PROVIDER
NOVEMBER 1, 2022
# UPDATE
NEWS FOR THE NETWORK | TUFTS Health Plan

*Provider Update* includes information for all Tufts Health Plan products: Commercial products, Tufts Medicare Preferred HMO, Tufts Health Plan Senior Care Options (SCO) and Tufts Health Public Plans products (Tufts Health Direct, Tufts Health RITogether, Tufts Health Together – MassHealth MCO Plan and Accountable Care Partnership Plans [ACPPs], and Tufts Health Unify). You will also see these products referenced as "All products." Changes will apply to all those specified products unless product exclusions are specified for that particular change.

*Provider Update* is a monthly, online provider newsletter. We encourage you to register to receive *Provider Update* by email. If you have registered for email distribution but aren't receiving *Provider Update* at the beginning of each month, look in your spam folder or check with your organization's system administrator to ensure the organization's firewall is adjusted to allow for receipt of *Provider Update* from providerupdate@email-tuftshealth.com.

## 60-DAY NOTIFICATIONS & POLICY UPDATES

### What's Ahead at Point32Health: Join a Webinar to Learn More

**All products**

In last month's issue of the provider newsletter, we let you know about the progress we have made in combining Harvard Pilgrim Health Care and Tufts Health Plan under the parent organization, Point32Helath.

We invited you to view our newly developed, in-depth provider FAQ that provides information on what is coming in 2023 where you can learn about our more unified product portfolio, behavioral health model, new pharmacy benefit manger, our aligned approach for Medical Benefit Drugs utilization management and more. If you haven't read the FAQ yet, we encourage you to do so today.

We'll also be hosting provider engagement events that will help you and your staff stay apprised of the latest news and updates.

**Register today!**
We encourage you and your office staff to sign up for one of the following sessions. To register, simply click the session of your choice:

- Wednesday, Nov. 16 from noon–1:30 p.m. ET
- Tuesday, Nov. 29 from 2–3:30 p.m. ET
- Wednesday, Dec. 7 from 8:30–10 a.m. ET
- Wednesday, Dec. 14 from noon–1:30 p.m. ET
- Tuesday, Dec. 20 from 2-3:30 p.m. ET

The sessions will cover key changes for 2023 noted below (product changes and continuity of care, pharmacy benefit manager, medical benefit drug utilization management, behavioral health, and more).

We'll continue to offer sessions in early 2023 — and will be offering dedicated behavioral health webinars in 2023 as well — so watch for more information in upcoming issues of the provider newsletter.

For more, please visit our Provider Training webpage.

**Integration changes in January**
As we noted in last month's newsletter, our combined organization has made great strides in unifying processes and products. We are committed to giving you the information you need to work efficiently with us and invite you to learn more on the following key updates via our What's Ahead at Point32Health FAQ:

- **More unified product portfolio** — Beginning on Jan. 1, 2023, Tufts Health Plan's employer group clients and members of individual and small group products (including those serviced by our intermediary partners) in Massachusetts will begin transitioning to the Harvard Pilgrim Health Care product portfolio, as the Commercial Markets business moves toward a more unified product portfolio. These transitions will occur on the plan renewal date.
- **Efforts to ensure a smooth transition** — Learn more about the efforts we are undertaking to ensure that you and your patients experience a smooth transition, including continuity of care, plans to migrate open referrals and prior authorizations, and training and education sessions.
- **Behavioral Health** — Read about our plans to offer an insourced behavioral health program for both Harvard Pilgrim Health Care and Tufts Health Plan. While Tufts Health Plan currently operates using an insourced behavioral health model, this is a change for Harvard Pilgrim Health Care, which currently utilizes a carve-out model managed by Optum/United Behavioral Health. Harvard Pilgrim Health Care will utilize an insourced behavioral health program effective July 1, 2023.
- **Medical Drug Program** — Learn about our aligned approach for Medical Benefit Drug utilization management. Point32Health has developed medical necessity guidelines for medical benefit drugs and will conduct utilization review, effective Jan. 1, 2023. Currently, CVS Health-Novologix conducts utilization management for medical drugs for Harvard Pilgrim Health Care members; however, as of Jan. 1, 2023, CVS Health-Novologix will no longer accept medical drug authorization requests for these members.
- **Pharmacy Benefit Manager** — Find answers to your questions about our pharmacy benefit manager for 2023, OptumRx, including key changes for each legacy organization, services provided by OptumRx, information on brand new drug formularies for 2023, guidance on requesting prior authorization, and support for members migrating from a Tufts Health Plan Commercial plan to a Harvard Pilgrim Commercial plan.

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## BH Designated Facility Program Discontinuation

**Commercial products, Tufts Medicare Preferred HMO**

As you may be aware, Tufts Health Plan has operated a Behavioral Health (BH) Designated Facility program for members of fully insured Massachusetts Commercial HMO plans and Tufts Medicare Preferred HMO. As Tufts Health Plan and Harvard Pilgrim Health Care continue integration efforts and prepare for migration of Commercial membership from Tufts Health Plan to Harvard Pilgrim Health Care products, we conducted an evaluation of this program and made a determination that we will discontinue the BH Designated Facility program effective Jan. 1, 2023.

Under this program, Tufts health Plan used a network of designated facilities to provide assigned members (based on PCP/practice organization selection) with certain behavioral health and substance use disorder (BH/SUD) services, such as crisis stabilization, BH/SUD emergency services, level-of-care determination, and acute inpatient BH/SUD treatment. Currently, two facilities — Bournewood Hospital and Northeast Hospital Corporation — participate.

With this change, starting on Jan. 1, providers can refer patients for covered behavioral health services to any contracted BH facility within the Tufts Health Plan network. Providers should follow standard Tufts Health Plan claims submission guidelines. You can check member eligibility and benefits via the secure Provider portal.

As mental and physical well-being are interconnected, Tufts Health Plan's behavioral health program emphasizes highly coordinated care manager that supports the whole health of the member. We will continue to strive to offer our members access to high-quality, patient-centered behavioral health care.

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## Pharmacy Program Updates

**All products**

As a reminder, Point32Health, the parent company of Harvard Pilgrim Health Care and Tufts Health Plan, is launching several enhancements to our pharmacy program, effective Jan. 1, 2023. This includes selecting OptumRx as our pharmacy benefit manager (PBM) for all products and streamlining utilization management for pharmacy and medical benefit drugs. Point32Health's Pharmacy Utilization Management team will manage the intake and review of pharmacy and medical drug prior authorization requests.

**2023 formularies and pharmacy guidelines now available**
Our Commercial and Tufts Health Direct 2023 prescription drug formularies as well as our pharmacy medical necessity guidelines and our medical benefit drug necessity guidelines (found in the online Resource Center), are now available on our provider website. We are retiring our 2022 formularies and medical necessity guidelines and introducing new versions for 2023.

For greater simplicity and an improved member and provider experience, we've unified our pharmacy medical necessity guidelines within product lines and our Commercial formularies. For example, our 2023 Commercial formularies apply for both Harvard Pilgrim and Tufts Health Plan Commercial members, and the same pharmacy medical necessity guidelines will apply for Harvard Pilgrim and Tufts Health Plan Commercial members alike. Guidelines may vary across product lines, however (for example, Commercial and Public Plans policies may differ. Refer to the Pharmacy and Medical Drug sections of our What's Ahead at Point32Health: Integration Updates page, as well as the medical necessity criteria, for more information.

**Online prior authorization submissions**
In addition to having a single point of contact for pharmacy and medical drug benefit prior authorization requests, we're making things even easier. Beginning Jan. 1, you will have access to PromptPA, a new online prior authorization submission tool for pharmacy and medical drugs. With PromptPA, you can submit both pharmacy and medical benefit drug prior authorization requests using the same platform. Through online submission, you can easily view drug specific criteria questions, attach clinical information, and receive a response more quickly.

We also encourage the use of electronic prior authorization (ePA) through EMR, CoverMyMeds, or Surescripts. Alternatively, you can submit prior authorization requests via FAX using the corresponding request forms. Updated forms — with new fax numbers — will be available in the pharmacy sections of our provider websites by to Jan. 1.

For more information on our pharmacy program, refer to our Quick Reference Guide with an overview of what to expect in 2023. Beginning Jan. 1, you'll be able to access PromptPA on our secure provider portal. Look for more on PromptPA in future issues of Provider Update.

**Changes to note**
While you should refer to formularies and pharmacy medical necessity guidelines for complete information, the following is an overview of some key changes that take effect on Jan. 1, 2023:

- **Tier changes & low-cost generic drugs** — For Commercial members, certain drugs are changing tiers (higher or lower tier) or will move to non-formulary status. In particular, tier changes were applied to low-

cost generic drugs. We encourage providers to refer to the formulary for lower copay alternatives, when available.

- **Changes in Prior Authorization and Step Therapy** — Please refer to the formulary and pharmacy medical necessity guidelines for details on drugs newly requiring prior authorization or step therapy.
- **Vaccine access** — For Commercial, Tufts Health Direct, and Tufts Health Together members, the only vaccines available through pharmacies will be: COVID, influenza, and Shingrix vaccines. For Tufts Health RITogether, only the COVID and influenza vaccines will be available through pharmacies. All preventive vaccines are covered under the medical benefit.
- **Compounded Medications —** For Tufts Commercial members, Tufts Health Direct, Tufts Health RITogether and Tufts Health Together members, we are updating the compounded medication program to require prior authorization for:
    - Any compound medication costing more than $500
    - Compounds for members 18 years of age and older

  For more information, please refer to the Pharmacy Medical Necessity Guideline for Compounded Medications in the Resource Center of our provider website.
- **Exclusions —** The following will be excluded from the pharmacy benefit for Tufts Commercial, Tufts Health Direct, Tufts Health RITogether and Tufts Health Together members:
    - Drug Efficacy Study Implementation (DESI) drugs assigned code 5 or 6 by the Centers for Medicare and Medicaid Services (i.e., drugs that are not approved as safe and efficacious)
    - Bulk chemicals
    - Surgical supplies
    - General anesthetics (including midazolam injection and oral syrup)
    - Coverage of repackaged products, clinic packs, and institution packs
    - Medical benefit drugs, unless otherwise listed on the formulary
- **Drugs Moving to Non-Formulary Status** — For Commercial and Tufts Health Plan Direct members, we will no longer cover brand medications with interchangeable generics and select brand name medications with therapeutic alternatives. Please refer to the formulary for complete information. For brand-name drugs moving to non-formulary status, generic equivalents, if available, will remain covered. For a patient to continue one of these non-formulary medications, the prescribing provider must request coverage as an exception through the medical review process subject to the Medical Necessity Guidelines for Non-Formulary Exceptions.
- **Routes of Administration** — Unless otherwise listed on the formulary, for Tufts Commercial members, Tufts Health Direct, Tufts Health RITogether and Tufts Health Together members, Tufts Health Plan will exclude drugs administered through the following routes of administration from the pharmacy benefit, as they should be limited to the medical benefit:

| | | |
|---|---|---|
| Enteral | Epidural | Hemodialysis |
| Intra-arterial | Intradermal | Intraspinal |
| Implant | Intramuscular | Intraocular |
| Intraperitoneal | Intravesical | Intrathecal |
| Intrauterine | Intravenous | |
| Intra-articular | Intravitreal | Intralesional |
| Periarticular | Perfusion | Intrapleural |
| Intratracheal | Urethral | Intraventricular |

## Coming in 2023: Tufts Medicare Preferred Access (PPO)

**Tufts Medicare Preferred Access (PPO)**

Beginning on Jan. 1, 2023, Tufts Health Plan will offer a Medicare Advantage PPO product, Tufts Medicare Preferred Access (PPO), to individuals in Massachusetts. With the addition of a PPO option alongside Tufts Medicare Preferred HMO, Medicare eligible individuals will have more choice when selecting a product to meet their unique needs.

Tufts Medicare Preferred Access (PPO) will initially be available throughout a service area that includes eight Massachusetts counties — Bristol, Essex, Hampden, Middlesex, Norfolk, Plymouth, Suffolk, and Worcester — and will feature comprehensive benefits along with access to both in-network and out-of-network providers. Members can search for an in-network provider using Tufts Health Plan's Find a Doctor search tool.

For in-network coverage, members will have access to an expansive network that consists of thousands of providers and facilities. Members who are outside our service area or who choose to see an out-of-network provider anywhere in the United States and its territories have the option to obtain out-of-network care, which may result in a higher member cost share.

Additionally, Tufts Medicare Preferred Access (PPO) offers members the flexibility to access in-network and out-of-network specialty care without a referral. Although members are encouraged to select a primary care physician (PCP) to support their medical needs, a PCP is not required.

As a reminder, while prior authorization is not required for out-of-network services, providers and members are encouraged to request a pre-visit coverage decision from Tufts Health Plan before rendering/seeking out-of-network services. Rendering/receiving such services without a pre-visit coverage decision may result in denials if it is later determined that the services are not covered or were not medically necessary.

Key benefits included with Tufts Medicare Preferred Access (PPO) are $0 premium, $0 medical deductible, $0 copay for in-network PCP services, $1,000 embedded dental benefit with $0 copay for preventive services and 50% coinsurance for basic and major services, $60 per calendar quarter over-the-counter (OTC) allowance, rich prescription drug benefit that includes $0 copay for Tier 1 drugs at preferred pharmacies, and more.

Please note that this is only a summary of benefit changes. Before services are rendered, providers are reminded to check member benefits and cost-share amounts using Tufts Health Plan's secure Provider portal or other self-service tools, even for members seen on a regular basis.

## Pharmacy Coverage Changes

### Commercial products, Tufts Health Direct, Tufts Health RITogether, Tufts Health Together

| Updates to Existing Prior Authorization Programs | | | |
|---|---|---|---|
| **Drug** | **Plan** | **Eff. date** | **Policy & Additional Information** |
| Abilify Maintena, Aristada, Aristada Initio, Invega Sustenna, Invega Trinza, Perseris, Risperdal Consta | Tufts Health RITogether | 1/1/2023 | Antipsychotic Medications |
| Amturnide, eprosartan, Tekamlo | Tufts Health Together – MassHealth MCO Plan and ACPPs, Tufts Health RITogether | 1/1/2023 | Antihypertensive Medications<br>Products being removed from the MNGs due to product discontinuation. |
| Compounded Medications | Tufts Health Together – MassHealth MCO Plan and ACPPs, Tufts Health RITogether | 1/1/2023 | Compounded Medications (RITogether)<br>Compunded Medications (Together) |

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|---|---|---|---|
| | | | (See related article on coverage changes for Tufts Health Together and Tufts Health RITogether). |
| Emgality 120 mg/mL, Nurtec ODT | Tufts Health RITogether | 1/1/2023 | Migraine Medications: Calcitonin Gene-Related (CGRP) Receptor Antagonists, Serotonin (5-HT) 1F Receptor Agonists, and Triptans |
| Evekeo ODT | Tufts Health RITogether | 1/1/2023 | CNS Stimulant Medications |
| Febuxostat | Tufts Health Together – MassHealth MCO Plan and ACPPs, Tufts Health RITogether | 1/1/2023 | Febuxostat (Together)<br>Febuxostat (RITogether) |
| Klisyri | Tufts Health RITogether | 1/1/2023 | Immunomodulators, Topical |
| Noncovered Pharmacy Products | Tufts Health RITogether | 1/1/2023 | Pharmacy Products Without Specific Criteria |
| Picato | Tufts Health Together – MassHealth MCO Plan and ACPPs, Tufts Health RITogether | 1/1/2023 | Immunomodulators, Topical (Together)<br>Immunomodulators, Topical (RITogether)<br>Product being removed from the MNGs due to product discontinuation. |
| Ulesfia | Tufts Health Together – MassHealth MCO Plan and ACPPs, Tufts Health RITogether | 1/1/2023 | Pediculicide Mediations (Together)<br>Pediculicide Mediations (RITogether)<br>Product discontinued and removed from guidelines . |
| **Drug Status Changes** | | | |
| **Drug** | **Plan** | **Eff. date** | **Policy & Additional Information** |
| Avonex, Betaseron, Extavia, Mavenclad, Rebif | Tufts Health RITogether | 1/1/2023 | Pharmacy Products Without Specific Criteria<br>These agents, used for multiple sclerosis, are moving to noncovered status. |
| FreeStyle Precision Neo test strips and glucometer | Tufts Health RITogether | 1/1/2023 | Pharmacy Products Without Specific Criteria<br>FreeStyle Precision Neo test strips and glucometer are moving to noncovered status. |
| Gilenya | Tufts Health Together – MassHealth MCO Plan and ACPPs | 1/1/2023 | Multiple Sclerosis Agents<br>Brand Gilenya will be preferred over generic fingolimod. |
| Hemlibra | Commercial products, Tufts Health Direct | 1/1/2023 | Hemlibra (emicizumab-kxwh) |

| | | | |
|---|---|---|---|
| | | | Coverage is moving to the medical benefit |
| Non-FreeStyle and Precision glucometers | Tufts Health Together – MassHealth MCO Plan and ACPPs, Tufts Health RITogether | 1/1/2023 | MA: Non-Covered Pharmacy Products<br><br>RI: Pharmacy Products Without Specific Criteria<br><br>All non-FreeStyle and Precision glucometers are moving to noncovered status. |
| Tresiba SoloStar, vial | Tufts Health RITogether | 1/1/2023 | Pharmacy Products Without Specific Criteria<br><br>Tresiba is moving to noncovered status. |
| Zarxio (filgrastim-sndz) | Tufts Health RITogether | 1/1/2023 | Filgrastim Products<br><br>Zarxio will require prior authorization. |
| Methadone injection | Tufts Health RITogether | 1/1/2023 | Opioid Analgesics<br><br>Methadone injection is a medical benefit drug effective 1/1/2023. |
| Dimethyl fumarate | Tufts Health Together - MassHealth MCO Plans and ACPPs | 1/1/2023 | Multiple Sclerosis Agents<br><br>Generic dimethyl fumarate will be preferred over brand name Tecfidera. |
| Dexcom G6 and accompanying supplies | Tufts Health Direct | 1/1/2023 | Dexcom G6 and accompanying supplies will be moved to non-formulary status. Refer to Continuous Glucose Monitors article in this issue for more information. |

## Continuous Glucose Monitors Update

**Tufts Health Direct**

Effective for fill dates on or after Jan.1, 2023, Tufts Health Direct will no longer prefer Dexcom G6 continuous glucose monitors (CGMs) and their accompanying supplies. All FreeStyle Libre Flash CGMs and accompanying supplies will be preferred and covered under the pharmacy benefit with a prescription and prior authorization.

To aid in member access, Tufts Health Plan is automatically entering an authorization for Freestyle Libre Flash CGM and supplies for any Tufts Health Direct members who received pharmacy authorization for Dexcom G6 and accompanying supplies. A new prescription for the Freestyle Libre Flash CGM and accompanying supplies will need to be written for the patient to fill at an in-network pharmacy.

For all new starts, FreeStyle Libre and its supplies will continue to require prior authorization and will be reviewed against criteria in the Pharmacy Medical Necessity Guideline for Insulin and Diabetes Supplies.

Dexcom G4®, Dexcom G5®, Dexcom G6 and Medtronic Guardian™ will be non-formulary. For a member to continue using any of these non-formulary products, the prescribing provider must request coverage through the medical review process subject to the Pharmacy Medical Necessity Guidelines Formulary Exceptions. Should a request for any of these products be approved, members must obtain the CGM and supplies at a pharmacy as they will not be available through the DME supplier.

Quantity limits apply for all CGMs. To request prior authorization, please refer to the applicable pharmacy medical necessity guidelines and fax your request to the Pharmacy Utilization Management Department at 617-673-0988.

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## Formulary Coverage Changes

**Tufts Medicare Preferred HMO, Tufts Medicare Preferred PDP, Tufts Health Plan SCO, Tufts Health Unify**

**Non-Covered Drugs (Tufts Medicare Preferred HMO, Tufts Medicare Preferred PDP, Tufts Health Plan SCO, Tufts Health Unify)**
Effective for fill dates on or after Jan. 1, 2023, Tufts Medicare Preferred will no longer cover certain drugs, including drugs with interchangeable generics or therapeutic alternatives. For members currently taking these drugs, coverage will continue without disruption through Dec. 31, 2022. A prescribing provider must submit a formulary exception request if they wish for a member to continue taking the drug.

**Drugs Moving to Higher Tier *(*Tufts Medicare Preferred HMO, Tufts Medicare Preferred PDP*)***
Effective for fill dates on or after Jan. 1, 2023, Tufts Health Plan will move Eprontia and Prolia to a higher tier. For members currently taking these drugs, current coverage will continue for these drugs unchanged through Dec. 31, 2022. Providers are encouraged to refer to the formulary for lower copay alternatives. If the available alternatives are not clinically appropriate, and your patient cannot afford the new copay, a tier exception can be requested and will be reviewed in accordance with CMS regulations as not all drugs are eligible for tier exceptions.

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## Referral and Authorization Updates: Behavioral Health and SNF Services

**Tufts Medicare Preferred HMO, Tufts Health Plan SCO**

As we identified in our Updates to Medical Necessity Guidelines chart, effective Jan. 1, 2023 for Tufts Medicare Preferred HMO and Senior Care Options, Tufts Health Plan is making updates to referral and authorization requirements related to Skilled Nursing Facility care, Repetitive Transcranial Magnetic Stimulation, Psychological/Neuropsychological Testing and Assessment, BH Outpatient Psychotherapy, and Intensive Outpatient Programs.

The requirements that will apply to these services and products as of Jan. 1 are outlined below:

**Repetitive Transcranial Magnetic Stimulation**
Repetitive Transcranial Magnetic Stimulation will require prior authorization for Tufts Medicare Preferred HMO and Senior Care Options, and referrals will no longer be required.

We have developed Medical Necessity Guidelines for Transcranial Magnetic Stimulation (TMS), and will utilize the Medicare Behavioral Health: Transcranial Magnetic Stimulation (TMS) InterQual Smartsheet for prior authorization review.

**Skilled Nursing Facility care**

Skilled Nursing Facility care will require prior authorization for Senior Care Options (and notification will also be required upon admission). Please note that this prior authorization requirement will not apply to Tufts Medicare Preferred HMO at this time; however, notification will continue to be required upon admission.

**Psychological and Neuropsychological Testing and Assessment**
For Senior Care Options, neither prior authorization nor a referral will be required. For Tufts Medicare Preferred, prior authorization will be required, but a referral will not.

The following prior authorization/notification lists have been updated to reflect the updated referral and authorization requirements detailed in this article:

- Tufts Medicare Preferred (HMO and PPO) Prior Authorization and Inpatient Notification List
- Tufts Health Plan Senior Care Options (SCO) Prior Authorization List
- Tufts Health Plan Senior Care Options Notification List

**Additional Behavioral Health Services**
No referral or prior authorization will be required for BH Outpatient Psychotherapy or for Intensive Outpatient Programs for Tufts Medicare Preferred HMO or Tufts Health Plan SCO (in-network services only).

**Editor's note: we clarified prior authorization requirements related to Skilled Nursing Facility Care for Senior Care Options and Tufts Medicare Preferred HMO.*

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## 2023 Benefit Changes

**Tufts Medicare Preferred HMO**

The following benefit changes apply to Tufts Medicare Preferred HMO members and are effective for dates of service on or after Jan. 1, 2023, upon the plan's effective or renewal date:

### Summary of Benefit Changes

The following changes may not apply to all plans.

- Increased premiums by up to $8 on non-$0 premium plans in most segments.
- Benefit changes to Smart Saver Rx plan include
    - Reduced copay for Specialist services to $45 per visit. This change also applies to other Specialist related services including Medicare-covered dental services, annual diagnostic hearing exam, podiatry services, diagnostic eye exam, and diabetic retinopathy exam performed by an ophthalmologist.
    - Reduced inpatient hospital care and rehabilitation copay to $380 per day for days 1-5.
    - Reduced copay for outpatient surgery at an ambulatory surgical center (ASC) to $270 per day.
    - Increased over the counter (OTC) benefit to $60 per quarter
    - Increased Wellness Allowance to $350/year
    - Reduced Rx deductible to $100 (Tiers 3-5) and Tier 2 copay at preferred pharmacies to $2 for a 30-day supply.
- Benefit changes (all other HMO plans)
    - Increased maximum out-of-pocket to $3,650 for Basic, Value, Prime, and Prime Rx+
    - Increased copay for outpatient diagnostic tests and outpatient x-ray services to $10 - $20 for HMO Saver Rx, HMO Basic, and HMO Value
    - Increased copay for outpatient hospital services to $270 - $370 per day for HMO Saver Rx and HMO Basic
    - Reduced copay for outpatient surgery at an ASC to $170 - $270 per day for HMO Saver Rx and HMO Basic
    - Increased copay for outpatient surgery at an acute care hospital to $270 - $370 per day for HMO Saver Rx and HMO Basic
    - Increased OTC benefit to $60 per quarter for HMO Saver Rx.
    - Increased Wellness Allowance to $350/year for Saver Rx.
- Other benefit changes (all plans)
    - Reduced annual routine hearing exam copay to $0
    - Capped Part B insulin copay at $35 per month when used with insulin pump

- Capped Part D Insulin copay at $35 for one month (30-day) supply
- Tier 6 Vaccine drugs covered at $0 copay in all stages
- Copays for outpatient diagnostic labs, tests, or x-rays will not apply if performed and billed as part of an urgent care visit (copays already waived if part of an office visit)
- Office visit copay will apply to surgery services performed during an office visit
- Covered Continuous Glucose Monitors (CGMs) includes therapeutic and adjunctive CGMs
- Covered therapeutic CGMs will be limited to FreeStyle Libre products
- Removed referral requirements for all Behavioral Health (BH) Outpatient Psychotherapy services except Medication Visit and Opioid Replacement Therapy.
- Removed referral requirements for BH Special Procedures:
  - For Repetitive Transcranial Magnetic Stimulation (rTMS) a prior authorization will be required, in-network services only.
  - For Psychological/Neuropsychological Testing a prior authorization will be required, in-network services only.
  - For Intensive Outpatient Programs no referral or prior authorization will be required, in-network services only.
- Removed referral requirements for BH outpatient mental health care, except psychiatrist services. For psychiatrist services, the referral requirement remains in place, in-network services only.
- Removed referral requirements for substance abuse services.
- Expanded Part B Step Therapy program to include EG HMO plans.

Please note that this is only a summary of benefit changes. Before services are rendered, providers are reminded to check member benefits and cost-share amounts using Tufts Health Plan's secure Provider portal or other self-service tools, even for members seen on a regular basis.

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## 2023 Benefit Changes

**Tufts Health Plan SCO**

The following benefit changes apply to Tufts Health Plan Senior Care Options (SCO) members and are effective for dates of service on or after Jan. 1, 2023, upon the plan's effective or renewal date:

### Summary of Benefit Changes

- Increased DailyCare+ Card allowance to $150 per calendar quarter for groceries and other Medicaid-approved items. Unused balance at end of quarter will rollover to next quarter. (Allowance was increased to $125 per calendar quarter effective July 1, 2022 as part of COVID flexibilities.)
- Increased Instant Savings Card allowance to $128 per calendar quarter for Medicare-approved over-the-counter (OTC) items. Unused balance at end of quarter will rollover to next quarter. (Allowance was increased to $100 per calendar quarter effective July 1, 2022 as part of COVID flexibilities.)
- Increased non-medical transportation to 24 round trips per year.
- Added Lidocaine 4% Topical Patch to list of covered over-the-counter Rx drugs.
- Increased maximum out-of-pocket to $8,300 (no impact to members).
- Removed prior authorization requirements for behavioral health (BH) Specialing Services.
- Removed referral requirements for all BH Outpatient Psychotherapy services except Medication Visit and Opioid Replacement Therapy.
- Removed referral requirements for BH Special Procedures:
  - For Repetitive Transcranial Magnetic Stimulation (rTMS) a prior authorization will be required, in-network services only.
  - For Psychological/Neuropsychological Testing no referral or prior authorization will be required, in-network services only.
  - For Intensive Outpatient Programs no referral or prior authorization will be required, in-network services only.
- Removed referral requirements for BH outpatient mental health care, except psychiatrist services. For psychiatrist services, the referral requirement remains in place, in-network services only.

- Removed referral requirements for substance use disorder services.
- Added prior authorization requirement for skilled nursing facility (SNF) care.

Please keep in mind that this is only a summary of benefit changes. Before services are rendered, providers are reminded to check member benefits using Tufts Health Plan's secure Provider portal or other self-service tools, even for members seen on a regular basis.

## Update to Reimbursement for Acupuncture Claims

**Tufts Medicare Preferred HMO, Tufts Medicare Preferred Access PPO**

Acupuncture services administered for any condition other than chronic low back pain are considered non-medical and non-covered by Medicare. Effective Jan. 1, 2023 for Tufts Medicare Preferred HMO and Tufts Medicare Preferred Access PPO members, acupuncture claims submitted for non-medical services will be denied, regardless of whether the member's plan includes a Wellness Allowance benefit for supplemental acupuncture services.

Medicare-covered acupuncture services for chronic low back pain should be billed using CPT codes 97810, 97811, 97813, 97814, 20560, and 20561, per Section 410.2, Chapter 32, of the Medicare Claims Processing Manual.

Providers can resubmit claims with the appropriate Medicare-covered CPT code(s) if a denial was the result of an error.

Members whose plans have a Wellness Allowance benefit can file a reimbursement request for supplemental acupuncture services not covered by their medical benefit.

## Tufts Health Unify Expansion

**Tufts Health Unify**

Beginning Jan. 1, 2023, Tufts Health Unify will be available to members living in Essex and Barnstable counties in Massachusetts.

Tufts Health Unify offers members wrap around care management in collaboration with Cityblock Health. Every member is assigned a designated care manager who serves as a point person and assists with:

- Connections to needed social, behavioral, and or medical services to meet their goals
- Coordinating transportation to medical appointments
- Efficiently obtaining durable medical equipment and long-term services and supports
- Accompanying patients to medical office appointments as needed

Tufts Health Unify looks forward to working with our provider network to support your patient in 2023. For more information or to speak directly with a Cityblock Health care manager, please call 508-217-9030.

## 2023 PANDAS and PANS Coverage

**Rhode Island Commercial products**

Effective for Rhode Island fully insured Commercial plans issued or renewed on or after Jan. 1, 2023 — in accordance with state mandate R.I.G.L. § 27-18-89, which applies to commercial health insurers in Rhode Island — Tufts Health Plan will cover the medically necessary treatment of pediatric autoimmune

neuropsychiatric disorders associated with streptococcal infections (PANDAS) and pediatric acute-onset neuropsychiatric syndrome (PANS).

Services for the treatment of PANDAS/PANS should be billed using diagnosis code G04.81 (other encephalitis) until a code specific to PANDAS/PANS is released.

Covered PANDAS/PANS treatment includes, but is not limited to, intravenous immunoglobulin (IVIg) therapy. Tufts Health Plan's Medical Necessity Guidelines for Intravenous Immune Globulin (IVIg) and Subcutaneous Immune Globulin (SCIG) Products have been updated to reflect the new coverage.

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## Medical Necessity Guideline Updates

**All products**

As a reminder, we've introduced the following enhancement in how we present updates on our Medical Necessity Guidelines (MNGs). Each month, MNG updates will be presented in a chart format to make it easier for providers and office staff to review changes, updates, and new policies in a more streamlined way.

| Updates to Medical Necessity Guidelines (MNG) | | | |
|---|---|---|---|
| MNG Title | Products Affected | Effective Date | Summary |
| Transcranial Magnetic Stimulation (TMS)<br><br>Tufts Medicare Preferred (HMO and PPO) Prior Authorization and Inpatient Notification List<br><br>Tufts Health Plan Senior Care Options (SCO) Prior Authorization List<br><br>Tufts Health Plan Senior Care Options (SCO) Notification List | Tufts Medicare Preferred, Tufts Health Plan Senior Care Options (SCO) | Jan. 1, 2023 | New MNG for Transcranial Magnetic Stimulation (TMS). Prior authorization will be required for Tufts Medicare Preferred and Senior Care Options and will utilize the Medicare Behavioral Health: Transcranial Magnetic Stimulation (TMS) InterQual Smartsheet. Referral will not be required.<br><br>Skilled Nursing Facility care will require prior authorization (as well as notification upon admission) for Senior Care Options. Referral will not be required.<br><br>Psychological and Neuropsychological Testing and Assessment will require prior authorization, but not referral, for Tufts Medicare Preferred. For Senior Care Options, neither prior authorization nor referral will be required. |
| Assisted Reproductive Technology Services – Massachusetts Products<br><br>Assisted Reproductive Technology Services – Rhode Island Products | Commercial products, Tufts Health Direct | Jan. 1, 2023 | New MNGs, with extensive clinical coverage and prior authorization criteria. These new MNGs have been developed as an addition to, not in replacement of, our existing Infertility Services MNGs.<br><br>CPT codes S4026, S4028, 89253, and 89268 will require prior authorization. |

| | | | |
|---|---|---|---|
| Peer Recovery Coach | Tufts Health Direct | Jan. 1, 2023 | Updated to note that the Peer Recovery Coach benefit will be applicable for Tufts Health Direct. |
| Transcervical Radiofrequency Ablation of Uterine Fibroids | Commercial products, Tufts Health Public Plans products | Jan. 1, 2023 | New MNG. Prior authorization will be required for CPT code 0404T. |
| Respite for Children for Tufts Health RITogether | Tufts Health RITogether | Nov. 1, 2022 | Prior authorization no longer required for additional respite services needed after the initial 200 hours. |
| Video Capsule Endoscopy | Commercial products, Tufts Health Public Plans products | Nov. 1, 2022 | Annual review, editorial/general administrative updates. |

## Medicare Part B Step Therapy Policy

**Tufts Medicare Preferred HMO Employer Groups**

Beginning on Jan. 1, 2023, Tufts Health Plan's Medicare Part B Step Therapy Policy will apply to members of Tufts Medicare Preferred HMO Employer Groups.

The policy requires members to first try certain preferred drugs to treat their medical condition before coverage of another non-preferred drug for that condition is approved as medically necessary.

Currently this policy applies only to Tufts Medicare Preferred HMO, Tufts Health Plan Senior Care Options (SCO) and Tufts Health Unify members, As of Jan. 1, the step therapy requirement will apply to Tufts Medicare Preferred HMO Employer Group members initiating a new course of treatment.

For these requests, the prescribing provider must request coverage through the medical review process subject to the Medicare Part B Step Therapy Policy. Tufts Health Plan makes regular updates to the policy, so be sure to review it periodically for complete information on drugs for which the step therapy requirement applies, as well as their preferred alternatives.

## Medical Drug Step Therapy Changes for Medicare

**Tufts Medicare Preferred, Tufts Health Plan SCO, Tufts Health Unify**

Effective for dates of service beginning Jan. 1, 2023, Tufts Health Plan is updating our step therapy requirements for medical benefit drugs.

Step therapy requires that members first try certain preferred drugs to treat their medical condition before coverage of another non-preferred drug for that condition is approved as medically necessary. Non-preferred products must meet the following criteria: history of use of at least one preferred product resulting in substandard response, history of intolerance or adverse event of at least one preferred product or have rationale that the preferred products are not clinically appropriate.

For complete information, please refer to the Medicare Part B Step Therapy Medical Necessity Guideline. Some of the changes include:

- Cerezyme (J1786) will be a non-preferred product and will require prior authorization. Preferred products in this class, which do not require prior authorization are: Eleyso (J3060) or Vpriv (J3385).

- Riabni (Q5123) will now be a non-preferred product in the rituximab class — along with existing non-preferred medical drugs Rituxan (J9312) and Rituxan Hycela (J9311) — and will require prior authorization. Preferred products are Ruxience (Q5119) or Truxima (Q5115).
- Herzuma (Q5113) and Ontuzant (Q5112) will now be non-preferred products in the trastuzumab class — along with existing non-preferred medical drugs Herceptin (J9355) and Herceptin Hylecta (J9356) — and will require prior authorization. Preferred products Kanjinti (Q5117), Ogivri (Q5114), and Trazimera (Q5116) will not require prior authorization.

For more information, also refer to the applicable Medical Benefit Drug Medical Necessity Guideline.

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## Use HCPCS Code S0013 for Spravato as of Jan. 1, 2023

**All products**

When submitting prior authorization requests for Spravato on or after Jan. 1, 2023, please use HCPCS code S0013.

Spravato is a prescription nasal spray indicated, in conjunction with an oral antidepressant, for the treatment of treatment-resistant depression in adults and depressive symptoms in adults with major depressive disorder with acute suicidal ideation or behavior.

For more details, including coverage criteria, exclusions, and FDA-approved dosing information, please refer to Tufts Health Plan's Spravato Medical Necessity Guidelines.

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## Modifier Payment Policy Updates

**Commercial products**

Tufts Health Plan is making updates to our Modifier Payment Policy, effective for dates of service beginning Jan. 1, 2023.

Updates will include the following changes to modifier reimbursement amounts:

- Modifier 52 (Reduced services) will be reimbursed at 50% of the fee schedule/allowable amount.
- Modifier 53 (Discontinued procedure) will be reimbursed at 25% of the fee schedule/allowable amount.
- Modifier AS (Physician assistant, nurse practitioner, or clinical nurse specialist services for assistant at surgery) will be reimbursed at 14% of the fee schedule/allowable amount.

In addition, Tufts Health Plan will deny any anesthesia code when it is billed without an appropriate physical status modifier (P1-P6).

For more information, refer to the Modifier Payment Policy.

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## Behavioral Health Screening Tools and Codes Update

**Tufts Health Together**

Effective Jan. 1, 2023 and per MassHealth All Provider Bulletin 348, providers will be required to use a new service code (**96127**) when billing for developmental and behavioral health screening. Providers will continue to be paid at the same rate.

In addition the bulletin also:

- Outlines the discontinuation of specific behavioral health tools, and instead directs providers to refer to the Bright Futures toolkit
- Strongly recommends Autism screening at the 18- and 24-month well child visits

The Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services Payment Policy has been updated to reflect these changes.

# ADMINISTRATIVE UPDATES

## Albuterol HFA Inhaler Coverage Update

**Tufts Health Together**

MassHealth's preferred albuterol inhalers on the ACPP/MCO Unified Pharmacy Product List (UPPL) now include brand Ventolin HFA (albuterol sulfate inhalation aerosol) and brand Proventil HFA (albuterol sulfate inhalation aerosol), both of which are covered without prior authorization.

Previously, MassHealth preferred brand name Proair HFA (albuterol sulfate inhalation aerosol). However, Teva Pharmaceuticals recently announced that as of Oct. 1, 2022 it no longer manufactures this product. As a result, pharmacies report not being able to stock the branded Proair HFA product.

It is recommended that providers immediately begin switching MassHealth members — including Tufts Health Together members — on albuterol inhalers to brand name Ventolin HFA or brand name Proventil HFA**.**

MassHealth is continuing to restrict generic albuterol inhalers with prior authorization.

## Billing for Member Boarding

**Massachusetts Commercial products, Tufts Health Direct**

For dates of service on or after Nov. 1, 2022, Tufts Health Plan will require Massachusetts facilities to bill specific procedure/revenue codes for services provided to Massachusetts members boarding in an acute care facility while awaiting an inpatient psychiatric admission. These services must be billed on a separate claim. Prior authorization is not required.

The need for inpatient psychiatric treatment has increased over the past several years, and as a result, members boarding in Emergency Departments (ED), observation units, and/or inpatient (non- psychiatric) units while they await placement has become more prevalent. The DOI issued Massachusetts DOI Bulletin 2022-08, and previous bulletins, to help address this issue.

For more information and a list of codes, please refer to the updated Emergency Department Services Payment Policy, Observation Services Payment Policy and Inpatient Facility Payment Policy.

## Standard Form for Chemotherapy Prior Authorization

**All products**

Tufts Health Plan requests that you begin using the new Massachusetts Standard Form for Chemotherapy and Supportive Care Prior Authorization Requests. The form is available in the Resource Center on Tufts Health Plan's public Provider website.

Beginning on Feb. 23, 2023, Tufts Health Plan will require use of the new form and will not accept any previous versions. For more information, please refer to this Mass DOI bulletin.

# REMINDERS

## Pediatric Infant Formula: Prior Authorization Reinstated

**Commercial products**

Tufts Health Plan announced in the September issue of our provider newsletter that we would continue to waive prior authorization requirements for coverage of prescription pediatric infant formula through Oct. 31, 2022, due to ongoing supply chain issues.

Effective Nov. 1, 2022, the requirement has been reinstated, and in order for members to receive coverage for prescription infant formula through a contracted DME provider, prior authorization must be obtained.

As a reminder, Rhode Island Commercial plans do not require prior authorization as outlined in the medical necessity guidelines for Oral Formula: Rhode Island Products.

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## Modifier Reminder: Reporting a Separate and Distinct Procedural Service

**All products**

As we continue to enhance our existing claim editing to improve the overall accuracy of our claims processing, we would like to provide the following reminders related to the reporting of a separate and distinct procedural service.

Modifier 59 should only be appended/reported for a distinct procedural service that is not normally reported together with the primary procedure, such as:

- Different session or patient encounter
- Different procedure or surgery
- Different anatomical site or organ system
- Separate incision or excision
- Separate injury

Modifier 59 should only be used if no other, more descriptive modifier is available, such as one of the following modifiers in the X (EPSU) category:

- XE: Separate encounter, a service that is distinct because it occurred during a separate encounter
- XP: Separate Practitioner, a service that is distinct because it was performed by a different practitioner
- XS: Separate Structure, a service that is distinct because it was performed on a separate organ/structure
- XU: Unusual non-overlapping service, the use of a service that is distinct because it does no overlap usual components of the main service

Reporting one of the above modifiers provides a greater degree of specificity and paints a more accurate and complete picture of the encounter. Please note, as well, that modifier 59 should not be appended to the same claim line as an X {EPSU} modifier.

When a modifier is appropriately applied, as determined through the coding validation process, providers will be eligible for reimbursement. In cases where a modifier has been incorrectly applied, payment will be denied. For more information, refer to the Modifier Payment Policy.

## Kidney Health Management Program: Sign Up for a Webinar

**Commercial Fully Insured products**

As a reminder, Point32Health is collaborating with Monogram Health for in-home chronic kidney disease (CKD stages 3b-5) and end-stage renal disease (ESRD) care management services for commercial fully insured members. As the management of CKD often results in poor outcomes and high costs, we are collaborating with Monogram to identify and address CKD earlier by leveraging analytics, multidisciplinary medical management, and industry expertise. Monogram Health will be hosting webinars to provide an overview of the program. To register for an upcoming webinar, click on the date below that works best for you and submit the requested information:

- Thursday Nov. 10 at 5 p.m.
- Tuesday Nov. 29 at 12:30 p.m.

For more information about Monogram Health, visit www.monogramhealth.com. If you have questions, contact James Porter with Monogram Health's Provider Services at 855-529-2778 or PCPservices@monogramhealth.com.

## Star Measures and Provider Reminders

**All products**

We share your commitment to making sure that our members — your patients — receive outstanding care, coordination of care, and follow up. To that end, we offer the following reminders on two important health topics: controlling blood pressure and transitions of care.

Each fall, the Centers for Medicaid & Medicare (CMS) and the National Committee for Quality Assurance (NCQA) Star Ratings program evaluates health plans based on a five-star rating program. Star Ratings program gauges patient satisfaction and the quality of care delivered to members of Medicare plans by evaluating health plans' performance on weighted measures related to clinical outcomes, patient experience, access to care, and general process.

In October, Tufts Health Plan eared a 5 Star rating for its Tufts Medicare Preferred HMO plans from CMS for the 8th straight year. Tufts Health Plan is the only Massachusetts plan to receive a 5 Star rating this year, and one of a very few plans in the country to receive this rating for eight years in a row.

The following tips can help improve patient experience and outcomes, and Star Ratings:

**Controlling High Blood Pressure**
This Star measure evaluates adequate control of blood pressure over the course of a year in members 18 to 85 years of age who have been diagnosed with hypertension. Some best practices include:

- Creating a treatment plan that includes setting attainable goals with patients
- Educating patients on methods for controlling and or lowering their blood pressure
- Ensuring members understand that while medications may be necessary, taking medication alone does not eliminate high blood pressure
- Documenting blood pressures taken both in the office and by the patient at home in the medical record
- Submitting CPT II codes to report the lowest systolic and diastolic blood pressure readings taken on the same date

**Transitions of Care**
This measure looks evaluates transitions of care by assessing the following among discharged members:

- Notification of Inpatient Admission: Documentation of receipt of notification of inpatient admission on the day of admission through 2 days after the admission (3 total days).
- Receipt of Discharge Information: Documentation of receipt of discharge information on the day of discharge through 2 days after the discharge (3 total days).
- Patient Engagement After Inpatient Discharge: Documentation of patient engagement (e.g., office visits, visits to the home, telehealth) provided within 30 days after discharge.
- Medication Reconciliation Post-Discharge: Documentation of medication reconciliation on the date of discharge through 30 days after discharge (31 total days).

Providers should be sure to document these steps in the patient's medical records and to bill with the correct CPT codes. Providers are also asked to review all prescriptions listed in the medical record and be sure to clearly document "follow-up visit after hospitalization."
By following these best practices, you help ensure your patients receive outstanding care — and help us maintain our rating as a 5-Star health plan in Massachusetts.

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## Helpful Information for Providers

- **Avoid Printing:** For the most current information, providers should view all documentation online and avoid printing.
- **Browser Note:** For the best experience in accessing the newsletter, we recommend upgrading your browser to the latest version of Mozilla Firefox or Google Chrome.

**Secure Provider Portal Self-Service Tools:** We encourage providers and office staff to use our secure Provider portal to perform a variety of transactions quickly and easily — electronically submit transactions and access information related to claims submission, claims status, referrals, prior authorizations, electronic remittance advice, member eligibility, panel information and more. For more information, log on to the secure Provider portal or refer to the Electronic Services.

## FOR MORE INFORMATION

### PUBLIC PROVIDER WEBSITE

- Tufts Health Plan

### SECURE PROVIDER PORTAL

- All Tufts Health Plan Products

### CONTACT INFORMATION

- Tufts Health Plan

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