Recommendation Number	Recommendation	Response	Implementation Date
15a	Tufts Health Plan shall revise its behavioral health utilization review processes in the manner set forth below: a. Tufts Health Plan shall revise its utilization review criteria as necessary to assure compliance with current rules and regulations and to operationalize the use of this criteria to ensure its general medical necessity standard cannot be used to deny services which otherwise meet Tufts Health Plan utilization review guidelines.	Tufts Health Plan updated its policies to clarify that when applying behavioral health utilization review criteria, the medical necessity standard cannot be used to deny services which otherwise meet Tufts Health Plan utilization review guidelines.	December 31, 2020
16	Tufts Health Plan shall document and maintain a process that offers providers an opportunity to request approval of a behavioral health service inconsistent with the formal criteria, based on the unique or unusual nature of the patient's clinical condition or circumstances. Such decisions shall be considered medical necessity decisions. The Utilization Review (UR) Agent physician reviewer shall consider, address, and document all information submitted by the ordering provider in connection with this exceptions process as part of the medical necessity decision.	Tufts Health Plan currently allows providers the opportunity to request approval for behavioral health services if there are unique clinical circumstances that warrant an authorization even if all guideline criteria are not met. Clinical reviewers may utilize their clinical judgement after considering, addressing, and documenting all information submitted by the ordering provider in connection with this exceptions process as part of their medical necessity decision. Supporting this process, all Tufts Health Plan medical necessity guidelines state, in the "Background, Product, and Disclaimer Information" the following: Medical Necessity Guidelines are developed to determine coverage for benefits and are published to provide a better understanding of the basis upon which coverage decisions are made. We make coverage decisions using these	December 31, 2020

		guidelines, along with the Member's benefit document, and in coordination with the Member's physician(s) on a case-by-case basis considering the individual Member's health care needs. To further support this recommendation, Tufts Health Plan developed an internal process document to further detail this exception review process and specify for our UM clinical reviewers to include information considered, addressed, and documented as part of the medical necessity decision. Additional training was provided on this existing process and the new policy.	
17a	Tufts Health Plan shall revise its behavioral health utilization policies and procedures to include the items set forth below. Each revised policy and procedure shall be subject to an explicit component of a utilization review program training manual and training module. Compliance with the revised policies and procedures shall be monitored by an oversight policy, conducted by Tufts Health Plan: a. Tufts Health Plan shall revise the manner in which its level of care criteria are applied to patients with opioid addiction, in the following manner (Tufts Health Plan should ensure that third-party delegates also conform to these recommendations): i. The patient's risk of relapse, overdose, and death should be given appropriate weight and	Tufts Health Plan developed a process document that provides the review framework for how level of care criteria are applied to patients with opioid addiction. This document includes: (1) giving explicit consideration and appropriate weight to the patient's risk of relapse, overdose, and death; (2) consideration for the patients clinical condition, the attending provider's treatment recommendation and rationale for the request, relevant information offered or included in the medical record, inclusion of medical assisted treatment (MAT) status as part of continuity and transition of care, and the safety and wellness of the patient; and (3) a process to substantiate any dispute in material facts and/or clinical circumstances presented by attending provider when utilization review decisions differ from length of stay or level of care recommendation. This information was updated	December 31, 2020

	explicit consideration. ii. Any utilization review decision should adequately consider (i) the patient's clinical condition, (ii) the attending provider's ("attending provider" shall have the same meaning as "ordering provider" and "treating provider" in this document) treatment recommendation and rationale for the request, (iii) all relevant information offered or included in the record, (iv) continuity and transition of care to include a patient status on a particular Medication Assisted Treatment (MAT) and (v) the safety and welfare of the patient. iii. When the material facts and clinical circumstances presented by the attending provider for treatment of opioid addiction are not in dispute, the utilization review decision should not conflict with the attending provider's level of care or length of stay recommendation unless Tufts Health Plan substantiates that the provider's recommendation is unreasonable.	in Tufts Health Plan's policies. Tufts Health Plan trained staff on these materials and maintained evidence of training. Tufts Health Plan developed a new oversight policy that includes monitoring compliance with requirements regarding the application of level of care criteria for members with opioid addiction.	
17b	b. Notice of Adverse benefit determinations shall clearly identify the specific criteria or criteria subset not met and the facts supporting the reviewer's conclusion that the specific criteria or criteria subset were not met.	Tufts Health Plan clarified its workflows to include instruction to specifically document the criteria/criteria subset that are not met for adverse determinations and also include reasoning to support why those criteria are not met with the submitted clinical information. Tufts Health Plan has implemented standard language templates for adverse determinations to capture all these points and continues to update and enhance that language to make it optimal.	December 31, 2020

		Tufts Health Plan trained staff on updates made to its policies and maintained evidence of said training.	
17c	c. Ensure that, before any denial or appeal decision is made, a Tufts Health Plan physician (if the service and/or treatment request is made by a physician) conducts and documents a thorough and independent review of the case, rather than simply relying or upholding the observations and recommendations of non-physician case management staff. The Tufts Health Plan physician shall review all material clinical information, consider whether all necessary information has been collected, give sufficient weight to the ordering provider's clinical judgment or recommendation, and offer a clinically-based rationale for any denial.	The Tufts Health Plan 's policies were updated to include an explicit statement that physician reviewers must conduct and document a thorough and independent review of the case, including the request, clinical notes, any letter of medical necessity etc. The Tufts Health Plan physician must review all relevant material clinical information, follow-up with a request for any necessary additional information that may be needed, give sufficient weight to the ordering provider's clinical judgment or recommendation, and offer a clinically-based rationale for any denial. Tufts Health Plan updated the denial language template and policies to explicitly document that the MD has independently reviewed all the above information prior to making the decision. Tufts Health Plan trained staff on updates made to its policies and maintained evidence of said training.	December 31, 2020
17d	d. The utilization review denial and appeal decision shall adequately consider (i) the patient's clinical condition, (ii) the attending provider's treatment recommendation and rationale for the request, (iii) all relevant information offered or included in the record, (iv) continuity and	Tufts Health Plan updated its policies to specifically include language requiring the MD to adequately consider: (i) the patient's clinical condition, (ii) the attending provider's treatment recommendation and rationale for the request, (iii) all relevant information offered or included in the record, (iv) continuity and transition of	December 31, 2020

	transition of care, and (v) safety and welfare of the patient.	care, and (v) safety and welfare of the patient. The physicians then must utilize the criteria set in the medical necessity guidelines, InterQual guidelines and /or benefits document, along with clinical judgement to make a decision based upon all factors. Documentation was created clarifying that physician reviewers have the ability to make exceptions to the criteria / guidelines based on unique circumstances. Tufts Health Plan trained staff on updates made to its policies and maintained evidence of said training.	
17e	e. When the material facts and clinical circumstances presented by the attending provider for treatment of a behavioral health patient are not in dispute, the utilization review decision shall not conflict with the attending provider's level of care or length of stay recommendation unless Tufts Health Plan substantiates that the provider's recommendation is unreasonable.	Tufts Health Plan updated its policies to include a review instruction that when there is not a dispute in the material facts and clinical circumstances presented, a requirement that Tufts Health Plan reviewers must approve the attending provider's length of stay recommendation or must document a clinically-based rationale to substantiate a denial of a provider's recommendation as unreasonable. Tufts Health Plan trained staff on updates made to its policies and maintained evidence of said training.	December 31, 2020
17f	f. Ensure that, when the facts and circumstances presented suggest reason to believe that necessary clinical information critical to the utilization review decision is missing, such necessary clinical information should be	Tufts Health Plan currently has a formal request for more information (RFMI) letter that is used to obtain additional clinical information necessary to complete a review. In addition, the applicable policies have been updated to emphasize that reasonable efforts must be made to specify and	December 31, 2020

	specifically and reasonably solicited from the provider.	obtain additional clinical information necessary for utilization review if there is reason to believe information is missing. Guidelines to define reasonable efforts will be detailed as well as instructions regarding how missing clinical information must be specified in the RFMI. Tufts Health Plan trained staff on updates made to its policies and maintained evidence of said training.	
17g	g. The utilization review process shall require Tufts Health Plan to explicitly consider and document whether a potential utilization review denial might impede care or delay care.	Tufts Health Plan's policies were updated to include ample and explicit consideration to unique circumstances and urgency of care required, and to document whether the denial may impede care or delay care. Denials are issued for requests which do not meet medical necessity criteria or are not proven to be standard of care. The physician reviewers are able to make exceptions to authorize a part of or the entire requested service if there are unique clinical circumstances that warrant an authorization even if all guideline criteria are not met. Documentation was created to clarify this as referenced in item 17d. Tufts Health Plan trained staff on updates made to its policies and maintained evidence of said training.	December 31, 2020
18a	Tufts Health Plan shall revise its documentation policy for utilization review records for behavioral health services.	Tufts Health Plan developed a Behavioral Health department case record documentation policy and documentation template that includes all provisions in 18a-18e and 18g.	December 31, 2020

	Compliance with the case record documentation policy should be an explicit component of a utilization review program training manual and training module. The revised documentation policy should require case records to include: a. The ordering provider's initial request for service and/or coverage of treatment, including the level of care requested and the number of days requested.	Tufts Health Plan trained applicable staff on the documentation policy and usage of template and maintained evidence of said training.	
18b	b. Any modification of the ordering provider's initial request made by Tufts Health Plan, the clinical rationale for the modification, and the bona fide, voluntary agreement of the provider to the modification.	Please see the response provided in 18a.	December 31, 2020
18c	c. Detail concerning, and/or reasonable efforts to obtain, the patient's clinical condition, history of treatment, and relationships with family members sufficient to make a decision to assure the safety and welfare of the patient.	Please see the response provided in 18a.	December 31, 2020
18d	d. All the clinical information communicated by the treating facility or a provider, and the treating facility's or provider's rationale for treatment, including continued treatment.	Please see the response provided in 18a.	December 31, 2020
18e	e. The specific criteria or criteria subset not met, and the facts supporting the conclusion that the specific criteria or criteria subset were not met.	Please see the response provided in 18a.	December 31, 2020

18f	f. Where a Tufts Health Plan physician reviewer has reviewed a case, the independently prepared review of that Tufts Health Plan's physician reviewer must be documented. In the event of a denial, the review shall include documentation of (i) all material clinical information reviewed, (ii) the utilization review criteria not met, (iii) the information supporting the denial, and (iv) the reviewer's rationale for rejecting or disagreeing with the ordering provider's clinical judgment or recommendation.	Tufts Health Plan updated its policies to include an explicit requirement that the independently prepared review made by the Tufts Health Plan physician reviewer will be documented in the case review documentation, as described in 18a. In the event of a denial, the review will include documentation of (i) all material clinical information reviewed, (ii) the utilization review criteria not met, (iii) the information supporting the denial, and (iv) the reviewer's rationale for rejecting or disagreeing with the ordering provider's clinical judgment or recommendation. The physician case review documentation was updated to include language containing all of these points.	December 31, 2020
18g	g. Modify the electronic documentation process to more clearly indicate that prior authorization is not required for emergency services and to specify that emergency services are not pended.	Please see the response provided in 18a.	December 31, 2020
19a	In addition to those recommendations stated in Paragraphs 15-18 above, Tufts Health Plan shall ensure that it and any third-party entity to which it delegates the utilization review function for Tufts Health Plan members shall: Have and utilize utilization review criteria that are in compliance with all federal and state laws and regulations, hold a current Rhode Island certification to perform non-administrative benefit determinations, and be audited by Tufts Health Plan for compliance with the following utilization review criteria related requirements:	Tufts Health Plan confirmed its utilization management policies and procedures adhere to the requirements as noted in items 15-18 above as well as contained in section 19. Tufts Health Plan confirmed that its third-party behavioral health delegates' utilization management policies and procedures contain references to adhere to the same requirements noted in items 15-18 above through the Oversight Committee that has been developed. Tufts Health Plan has revised its current	Oversight Committee was developed in Q4 2020. Oversight and monitoring of Behavioral Health delegated entities to begin for Q3 2021

	i. That only objective, clinically-based, and measurable written criteria shall be used to deny requests for behavioral health services. ii. Use a clinically appropriate national utilization review criteria set that includes an Estimated Length of Stay (ELOS) component or a comparable process approved by the Commissioner. iii. Adopt a criteria set based on national standards and acceptable to the Commissioner. iv. That the criteria and use of criteria shall provide for the coverage of continued stay or care when there is no treatment setting available for the patient on discharge or if there is a delay in the availability of an essential component of the patient's treatment environment. v. Assurance that the criteria and use of criteria that does not permit denial of coverage of a continued level of care or length of stay recommendation for a patient because the patient is not participating in treatment when the patient's non-participation may be related to the patient's behavioral health condition. vi. Assurance that criteria and use of criteria shall not permit the denial of coverage for treatment because the patient has failed in treatment in the past.	delegation oversight program to include a clinical utilization management program that provides active oversight and monitoring of utilization review functions performed by delegated third-party entities. This Program includes confirmation that the third-party entity holds a current Rhode Island utilization review certification, sample case file review, ongoing monitoring of utilization management decisions and delegated activities, and review of third-party criteria and policies and procedures as further described in 19b and 19c. The criteria review will ensure: i. That only objective, clinically-based, and measurable written criteria shall be used to deny requests for behavioral health services. ii. Use of a clinically appropriate national utilization review criteria set that includes an Estimated Length of Stay (ELOS) component or a comparable process approved by the Commissioner. iii. Criteria are based on national standards that are acceptable to the Commissioner. iv. That the criteria and use of criteria shall provide for the coverage of continued stay or care when there is no treatment setting available for the patient on discharge or if there is a delay in the availability of an essential component of the patient's treatment environment. Such continued stay or care may	

		be discontinued if the duration becomes unreasonable. v. Assurance that the criteria and use of criteria does not permit denial of coverage of a continued level of care or length of stay recommendation for a patient because the patient is not participating in treatment when the patient's non-participation may be related to the patient's behavioral health condition. vi. Assurance that criteria and use of criteria shall not permit the denial of coverage for treatment because the patient has failed in treatment in the past.	
19b	b. Tufts Health Plan shall ensure that third-party entities maintain and use utilization review policies and procedures that are in compliance with all federal and state laws and regulations, including compliance with the following: i. There shall be a documented and clinically-based rationale to recommend discharge to a lower level of care prior to the completion of the estimated length of stay where an ELOS is available. ii. Any decision that does not authorize the provider's request, at the level of care and for the number of days requested, shall be classified as a denial, absent the provider's documented communication of a voluntary agreement to modify the request. When the third-party entity	The clinical utilization management program described in 19a will collect and review the third-party behavioral health delegate's utilization review policies and procedures to confirm compliance with State and Federal laws and regulations, including the following: i. There shall be a documented and clinically-based rationale to recommend discharge to a lower level of care prior to the completion of the estimated length of stay where an ELOS is available. ii. Any decision that does not authorize the provider's request, at the level of care and for the number of days requested, shall be classified as a denial, absent the provider's documented communication of a voluntary	Oversight Committee was developed in Q4 2020. Oversight and monitoring of Behavioral Health delegated entities to begin for Q3 2021

	suggests a modification of the request, the third-party entity shall communicate and document a clinically-based rationale for the suggested modification. iii. There shall be clear and explicit evidence to support a conclusion that the ordering provider has voluntarily agreed to modify the request so as to reduce the requested length of stay or lower the level of care. In the absence of such clear and convincing evidence, the modified request should be considered a denial, not an authorization. iv. A patient shall not be denied coverage of a continued level of care or length of stay recommendation for a patient (typically leading to a discharge) based on a rationale of lack of progress or improvement, treatment failure in the past, or lack of participation when the patient non- participation may be related to the patient's behavioral health condition. v. The third-party entity shall have a process to provide for coverage for continued stay or care when there is no clinically appropriate treatment setting available for the patient on discharge, or if there will be a delay in the availability of an essential component of the patient's treatment environment. vi. The utilization review process shall require the third-party entity to explicitly consider and document whether potential utilization review decisions might impede care, delay care, fail to	agreement to modify the request. When the third-party entity suggests a modification of the request, the third-party entity shall communicate and document a clinically-based rationale for the suggested modification. iii. There shall be clear and explicit evidence to support a conclusion that the ordering provider has voluntarily agreed to modify the request so as to reduce the requested length of stay or lower the level of care. In the absence of such clear and convincing evidence, the modified request should be considered a denial, not an authorization. iv. A patient shall not be denied coverage of a continued level of care or length of stay recommendation for a patient (typically leading to a discharge) based on a rationale of lack of progress or improvement, treatment failure in the past, or lack of participation when the patient non- participation may be related to the patient's behavioral health condition. v. The third-party entity shall have a process to provide for coverage for continued stay or care when there is no clinically appropriate treatment setting available for the patient on discharge, or if there will be a delay in the availability of an essential component of the patient's treatment environment. Such continued stay or care may be discontinued if the duration becomes unreasonable.	

	ensure continuity of care, or lead to an inappropriate transition of care.	vi. The utilization review process shall require the third-party entity to explicitly consider and document whether potential utilization review decisions might impede care, delay care, fail to ensure continuity of care, or lead to an inappropriate transition of care.	
19c	c. Tufts Health Plan shall ensure that the documentation policies and procedures of the third-party entity are in compliance with all federal and state laws and regulations, including compliance with the following: i. Case Records shall include the date, time, and detail of each event in the utilization review process. ii. Case Records shall document in detail all conversations or other communications with the ordering provider. iii. When the third-party entity recommends a modification of the ordering provider's request, the Case Record shall document a clinically-based rationale for the recommended modification. iv. Case Records shall be collected, organized, and maintained in a form and in a manner that permits the Commissioner to readily ascertain compliance with state and federal laws and regulations, and implementation of these Recommendations.	The clinical utilization management program described in 19a and 19b will collect and review the third-party behavioral health delegate's utilization review policies and procedures to confirm compliance with State and Federal laws and regulations, including the following: i. Case Records shall include the date, time, and detail of each event in the utilization review process. ii. Case Records shall document in detail all conversations or other communications with the ordering provider. iii. When the third-party entity recommends a modification of the ordering provider's request, the Case Record shall document a clinically-based rationale for the recommended modification. iv. Case Records shall be collected, organized, and maintained in a form and in a manner that permits the Commissioner to readily ascertain compliance with state and federal laws and regulations, and implementation of these Recommendations.	Oversight Committee was developed in Q4 2020. Oversight and monitoring of Behavioral Health delegated entities to begin for Q3 2021

19d	Tufts Health Plan shall revise its oversight program to include periodic compliance audits of entities delegated any portion of the utilization review function for members of Tufts Health Plan health benefits plans. Revised oversight should include review of medical necessity criteria used by the delegated entity to make utilization review decisions to determine whether the criteria are clinically appropriate and reasonably consistent with Tufts Health Plan criteria. Audits shall include a review of the utilization review Case Records of the delegated entity to determine whether the criteria were applied in a clinically appropriate manner, and in a manner consistent with federal and RI laws and regulations.	As noted in 19a, Tufts Health Plan has revised its oversight program to include periodic compliance audits of entities delegated any portion of the behavioral health utilization review function. Revised oversight will include review of medical necessity criteria used by the delegated entity to make utilization review decisions to determine whether the criteria are clinically appropriate and reasonably consistent with Tufts Health Plan criteria. Audits will include a sample review of utilization review Case Records of the delegated entity to determine whether the criteria were applied in a clinically appropriate manner, and in a manner consistent with federal and RI laws and regulations.	Oversight Committee was developed in Q4 2020. Oversight and monitoring of Behavioral Health delegated entities to begin for Q3 2021
19e	e. Tufts Health Plan shall revise adverse benefit and appeal notifications sent by third party entities to explicitly identify the role of the third-party entity and to clearly identify Tufts Health Plan as the member's insurer.	Tufts Health Plan confirmed the third-party delegates explicitly identify the role of the third-party entity and clearly identify Tufts Health Plan as the member's insurer in adverse benefit and appeal letters sent by third party entities.	Third-party delegate adverse determination letter language implemented November 2019.
20a	Tufts Health Plan shall review, and as necessary revise, its scope of behavioral health services subject to prior authorization. To the satisfaction of the Commissioner, Tufts Health Plan shall ensure that its utilization review or care management programs are conducted in a manner comparable to, and no more stringent than, its utilization review or care management	Tufts Health Plan notes that it has not required prior authorization for outpatient psychotherapy since March 2016. Tufts Health Plan will be submitting its mental health parity disclosure forms in accordance with the Federal Consolidated Appropriations Act (enacted on December 27, 2020 for an effective	Tufts Health Plan will be submitting its mental health parity disclosure forms in accordance with the Federal Consolidated Appropriations Act by Q4 2021

	programs for medical surgical services. Tufts Health Plan shall propose for the Commissioner's approval the form, content, and plan year for data collection purposes of a utilization review parity analysis. If feasible, the analysis should be conducted in the following manner. If Tufts Health Plan believes that some elements of the following are not feasible or can be substituted with another parity information or analysis, Tufts Health Plan shall explain its reasoning as part of its Plan of Correction to the Commissioner's satisfaction: a. Identify which mental health, substance use disorder, and medical surgical benefits (excluding prescription drug benefits) are subject to utilization review and: (i) describe the utilization program for each mental health, substance use disorder, and medical surgical benefit; (ii) state the number of requests processed for each mental health, substance use disorder, and medical surgical benefit; and (iii) state the number of denials, appeals, and denials on appeal for those requests processed for each mental health, substance use disorder, and medical surgical benefit.	date of February 10, 2021) as requested by OHIC.	
20b	b. Identify which mental health, substance use disorder, and medical surgical benefits (excluding prescription drug benefits) were not subject to utilization review and state the number of claims processed for each mental health, substance use disorder, and medical surgical benefit.	Tufts Health Plan will be submitting its mental health parity disclosure forms in accordance with the Federal Consolidated Appropriations Act (enacted on December 27, 2020 for an effective date of February 10, 2021) as requested by OHIC.	Tufts Health Plan will be submitting its mental health parity disclosure forms in accordance with the Federal Consolidated

			Appropriations Act by Q4 2021
20c	c. For each mental health, substance use disorder, and medical surgical benefit identified in Paras. 20(a) and 20(b), above: (i) state the reasons or other factors actually used in deciding whether or not utilization review would apply: (ii) identify and summarize the data and other information used to support the reasons or other factors; and (iii) document the decision process.	Tufts Health Plan will be submitting its mental health parity disclosure forms in accordance with the Federal Consolidated Appropriations Act (enacted on December 27, 2020 for an effective date of February 10, 2021) as requested by OHIC.	Tufts Health Plan will be submitting its mental health parity disclosure forms in accordance with the Federal Consolidated Appropriations Act by Q4 2021
20d	d. For each mental health, substance use disorder, and medical surgical benefit subject to utilization review identified in Para. 20(a), above, propose a methodology for determining whether utilization review for mental health and substance use disorder benefits are applied no more stringently than utilization review applied to medical surgical benefits. Such a methodology should: (i) use actual utilization review Case Records in comparing the degree of stringentness; (ii) use independent and/or objective providers to conduct the reviews; (iii) compare the time needed to complete utilization review requests for behavioral health services versus medical surgical services; (iv) compare the complexity of making behavioral health requests versus medical surgical requests; and	Tufts Health Plan will be submitting its mental health parity disclosure forms in accordance with the Federal Consolidated Appropriations Act (enacted on December 27, 2020 for an effective date of February 10, 2021) as requested by OHIC.	Tufts Health Plan will be submitting its mental health parity disclosure forms in accordance with the Federal Consolidated Appropriations Act by Q4 2021

	(iv) consider any other appropriate factors in determining the comparable rigorousness of the reviews.		
29a	Tufts Health Plan shall revise its prescription drug utilization review criteria for medications typically prescribed for behavioral health conditions in the manner set forth below**.** a. Tufts Health Plan's pharmaceutical formularies will continue to include, at a minimum; i. One buprenorphine combination Medication Assisted Treatment product approved for use by the FDA in the treatment of opioid use disorder (commonly known as buprenorphine/naloxone), in a tablet or film form; and ii. One buprenorphine (mono-formulation) Medication Assisted Treatment product approved for use by the FDA in the treatment of opioid use disorder (commonly known as buprenorphine) in a tablet or film form.	Request for 29a was completed as part of the Agreement between OHIC and Tufts Health Plan executed on May 16, 2017.	Implemented as part of the Agreement between Tufts Health Plan and OHIC on 5/16/2017
29b	b. To the extent they exist, Tufts Health Plan shall discontinue any prior authorization requirements or programs for the formulary medications identified in Para.29 (a), above, with the limited exceptions that: i. Tufts Health Plan may propose the adoption of dose limit and supply limit criteria consistent with federal guidelines; however, any such dose or supply limit criteria must allow for the coverage of formulary Medication Assisted Treatment	Request for 29b was completed as part of the Agreement between OHIC and Tufts Health Plan executed on May 16, 2017.	Implemented as part of the Agreement between Tufts Health Plan and OHIC on 5/16/2017

	dispensed within FDA recommended dose guidelines without any prior authorization requirements while the prescribing clinician is provided the opportunity to clinically justify a dose outside the guidelines. ii. Tufts Health Plan may establish prior authorization requirements for mono formulation MAT provided that coverage is provided for the mono formulation MAT for pregnant women without prior authorization.		
29c	c. In connection with: (i) a member that is already taking a MAT medication not identified in Para. 29(a), above; and (ii) a member that is already taking a MAT medication at a prescribed dose level outside the FDA recommended dose guidelines, Tufts Health Plan shall continue to permit such coverage while the prescribing clinician is provided the opportunity to clinically justify continued coverage through the formulary exception process.	Request for 29c was completed as part of the Agreement between OHIC and Tufts Health Plan executed on May 16, 2017.	Implemented as part of the Agreement between Tufts Health Plan and OHIC on 8/1/2017
29d	d. Tufts Health Plan shall revise its utilization review criteria for aripiprazole to ensure that they are reasonable and address the concerns raised in Para., 25(b).	Prior to identification of this audit finding, Tufts Health Plan updated the utilization review Criteria for aripiprazole.	Implemented on August 11, 2015
29e	e. The utilization review criteria or process shall include an "exceptions process" that offers prescribers an opportunity to request approval of a medication (or of a quantity, supply, or dose of a prescription drug) inconsistent with the formal criteria, based on the nature of the patient's	The Tufts Health Plan's policies were updated to confirm that the utilization review process includes an exception process that offers prescribers an opportunity to request approval of a medication (or of a quantity, supply, or dose of a prescription drug) inconsistent with the	December 31, 2020

	clinical condition or circumstances. Such decisions shall be considered medical necessity decisions. The UR Agent physician reviewer shall consider, address, and document all information submitted by the prescriber in connection with the exceptions request.	formal criteria, based on the nature of the patient's clinical condition or circumstances. It will be documented that such decisions are considered medical necessity decisions and the utilization review physician reviewers consider and document all information submitted by the prescriber in connection with the exceptions request. Tufts Health Plan's work instruction has been updated to indicate use of compendia for off-label requests when inconsistent with formal criteria. Tufts Health Plan provided training to staff on the work instruction and maintained evidence of training. Off-label use coverage is included within the publicly posted Pharmacy Medical Necessity Guidelines: Off-Label Use Policy and internal Commercial and Direct Coverage Determination and Exception Policy.	
30a	a. Tufts Health Plan shall classify as a denial any utilization review decision that does not explicitly authorize the prescription drug initially requested, or does not explicitly authorize the initially requested quantity, supply, or dose of the prescription drug.	New partial adverse determination letters were created to specifically deny any request that does not authorize the prescription drug initially requested or does not explicitly authorize the exact specifications initially requested for quantity, supply, or dose of the prescription drug.	May 3, 2021
30b	b. Tufts Health Plan approval letters shall be revised to reflect an unambiguous approval of the medication initially requested and approved, at the dose and quantity requested.	Approval determination letters were amended and implemented to remove ambiguous approval language and to specify the requested drug, dose and quantity.	May 3, 2021

30c	c. Tufts Health Plan shall revise its denial letter content to consider the doctor-patient relationship.	Tufts Health Plan retired the lack of information (LOI) denial letters which were identified as having a potential to harm the Doctor- Patient relationship. Tufts Health Plan will be mindful of the Doctor – Patient Relationship when creating and reviewing letters going forward.	Implemented on August 15, 2020,
30d	d. Tufts Health Plan shall ensure that sufficient information is collected to ensure a safe denial.	Tufts Health Plan's work instruction has been updated to include appropriate outreach to the provider to ensure sufficient information has been collected prior to making a determination. Tufts Health Plan provided training to staff on the work instruction and maintained evidence of training.	October 30, 2020
30e	e. In making a denial, Tufts Health Plan shall consider and document that (i) the denial is consistent with the patient's safety and welfare, (ii) patient care will not be impeded or delayed, and (iii) continuity of care and treatment will not be adversely affected.	Tufts Health Plan's documentation policies were updated to include consideration of and documentation that (i) the denial is consistent with the patient's safety and welfare, (ii) patient care will not be impeded or delayed, and (iii) continuity of care and treatment will not be adversely affected.	December 31, 2020
30f	f. Tufts Health Plan shall establish reasonable policies and procedures around the use of samples, including to ensure continuity of care and the welfare and safety of the patient.	Tufts Health Plan revised the Pharmacy Medical Necessity Guidelines (MNGs) for all Behavioral Health Medications to ensure the guidelines note the use of samples may be considered during the review determination. Tufts Health Plan policies were updated to include a note that samples may be considered during the review determination.	July 20, 2020

30g	g. Tufts Health Plan's prescriber fax form request process shall be revised, as necessary, so as not to result in unnecessary delay in processing requests.	Tufts Health Plan created a new Prior Authorization request form in May 2019 to reduce unnecessary delay in processing requests. This new Prior Authorization form is specific to Rhode Island and the urgency indicator is properly noted for provider to select when needed.	This version of the drug authorization request form was implemented in May 2019
30h	h. Tufts Health Plan's prescriber fax form request process shall ask the prescriber whether or not the request is urgent.	The Tufts Health Plan Medication Prior Authorization Request form referenced in 30g includes a box to check to indicate the request is an "Expedited Review/Urgent Request".	This version of the drug authorization request form was implemented in May 2019
30i	i. If the facts and circumstances presented suggest reason to believe that clinical information critical to the utilization review decision is missing, Tufts Health Plan shall revise its process to more effectively solicit the necessary information from the prescriber that allows a reasonable period of time for the prescriber to respond. Tufts Health Plan shall always ensure that it has sufficient information to make a safe denial with respect to the patient's condition.	The work instruction has been updated to include appropriate outreach instructions to the provider to ensure sufficient information has been collected prior to making a determination. Tufts Health Plan provided training to staff on the work instruction and maintained evidence of training.	October 30, 2020
30j	j. The utilization review process shall be revised to assure that decision-makers explicitly consider whether a potential utilization review denial might impede care, delay care, fail to ensure continuity of care, or result in an unsafe denial.	Tufts Health Plan updated its policies to instruct physician reviewers to consider and document whether an adverse determination will impede care, delay care, fail to ensure continuity of care, or result in an unsafe denial.	December 31, 2020
30k	k. Tufts Health Plan physician reviewers shall conduct and document a thorough, independent review of the prescriber's request, rather than simply relying on the observations and	Tufts Health Plan updated its policies to clarify that Pharmacists are not able to make denial decisions for medication requests for fully insured Rhode Island members. Tufts Health Plan	December 31, 2020

	recommendations of non-physician staff. Pharmacists shall not make denial decisions.	policies were updated to instruct the physician reviewers to conduct and document a thorough, independent review of the prescriber's request.	
30l	l. Tufts Health Plan physician reviewers shall explicitly consider all of the information offered by the prescriber, and explicitly consider the rationale stated by the prescriber in support of the approval request.	Tufts Health Plan policies were updated to clearly instruct physician reviewers that all information submitted by the prescriber is considered when making a determination, including the rationale stated by the prescriber in support of the request. Tufts Health Plan instructed and educated physician reviewers to enhance denial language in adverse determination letters to explicitly document this activity.	December 31, 2020
31a	a. Tufts Health Plan medical reviewer shall include documentation of all material clinical information obtained from the prescriber and what was reviewed, the utilization review criteria not met, and the reviewer's rationale for rejecting or disagreeing with the ordering prescriber's request, clinical judgment, or recommendation.	Tufts Health Plan updated its policies to specify that all physician reviewers follow work flows to document that all available relevant information was reviewed, the specific criteria / criteria subset that are not met for adverse determinations, and the reasoning to support why those criteria are not satisfied by the clinical information submitted.	December 31, 2020
31b	b. Tufts Health Plan shall document the prescriber's initial request, including the dose and quantity of the medication requested and any modification of the provider's initial request made by Tufts Health Plan, the clinical rationale for the modification, and the bona fide, voluntary agreement of the prescriber to the modification.	New determination letters were created and implemented which will specify the prescriber's requested drug, dose and quantity. The work instruction was updated to include appropriate outreach to provider for additional information as well as additional documentation to confirm modification of an initial request. Tufts Health Plan provided training to staff on the work instruction and maintained evidence of training.	Letters implemented on May 3, 2021

31c	c. Tufts Health Plan approval letters shall document the dose and quantity of the requested medication.	Coverage authorization letter templates were amended to include dose and quantity of the requested medication.	May 3, 2021