Rights and Responsibilities

This chapter outlines provider and member rights and responsibilities. Refer to this chapter for information about:

Refer to the Tufts Health One Care chapter for specific rights and responsibilities information regarding members of Tufts Health One Care.

Provider Termination

In accordance with the provider's contract advance notice must be provided in writing of intent not to renew consistent with the time frame specified in the contract. Once notified, Tufts Health Public Plans will notify members that the provider will no longer be affiliated with the Tufts Health Public Plans network. If a provider is not directly contracted with Tufts Health Public Plans and is contracted through a Provider Organization, the provider is responsible for contacting the Provider Organization regarding the process for termination.

To facilitate continuity of care, whenever possible, Tufts Health Public Plans permits members to continue ongoing courses of treatment with their current provider during a transitional period from the time the member is notified about the provider's termination. Providers must make available, pursuant to the provider contract, a transitional period when a member asks for one. When appropriate, Tufts Health Public Plans will work with providers to reassign members to an in-network provider. For information about member continuity of care, refer to the Utilization Management Guidelines chapter.

For information about involuntary provider suspension or termination, which Tufts Health Public Plans addresses through credentialing, refer to the Providers chapter.

Disenrolling a Member from a Panel

Providers cannot involuntarily disenroll MassHealth members from their panel without taking significant steps to address the issue at hand. Providers who are interested in pursuing disenrollment of a member should contact Tufts Health Plan's Provider Service Center with the following information.

- A thorough, objective explanation of the reason for the request detailing how the individual's behavior has impacted the provider's ability to arrange for or provide services to the individual or other members of the provider, including:
  - Statements from providers describing their experiences with the member
  - Any information provided by the member (e.g., complaints, statements)
- Member information: age, diagnoses, mental status and functional status, a description of his or her social support systems, and any other relevant information
- Information on steps taken to address situation/follow up:
  - Outline of the serious efforts to resolve the problem with the individual, including providing reasonable accommodations and utilizing care management or care coordination services.
  - Attestation that the member received at least one written notice in advance
- Additional information/other:
  - Documentation establishing that the member's behavior is not related to the use, or lack of use, of medical, BH or other services;
  - Description of any extenuating circumstances

Tufts Health Plan, and subsequently EOHHS, will review the submission and supporting materials and contact you with next steps. Providing this information to Tufts Health Plan does not ensure that disenrollment will be granted.

Member Grievances, Appeals, Rights and Responsibilities

Members may designate a provider to exercise rights on their behalf as a designated representative. Tufts Health Public Plans requires that members of Tufts Health Together MCO, Tufts Health Together ACPPs and Tufts Health Direct complete a Designated Representative Form or Tufts Health RITogether members complete a Tufts Health RITogether Designated Representative Form as documentation that the member did authorize the provider to file an appeal on their behalf.

Tufts Health Public Plans does not retaliate or take any punitive action against a provider who requests an expedited resolution or supports a member's expedited appeal or grievance.

Definition of Terms (Tufts Health Together and Tufts Health RITogether)

An **authorized representative** is a person authorized in writing or allowed by law to act on a member's behalf regarding a specific grievance, grievance decision review, internal appeal or external review. If a member is not able to pick an authorized representative, in a case where one is needed, a guardian, conservator, holder of a power of attorney, or family member, in that order of priority, may be named the member's authorized representative or may pick another person to be the member's authorized representative. If the member is under the age of 18 and is able by law to consent to a medical procedure, they can also pick an authorized representative without the consent of a parent or guardian.

A **grievance** is when a member or a member's authorized representative tells Tufts Health Public Plans they are dissatisfied with any action or inaction other than an adverse action (for Tufts Health Together members) or adverse determination (for Tufts Health Direct or Tufts Health RITogether members). A grievance for Tufts Heath RITogether members may also include a request for disenrollment. Grievances may relate to quality of care or services provided; aspects of interpersonal communication, such as a provider's or a Tufts Health Public Plans employee's unprofessional behavior; failure to respect a member's rights; a disagreement a member may have with Tufts Health Public Plans' decision not to approve a request that an internal appeal be expedited; or a disagreement with Tufts Health Public Plans' request(s) to extend the time frames for resolving an authorization decision or an internal appeal.

An **internal appeal** is an oral or written request for Tufts Health Public Plans to review any adverse action/determination.

An **external review/appeal** is a request for an external medical review agency to review Tufts Health Public Plans' final internal appeal decision. An external review may be with the state fair hearing agency of the external appeal medical review agency, including the Office of Medicaid's Board of Hearings (BOH) in Massachusetts and the Office of the Health Insurance Commissioner (OHIC) in Rhode Island.

An **expedited appeal** is an oral or written request for an expedited review of an adverse action/determination when a member's life, physical or mental health, or ability to attain, maintain or regain maximum function will be at risk if we follow our standard time frames when reviewing the member's request.

Adverse actions (whether actions or inactions) are when:

- Tufts Health Public Plans denies payments for all or part of a requested service
- A provider fails to provide covered services within the time frames we describe in the applicable *Member Handbook*
- Tufts Health Public Plans denies or limits authorization for a requested service
- Tufts Health Public Plans reduces, suspends or ends a service previously authorized
- Tufts Health Public Plans does not act on a prior authorization request within the time frames described in the applicable *Member Handbook*
- Tufts Health Public Plans does not follow the internal appeal time frames described in the applicable *Member Handbook*
- Tufts Health Public Plans denies a RITogether member's request to dispute financial liability

A **grievance decision** review is our process for reviewing one of our grievance decisions at the provider's request as a Tufts Health Public Plans member's authorized representative.

Definition of Terms (Tufts Health Direct)

An **adverse determination** is a decision, based upon a review of information the member or the member's authorized representative provides to Tufts Health Public Plans or the designated utilization review organization to deny, reduce, modify or end an admission, continued inpatient stay or the receipt of any other services for failing to meet the requirements for coverage based on medical necessity, appropriateness of health care setting, and level of care or effectiveness.

Member Grievances

As a member's designated representative, providers may file a grievance in the following ways:

Product	Phone	Fax	Mail	In person
Tufts Health Public Plans – MA	888-257-1985[1] TTY/TTD: 711	617-972-9509	Tufts Health Plan Attn: Appeals & Grievances Department P.O. Box 474 Canton, MA 02021	1 Wellness Way Canton, MA 02021[1]
Tufts Health Public Plans – RI	844-301-4093[2] TTY/TTD: 711	857-304-6406	Tufts Health Plan Attn: Grievance Coordinator P.O. Box 474 Canton, MA 02021	75 Fountain Street Floor 1 Providence, RI 02903[2]

Members may file a grievance at any time. Tufts Health Public Plans will offer assistance in the filing process as needed. Tufts Health Public Plans will not take action on a member's grievance from anyone other than the member unless the member signs a Designated Representative Form (for Massachusetts Members) or Tufts Health RITogether Designated

[1] Tufts Health Plan's Massachusetts office is open Monday through Friday, from 8 a.m. to 5 p.m., excluding holidays.

[2] Tufts Health Plan's Rhode Island office is open Monday through Friday, from 8 a.m. to 6 p.m., excluding holidays.

Representative Form (for RITogether Members) or submits other legal documentation designating an authorized representative. Members may call the number listed above to request the appropriate form. If the signed Designated Representative Form or other type of legal documentation is not received within 30 calendar days of the initial request, Tufts Health Public Plans will dismiss the grievance.
Once a grievance is filed by a member or authorized representative, Tufts Health Public Plans will:

- Inform the member or authorized representative that the grievance was received by sending a written notice within one business day (Massachusetts) or five calendar days (Rhode Island)
- Look into and resolve the grievance within 30 calendar days (Massachusetts) or 90 calendar days (Rhode Island) from when the grievance is received
- Communicate to the member or authorized representative, in writing, of the outcome of the grievance, which will include the information considered, and explain the decision
- Provide interpreter services and offer assistance upon request

Request a Grievance Decision Review (Tufts Health Together and Tufts Health RITogether)

If a member is dissatisfied with how Tufts Health Public Plans resolved a grievance, the member, or provider as an authorized representative, may request a grievance decision review from in the same ways that members can file a grievance, as described previously.

Once a grievance decision review request is filed by a member or an authorized representative, Tufts Health Public Plans will:

- Inform the authorized representative or the member that the grievance decision review request was received by sending a written notice within one business day (Massachusetts) or five calendar days (Rhode Island)
- Look into the substance of the request, including any aspect of clinical care involved
- Resolve the grievance decision review within 30 calendar days (Massachusetts) or 90 calendar days (Rhode Island) of getting the request and let the member or authorized representative know of the outcome in writing
- Document the substance of the grievance decision review request and the actions taken
- Provide interpreter services and offer assistance upon request

Member Appeals

The appeals process differs by plan. Refer to the appropriate section below depending on the Member's plan.

Refer to the Tufts Health One Care chapter for Tufts Health One Care member appeals information.

Note: Tufts Health Public Plans will not take action on a member's appeal from anyone other than the member unless the member signs an Authorized Representative Form or submits other legal documentation selecting the provider, a family member, friend, or legal guardian as an authorized representative. If the member does not complete the Designated Representative Form in a timely fashion, the appeal will be dismissed. For expedited appeals, or when a member is inpatient, Tufts Health Public Plans will allow the appeal process to proceed without the Designated Representative Form. However, we do require that a Designated Representative Form is completed, for Tufts Health Together MCO, Tufts Health Together ACPP or Tufts Health RITogether as documentation that the member had, in fact, authorized the provider to file the expedited appeal on the member's behalf.

Tufts Health Direct Appeals

The following appeals information is for Tufts Health Direct Members.

Request an Internal Appeal

A member, an in-network provider on behalf of a member, or an authorized representative of the member may file an internal appeal within 180 calendar days of an adverse determination. To process an internal appeal request, Tufts Health

Public Plans requires a copy of the notice of adverse determination and any additional information about the internal appeal. File an internal appeal in the following ways:

Phone	Fax	Mail	In person
888-257-1985[1] TTY/TTD: 711	857-304-6321	Tufts Health Plan Attn: Appeals & Grievances Department P.O. Box 474 Canton, MA 02021	1 Wellness Way Canton, MA 02021[1]

A member, provider or authorized representative has 180 days to request an internal appeal, however, acting as soon as possible is encouraged.

Tufts Health Public Plans will let the member and the provider or authorized representative know that the internal appeal request was received by sending a written notice within 48 hours.

Service Continuation During the Internal Appeal

If a Tufts Health Direct member files an appeal concerning the termination of ongoing coverage or treatment, Tufts Health Public Plans will continue the disputed coverage at our expense through the end of the appeal process as long as the member or authorized representative requests the internal appeal in a timely manner, based on the course of treatment. Ongoing coverage or treatment includes only services that had previously been authorized, and does not include services that were terminated pursuant to a specific time- or episode-related exclusion from the member's contract for benefits, unless:

- The treatment or proposed treatment that is the subject of the appeal is, in the opinion of the physician responsible, medically necessary
- A denial of coverage for such services would create substantial risk of serious harm to the patient
- Such risk of serious harm is so immediate that the provision of such services should not await the outcome of the appeal process

Standard Internal Appeal Time Frames

Tufts Health Public Plans will review and make a decision about internal appeal requests within 30 calendar days from the date the request is received. Any Tufts Health Direct member internal appeal not properly acted on by Tufts Health Public Plans within the time frames specified will be decided in the member's favor. Time limits any extensions must be made by mutual written agreement between the member, or the authorized representative, and Tufts Health Public Plans.

Reviewing Medical Records as Part of the Internal Appeal

A Tufts Health Direct member or an authorized representative may send Tufts Health Public Plans written comments, documents or other information relating to a member's internal appeal. If Tufts Health Public Plans needs to review additional medical records, the standard internal appeal period of 30 calendar days begins when the member or authorized representative sends a signed authorization for release of medical records and treatment information, as required. If Tufts Health Public Plans does not receive this authorization within 30 calendar days of receipt of the internal appeal request, a decision on the internal appeal may be issued without reviewing some or all of the medical records. The member has a right to review their case file, which includes information such as medical records and other documents and records considered during the appeal process.

Expedited Appeals

If Tufts Health Public Plans' standard time frame of 30 calendar days could seriously harm a Tufts Health Direct member's life, health or ability to get back to maximum function, or if it will cause a member severe pain that cannot be adequately managed without the requested service, then the member, provider or authorized representative may request an expedited appeal. The member or authorized representative may request an expedited appeal orally, in writing or in person rather than requesting a standard internal appeal. The member or authorized representative may also request

an expedited external review from the Massachusetts Office of Patient Protection (OPP) at the same time they request an expedited appeal.

There are three situations when Tufts Health Public Plans may review an internal appeal in an expedited manner, and each situation has a certain time requirement in which the internal appeal must be decided:

- If the member is a patient in a hospital, Tufts Health Public Plans must issue a decision before the member is discharged from the hospital.
- If the provider informs Tufts Health Public Plans in writing that a delay in providing the requested service or supply would result in risk of substantial harm to the member, Tufts Health Public Plans must issue a decision within 72 hours.
- If the member is terminally ill, Tufts Health Public Plans must issue a decision within five business days, unless the services are needed urgently, which shall be resolved within 72 hours.

Tufts Health Public Plans will issue a decision within 48 hours, or in less time for durable medical equipment (DME), as specified in 958 CMR 3.309(3), when the provider:

- Certifies that the use of the DME is medically necessary
- Certifies that a denial of coverage for such DME would create a substantial risk of serious harm to the member
- Certifies that such risk of serious harm is so immediate that the provision of such DME should not await the outcome of the normal appeal process

For DME in the event the certifying physician exercises the option of automatic reversal earlier than 48 hours, the physician must further certify as to the specific, immediate and severe harm that will result to the patient absent action within the 48-hour time period.

Any expedited appeal not properly acted on by Tufts Health Public Plans within the time limits specified will be decided in the Tufts Health Direct member's favor. Time limits include any extensions mutually agreed upon between the member, or the authorized representative, and Tufts Health Public Plans.

If the expedited appeal upholds the denial of coverage, Tufts Health Public Plans will allow the member or the authorized representative to ask for a conference. Tufts Health Public Plans will schedule the conference within 10 business days of receiving a request. The conference will be held within five business days of the request if the treating provider determines, after consulting with a Tufts Health Public Plans medical director, that the effectiveness of the proposed treatment or supplies, or any alternative treatment or supplies, would be greatly reduced if not provided at the earliest possible date. The member or the authorized representative can attend the conference.

Written Notice of Appeal Decisions

Tufts Health Public Plans will notify the member and any authorized representative of the appeal decisions in writing. For adverse determinations, this notice will include a clinical explanation for the decision and will:

- Include information about the claim including, if applicable, the date(s) of service, the health care provider(s), the claim amount, and any diagnosis, treatment and denial code(s) and their corresponding meaning(s)
- Give specific information upon which Tufts Health Public Plans based the adverse determination
- Discuss the member's symptoms or condition, diagnosis and the specific reasons why the evidence submitted does not meet the relevant medical review criteria
- Specify alternate treatment options Tufts Health Public Plans covers
- Reference and include applicable clinical practice guidelines and review criteria
- Provide a summary of the reviewer's professional qualifications
- Let the member or authorized representative know about options to further appeal the decision, including procedures for requesting an external review and an expedited external review

External Review Process

Tufts Health Direct members who receive a final adverse determination for a medical necessity appeal have the opportunity to file a request for an external review from the Massachusetts Office of Patient Protection (OPP).

Members, providers or their authorized representatives are responsible for starting the external review process. Tufts Health Public Plans will enclose an External Review Form any time a final adverse determination is issued. To start the review, the member or authorized representative must complete and submit the required form to the OPP within four months of receiving the final adverse determination.

If a Tufts Health Direct member has been receiving a covered service and the plan is terminating these services, the disputed coverage will continue at our expense through the end of the appeal process, as long as the member or authorized representative files the external review request by the end of the second business day after receiving the final adverse determination. If the external review agency decides a member should keep getting the service because there could be substantial harm if the service ends, Tufts Health Public Plans will keep covering the service until the external review is decided, no matter what the final external review decision is.

The OPP will screen all requests for external reviews to see if they:

- Meet the requirements of the external review
- Do not involve a service or benefit we specify in the applicable *Member Handbook* as excluded from coverage
- Result from our issuing a final adverse determination

The member will not need a final adverse determination if the member filed for an expedited external review from the OPP and an expedited appeal from Tufts Health Public Plans at the same time.

The OPP will screen the request for an external review within five business days of receiving the request. Once the case is deemed eligible for external review, the OPP will submit it to the external review agency. The external review agency will then send the member and the authorized representative a written decision within 45 calendar days.

Expedited External Reviews

A member, provider or an authorized representative may request an expedited external review if a provider certifies in writing to the OPP that a delay in providing the care would result in a serious threat to the member's health. The OPP will screen the request within 48 hours of receiving it. Expedited external reviews are resolved within 72 hours from when the external review agency gets the referral from the OPP. Providers may request an expedited external review at the same time an expedited appeal from Tufts Health Public Plans is requested.

How to Contact the OPP

If providers or members of Tufts Health Direct have questions about member rights or the external review process, contact the OPP the following ways:

- **Phone:** 800-436-7757
- **Fax:** 617-624-5046
- **Website:** mass.gov/orgs/office-of-patient-protection
- **Email:** hpc-opp@state.ma.us
- **Mail:** Health Policy Commission
  Office of Patient Protection
  50 Milk Street, Eighth Floor
  Boston, MA 02109

Medicaid Appeals (Tufts Health Together and Tufts Health RITogether)

A member or an authorized representative can request an internal appeal for Tufts Health Public Plans to review an adverse action.

Tufts Health Public Plans will offer assistance in the filing process, as needed.

Appeal Rights

All members of Tufts Health Together and Tufts Health RITogether and their authorized representatives have specific rights during the internal appeals process, including the right to:

- Make an appointment to present information in person or in writing within the internal appeal time frames
- Send Tufts Health Public Plans written comments, documents or other information about the internal appeal
- Review the member's case file, including such information as medical records and other documents considered during the internal appeal process
- File a grievance if Tufts Health Public Plans asks for more time to make an internal appeal decision, and the member or the authorized representative disagrees
- File a grievance if Tufts Health Public Plans denies a request for an expedited appeal, and the member or the authorized representative disagrees with that decision
- File directly with the BOH (Massachusetts) or OHIC (Rhode Island) if Tufts Health Public Plans does not make an appeal decision within the required time frames (as outlined in the following sections)

Requesting an Internal Appeal

A member or an authorized representative can request an internal appeal to ask that Tufts Health Public Plans reviews any adverse action. To process the request, Tufts Health Public Plans requires a copy of the notice of adverse action, and any additional information about the internal appeal. File an internal appeal in the following ways:

<table>
<tr><th>Product</th><th>Phone</th><th>Fax</th><th>Mail</th><th>In person</th></tr>
<tr><td>Tufts Health Public Plans – MA</td><td>888-257-1985[1]
TTY/TTD: 711</td><td>857-304-6321</td><td rowspan="2">Tufts Health Plan
Attn: Appeals & Grievances Department
P.O. Box 474
Canton, MA 02021</td><td>1 Wellness Way
Canton, MA 02021[1]</td></tr>
<tr><td>Tufts Health Public Plans - RI</td><td>844-301-4093[2]
TTY/TTD: 711</td><td>857-304-6406</td><td>75 Fountain Street, Floor 1
Providence, RI 02903[2]</td></tr>
</table>

Note: If an internal appeal is requested by a member or an authorized representative via telephone or in person, Tufts Health Public Plans will request follow-up with a written internal appeal request, unless requesting an expedited appeal.

If Tufts Health Public Plans does not have enough information to make a decision about the internal appeal, we will ask the member or the authorized representative for it. If the additional information is not received, the internal appeal may be denied.

The member or the authorized representative must request an internal appeal within 60 calendar days of the notification of adverse action (or, if the authorized representative or member does not get a notice, within 60 calendar days of learning of the adverse action). The member or the authorized representative may also send written comments, documents or any additional information about the internal appeal. Tufts Health Public Plans will inform the member or the authorized representative in writing within one business day (Massachusetts) or five calendar days (Rhode Island) that the internal appeal request was received.

If Tufts Health Public Plans does not receive the internal appeal request within 60 calendar days, the adverse action will be considered final. Tufts Health Public Plans will dismiss internal appeals the member or the authorized representative requests after 60 days. If the member or the authorized representative believes that the internal appeal was requested on time, the member or the authorized representative has the right to request that the dismissal be reversed and continue

the internal appeal. To do so, the member or the authorized representative must send a written request within 10 calendar days of the dismissal. Tufts Health Public Plans will decide whether to reverse the dismissal and continue the internal appeal.

Standard Internal Appeal

After looking into an internal appeal, including any additional information, Tufts Health Public Plans will make a decision based on a review by a health care professional with the appropriate clinical expertise within 30 days of receiving the appeal. If additional information is needed, and we expect our review to take longer than 30 calendar days, we will inform the member or the authorized representative in writing within two calendar days and ask for an extension of 14 calendar days. At that time, Tufts Health Public Plans will give the member and the authorized representative a new date to resolve the issue. Tufts Health Public Plans may ask for an extension if more information is needed to make a decision, if it is believed the information would lead to approving the request and if Tufts Health Public Plans can reasonably expect to receive this information in 14 calendar days. If the member or the authorized representative disagrees with the decision to take an extension, the member or the authorized representative can file a grievance as described previously. Also, the member or the authorized representative has the right to ask for an extension of 14 calendar days to provide more information.

Unless the member or the authorized representative indicates that the member does not want to get continuing services, Tufts Health Public Plans will keep covering previously approved services until the internal appeal is decided, as long as the request for an internal appeal is received within 10 calendar days of the notice of adverse action (or, if the member or the authorized representative does not get any notice, within 10 calendar days of learning of the adverse action). Note, this does not include denied requests to extend treatment beyond a previously authorized period. If the internal appeal is denied, the member may have to pay for these services.

If Tufts Health Public Plans denies the internal appeal, the member or the authorized representative may request an external appeal/review (fair hearing), following the process described in the Requesting an External Appeal and Requesting an External Review sections.

Requesting an Expedited Appeal

The expedited appeal process exists for circumstances that involve acute medical and/or behavioral health services, and when taking the time for a standard internal appeal could seriously jeopardize the member's life, physical or mental health or ability to attain, maintain or regain maximum function.

A member or an authorized representative can request an expedited appeal in any of the ways previously described how to request an internal appeal. In addition, the member or the authorized representative may request an expedited appeal at night, on weekends or on holidays by calling **888-257-1985** (Massachusetts) or **866-738-4116** (Rhode Island). Hearing impaired dial **711**. The Member or the authorized representative must request the expedited appeal within 60 calendar days of the notification of adverse action (or, if the Member did not receive any notice, within 60 calendar days of learning of the adverse action).

Unless a member of Tufts Health Together or Tufts Health RITogether indicates they do not want to continue getting services, Tufts Health Public Plans will continue covering previously approved services until a decision is made about the expedited appeal or the appeal is withdrawn, as long as the request is received within 10 calendar days of the notice of adverse action (or, if the member did not receive any notice, within 10 calendar days of learning of the adverse action). Note, this does not include denied requests to extend treatment beyond a previously authorized period. If Tufts Health Public Plans denies the expedited appeal, the member may have to pay back the cost of these services.

If the provider, files the expedited appeal request, or if the provider supports the member's expedited appeal request, then Tufts Health Public Plans will approve the request to speed up the appeal when the request has to do with the member's health condition. Tufts Health Public Plans must have the Designated Representative Form showing the provider has permission to act on the member's behalf. Please note that although Tufts Health Public Plans requires a Designated Representative Form giving the provider permission to act on the member's behalf, processing the expedited appeal will not be delayed while waiting to receive the form.

If the request for an expedited appeal does not relate to a specific health condition, Tufts Health Public Plans may or may not decide to speed up the appeal. If Tufts Health Public Plans denies the expedited appeal request, the member and the authorized representative will be informed within one business day (Massachusetts) or two calendar days (Rhode Island) and treat the request as a standard internal appeal (as described earlier). The member or the authorized representative may file a grievance if they disagree with the decision to deny the request for an expedited appeal.

If Tufts Health Public Plans accepts the expedited appeal request, a decision will be made as quickly as the member's condition requires, and in no more than 72 hours, and the member or the authorized representative will be informed of the decision by phone and in writing. If more information is required, if there is a reasonable likelihood that such information would lead to the approval of the request and Tufts Health Public Plans can reasonably expect to receive this information in 14 calendar days, the member or any authorized representative will be notified in writing within two calendar days and take a 14-calendar-day extension. The member or any authorized representative may file a grievance if they disagree with the need for this extension. The member or the authorized representative also has the right to ask for an extension of up to 14 calendar days to provide more information.

If the appeal is denied, the member or the authorized representative may request an external review (fair hearing) from the Office of Medicaid's Board of Hearings (BOH) for Massachusetts or OHIC for Rhode Island, following the process described in the Requesting an External Appeal and Requesting an External Review sections.

Requesting an External Appeal (Tufts Health Together)

When requesting an external review (fair hearing) with the BOH, a member or an authorized representative may request an external review (fair hearing) directly from the BOH after Tufts Health Public Plans denies an internal appeal; denies an expedited appeal; or if any of these appeals were not resolved within the appropriate time frames.

Tufts Health Public Plans will send a notice of the decision and a copy of the How to Ask for a Fair Hearing form and instructions any time an internal appeal is denied. The provider or the Member can call **888-257-1985** to obtain a copy of the form.

The member or the authorized representative must file a request for an external review (fair hearing) within 120 calendar days from the date of the internal appeal decision.

If the external review involves a decision by Tufts Health Public Plans to reduce, suspend or terminate a member's previously-approved services and a provider wishes for the member to continue receiving the services under dispute during the external review, the BOH must receive the completed form within 10 calendar days of the decision, and the member or the authorized representative must indicate on the BOH application form that the member wants to continue receiving these services. If the external review decision upholds the appeal decision, the member may be held responsible to pay for the cost of these services.

Tufts Health Public Plans will comply with and implement BOH decisions as required.

Requesting an External Review (Fair Hearing) with the Rhode Island EOHHS (Tufts Health RITogether)

If the member isn't satisfied with the outcome of our internal appeal, the member can request an External Review or State Fair Hearing. This hearing is free-of-charge. Members must exhaust Tufts Health Public Plans' internal appeal process before requesting a State Fair Hearing. To request a State Fair Hearing, call the Executive Office of Health and Human Services Appeals Office at 401-462-2132 (TYY: 401-462-3363) (English and Español).

A State Fair Hearing must be asked for within 120 calendar days of the outcome date of Tufts Health Public Plans' internal appeal decision.

Members may also ask for an external appeal through an External Review Agency chosen by the Office of the Health Insurance Commission (OHIC). An external appeal must be filed with the External Review Agency (ERA) within 4 months of receiving the notice that the appeal was denied. There is no cost to a member for an external review associated with filing an external appeal with an ERA. However, for providers who request an independent external review on their own behalf, there is an upfront cost of $210.00.

If the external review involves a decision by Tufts Health Public Plans to reduce, suspend or terminate a member's previously-approved services and a provider wishes for the member to continue receiving the services under dispute during the external review, the DHS must receive the completed form within 10 calendar days of the decision, and the member or the authorized representative must indicate on the DHS application form that the member wants to continue receiving these services. If the external review decision upholds the appeal decision, the member may be held responsible to pay for the cost of these services.

Members who are not satisfied with the outcome of their appeal also have the right to notify the Rhode Island Department of Health at:

EOHHS Appeals Office
Virks Building
3 West Road
Cranston, RI 02920
Phone: 401-462-2132 (TTY: 401-462-3363)

For additional assistance, members may contact Rhode Island Parent Information Network (RIPIN) at 401-270-0101.

Tufts Health Public Plans will comply with the External Review decision or Fair Hearing Decision.

Member Rights and Responsibilities

As part of Tufts Health Public Plans' strong commitment to quality care and customer service it is important that 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 receiving the most of their memberships.

Member Responsibilities

- Treat all health care providers with respect and dignity
- Keep scheduled appointments with healthcare providers or provide adequate cancellation or late notice
- Give Tufts Health Public Plans, their PCP, specialists and other health care providers complete and correct information about their medical history, current medications and other matters about their health
- 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 health improvement plans and goals
- Follow care plans and instructions agreed to with their providers. Understand their health problems and participate in mutually agreed-upon treatment goals, to the degree possible and that refusing treatment may have serious effects on their health
- Contact their PCP or behavioral health provider for follow-up care within 48 hours of visiting the emergency room
- Change their PCP or behavioral health provider if they are not happy with their current care
- Voice concerns and complaints clearly
- Inform Tufts Health Public Plans of the following:
  - If they have access to any other insurance
  - If potential fraud and/or abuse is suspected
  - Of any address, phone or PCP changes.
    Note: The member is responsible for reporting changes to the state as well.
  - If they are pregnant or any other family composition changes
- Supply, to the extent possible, information needed by their healthcare providers and Tufts Health Public Plans and to the providers who provide their care

Member Rights

- 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
- Receive information on all available treatment options and alternatives, presented in a manner appropriate to the member's condition and ability to understand
- Receive a second opinion on a medical procedure, and to have Tufts Health Public Plans cover a second opinion consultation for members of Massachusetts plans
- Receive a second opinion for proposed treatment and care for members of RITogether
- Obtain medically necessary treatment, including emergency care
- Receive information about our organization, services, PCPs, specialists, other providers and member rights and responsibilities
- Have a candid discussion of appropriate or medically necessary treatment options for condition(s) regardless of cost or benefit coverage
- Work with their PCP, specialists and other providers to make decisions about their health care
- Accept or refuse medical or surgical treatment
- Call their PCPs and/or behavioral health provider's office 24 hours a day, seven days a week
- Expect that their health care records are private, and that Tufts Health Public Plans and their providers abide by all laws regarding confidentiality of patient records and personal information, in recognition of members' rights to privacy
- File a grievance to express dissatisfaction with Tufts Health Public Plans, their providers or the quality of care or services received
- Appeal a denial or adverse action/determination Tufts Health Public Plans makes for their care or services
- Be free from any form of restraint or seclusion used as a means of coercion, discipline or retaliation
- Receive services in a culturally competent manner
- Obtain written notice of any significant and final changes to our provider network, including but not limited to PCP, specialist, hospital and facility terminations that affect them
- Ask for and get copies[3] of their medical records, and ask that Tufts Health Public Plans amend or correct the records, if necessary
- Receive covered services
- Make recommendations about member rights and responsibilities
- Ask for more information or explanation on anything included in the *Member Handbook*, either orally or in writing
- Ask for a duplicate copy of the *Member Handbook* at any time
- Ask for and receive the *Member Handbook* and other Tufts Health Public Plans information translated into their preferred language or in their preferred format
- Exercise their rights without having treatment adversely affected
- Be furnished ACPP Covered Services when applicable
- Be furnished MCO Covered Services when applicable

[3] Massachusetts providers may charge a reasonable fee for the expense of providing copies, in compliance with 243 CMR 2.07(13)(b). The provider may not charge a fee to any member if the record is requested for the purpose of supporting a claim or appeal.

Rhode Island providers may charge a reasonable administrative fee for copying medical records; however, the transfer of medical records cannot be delayed due to non-payment of administrative fees. Records should be provided within 30 days.

Privacy Rights

Tufts Health Public Plans is committed to protecting the rights and privacy of members. Our Notice of Privacy Practices describes how Tufts Health Public Plans may use and disclose protected health information (PHI), and how members can get this information.

Notice of Privacy Practices is available online, in the *Member Handbooks* or by calling Provider Services at **888-257-1985** (Massachusetts) or **866-738-4116** (Rhode Island). Tufts Health Public Plans and the member's provider are required by state and federal law (including HIPAA) to maintain the privacy of members' PHI and members' other personal information across our organizations, including oral, written and electronic forms of member information. The provider's obligation to maintain the confidentiality of member information is also included in the provider contract.

Advance Directives

Members have certain rights relating to an advance directive. Advance directives are written instructions, sometimes called a living will, health care proxy or durable power of attorney for health care. If a member is no longer able to make decisions about their health care, having an advance directive in place can help. These written instructions tell providers what to do if the member cannot make health care decisions and may authorize a Tufts Health Public Plans designated individual, also known as a health care agent or proxy, to make decision on their behalf. Tufts Health Public Plans has the authority to audit member records for the presence of advance directives.

Members who execute an advance directive or health care proxy also have the right to:

- Make decisions about their medical care
- Get the same level of care as Members without an advance directive and be free from any form of discrimination
- Get written information about their health care provider's advance directive policies
- Have their advance directive, if they have one, in their medical record

In Massachusetts, members at least 18 years old and who have sound mind can make decisions for themselves. Members may also choose someone else to be their health care agent or health care proxy. The health care agent or proxy is a person who can make health care decisions for them in the event that their health care providers determine that they are unable to make their own decisions.

To choose a health care agent or proxy, a member must fill out a Health Care Proxy Form, available from their provider, another provider or Contacting Member Services. Tufts Health Public Plans members can also request a Health Care Proxy Form from the Commonwealth of Massachusetts. Members can write to the address below and send a self-addressed stamped envelope to:

Commonwealth of Massachusetts
Executive Office of Elder Affairs
1 Ashburton Place, Fifth Floor
Boston, MA 02108

Permissible Marketing Activities

As a state-contracted Managed Care Organization (MCO) and Accountable Care Partnership Plan (ACPP), Tufts Health Public Plans must meet, as appropriate, MassHealth, Health Connector, EOHHS and Centers for Medicare & Medicaid Services (CMS) requirements, and other applicable state and federal regulations related to Member marketing activities.

Massachusetts Marketing Activities

Our Massachusetts state contract includes the following definitions:

Marketing is any communication from Tufts Health Public Plans, its employees, providers, agents or subcontractors, to an eligible member who is not enrolled in Tufts Health Public Plans and that reasonably can be interpreted as intended to influence the eligible member to enroll in Tufts Health Public Plans, or either to not enroll in, or to disenroll from, another

MCO or MassHealth Primary Care Clinician plan. This includes the production and dissemination by or on behalf of Tufts Health Public Plans of any marketing materials. Marketing shall not include any personal contact between a provider and a member who is a prospective, current or former patient of that provider regarding the provisions, terms or requirements of MassHealth, the Health Connector or CMS as they relate to the treatment needs of that particular member.

Provider-site marketing is any activity occurring at or originating from a provider site, whereby Tufts Health Public Plans staff or designees, including physicians and office staff, personally present Tufts Health Public Plans and/or MassHealth marketing materials or other provider-site marketing materials to eligible individuals to convince them to enroll in Tufts Health Public Plans. This type of marketing also includes direct mail campaigns you send to your patients eligible for MassHealth or qualified health plans.

Marketing materials are materials that are produced in any medium, by or on behalf of Tufts Health Public Plans, and can reasonably be interpreted as intended for marketing to eligible individuals. This includes the production and dissemination by or on behalf of Tufts Health Public Plans of any promotional material or activities by any medium including, but not limited to, oral presentations and statements, community events, print media, online, audiovisual tapes, radio, television, billboards, Yellow Pages, and advertisements that explicitly or implicitly refer to MassHealth, the Health Connector or CMS, and are targeted in any way toward eligible individuals.

Our contracts require Tufts Health Public Plans to inform providers of this and, as a contracted provider, you must comply as well. Tufts Health Public Plans regularly reviews these policies and will provide any changes in writing.

Tufts Health Public Plans and contracted Tufts Health Public Plans providers may engage in only the following marketing activities, in accordance with MassHealth, Health Connector and CMS requirements:

- Implementing state-approved targeted marketing campaigns and distributing and/or publishing approved marketing materials in our service area by:
  - Posting written marketing materials at provider sites and other service areas
  - Initiating mailing campaigns
  - Advertising via television, radio, newspaper, websites, online, and other audio or visual advertising
- Sponsoring a health fair or community activity. We may conduct or participate in health fair marketing and other community activities if:
  - Regulators preapprove any marketing materials we distribute
  - Any free samples and gifts we offer (which will be of only a nominal value) are made available to all event attendees, regardless of their intent to enroll in our plan
- Participating in state-sponsored health benefit fairs

Tufts Health Public Plans and contracted Tufts Health Public Plans providers may NOT engage in the following marketing activities, in accordance with MassHealth, Health Connector and CMS requirements:

- Distributing any marketing materials EOHHS or the Health Connector does not approve
- Distributing any inaccurate, false, misleading, confusing or fraudulent marketing materials, including but not limited to making any assertion or statement, whether written or oral, that:
  - The recipient of the material must enroll in our plan to obtain benefits or to not lose benefits
  - CMS, the federal or state government, or a similar entity endorses Tufts Health Public Plans
- Engaging in any misleading, confusing or fraudulent marketing activities that misrepresent MassHealth, EOHHS, the Health Connector, Tufts Health Public Plans or CMS
- Seeking to influence a member's Tufts Health Public Plans enrollment in conjunction with the sale or offering of any non-health-insurance products (e.g., life insurance, which Tufts Health Public Plans does not offer)
- Seeking to influence a member's Tufts Health Public Plans enrollment in conjunction with the sale or offering of cash, cash equivalents or in-kind gifts
- Engaging directly or indirectly in door-to-door, telephonic or any other cold-call marketing activities
- Conducting any provider-site marketing, except as previously discussed

- Engaging in marketing activities that target members on the basis of health status or future need for health care services, or which otherwise may discriminate against individuals eligible for health care services

Contact Provider Services at **888-257-1985** with any questions about marketing activities.

Rhode Island Marketing Activities

Marketing means any communication, to a Medicaid member that can reasonably be interpreted as intended to influence the recipient to enroll in Medicaid Managed Care (42 CFR 438.104).

Marketing materials means materials that are produced in any medium that can reasonably be interpreted as intended to market to Potential Enrollees or Enrollees to change Health Plans.

Providers contracted with Tufts Health Public Plans must comply with all marketing requirements as outlined by the Rhode Island Executive Office of Health and Human Services. Tufts Health Public Plans regularly reviews these policies and will provide any changes in writing.

Tufts Health Public Plans and contracted Tufts Health Public Plans providers may engage in only the following marketing activities in accordance with Rhode Island Executive Offices of Health and Human Services and CMS requirements:

- Implementing state-approved targeted marketing campaigns and distributing and/or publishing approved marketing materials in our services area by:
- Posting written marketing materials at provider sites and other locations
  - Initiating mailing campaigns
  - Advertising via television, radio, newspaper, websites, online and other audio or visual advertising
  - Sponsoring a health fair or community activity. We may conduct or participate in health care marketing and other community activities if:
    - Regulators pre-approve any marketing materials we distribute
    - Any free samples and gifts we offer (which will be of only a nominal value) are made available to all event attendees, regardless of their intent to enroll in our plan
- Participating in state-sponsored health benefit fairs

Tufts Health Public Plans and contracted Tufts Health Public Plans providers may NOT engage in the following marketing activities, in accordance with Rhode Island Executive Offices of Health and Human Services and CMS requirements:

- Distributing any marketing materials Rhode Island Executive Offices of Health and Human Services does not approve
- Distributing any inaccurate, false, misleading, confusing, or fraudulent marketing materials, including but not limited to making any assertion statement, whether written or oral that
- The recipient of the material must enroll in our plan to obtain benefits or to not lose benefits
  CMS, the federal or state government, or a similar entity endorses Tufts Health Public Plans
- Engaging in any misleading, confusing or fraudulent marketing activities that misrepresents Rhode Island Executive Offices of Health and Human Services, Tufts Health Public Plans, or CMS
- Seeking to influence a member's Tufts Health Public Plans enrollment in conjunction with the sale or offering of any non-health insurance products (e.g., life insurance, which Tufts Health Public Plans does not offer)
- Seeking to influence a member's Tufts Health Public Plans enrollment in conjunction with the sale or offering of cash, cash equivalents, or in-kind gifts
- Engaging directly or indirectly in door-to-door, telephonic, or any other cold-call marketing activities
- Conducting any provider-site marketing, except as previously discussed
- Engaging in marketing activities that target members on the basis of health status or future need for healthcare services, or which otherwise may discriminate against individuals eligible for health care services

Contact Provider Services at **844-301-4093** with any questions about marketing activities.

PUBLICATION HISTORY

01/01/24	Updated plan name to Tufts Health One Care
06/07/24	Revised footnote numbering to superscript following phone numbers and address in the table in the “Requesting an Internal Appeal” section