Summary of Benefit Changes - The following changes may not apply to all plans:

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

- Other benefit changes (all plans)
    - Reduced annual routine hearing exam copay to $0
    - Capped Part B insulin copay at $35 per month when used with insulin pump 10

- Capped Part D Insulin copay at $35 for one month (30-day) supply
- Tier 6 Vaccine drugs covered at $0 copay in all stages
- Copays for outpatient diagnostic labs, tests, or x-rays will not apply if performed and billed as part of an urgent care visit (copays already waived if part of an office visit)
- Office visit copay will apply to surgery services performed during an office visit
- Covered Continuous Glucose Monitors (CGMs) includes therapeutic and adjunctive CGMs
- Covered therapeutic CGMs will be limited to FreeStyle Libre products
- Removed referral requirements for all Behavioral Health (BH) Outpatient Psychotherapy services except Medication Visit and Opioid Replacement Therapy.
- Removed referral requirements for BH Special Procedures:
- For Repetitive Transcranial Magnetic Stimulation (rTMS) a prior authorization will be required, in-network services only.
- For Psychological/Neuropsychological Testing a prior authorization will be required, in network services only.
- For Intensive Outpatient Programs no referral or prior authorization will be required, in network services only.
- Removed referral requirements for BH outpatient mental health care, except psychiatrist services. For psychiatrist services, the referral requirement remains in place, in-network services only.
- Removed referral requirements for substance abuse services.
- Expanded Part B Step Therapy program to include EG HMO plans. Please note that this is only a summary of benefit changes. Before services are rendered, providers are reminded to check member benefits and cost-share amounts using Tufts Health Plan's secure Provider portal or other self-service tools, even for members seen on a regular basis. For more information, please click here.

2023 Benefit Changes Tufts Health Plan SCO

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

Summary of Benefit Changes:

- Increased DailyCare+ Card allowance to $150 per calendar quarter for groceries and other Medicaid approved items. Unused balance at end of quarter will rollover to next quarter. (Allowance was increased to $125 per calendar quarter effective July 1, 2022 as part of COVID flexibilities.)
- Increased Instant Savings Card allowance to $128 per calendar quarter for Medicare-approved over the-counter (OTC) items. Unused balance at end of quarter will rollover to next quarter. (Allowance was increased to $100 per calendar quarter effective July 1, 2022 as part of COVID flexibilities.)
- Increased non-medical transportation to 24 round trips per year.
- Added Lidocaine 4% Topical Patch to list of covered over-the-counter Rx drugs.
- Increased maximum out-of-pocket to $8,300 (no impact to members).
- Removed prior authorization requirements for behavioral health (BH) Specialty Services.
- Removed referral requirements for all BH Outpatient Psychotherapy services except Medication Visit and Opioid Replacement Therapy.
- Removed referral requirements for BH Special Procedures:
- For Repetitive Transcranial Magnetic Stimulation (rTMS) a prior authorization will be required, in-network services only.
- For Psychological/Neuropsychological Testing no referral or prior authorization will be required, in-network services only.
- For Intensive Outpatient Programs no referral or prior authorization will be required, in-network services only.
- Removed referral requirements for BH outpatient mental health care, except psychiatrist services. For psychiatrist services, the referral requirement remains in place, in-network services only. 11
- Removed referral requirements for substance use disorder services.
- Added prior authorization requirement for skilled nursing facility (SNF) care. Please keep in mind that this is only a summary of benefit changes. Before services are rendered, providers are reminded to check member benefits using Tufts Health Plan's secure Provider portal or other self-service tools, even for members seen on a regular basis. For more information, please click here.

Tufts Health Unify Expansion Tufts Health Unify Beginning Jan. 1, 2023, Tufts Health Unify will be available to members living in Essex and Barnstable counties in Massachusetts. Tufts Health Unify offers members wrap around care management in collaboration with Cityblock Health.

Every member is assigned a designated care manager who serves as a point person and assists with:

- Connections to needed social, behavioral, and or medical services to meet their goals
- Coordinating transportation to medical appointments
- Efficiently obtaining durable medical equipment and long-term services and supports
- Accompanying patients to medical office appointments as needed Tufts Health Unify looks forward to working with our provider network to support your patient in 2023. For more information or to speak directly with a Cityblock Health care manager, please call 508-217-9030. For more information, please click here.
- Behavioral Health Screening Tools and Codes Update Tufts Health Together Effective Jan. 1, 2023 and per MassHealth All Provider Bulletin 348, providers will be required to use a new service code (96127) when billing for developmental and behavioral health screening.

Providers will continue to be paid at the same rate. 15 In addition the bulletin also:

- Outlines the discontinuation of specific behavioral health tools, and instead directs providers to refer to the Bright Futures toolkit
- Strongly recommends Autism screening at the 18- and 24-month well child visits The Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services Payment Policy has been updated to reflect these changes. For more information, please click here.

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

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

Star Measures and Provider Reminders, All products

We share your commitment to making sure that our members — your patients — receive outstanding care, coordination of care, and follow up. To that end, we offer the following reminders on two important health topics: controlling blood pressure and transitions of care. Each fall, the Centers for Medicaid & Medicare (CMS) and the National Committee for Quality Assurance (NCQA) Star Ratings program evaluates health plans based on a five-star rating program. Star Ratings program gauges patient satisfaction and the quality of care delivered to members of Medicare plans by evaluating health plans' performance on weighted measures related to clinical outcomes, patient experience, access to care, and general process. In October, Tufts Health Plan eared a 5 Star rating for its Tufts Medicare Preferred HMO plans from CMS for the 8th straight year. Tufts Health Plan is the only Massachusetts plan to receive a 5 Star rating this year, and one of a very few plans in the country to receive this rating for eight years in a row.

The following tips can help improve patient experience and outcomes, and Star Ratings: Controlling High Blood Pressure This Star measure evaluates adequate control of blood pressure over the course of a year in members 18 to 85 years of age who have been diagnosed with hypertension. Some best practices include:

- Creating a treatment plan that includes setting attainable goals with patients
- Educating patients on methods for controlling and or lowering their blood pressure
- Ensuring members understand that while medications may be necessary, taking medication alone does not eliminate high blood pressure
- Documenting blood pressures taken both in the office and by the patient at home in the medical record
- Submitting CPT II codes to report the lowest systolic and diastolic blood pressure readings taken on the same date 18 Transitions of Care This measure looks evaluates transitions of care by assessing the following among discharged members:
- Notification of Inpatient Admission: Documentation of receipt of notification of inpatient admission on the day of admission through 2 days after the admission (3 total days).

- Receipt of Discharge Information: Documentation of receipt of discharge information on the day of discharge through 2 days after the discharge (3 total days).
- Patient Engagement After Inpatient Discharge: Documentation of patient engagement (e.g., office visits, visits to the home, telehealth) provided within 30 days after discharge.
- Medication Reconciliation Post-Discharge: Documentation of medication reconciliation on the date of discharge through 30 days after discharge (31 total days). Providers should be sure to document these steps in the patient's medical records and to bill with the correct CPT codes. Providers are also asked to review all prescriptions listed in the medical record and be sure to clearly document "follow-up visit after hospitalization."

By following these best practices, you help ensure your patients receive outstanding care — and help us maintain our rating as a 5-Star health plan in Massachusetts. For more information, please click here.