans and related service packages necessary to improve or maintain member health and functional status

- Participating in the development and execution of a member's IPC
- Participating as part of a member's PCT
- With authorization from Tufts Health Plan SCO, arranging and coordinating the provision of appropriate community long-term care and social support services, such as assistance with housing, home-delivered meals, transportation, or other community-based services
- Monitoring the provision and outcome effectiveness of community based services as defined by the member's IPC

### Nurse Care Managers (RN Care Manager)

As part of the PCT, RN care managers are registered nurses responsible for the following:

- Acting as the care manager for the majority of complex members and those living in the institutional setting for long-term care
- Implementing and executing the IPC for all SCO members on their caseload
- Monitoring the provision and effectiveness of community-based services as defined by the member's IPC
- Conducting the minimum data set-home care (MDS-HC) assessment for all SCO members on their caseload
- Facilitating the implementation of all HCBS to keep members in the least restrictive setting
- Ensuring the safe transition of members from one setting to another (i.e., hospital to home) and facilitating the implementation of all HCBS
- Participating in PCT meetings
- Ensuring the completion of clinical and functional member assessments, including those required by the Massachusetts Executive Office of Health and Human Services (EOHHS), to determine the enrollee's rating category
- Monitoring the care and provide consistent feedback to the PCT on member progress
- Working closely with the care coordinator, PCP and GSSC to help ensure open lines of communication

### Behavioral Health Care Managers

BH care managers may be assigned as a member of the PCT for those members with complex behavioral health issues. They are responsible for the following:

- Conducting special assessments for behavioral health on an as-needed basis
- Acting as a consultant to the PCT for difficult to manage members
- Providing access to behavioral health services
- If they are the primary care manager for a member then they are also responsible for Comprehensive Assessments, and Service and Care Plan updates.

### Customer Relations Representative

While not a member of the PCT, CRRs play an important role in educating members about the plan, as well as their rights. CRRs work with members to assign an in-network PCP and quickly address nonclinical questions or concerns that members may have.

**Note:** Tufts Health Plan attempts to hire CRRs who speak the members' primary languages and assign these CRRs to members based on relevant language skills.

CRRs are responsible for executing ongoing administrative tasks for members (e.g., processing grievances, replacing lost membership cards) as well as facilitating a mailing of the welcome letter and completion of the orientation call.

### Care Management Process

Tufts Health Plan is committed to supporting members in such a way that allows them to remain safely in the community for as long as possible. Because a member's health status and care can change, they are frequently reassessed and re-stratified into levels of care management that respond to changing needs.

Assessments are used to stratify members into the appropriate level of care management. The levels of care, the associated level of risk, how these members typically present, and the type of care manager for each subset

of membership are defined in the following table:

Level of Care	Level of Risk	Definition	Primary Care Manager
Community Well (with no HCBS)	Noncomplex	No activities of daily living (ADL) or instrumental activities of daily living (IADL) deficits High functioning Limited or no chronic diseases	Care coordinator or GSSC
Community Well (some HCBS)	Noncomplex	Members living in the community with conditions or situations requiring coordination of one or more support services due to ADL or IADL deficits, but who are deemed to be in a stable state	GSSC
Alzheimer's Dementia/Chronic Mental Illness (AD/CMI)	Complex or Noncomplex	Members living in the community with a diagnosis of Alzheimer's, dementia, or a chronic mental illness, often with conditions or situations that require coordination of one or more support services due to ADL or IADL deficits	Behavioral Health Care Manager
Nursing Home Certifiable	Complex	Members with conditions or situations that require expert coordination of multiple support services due to two or more ADL deficits, and who are deemed to be in an unstable state	RN care manager supported by interdisciplinary team as needed; supportive roles as needed include medical director, behavioral health clinician, advanced illness consultant, dementia care consultant
Institutional	Long-term custodial care	Long-term resident of a nursing facility	RN care manager

## Assessment and Risk Categories

At a minimum, all SCO members receive an initial assessment, as well as ongoing assessments, at state-mandated intervals consistent with their health and social support needs.

### Initial Assessments

An initial assessment is a comprehensive assessment of a member that includes the following:

- An evaluation of a member's clinical, functional, nutritional and physical status
- Determination of a member's advance directive and service preferences
- The medical history of the member
- Key contact information, including relevant family members
- A screening for potential behavioral health issues, including tobacco, alcohol and drug use
- An assessment of the member's need for long-term care services, including the availability of informal support
- Specific elements of the minimum data set (MDS), if required

### Ongoing Assessments

An ongoing assessment is a periodic reevaluation of a member that is conducted on a routine basis after the initial assessment. The purpose of this assessment is to monitor and assess a member's ongoing clinical, functional and nutritional status and to determine if the current plan of care adequately supports the member in their current living arrangement.



## Change in Condition

In addition to regularly scheduled ongoing assessments, trigger events due to a member's change in condition can result in a reassessment. There are several categories of trigger events:

- An acute episode (e.g., an emergency department visit or hospitalization)
- A change in medical condition (e.g., development of pneumonia)
- A change in social condition (e.g., loss of a caregiver)

## Features of the Tufts Health Plan SCO Care Model

Tufts Health Plan's holistic approach to care management incorporates the steps described below.

### Intake

After enrollment, intake into the Tufts Health Plan care management system occurs as quickly as possible to help ensure the following:

- Continuity of care with existing providers, services, medications, etc.
- Rapid identification of risk factors and new services needed to stabilize the member

The care coordinator conducts an orientation call and sends a welcome letter within the first 30 calendar days of a member's enrollment. The goals of the welcome letter are to:

- Welcome the member to the program
- Ensure that all orientation materials were received and understood
- Provide a description of the PCT and the role of the care manager
- Highlight some key elements in the evidence of coverage (EOC)

### Initial Assessments

The care manager typically conducts an initial in-home assessment within 30 calendar days of a member's enrollment and within five business days if a member is institutionalized or if institutional placement is pending. Initial assessments are comprised of the following four mandatory key elements:

- An evaluation of clinical status, functional status, nutritional status and physical well-being
- The medical history, including relevant family members and illnesses
- Screenings for behavioral health status and tobacco, alcohol and drug use
- An assessment of the need for long-term care services, including the availability of informal support

The initial assessment also serves as the health risk assessment (HRA) that drives identification of the appropriate level of care for each member. The HRA is a health screening assessment tool used to identify the initial health, functional and psychosocial needs of the member. Based on the results of this assessment, the most appropriate care manager is assigned. The initial assessment includes a functional assessment tool that evaluates the member's current functional needs and the member's need for additional or more appropriate community-based support services (e.g., Meals on Wheels, homemaker services), based on a review of ADLs and IADLs.

If the initial assessment determines that a member's care needs are outside the scope of the care manager that member is assigned a different level of care and the most qualified care manager.

In addition, the IPC is completed as part of the initial assessment. The IPC is always reviewed with and agreed upon by the PCP, member, caregiver and other members of the PCT before being considered final. The IPC is developed after the initial assessment and updated thereafter with any major change in condition. A plan of care is developed and includes identified problems, goals and interventions. The plan of care is reviewed and updated with each assessment.

For those members living in the community who are identified as being nursing home certifiable, RN care managers conduct the MDS-HC assessment. This assessment is a clinical screening tool mandated by federal law that assesses key domains of function, health and service use. For institutional members, the care manager reviews the MDS 3.0 conducted by the SNF for completeness and accuracy.

## Monitoring and Ongoing Assessments

An ongoing assessment is a periodic reevaluation of a member. This assessment is conducted on a routine basis after the initial assessment. The purpose of this assessment is to monitor and assess a member's ongoing clinical, functional and nutritional status and to determine if the current plan of care is adequately supporting the member in their current living arrangement.

The care manager reassesses members at established intervals depending on their acuity and level of need. The established intervals are as follows:

- Community Well members (with no HCBS) are assessed telephonically every six months
- Community Well members (with HCBS) are assessed via home visits every six months
- AD/CMI members are assessed via home visits alternating with telephonic assessments every quarter (for complex cases) or every six months
- Nursing home certifiable members are assessed via home visits every quarter
- Institutional members are assessed in the facility every quarter
- Any member can be reassessed at any time with a significant change in condition

Medical reassessment of all enrollees by the PCP includes a complete history, annual physical and routine and episodic visits as needed. It is the expectation that the PCP uses their clinical judgment to determine how frequently they need to reassess the enrollee.

## Centralized Enrollee Record

The centralized enrollee record (CER) is a single, centralized electronic record with the primary purpose of documenting SCO member status. The CER is used to facilitate communication among the PCT and other providers that could require access (e.g., behavioral health providers, ER physicians). The CER or a summary abstract is available to any provider who requires access 24 hours a day, 7 days per week.

## Care Transitions

Tufts Health Plan is committed to ensuring continuity of care between settings. The foundation of coordinated transitions is to:

- Communicate information about the member's baseline status from the PCT to the treating provide
- Communicate information about the member's status from the treating provider to the PCT to facilitate planning for return to the most appropriate care setting

The PCT coordinates transitions between care settings through the use of established communication processes between the PCP, care manager, member and caregiver/family member. As part of the transitions between settings, the PCT is responsible for:

- Reinstating prior services, as applicable and arranging new services, as needed
- Coaching the member on the discharge summary either prior to the member leaving the hospital or at home within 48 hours of discharge
- Arranging an appointment with the member's PCP within seven days of discharge
- Conducting an intense follow-up with the member to help ensure adherence to appointments, medication and treatment regimens, as well as educating the member on early identification of changes in condition
- Reassessing and restratifying the member, as appropriate
- Updating the IPC accordingly

## Advance Directives

Tufts Health Plan conducts advanced care planning discussions with members early and often, and encourages PCPs to do the same. Tufts Health Plan's goal is to have discussion regarding advance directive with all SCO members within 90 days of enrollment and to have an advance directive in place within the first year of enrollment.

## AGING SERVICES ACCESS POINTS AND LONG-TERM SERVICE SUPPORTS

The following information applies to Tufts Health Plan SCO members only.

### Aging Services Access Points (ASAPs) and Geriatric Support Services Coordinators (GSSCs)

To provide home- and community-based services (HCBS) for the geriatric population, Tufts Health Plan contracts with aging services access points (ASAPs) that were established in accordance with Massachusetts state law. These services, which are aimed at helping prevent hospitalization, include:

- Home care program
- Care management
- Screening
- Authorization activities for certain long-term care services
- Collaboration with the primary care team (PCT) in promoting independent functioning of member and providing services in the most appropriate and least restrictive setting

ASAPs use geriatric support services coordinators (GSSCs) to manage these services for Tufts Health Plan SCO members. GSSCs collaborate with the PCT in care planning and service implementation.

#### General Responsibilities

ASAPs are responsible for providing community services, including:

- Information and referral
- Interdisciplinary case management
- Monitoring of service plans
- Reassessment of needs
- Protective services
- Investigations of abuse and neglect of elders

#### Key Functions of an ASAP for Tufts Health Plan SCO Members

The ASAP's key functions are to:

- Conduct comprehensive needs assessment, when necessary
- Develop a care plan to address unmet needs in conjunction with the PCT
- Purchase services necessary to implement the care plan
- Monitor the effectiveness of the care plan over time

#### How Tufts Health Plan Works with ASAPs

Tufts Health Plan contracts with ASAPs to assist in coordinating the following services to members:

- Homemaker
- Supportive day care
- Adult day health
- Supportive home care aide
- Laundry service
- Personal emergency response
- Adaptive housing/equipment
- Companion
- Medication dispensing
- Personal care
- Dementia day care
- Home health services
- Home delivered meals
- Emergency shelter
- Transportation
- Grocery shopping/delivery
- Chores
- Wanderer locator
- Vision rehabilitation
- Respite
- Habilitation therapy
- Behavioral health counseling

For more information or a list of Tufts Health Plan's contracted ASAPs, see the Tufts Health Plan SCO [Provider Directory](#).

### How SCO Providers Work with ASAPs

As a member of the PCT, the Tufts Health Plan SCO care manager will collaborate with the PCP or other providers to implement an appropriate service plan that meets the member's identified needs.

## Long-Term Service Supports (LTSS)

Tufts Health Plan contracts with long-term service support (LTSS) agencies to provide services to Tufts Health Plan SCO members.

**Note:** Members must meet clinical eligibility requirements.

### Adult Foster Care

The adult foster care, also known as adult family care (AFC), program enables a qualified member to receive care in a home-based setting for activities of daily living (ADLs) and instrumental activities of daily living (IADLs). The member and the caregiver must live together.

In conjunction with a Tufts Health Plan SCO care manager, nursing and care management oversight are provided by the AFC agency. Two levels of care are available based on clinical acuity.

### Day Habilitation

A program of services, for members with intellectual disabilities, that sets forth measurable goals and objectives; and prescribes an integrated program of activities and therapies necessary to reach the stated goals and objectives.

### Group Adult Foster Care (GAFC)

This program provides assistance with ADLs, IADLs, nursing and care management oversight through the GAFC agency. GAFC services must be provided in a qualified group residential setting (assisted living, senior housing, and supportive housing).

All services are provided by the GAFC agency in the member's home. This service provides care up to two hours per day, seven days per week.

### Personal Care Attendant (PCA) Program

This program provides training and reimbursement to employ and manage personal care services, for qualified members. Services received through the PCA Program are consumer-directed and intended to allow for maximum independence in their home environment. To be eligible for this program, the member must have a chronic or permanent disability for which they cannot perform ADLs without physical assistance.

### Adult Day Health (ADH) Program

The Adult Day Health Care (ADH) Program is provided in a Massachusetts agency-approved ADH provider. The general goal of these services is to provide an organized program of nursing services and supervision, maintenance-therapy services, and socialization.