Tufts Health One Care

Medicare-Medicaid Plan

Tufts Health One Care, Tufts Health Public Plans' One Care plan for individuals between 21 and 64 years of age, integrates care for members who are eligible for both Medicare and Medicaid services. One Care was established by MassHealth and the Centers for Medicare & Medicaid Services (CMS) to streamline delivery and financing of care for patients who typically receive services from both agencies (dually eligible).

As a Medicare-Medicaid One Care plan, Tufts Health One Care focuses on the effective integration of services and is designed to:

- Establish and enhance care coordination with care providers
- Streamline care among providers
- Improve health and functional outcomes
- Recognize and address care needs holistically, keeping members central to their own care plan
- Improve quality of care by addressing member needs across the care continuum
- Promote independence within the community

Refer to this chapter for more information about:

Refer to other chapters of this *Provider Manual* for information not covered in this chapter.

Model of Care (MOC) Overview

Tufts Health Public Plans collaborates with PCPs, specialists and community organizations to strengthen member care coordination across medical, pharmacy and behavioral health (BH) services; community-based long-term services and supports (LTSS); and wellness services. This method of care coordination is the foundation of the Tufts Health Public Plans' approach to care management. Tufts Health Public Plans facilitates data and information sharing among community providers.

Tufts Health Public Plans has partnered with **Cityblock Health,** an innovative care management vendor, to supply all care management services to members of Tufts Health One Care. The Cityblock Health care model is described below.

Cityblock Health supports the following critical features:

- A person-centered, integrated care strategy organized around a flexible interdisciplinary care team (ICT) that focuses on engaging the member in all care planning efforts
- Close collaboration with providers to holistically coordinate medical, behavioral, social, and community needs, including supporting the members with any provider transitions
- Flexibility based on the infrastructure of the primary care site, including BH services, as appropriate
- Member-focused ICT composition based on member needs and practice capacity
- A secure online tool to maintain member records and ensure that the authorized member, family advocates, and ICT providers can access and share updated information quickly

Interdisciplinary Care Team (ICT)

The member-specific ICT includes the member and their chosen family, friends or advocates, the member's assigned care manager and the Member's PCP. The ICT can encompass all providers involved in a member's care, including BH and LTSS providers, state agencies, the member's Long-Term Services Coordinator (LTS-C), care coordinators, community health workers, peer specialists and anyone else the member delegates. Each ICT participant has a defined role appropriate to their licensure and relationship to the participant. However, the team collectively shares responsibility for delivering coordinated care and providing services that best meet the member's needs. This includes assisting the member in developing a member-approved care plan. As needed, the ICT may also include additional organizations across the continuum of care and support. (Refer to the Additional ICT participants section in this chapter for additional background.)

Cityblock Health Care Team

Cityblock Health works with ICTs to designate a care manager to serve as the member's primary contact, and to lead care coordination or clinical care management services. Each member of the Cityblock Health care team is involved in the care management of each member, and the frequency and nature of provided care is dependent on the specific requirements of each member, and their existing PCP and social care network. Cityblock Health's care teams may consist of the following roles:

- **Care Coordinator –** The Care Coordinator works under the direction of the Care Team Lead and serves as the relationship lead for low and moderate risk members to ensure they receive timely and coordinated care. The Care Coordinator works closely with the other members of the care team to create a member-approved care plan and executes on the identified problems, goals and interventions. Care Coordinators help identify and address a member's social and environmental needs in a culturally sensitive manner with the goal of keeping the member in the community. The Care Coordinator specializes in face-to-face engagement and will support members in the community by delivering health and wellness interventions, disease management services, and managing member's care across the physical, social and behavioral continuum.
- **Nurse Care Manager –** The Nurse Care Manager is an RN who works closely with the ICT and provides in-community direct care to all members as is beneficial to that member and their ICT. The Nurse Care Manager serves as the relationship lead for high-risk members.

- **Behavioral Health Specialist –** The Behavioral Health Specialist is a licensed clinician who provides intensive care management services for members with primary behavioral health diagnoses, in close collaboration with the member's PCP and ICT. The Behavioral Health Specialist will also serve as a consultative resource to all other care team members to ensure that all members have access to coordinated and appropriate behavioral health services.
- **Advanced Practice Clinicians –** The Cityblock Health care team includes NPs and Psych NPs who work under the direction of a physician or psychiatrist, and in close coordination with existing PCPs and ICT, to provide community-based care.

The member may request a new primary point of contact at any time to allow for flexibility and to address changes in wellness.

Additional ICT Participants for the Cityblock Health Care Team

The Tufts Health One Care medical director and/or behavioral health medical director are available to all ICTs to provide consultative assistance. As appropriate, and at the discretion of the member, the ICT also may include:

- **Behavioral health (BH) clinicians:** For members primarily with BH needs, Tufts Health Public Plans will encourage and support PCPs to offer and deliver care coordination services by a BH clinician at the point of service. Where insufficient capacity exists within the PCP site, Tufts Health Public Plans will support the PCP to deliver these services with a Tufts Health Public Plans-employed or contracted BH clinician. Tufts Health Public Plans will also work with the PCP to enhance care coordination efforts with BH clinicians during the course of the program. For some members, the BH clinician may serve as the primary provider on the Integrated Care Team.
- **Long-term services (LTS) coordinator:** Each Tufts Health One Care member has access to an LTS Coordinator who may help identify and coordinate the delivery of LTSS services that support a member's independent living goals. Cityblock's care managers can support members in acquiring an LTS Coordinator. Members with LTS Coordinators may choose to have their LTS Coordinators participate in the ICT.
- **Family caregivers/peers or member-appointed representatives:** With the member's permission, caregivers, peers, and/or other appointed representatives may be ICT participants. These individuals often provide critical support and care and can provide valuable insights into the member's needs.
- **State and other agency representatives or case managers:** State and other agency (e.g., independent learning center [ILC] or recovery learning center [RLC]) representatives or case managers may be included on a member's ICT with the member's permission. In addition, as part of the ICT, the agency representatives would be able to access member information on the centralized enrollee record (CER), if the member gives permission.
- **Clinical pharmacists:** Clinical pharmacists are available to provide the ICT with support for members with complex medical management needs.
- **Other identified professionals as appropriate:** A member's ICT may incorporate other professionals as the member allows, including:
  - A specialist with knowledge and experience who can support the ICT
  - A home health nurse
  - A health educator
  - Advocates

Enrollment and Member Transition

- **Enrollment:** Tufts Health One Care members may enroll in the plan without an established PCP relationship. Tufts Health Public Plans works with new members, as part of their initial assessment, to identify and establish a PCP relationship, including facilitating early access for members with acute needs. The goal is to establish PCP relations within the continuity of care period, if possible. Providers are notified when selected to be a Tufts Health One Care member's PCP.

- **Continuity of care:** If an out-of-network provider is actively treating a newly enrolled Tufts Health One Care member, the member may continue to receive services through that provider for up to 90 days or until a Cityblock Health Care Team completes an initial comprehensive assessment and Individualized Care Plan (ICP). At that time, a member must transition their care to an in-network provider.
  - Special Consideration: If a Tufts Health One Care member enrolls in the plan while pregnant, the member may choose to remain with her current provider of obstetrical and gynecological services until six weeks after delivery of the child, even if the provider is not in-network. All Medically Necessary obstetrical and gynecological services, as well as immediate post-partum care and the follow-up appointments, will be covered during this time.
- **Provider Termination:** A provider must notify Tufts Health Plan with at least 60 calendar days' written notice prior to the effective date of a PCP or behavioral health provider termination from the network, subject to any notice requirements as may be found in the provider's contract.
  - Tufts Health Plan must notify members with at least 45 calendar days' written notice and one telephonic notice prior to the effective termination date of their PCP or behavioral health provider is terminating. Notification will be sent to all impacted members who are currently assigned to that PCP and who have been a patient of that primary care or behavioral health provider within the past three years.
  - For specialty providers other than PCP and behavioral health, Tufts Health Plan must provide written notice to impacted members with at least 30 calendar days prior to the termination effective date. Notification will be sent to all members who are patients seen on a regular basis by the provider, whose contract is terminating, or who are currently or have received care from such provider within the past three months.

Care Management

Assessment

Cityblock Health will schedule an in-person comprehensive assessment with new members within 90 days of enrollment and will perform additional assessments as necessary for members requiring more intensive behavioral health services or community-based LTSS. Reassessments are completed annually or sooner if there is a change in the member's condition.

Providers who are active members of Tufts Health One Care's ICT may view member assessments in the member's record through the secure Provider portal.

Regular Member Outreach and Engagement

Tufts Health One Care members will receive frequent contact, informed by the member's preference, in person, by telephone, and by electronic forms of communication from the ICT. These outreach efforts aim to direct members to manage their own care and wellness interventions by:

- Helping them understand their current status (health, social, issues of daily living)
- Identifying their needs based on their preferences
- Coordinating their care and services
- Addressing their concerns and barriers to care
- Proactively monitoring progress toward agreed-upon goals
- Facilitating access to care and services to meet their needs and maintain their independence in the community

Individualized Care Plan (ICP)

Each member or their appointed representative will be integrally involved in collaborating with the ICT to develop a person-centered ICP that is based on their own beliefs and desires, and addresses all of the member's medical, behavioral, functional, environmental, and social needs. The Relationship Lead or Care Coordinator will actively manage

the ICP in collaboration with other members of the care team, for example, by updating a member's health status or care transitions, as the member's situation requires. Members, their families, and their caregivers are all critical to the case management process, and Tufts Health Public Plans will engage them all to the greatest extent possible. Through the ICT, Tufts Health Public Plans will also educate members about their conditions, strategies to improve or maintain their health and functioning, and community or other resources available to them.

Centralized Enrollee Records (CER)

Tufts Health Public Plans' CER houses the member's clinical record, including assessment, care plan, care team and other important information. Tufts Health One Care members and providers have the ability to access the member's record in the CER through the secure Provider portal or the secure member portal. In addition to being able to view member assessments and ICPs, the secure Provider portal also allows for the submission of notes to be appended to the member's record in the CER. This information can then be communicated to members and their ICT. To comply with the Health Insurance Portability and Accountability Act (HIPAA), members determine the level of access to their protected health information they want to give to a particular provider or caregiver. Members and the ICT will have access to the web-based tool, 24 hours a day, seven days a week.

Coordination of Care

Tufts Health Public Plans places great importance on continuity of care between health care and community-based settings to reduce inefficiencies and duplication of services and to ensure that the member receives care in the most appropriate setting to meet their needs effectively. Tufts Health Public Plans will actively engage appropriate ICT members and providers, including care coordinators, peer specialists, or CHWs, to support members during these challenging transitions.

Community Supports

Community supports are services provided in a home or other community setting that promote disease management, wellness, and independent living, and that help avert unnecessary medical interventions (e.g., avoidable or preventable emergency department visits and facility admissions).

Community-based LTSS programs are essential to supporting Tufts Health Public Plans members' independence and well-being. Tufts Health One Care includes coverage for services such as:

- Community health workers
- Community support services (CSP)
- Day habilitation
- Group adult foster care
- Home care/Homemaker services
- Home health care services
- Home modifications
- Nurse midwife services
- Peer support/Counseling/Navigation
- Personal care assistance
- Program of assertive community treatment (PACT)
- Respite care

Refer to the Tufts Health One Care medical and behavioral health benefit summary grids for coverage details and prior authorization requirements.

LTSS include a wide variety of services and supports that help people with disabilities meet their daily need for assistance and improve the quality of their lives. Examples include, but are not limited to, durable medical equipment; home health; therapies; assistance with bathing, dressing, and other basic activities of daily life and self-care; as well as support for

everyday tasks such as laundry, shopping, and transportation. LTSS are provided over an extended period, predominantly in homes and communities, but also in facility-based settings such as nursing facilities.

Provider Training

The Executive Office of Health and Human Services (EOHHS) and the Centers for Medicare and Medicaid Services (CMS) require ICT members to complete comprehensive training on the One Care program.

This training program has two tracks:

- **Track One:** A general training series developed, coordinated, and delivered by MassHealth via Umass Medical School. Providers can access Track One trainings through the One Care Shared Learning website at: onecarelearning.ehs.state.ma.us/. To access the trainings, providers need a One Care account. Providers can select "create new account" on the One Care Shared Learning website to establish one.
- **Track Two:** A plan-specific training for Tufts Health One Care. Providers can access Track Two trainings by visiting https://www.point32health.org/provider/training/

Providers must complete both training program tracks to meet One Care requirements. Participation will be recorded and submitted to both EOHHS and CMS. For questions about Tufts Health One Care training requirements, please contact Tufts Health Plan Provider Services at 888-257-1985.

Tufts Health One Care Provider Responsibilities

As a member of the ICT, Tufts Health One Care providers are responsible for the following:

- Reasonably accommodate members and ensure that programs and services are equally accessible to an individual with disabilities, including diverse linguistic and cultural competence needs, as they are to an individual without disabilities
- Comply with all state and federal laws and regulations governing accessibility and accommodations
- Coordinate care with a member's other health care providers to ensure appropriate access to care, including BH, LTSS, and community supports providers
- Utilize waiting room and exam room furniture that meet the needs of all members, including those with physical and nonphysical disabilities
- Provide accessibility along public transportation routes and/or provide enough parking
- Use clear signage and way finding (e.g., color and symbol signage) throughout facilities
- Provide secure access for staff-only areas
- Not discriminate based on race, ethnicity, national origin, religion, sex, age, sexual orientation, medical or claims history, mental or physical disability, genetic information, or source of payment
- Provide covered services listed in the Tufts Health One Care contract
- Complete an ADA accessibility survey
- Accept and treat all Tufts Health Public Plans members regardless of English proficiency and health status and to assist members with interpreter services, if necessary

Provider Advice and Advocacy

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

- Their medical status, care or treatment options for the member's health condition or disease (including any alternative treatments that may be self-administered). Providers should always share sufficient information with the member so that the member has an opportunity to decide among all relevant treatment options, regardless of any coverage limitations, exclusions, or the cost of the treatment.

- The risks, benefits and consequences of any medical treatment or non-treatment options involved in the member's health condition or disease. Of note, the provider must tell the member in advance if any proposed medical care or treatment is part of a research experiment. The member has the right to refuse any experimental treatments.
- The member's right to participate in decisions about their medical care and treatment, including the opportunity for the member to refuse treatment and to express preferences about future treatment decisions regardless of whether the Plan provides coverage for such medical care or treatment. This includes the right of a member to request to leave a hospital or other medical facility and/or the right to stop taking medication, even when the provider advises or advocates against the decision.

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

Tufts Health One Care Member Rights and Responsibilities

As part of Tufts Health Public Plans' strong commitment to quality care and customer service, it is important that Tufts Health One Care members remain informed about their rights and responsibilities. Members are allowed to exercise these rights without having their treatment adversely affected. The following list is included to inform providers of member's rights and responsibilities in order to assist members in getting the most of their memberships.

Member Rights

Members have the right to:

- Be treated and accepted with respect, privacy and dignity regardless of race, ethnicity, creed, religious belief, sexual orientation, privacy, health status, gender, age, language needs, disability or source of payment for care
- Reasonable accommodation
- The delivery of services in a prompt, courteous, responsible, and culturally competent manner
- Obtain medically necessary treatment, including emergency care
- Make decisions concerning their medical care
- Obtain information about Tufts Health Public Plans and our services, limitations on services, or services not covered, as well as PCPs, specialists, and other health care providers. Tufts Health Public Plans will provide the information in a manner that is easily understood, by alternative technologies if necessary, including, but not limited to, TDD/TTY, Video Relay Service (VRS), written format, large print (at least 16-point font), and language lines with qualified interpreters that include ASL. All notices can be read to members upon request, and assistance can be given to members to complete forms.
- Be told by a provider about all medical and treatment information in words they understand
- Have their provider ask them for permission for all treatment, except in emergencies wherein an individual's health is in serious danger and they cannot sign a consent form
- Discuss any illness they have and the recommended treatment options, regardless of cost or benefit coverage
- Choose a PCP from the list of contracted providers
- Work with their PCP, specialists, and other health care providers to make decisions about their health care, and do so without interference from Tufts Health Public Plans
- Accept or refuse medical, surgical, or trial treatment and be informed of the possible outcomes of that choice
- Contact their PCP and/or BH provider's office by phone, 24 hours a day, seven days a week
- Expect that all records regarding their health care are private, and that Tufts Health Public Plans abides by all laws regarding confidentiality of patient records and personal information, in recognition of the member's right to privacy
- Seek a second opinion for proposed treatments and care, including in such instances where the member does not agree to a treatment for moral or religious reasons

- File a grievance to express dissatisfaction with their providers and the quality of care or services they have received and receive a timely response
- Appeal a denial made by Tufts Health Public Plans for care or services and receive a timely response
- Be free from any form of restraint or seclusion used as a means of coercion, discipline, or retaliation
- Request more information or explanation on anything, either verbally or in writing
- Obtain written notice of any significant and final changes to the Tufts Health Public Plans provider network, including, but not limited to, PCP, specialist, hospital, and facility terminations that affect the member
- Request and receive a copy of their medical records in a timely manner and request that the records be amended or corrected as necessary
- Get services as described in the One Care program covered services list
- Have their provider advocate on their behalf without restriction
- Certain rights that relate to an advance directive
- Not be balance billed by a provider for any covered service
- Make suggestions about member rights and responsibilities
- Exercise their rights without having their treatment adversely affected

Member Responsibilities

Members have a responsibility to:

- Treat all health care providers with respect and dignity
- Keep appointments, be on time, or call if they will be late or need to cancel an appointment
- Present a Tufts Health Public Plans member ID card prior to receiving services
- Protect their Tufts Health Public Plans member ID card from being used by another person
- Give Tufts Health Public Plans, their PCP, specialists, and other health care providers complete and correct information about their medical history, medicines they take, and other matters about their health
- Ensure they get services from providers who are part of the Tufts Health Public Plans provider network
- Ask for more information from their PCP and other health care providers if they do not understand what they have been told
- Participate with their PCP, specialists, and other health care providers to understand and help develop plans and goals to improve their health
- Follow plans and instructions for care that they have agreed to with their providers
- Know and confirm benefits before getting treatment
- Understand that refusing treatment may have serious effects on their health
- Contact their PCP or mental health and/or substance abuse provider within 48 hours after a visit to the emergency room so they can provide follow-up care
- Use emergency room services only for an injury or illness that they believe may be a serious threat to their life or health
- Change their PCP or mental health and/or substance abuse provider if they are not happy with their current care
- Communicate their concerns and complaints as clearly as possible to their provider and to Tufts Health Public Plans
- Report to Tufts Health Public Plans if they have access to any other insurance
- Report to Tufts Health Public Plans if they suspect potential fraud and/or abuse
- Inform Tufts Health Public Plans and the state of any address, phone, or PCP changes

Tufts Health One Care Coverage Decisions, Grievances and Appeals

Grievances and appeals may be submitted by the member or the provider by telephone, mail, email, fax, or in person. Providers can request the appeal on a member's behalf. If members want a relative, friend, attorney, or someone besides the provider to make the appeal for them, an Appointment of Representative Form must be completed first. The form gives the other person permission to act on behalf of the member. Providers do not need to complete this form to appeal on a member's behalf. Members are notified of grievance and appeal rights upon enrollment, and on an annual basis thereafter.

Tufts Health One Care Coverage Decisions

Tufts Health One Care members may request a coverage decision on any service or benefit that they think should be covered. All coverage decision requests must be made through Tufts Health Public Plans. Tufts Health Public Plans does not retaliate or take any punitive action against a provider who requests an expedited resolution or supports an enrollee's appeal or grievance.

There are two kinds of coverage decisions:

- **Standard coverage decision** — Tufts Health Public Plans must notify the member of a nondrug standard coverage decision within 14 days after it's received. If Tufts Health Public Plans does not provide a decision within 14 days, the member can file an appeal. Tufts Health Public Plans will inform the member if additional time is needed and explain the reasoning for extra time. For a standard coverage decision regarding Part D drug coverage, Tufts Health Public Plans must notify the member within 72 hours after receipt, but no more than 14 calendar days if supporting statement is needed from the provider.
- **Fast coverage decision** — Tufts Health Public Plans must notify the member of a nondrug fast coverage decision within 72 hours after receipt but can take up to 14 additional days if it is determined that more time is needed. If Tufts Health Public Plans does not provide a decision within 14 days, then the member can file an appeal. For a fast coverage decision regarding Part D drug coverage, Tufts Health Public Plans must notify the member within 24 hours after receipt, but no more than 14 calendar days if a supporting statement is needed from the provider. The member can ask for a fast coverage decision if they or their health care provider believe the member's health, life, or ability to regain maximum function may be put at risk.

Tufts Health Public Plans will automatically give a member a fast coverage decision when a provider asks for one or supports the member's request. If a member asks for a fast coverage decision without support from their health care provider, Tufts Health Public Plans will decide if the member's health requires a fast coverage decision. If Tufts Health Public Plans does not grant a fast coverage decision, a decision will be provided to the member within 14 days for a non-drug coverage and 72 hours regarding Part D drug coverage.

Medicare Part B Prescription Drug Requests

Standard (nonurgent) prospective and concurrent requests: Tufts Health Public Plans will make a determination and notify the member 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.

Expedited (urgent) prospective and concurrent requests — Tufts Health Public Plans will make a determination and notify the member as expeditiously as the member's health condition requires, but not exceeding **24 hours** from the receipt of the request. This time frame cannot be extended.

Requests for Part B drugs may be submitted to the Pharmacy Utilization Management Department through PromptPA or via the following:

Mail: Tufts Health Plan
Attn: Pharmacy Utilization Management Department
1 Wellness Way, Canton, MA 02021
Fax: 617-673-0956

Tufts Health One Care Grievances

Tufts Health One Care members may file a complaint or grievance to address concerns such as quality of care or services provided, aspects of interpersonal relationships, such as rudeness, on the part of a provider or employee of Tufts Health Public Plans, a failure to respect certain rights, a disagreement with Tufts Health Public Plans' decision not to approve a request that an internal appeal be expedited, and/or a disagreement with Tufts Health Public Plans' request to extend the time frame for resolving an authorization decision or an internal appeal. Tufts Health Public Plans will respond to all clinical grievances in writing. Tufts Health Public Plans will undertake an investigation of all grievances, including those that relate to potential provider violation of enrollee rights. Tufts Health Public Plans will resolve grievances within 30 calendar days of receiving them. Tufts Health Public Plans can take up to 14 additional days if it determines that more time is needed to resolve the grievance. An extension may be taken in instances where a member requests an extension, or if we determine there is a need for additional information and can demonstrate how the delay is in the best interest of the member. Tufts Health Public Plans will give the member prompt oral notice of the delay and, within two business days, provide written notice for rationale with the delay. Members will be informed of their right to file an expedited grievance if the member disagrees with the decision to extend the grievance resolution timeframe.

Tufts Health One Care Appeals

Tufts Health One Care members have the right to appeal decisions through a two-level process. Because Tufts Health One Care combines the benefits of two programs (Medicare and Medicaid), the appeal process varies based on the program that provides the benefit. All appeals must begin at Level 1 Appeal, which is a plan-level appeal, and then, based on outcome, may be escalated further to the correct program entity in a Level 2 Appeal.

Level 1 Appeals

Members have the right to ask Tufts Health Public Plans to review the decision by requesting a Level 1 Appeal (sometimes called an internal appeal or plan appeal). Members can ask to see the medical records and other documents used to make the decision any time before or during the appeal. Members may also request a free copy of the guidelines used to make the decision.

Members must ask for a Level 1 Appeal within 60 days after receiving notice of the decision. Tufts Health Public Plans may provide members more time if there is a good reason for missing the deadline.

If a member appeals because Tufts Health Public Plans intends to reduce or stop a service a member is already receiving, the member has a right to keep receiving that service during the appeal when the appeal is received 10 calendar days from the date of the denial.

Providers can request the appeal on a member's behalf. If members want a relative, friend, attorney, or someone besides the provider to make the appeal for them, an Appointment of Representative Form must be completed first. The form gives the other person permission to act on behalf of the member. Providers do not need to complete this form to appeal on a member's behalf.

There are two kinds of Level 1 Appeals:

- **Standard appeal —** Tufts Health Public Plans must give members a written decision on a nondrug standard appeal within 30 days after receipt. For an appeal regarding a preservice Part D drug coverage, Tufts Health Public Plans must give members a written decision within 7 days of appeal receipt. For an appeal regarding a post service Part D drug coverage, Tufts Health Public Plans must give members a written decision within 14 days of appeal receipt. If the request is for a Medicare Part B prescription drug, Tufts Health Public Plans must give members a written decision, as expeditiously as the member's health condition requires, but not exceeding 7 days (for preservice requests) of appeal receipt. The decision might take longer if members ask for an extension, or if Tufts Health Public Plans needs more information about the appeal. Members will be informed if extra time is needed and an explanation for the additional time will be provided. The review time frame for Part B and Part D drug requests will not be extended.

- **Fast (expedited) appeal —** Tufts Health Public Plans must give a decision on a fast (expedited) appeal within 72 hours after receipt. Members can ask for a fast appeal if they or their health care provider believe the member's health, life, or ability to regain maximum function may be put at risk by waiting up to 30 days for a decision.

Tufts Health Public Plans will automatically give members a fast appeal when a provider asks for one or supports the request. If a member asks for a fast appeal without support from their health care provider, we will decide if the member's health requires a fast appeal. If we don't grant a fast appeal, we will give the member a decision within 30 days.

Level 2 Appeals

Members have the right to have Medicare, MassHealth, or both review Tufts Health Public Plans' decision by making a Level 2 Appeal (sometimes called an external appeal). A Level 2 Appeal is done by an independent organization that is not connected to the plan. Medicare's Level 2 Appeal organization is called the Independent Review Entity (IRE). MassHealth's Level 2 Appeal organization is called the MassHealth Board of Hearings. Members can ask Tufts Health Public Plans for the opportunity to see the medical records and other documents used to make the Level 1 Appeal decision any time before or during the Level 2 Appeal. Members may also ask for a free copy of the guidelines used to make the decision.

Members can ask the MassHealth Board of Hearings to review Tufts Health Public Plans' decision to deny the Level 1 Appeal. Members must ask for this within 120 days of the notice date.

If a member is making an appeal because Tufts Health Public Plans intends to reduce or stop a service they are already receiving, the member has a right to receive the service while appealing to the Board of Hearings. In order to receive a previously approved service while appealing, a member must ask for a Level 2 Appeal from the Board of Hearings within 10 days of the notice date.

Also, the Medicare IRE will automatically review Tufts Health Public Plans' decision to deny a Level 1 Part C Appeal for Medicare covered services. A member does not have to do anything to make a Level 2 Appeal to the Medicare IRE. Tufts Health Public Plans will send the case to the Medicare IRE to get its review. However, the member will not get the service while appealing unless they also make a Level 2 Appeal to the MassHealth Board of Hearings.

There are two kinds of Level 2 Appeals:

- **Standard appeal —** the IRE and Board of Hearings must give written decisions on a standard appeal within 30 days of appeal receipt. For an appeal regarding Part D or Part B drug coverage, the IRE and Board of Hearings must give members a written decision within 7 days of appeal receipt.
- **Fast (expedited) appeal —** A member can ask for a fast appeal if they or their health care provider believe the member's health, life, or ability to regain maximum function may be put at risk by waiting a standard appeal decision.

The IRE will give the member a Level 2 fast appeal if the health care provider asks for one or supports the request. If a member asks for a fast appeal from the IRE without support from their health care provider, the IRE will decide if the member's health requires a fast appeal. If a fast appeal is not granted, the member will receive a decision within 30 days.

If a member disagrees with a decision to stop coverage for home health care, skilled nursing care, or comprehensive outpatient rehabilitation facility (CORF) services, a Level 1 "fast track" appeal may be filed directly with a quality improvement organization (QIO). Level 1 "fast track" appeals require the QIO to notify the member of a decision within 24 hours of receiving all required information. A member must file the Level 1 appeal no later than noon of the day after receiving written notice of the initial decision. If the QIO approves the service, Tufts Health Public Plans must continue to cover the service. If the QIO does not approve the service, the member can file a Level 2 "fast track" appeal with the same QIO, and the QIO must notify the member of a final decision within 14 days of receiving all required information. The member must file the Level 2 Appeal within 60 days of the original QIO decision.

Members may contact One Care Member Services at **855-393-3154** (TTY: 711) Monday – Friday 8a.m. – 8p.m.

Tufts Health One Care Pharmacy Program

Pharmacy benefit information for Tufts Health One Care members is available on our Pharmacy webpage.

Pharmacies should bill Tufts Health Public Plans' pharmacy benefit manager, Optum Rx, for pharmacy services for Tufts Health One Care members.

Providers may submit pharmacy authorization requests through electronic prior authorization (ePA), PromptPA or submit a medication request form to Tufts Health Public Plans:

Mail: Tufts Health Plan
Attn: Pharmacy Utilization Management Department
1 Wellness Way, Canton, MA 02021
Fax: 617-673-0956

Expedited coverage decisions are made within 24 hours after receipt but may take up to 14 calendar days if a supporting statement is needed. Standard coverage determinations are made within 72 hours after receipt but may take up to 14 calendar days if supporting statements are needed. Notification of the decisions to approve or deny the request will be made via ePA, mail or fax.

Medication Therapy Management Program

Tufts Health One Care 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, 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).

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. Participation in the program is voluntary and a member can disenroll at any time.

For additional information refer to the Medication Therapy Management Program.

PUBLICATION HISTORY

01/01/24	updated timeliness of care and provider termination sections to align with CMS final rule CY 2024
01/03/24	updated track two training link
04/30/24	added Provider Advice and Advocacy section; administrative edits
09/20/24	removed Timeliness of Care section given revisions to the Provider Access Standards table in the Providers chapter; administrative edits
02/14/25	administrative edits