Referring Tufts Medicare Preferred HMO Members to Mental Health Providers

CMS regulations stipulate that any mental health provider who renders services to a Medicare or Medicare Advantage plan member must be eligible to bill Medicare.

Tufts Medicare Preferred HMO members are not covered for mental health services rendered by providers who are not eligible to bill Medicare. (This limitation does not apply for members of Tufts Health Plan Senior Care Options.)

Psychiatrists, licensed independent clinical social workers, licensed psychologists, and clinical nurse specialists may bill Medicare for services. However, licensed mental health counselors (LMHCs) and licensed marriage family therapists (LMFTs) are not eligible to bill Medicare.

If you refer a Tufts Medicare Preferred HMO member for mental health services, please be sure that the provider who will render those services is a Medicare-participating provider.

If you have previously referred a Tufts Medicare Preferred HMO member to an LMHC or LMFT, please educate the member that services rendered by LMHCs or LMFTs are not covered and offer to refer the member to a Medicare-participating mental health provider.

If you have questions, or if you need assistance in locating a Medicare-participating mental health provider for your Tufts Medicare Preferred HMO patient, please visit tuftsmedicarepreferred.org and click “Find a Doctor” or call Provider Relations at 800-279-9022.

Tufts Health Plan Adopts Clinical Practice Guidelines for Prevention of Elder Abuse and Neglect

Tufts Health Plan has adopted the American Psychological Association’s guidelines for preventing elder abuse and neglect.

These guidelines include a definition of elder abuse, the cues that may signal elder abuse, and why elder abuse occurs. The guidelines also include the following:

- Discussion of family and caregiving stressors
- Societal and cultural issues related to elder abuse and neglect
- Ways of preventing elder abuse
- Options on what to do if you suspect elder abuse, and
- Resources on where to go for help

Tufts Health Plan encourages providers to familiarize themselves with these and other clinical practice and preventive health guidelines that have been reviewed and approved by Tufts Health Plan.

Visit the Clinical Resources section of tuftshealthplan.com/providers for additional information. Copies of our guidelines are also available upon request by contacting Provider Relations at 800-279-9022.

Tufts Medicare Preferred HMO Changes to Health Risk Assessments

Based on your feedback, Tufts Health Plan Medicare Preferred has made changes to the Health Risk Assessment (HRA) for new members of the Tufts Medicare Preferred HMO plan. This improved HRA process will be more robust, timelier and more easily accessible to your electronic health record systems.

The Centers for Medicare & Medicaid Services requires that an HRA be sent to members who join a Medicare Advantage plan. The HRA gathers data via patient survey that enables physicians and other practitioners to provide the best possible care. The 2014 changes to the HRA include:

- **Multimodal data collection:** The option of completing the HRA via Interactive Voice Response (IVR), Web or paper to allow quicker reactions to positive responses for people who use the IVR system or Web.

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Tufts Medicare Preferred HMO Changes to Health Risk Assessments

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- **Updated, evidence-based, action-oriented questions:** Although the number of clinical questions was increased due to additional data elements, we eliminated questions with no affiliated action based on the response (except for some mandated questions).
- **New PCP reporting:** Our goal is to send limited, actionable information rather than raw data. PCPs will no longer receive paper copies of the complete HRAs. Instead, Tufts Medicare Preferred HMO-participating physician groups will have access to their patients’ HRA information via electronic files. Contact your group’s Medical Director responsible for the Tufts Medicare Preferred HMO product about how you can access this information.

If you have questions about the new HRA process, please contact your group’s Medical Director, or email Jatin Dave, M.D., Medical Director for Geriatrics, at jatin_dave@tufts-health.com.

Reminder: Referral Not Required for Behavioral Health Services in SNF, TCU

Effective January 1, 2014, a referral is no longer required for Tufts Medicare Preferred HMO and Tufts Health Plan Senior Care Options members to receive behavioral health services taking place within place of service 31 or 32.

This change is documented in the Tufts Medicare Preferred HMO, Tufts Health Plan Senior Care Options Skilled Nursing Facility and Transitional Care Unit Facility Payment Policy at tuftshealthplan.com/providers.

Preventive Health and Clinical Practice Guidelines

We’ve made it easier for providers to access Tufts Medicare Preferred HMO and Tufts Health Plan Senior Care Options resources on our public Provider website at tuftshealthplan.com/providers.

Sections dedicated to those plan resources are intended to support our providers by making it easier to find information and content specific to those plans.

The information included in these web pages includes the following resources:

- Plan overview documents
- Payment policies specific to the Tufts Medicare Preferred and Tufts Health Plan SCO products
- Provider manuals
- Clinical resources
- Pharmacy
- Forms
- Mental health

Links to these sections are available under “Plans & Products” on the Provider homepage at tuftshealthplan.com/providers. They also can be accessed by clicking the links under “Plans” in the left navigation bar.

The Patient Activation Measure

The Patient Activation Measure (PAM) is an evidence-based survey designed to assess an individual’s ability to manage his or her own health and health care. The tool is validated by more than 100 peer-reviewed research studies and used across the health care sector, including leading health plans, hospitals, disease management clinics, and research organizations.

The PAM tool can reliably segment the population into four levels, each characterized by distinct differences in knowledge, skills and confidence in managing their own health. Each of these levels is an “activation” level. Higher activation individuals are better self-managers and less likely to be admitted to an ER or to be hospitalized as compared to individuals with lower PAM scores.

Tufts Health Plan Medicare Preferred has licensed the PAM to be used in our Care Management programs beginning in April 2014. Assessing our members for activation level will allow our care managers to tailor their work with each member to activation level-specific coaching and teaching methods.

To assist them in this, Tufts Health Plan Medicare Preferred has also licensed the empirically derived coaching model called Coaching for Activation (CFA) for use by our care managers. CFA is a web-based content tool to support care managers in developing activation level-appropriate goals, focusing on core areas of self-management: condition and symptom understanding, medication adherence, diet and nutrition, physical activity, stress and coping, information-seeking and smoking cessation. The methodology is to guide individuals to experience success and steadily build knowledge, skills and confidence essential to effective self-management.

For questions about the Patient Activation Measure or the Coaching for Activation model, please email Sarah Fowler at sarah_fowler@tufts-health.com.
Attention Tufts Health Plan Senior Care Options Providers

The Centers for Medicare & Medicaid Services requires Tufts Health Plan Senior Care Options to provide their Special Needs Plan (SNP) provider network with training on their model of care. This training is required at the time of contracting for newly contracted SCO providers and annually thereafter for existing SCO providers.

To facilitate your completing this training, we have developed an online educational webcast specifically for primary care providers that includes the following topics:

- An overview of the plan
- Care model information
- Provider roles and resources

This online training, which can be completed in approximately 30 minutes, is available on our website. To access the training, go to the Provider Office Staff Education section at tuftshealthplan.com/providers. Under Webcasts, click on “Product Overviews & Descriptions” and then Tufts Health Plan SCO Care Model Training.

Once you have completed the webcast, please complete the evaluation survey at the end of the training and attest that you have reviewed the information to document your participation.

If you have any questions about the training or how to access the webcast, or should you wish to have an on-site training delivered by a Tufts Health Plan SCO clinical team member, please contact Provider Relations at 800-279-9022.

Tufts Health Plan SCO Members and the Role of the Care Manager

The health status of Tufts Health Plan SCO members may range from healthy to having needs requiring complex care management. While the health care needs of some members are more complex than those of others, all Tufts Health Plan SCO members are assigned a care manager who works directly with them and their caregivers to develop, implement and manage individualized plans of care (IPCs) that are unique to each member.

The care manager is available to primary care providers, as well as to all members of the primary care team, to provide answers to questions regarding a member’s home environment, home- and community-based service needs and/or to provide follow-up evaluation in the member’s home for any specific concerns. A Tufts Health Plan SCO member’s care manager can be identified within the IPC. As a reminder, all Tufts Health Plan SCO PCPs have access to the PCP portal, which provides direct access to member plans of care.

If you have questions about the Tufts Health Plan SCO Care Management Program and the role of the care manager, please contact the Director of Care Management, Gretchen Reynard, at 617-972-9400, ext. 9848.

For questions related to the PCP portal and/or about accessing Tufts Health Plan SCO member IPCs, please contact Provider Relations at 800-279-9022.

Additional HEDIS Measures for Tufts Health Plan Senior Care Options Special Needs Plans (SNPs)

Tufts Health Plan Senior Care Options uses Health Plan Employer Data and Information Set (HEDIS®) as one mechanism to assess its performance against established benchmarks. In addition to the standard HEDIS measures for Medicare Advantage plans, there are two additional SNP-only measures for Tufts Health Plan SCO members:

- The Care of Older Adults (COA) measure to assess members who received an annual assessment in the following four areas:
  - Advance care planning: Identification of patient health goals and advance care planning
  - Functional assessment: Assessing patient’s ability to care for himself or herself, including cognition status, ambulation and fall risk; assessment of hearing, vision and speech, and functional independence
  - Pain screening: Assessment of patient’s pain or pain management plan

- Medication review: Review of patient’s medications and any problems taking medications
- The Medication Reconciliation Post-Discharge (MRP) measure is used to assess members for whom medications were reconciled by a qualified clinician, such as a prescribing practitioner, clinical pharmacist or registered nurse, on or within 30 calendar days of discharge.

In the coming months, Tufts Health Plan Senior Care Options will begin assessing its members to see if they received COA and MRP services in 2014. For members who have not received those services, or for whom we do not have enough information to make an assessment, Tufts Health Plan Senior Care Options will provide gap in care reports to primary care providers to assist in identifying members who may be in need of follow-up care.

For more information about the COA and MRP measures and/or gap in care reports, please email patrice_fisher@tufts-health.com.
Transitional Care Management Visits: Update and Best Practices

Effective January 1, 2013, Medicare pays for two CPT codes (99495 and 99496) that are used to report physician or qualifying nonphysician practitioner transitional care management services for a patient following discharge from an inpatient hospital, skilled nursing facility, or community mental health center stay, observation, or partial hospitalization.

Transitional care management commences upon the date of discharge and continues for the next 29 days. The goal of transitional care management is to reduce gaps and errors in care coordination that frequently lead to rehospitalization.

Primary care clinicians contact patients immediately after discharge and support coordinated care by providing the following:
- Primary care input into discharge planning
- Reconciliation of hospital-prescribed medications with previous medications
- Early assessment of the patient’s follow-up needs and resources at home

Value Added by Transitional Care Management

According to CMS, about 20 percent of Medicare patients are readmitted within 30 days of discharge, at a cost of $15 billion (2007 Med PAC Report). The federal government has estimated the cost of readmissions for Medicare patients alone at $26 billion annually, and it is estimated that preventable readmissions for Medicare patients cost about $17.5 billion each year.

The readmission rate for Tufts Medicare Preferred HMO members is around 15 percent, with variability across groups, and best practices groups have readmission rate below 10 percent. Tufts Health Plan Medicare Preferred has long recognized the importance of TCM and therefore has identified a post-discharge follow-up visit within seven days of discharge as a key performance measure for the past two years.

CPT Codes for Transitional Care Management Visits

CPT codes 99495 and 99496 are used to indicate transitional care management visits for patients whose medical and/or psychosocial problems require moderate- or high-complexity medical decision making during transitions in care from an inpatient hospital setting, partial hospitalization, observation status, or skilled nursing facility, to the patient’s community setting (home, domiciliary, rest home, or assisted living). Appropriate code selection is based on medical decision making complexity and the date of the first face-to-face visit.

For both codes, medications must be reconciled no later than the date of the initial face-to-face visit. Transitional care management commences on the day of discharge and continues for the next 29 days, with the initial face-to-face visit in combination with non-face-to-face services occurring within 30 days of the patient’s discharge. The 30-day period for the transitional care management service begins on the day of discharge and continues for the next 29 days. One billing code is submitted after this global period, and payment for those services is bundled into one payment. The reported date of service should be the 30th day.

Non-face-to-face visits may be performed by the physician or by other qualified health care professional and/or licensed clinical staff under his or her direction.

There is no member copayment for transitional care management codes.

Transitional care management codes cannot be billed if the patient is readmitted within the 30-day period.

Subsequent medically necessary E&M visits occurring within the 30 days may be billed and are paid in addition to the transitional care management code.

Codes 99496 and 99496 cannot be used with codes G0181 (home health care plan oversight) or G0182 (hospice care plan oversight) because the services are duplicative.

If the patient is readmitted in the 30-day period, transitional care management services can still be reported as long as the services described by the code are furnished by the practitioner during the 30-day period, including the time following the second discharge. Alternatively, the practitioner can bill for transitional care management services following the second discharge for a full 30-day period as long as no other provider bills the service for the first discharge.
Documentation Required

Certain documentation is required to bill codes for transitional care management:

- A record of the interactive contact (face-to-face, telephonic, or electronic) with the patient or caregiver within two business days of discharge. At least two timely attempts must be made, and the provider should continue to communicate until successful in completing a face-to-face visit within the specified time frames.
- Documentation of the face-to-face visit, with medication reconciliation and management no later than the date of the face-to-face visit.

Best Practices

Additional best practices include the following:

- Communicating with home health and other relevant community services
- Assessing and supporting treatment and medication compliance
- Educating the patient/family/caretaker to support self-management, independent living and ADLs
- Identifying available resources (e.g., Alzheimer’s Association, chronic disease self-management program, or Fit for Life)
- Facilitating access to care and services needed

Additional Resources

The Centers for Medicare & Medicaid Services’ Transitional Care Management Services Fact Sheet (ICN908628) is available on the CMS website at cms.gov.

Tufts Health Plan Medicare Preferred: Committed to Helping Your Patients Get the Information They Need

We recognize that changing Medicare plans can sometimes be confusing for patients and their loved ones, so we have created several new tools to help aid the transition process to Tufts Medicare Preferred HMO, including:

- A welcome phone message and online welcome video from James Roosevelt, CEO.
- New member transition guide: A “Welcome” booklet included in our new member kits includes basic information to get started, including what to do first, benefit highlights, how to get care, tips for using prescription drug plans, how to get extra discounts, and more.
- An “Understanding Your Prescription Drug Plan” video: This online video, available at tuftsmedicarepreferred.org, explains how to use the Tufts Medicare Preferred HMO prescription drug plans.

We are committed to helping your patients every step of the way. If your patients have any questions regarding how to use their Tufts Medicare Preferred HMO plans, please direct them to our Customer Relations Department at 800-701-9000, TTY: 800-208-9562.

For those patients who have not chosen Tufts Medicare Preferred HMO, the Medicare Annual Election Period (AEP) is October 15–December 7. In addition, your patients can choose Medicare plans at any time of the year if they are:

- Turning 65 and enrolling in Medicare A and B
- Over age 65 (already entitled to Medicare Part A) and retiring, or losing coverage because a spouse is retiring, and enrolling in Medicare Part B
- Retiring from an employer that offers retiree coverage for health insurance whose open enrollment is in the spring (e.g., Group Insurance Commission)
- Eligible for a Special Election Period (SEP), one of many exceptions that Medicare allows for someone to change plans outside the AEP.

When your patients are ready to have a discussion with you or your staff about Medicare, suggest that they call Tufts Health Plan Medicare Preferred (800-867-2000) to get information about Medicare plans. For more information, or to receive updated provider office marketing materials, call Kathy Barniak at 888-880-8699, ext.
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