Tufts Health Plan Senior Care Options
Care Model Training

Designed for Providers
2018
Tufts Health Plan Senior Care Options (SCO) Overview

- Tufts Health Plan SCO is a benefit plan offered through a contract between Tufts Health Plan and the Commonwealth of Massachusetts Executive Office of Health and Human Services (EOHHS).

- Tufts Health Plan SCO provides MassHealth Standard (Medicaid) and Medicare coverage plus additional benefits.

- There is no member cost-share for covered services received from providers participating in the Tufts Health Plan SCO network.

- All members are required to choose a primary care provider (PCP) participating in the Tufts Health Plan SCO network.
Why Do Members Join?

Value for the Member

• Medicare, Medicaid, and Medicare Part D benefits integrated into one plan
• Initial and ongoing geriatric assessments
• Complete health care info accessible to PCT via a Centralized Enrollee Record (CER)
• Development of an Individualized Plan of Care (IPC)
• Access to an array of home and community-based services
• Coordination of all medical, social and behavioral care
• Active involvement in decisions about personal care

Key point: Individualized Plan of Care (IPC) is a detailed written description of the scope, frequency, and duration of all covered services for each member.
Tufts Health Plan SCO Plan Types

- Tufts Health Plan Senior Care Options (HMO SNP)
- For members with both Medicare and MassHealth

Providers should verify member eligibility prior to rendering services.

- Tufts Health Plan Senior Care Options
- For members with MassHealth only
Who Is Eligible to Enroll?

Individuals are eligible to enroll if they:

- Are at least 65 years of age or older
- Have MassHealth Standard (Medicaid) coverage
- Live within the service area
- DO NOT have End Stage Renal Disease (ESRD) at time of enrollment

Also DO NOT reside in an intermediate care facility for mental health conditions or in a chronic or rehabilitation hospital as an inpatient.
How Will Medicare Part D Affect SCO Members?

- SCO members should know that it is not necessary to sign up for Medicare Part D, as Tufts Health Plan SCO provides drug coverage.
- If a Tufts Health Plan SCO member signs up for Medicare Part D, they will be disenrolled from Tufts Health Plan SCO.
Standard Benefits

**Medicare benefits:**
- Inpatient hospital, outpatient hospital, skilled nursing, doctor visits, emergency services, lab and diagnostics, skilled home care, therapies, prescription drugs

**Medicaid (MassHealth) benefits:**
- Custodial nursing care, Personal Care Attendant (PCA) services, Home and Community-Based Services (HCBS), Over-the-Counter (OTC) drugs (with prescription)
- Some benefits and services are based on assessment or may need prior authorization

Benefits are the same for **both** Tufts Health Plan SCO plan options: SCO Dual and SCO Medi.
What Do SCO Members Pay?

SCO members pay NO copayments, deductibles or coinsurance!

SCO members pay NO monthly SCO plan premiums.

Please note: Members with Medicare who are enrolled in a SCO plan must continue to pay their Medicare premiums, but in most cases MassHealth covers this cost.
Funding

- Both Medicare and Medicaid provide funding through capitation to Tufts Health Plan for our SCO Dual plan members, and only MassHealth provides the funding for our SCO Medi plan members.
  - All dental services for Tufts Health Plan SCO members are provided through DentaQuest.
  - All preventive eye care services are provided through EyeMed.
  - Part D benefits are administered by Caremark.
Complaints, Appeals and Grievances

A Tufts Health Plan SCO Member may:

- File a complaint or a grievance (including a complaint about any of our providers) with the plan at any time regarding any aspect of their care
- File an Appeal with Tufts Health Plan SCO
- File an Appeal with the MassHealth Board of Hearings
- File an Appeal with Tufts Health Plan SCO and MassHealth Board of Hearings simultaneously

Of any decision to deny, terminate, suspend or reduce services.

A provider may appeal on behalf of a member with the member’s written consent.
Tufts Health Plan Online Resources

Tufts Health Plan SCO Member website:

tuftsmedicarepreferred.org/plans/senior-care-options-plan

Available on the Member website:
- ✓ Explanation of Coverage
- ✓ Summary of Benefits
- ✓ SCO Provider Directory

Tufts Health Plan SCO Provider website:

tuftshealthplan.com/provider

Available on the Provider website:
- ✓ Provider Manual
- ✓ Payment Policies
- ✓ Medical Necessity Guidelines
SCO Provider Network
Tufts Health Plan SCO Providers are located throughout Massachusetts.

All SCOs are required to contract with local Aging Services Access Points (ASAPs). Geriatric Service Support Coordinators (GSSCs) collaborate with Tufts Health Plan SCO staff to provide members with Medicaid/Home and Community-based Services (HCBS), such as:

- Adult Foster Care (AFC)
- Personal Care Attendant (PCA)
Community-Based Services and Authorizations

The provider prescribing the following Home and Community Based Services (HCBS) is responsible for obtaining Prior Authorization (PA):

- Respite care
- Home modification

Please refer to the Tufts Health Plan Provider website for more information on outpatient services requiring prior authorization.
Referrals and Authorizations

- SCO members can see any provider in the Tufts Health Plan SCO network with a valid referral.

- Members **DO NOT** need prior authorization to visit out-of-network providers, but payment will not be made by Tufts Health Plan SCO, Medicaid, or Medicare without a valid referral.
  - SCO members can see any provider **with** a valid referral from their PCP, and Tufts Health Plan SCO will cover the cost of the appointment.

- Inpatient Notification is required for all medical and behavioral health inpatient services.
Services **NOT** Requiring Prior Authorization

- ANY emergency conditions, including emergency behavioral health and emergent out-of-area renal dialysis.
- Urgent care sought out of the service area or under UNUSUAL/EXTRAORDINARY circumstances.
- Direct-access women’s services.
SCO Drug Coverage
Including OTC Drugs
Participating Pharmacies

- CVS/Caremark is the vendor for the Tufts Health Plan SCO pharmacy and mail order program.

- Complete listing of CVS/Caremark network pharmacies can be found in the provider directory.

- Members can contact CVS/Caremark at caremark.com/wps/portal to ask about a participating pharmacy.
Pharmacies

- Prescriptions must be authorized by a plan provider or doctor.
- Must be filled at a participating CVS/Caremark provider.
- Member must show their Tufts Health Plan SCO ID card.
- Mail-order is a good option for maintenance medications for health conditions such as:
  - Heart conditions, cholesterol, diabetes, arthritis and high blood pressure
The SCO mail order prescription option through Caremark is administered exactly like it is for Tufts Medicare Preferred HMO. The member is not charged for shipping costs.

Out-of-network pharmacy services require prior authorization (PA). Shipping charges, if any, need to be included in the PA and the supplier needs to be instructed not to bill the member.
Pharmacy Programs

- Due to costs and safety concerns, Tufts Health Plan has created a list of medications that are restricted.
- Members are not covered for these drugs.
- The PCP can request an exception.
- All restricted medications fall into one of the following categories:
  - Non-Covered
  - New-to-Market
  - Dispensing Limitations
  - Non-Formulary
  - Prior Authorization
  - Medicare Excluded
Drug Requirements and Restrictions

- Certain drugs may need prior authorization in order for it to be covered.

- For certain drugs, Tufts Health Plan SCO limits the amount of the drug that it will cover.

- Any additional requirements or restrictions are listed on the formulary.

- If there is a restriction or limits, a member can ask Tufts Health Plan SCO to make an exception.
## Definition of Prescription Restrictions

<table>
<thead>
<tr>
<th>Icon</th>
<th>Restriction</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td><img src="specialty" alt="SP" /></td>
<td>CVS/specialty</td>
<td>Drug is available through CVS/specialty (1-800-237-2767)</td>
</tr>
<tr>
<td><img src="generic" alt="G" /></td>
<td>Generic Indicator</td>
<td>This drug is available as a generic</td>
</tr>
<tr>
<td><img src="limited_access" alt="LA" /></td>
<td>Limited Access</td>
<td>Limited Access</td>
</tr>
<tr>
<td><img src="ndsd" alt="NDS" /></td>
<td>NDS</td>
<td>Non-extended Day Supply Drug</td>
</tr>
<tr>
<td><img src="part_b" alt="PB" /></td>
<td>Part B Drug</td>
<td>Covered under Medicare Part B – No copayment is required</td>
</tr>
<tr>
<td><img src="home_infusion" alt="HI" /></td>
<td>Part B; HI</td>
<td>Covered under Medicare Part B – No copayment is required</td>
</tr>
<tr>
<td><img src="prior_authorization" alt="PA" /></td>
<td>Prior Authorization</td>
<td>Prior authorization is required for all members</td>
</tr>
<tr>
<td><img src="prior_authorization" alt="PA" /></td>
<td>Prior Authorization – New Starts</td>
<td>Prior authorization is required for members newly starting on this medication</td>
</tr>
<tr>
<td><img src="prior_authorization_b_vs_d" alt="PA" /></td>
<td>Prior Authorization – Part B vs. Part D</td>
<td>Prior authorization is required to determine appropriate coverage under Medicare Part B or Part D</td>
</tr>
<tr>
<td><img src="quantity_limit" alt="QL" /></td>
<td>Quantity Limit</td>
<td>This drug has a quantity limit</td>
</tr>
<tr>
<td><img src="step_therapy" alt="ST" /></td>
<td>Step Therapy PA</td>
<td>Step therapy prior authorization applies</td>
</tr>
<tr>
<td><img src="transplant" alt="TX" /></td>
<td>Transplant</td>
<td>This drug is covered under Part B when used for a Medicare-approved transplant</td>
</tr>
</tbody>
</table>
Copayments

Like other benefits and services, SCO members pay **NO** copayments, deductibles, or coinsurance for prescriptions and over-the-counter drugs (with a prescription).
Instant Savings Card

- SCO members receive a $72 allowance every three months to use toward Medicare-approved OTC items, such as first aid and mouth care supplies.
  - Members are able to use their allowance with their Tufts Health Plan Instant Savings card – a debit card that is automatically reloaded with the allowance every quarter.
  - This benefit **does not** roll over to the next quarter; the member must use or lose the allowance.
  - Members can use their Instant Savings card at CVS Pharmacy, Walgreens, Rite Aid, Family Dollar and Dollar General.

This benefit is **separate** from the OTC items covered by MassHealth and the additional OTC items covered by Tufts Health Plan (covered at $0 with a prescription).
The SCO Formulary consists of the existing HMO individual formulary PLUS the MassHealth Over-the-Counter Drug List and the MassHealth Non-Drug Product List.

For more information on SCO drug coverage, please visit the Pharmacy section of the Tufts Health Plan Provider Website at tuftshealthplan.com/provider/pharmacy.
Section E of the form asks, “How would you like to pay for this order?”

As SCO members have a $0 copay, they do not need to provide payment information.

Regular delivery is free.

SCO members do have to pay if they choose 2nd day ($17) or next day ($23) shipping options.
The SCO Model of Care
Care Model

The care model focuses on an integrated approach to care management, including medical, behavioral, social, and long-term needs.

- A SCO member’s Primary Care Team (PCT) includes a Primary Care Provider (PCP), a Geriatric Support Services Coordinator (GSSC) from an Aging Services Access Point (ASAP), and a Registered Nurse (RN CM) for oversight and/or ongoing care management. Based on the member’s needs, the PCT may also include a Care Coordinator, Behavioral Health Clinician, a Pharmacist, and/or other health specialists.

Every member has an Individualized Plan of Care (IPC) that is developed during assessment.

- The plan is updated as the member’s condition and needs change.
- A Centralized Enrollee Record (CER), accessible to all members of the care team, contains all activity related to the member’s care.
Rate Cells and Levels of Care

• All members are enrolled as Community Well until they are evaluated by a RN Care Manager, who will submit an MDS-HC to MassHealth to determine their Rate Cell.
• Members are separated into Levels of Care based on their Rate Cell to determine the most appropriate Care Manager, services, and touch point frequency.

Non-complex

Community Well

Level 1 – no HCBS

Level 2 – HCBS

Complex

AD/CMI

Level 3

NHC

Level 4

Level 4a – Advanced Illness

Institutional
High risk Level 4 members can be referred to the House Calls Program, which includes additional oversight by a Nurse Practitioner (NP). Level 4a members continue to be managed by an RNCM, but will have ongoing NP oversight with face-to-face visits monthly (or more frequently, depending on member need). Members can be referred for:

1. High risk diagnosis
2. High risk medications or polypharmacy
3. Lack of access to medical care due to refusal or inability to leave home
4. RNCM unable to obtain PCP response to request for needed evaluation/treatment
5. Decline in functional and/or medical status with no treatment plan/response from PCP
6. Advance planning goals mismatch with medical conditions
7. Member at risk due to social/emotional/physical issues that require NP review
8. Opiate and narcotic overuse and abuse
9. Hospitalizations/ER visits last 6 months
10. Rehab Facility last 6 months
# Care Levels at a Glance

<table>
<thead>
<tr>
<th>Care Level Description</th>
<th>Level 1</th>
<th>Level 2</th>
<th>Level 3</th>
<th>Level 4</th>
<th>Level 4A – Advanced Illness</th>
<th>Institutional</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Rate Cell</strong></td>
<td>Community Well (no HCBS)</td>
<td>Community Well (some level of HCBS)</td>
<td>Alzheimer’s Dementia/Chronic Mental Illness (AD/CMI)</td>
<td>Nursing home Certifiable (NHC)</td>
<td>NHC</td>
<td>Institutional</td>
</tr>
<tr>
<td><strong>Assigned Care Manager</strong></td>
<td>CC</td>
<td>GSSC</td>
<td>BHCM/RNCM (with GSSC)</td>
<td>RNCM</td>
<td>RNCM with NP</td>
<td>RNCM</td>
</tr>
<tr>
<td><strong>Member Impairments</strong></td>
<td>Minimal to none</td>
<td>Functional impairments requiring supervision or assistance with 1 ADL and/or IADL</td>
<td>Cognitive and functional impairments requiring supervision or assistance with ADLs and/or IADLs</td>
<td>Several impairments requiring supervision with 2 or more ADLs. Needs assistance with IADLs.</td>
<td>Several impairments requiring supervision with 2 or more ADLs. Needs assistance with IADLs.</td>
<td>Several impairments requiring assistance – but most likely dependent with ADLs.</td>
</tr>
</tbody>
</table>

**ADL** – Activities of Daily Living  
**CC** – Care Coordinator  
**GSSC** – Geriatric Support Services Coordinator  
**HCBS** – Home and Community-Based Services  
**IADL** – Instrumental Activities of Daily Living  
**RNCM** – Registered Nurse Care Manager  
**BHCM** – Behavioral Health Care Manager  
**NP** – Nurse Practitioner
# Touch Point Frequency

<table>
<thead>
<tr>
<th></th>
<th>Level 1 Community Well</th>
<th>Level 2 Community Well w/HCBS</th>
<th>Level 3 AD/CMI</th>
<th>Level 4 NHC</th>
<th>Level 4A NHC Advanced Illness</th>
<th>Institutional</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Calls/Letters</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>Welcome Call first 30 days of the month by Customer Relations</td>
<td></td>
<td></td>
<td></td>
<td>Welcome letter sent first 30 days of the month by CR</td>
</tr>
<tr>
<td><strong>Initial Assessments</strong></td>
<td></td>
<td>Initial face-to-face assessment completed within 30 days of enrollment by RNCM</td>
<td></td>
<td>Member referred to NP after an initial assessment completed by RNCM</td>
<td>Initial assessment completed in-facility within first 5 business days by RNCM</td>
<td></td>
</tr>
<tr>
<td><strong>Ongoing Assessments</strong></td>
<td>Ongoing telephonic assessment every 6 months by GSSC</td>
<td>Ongoing face-to-face assessment every 6 months by GSSC</td>
<td>Ongoing assessment every 3 months by RNCM/GSSC/SW</td>
<td>Ongoing assessment every 3 months by RNCM (face-to-face and telephonic)</td>
<td>More frequent assessments as needed by NP (face-to-face and telephonic)</td>
<td>Ongoing in-facility assessments every 3 months by RNCM</td>
</tr>
<tr>
<td><strong>MDS Requirement</strong></td>
<td>No MDS-HC</td>
<td></td>
<td>MCH-HC Submitted Annually</td>
<td></td>
<td></td>
<td>SNF responsible for MDS 3.0</td>
</tr>
</tbody>
</table>
Care Transitions
Tufts Health Plan is committed to facilitating continuity of care between settings.

Our goals are to:

- Communicate information about the member’s baseline status from the PCT to the treating provider

- Communicate information about the member’s status from the treating provider to the PCT to facilitate planning for return
As part of the transitions between settings, the PCT is responsible for:

- Reinstating prior services, as applicable, and arranging new services as needed
- Coaching the member on the discharge summary either prior to the member leaving the hospital or at home within 48 hours of discharge
- Arranging an appointment with the member’s PCP within 7 days of discharge
- Conducting an intense follow-up with member to encourage adherence to appointments, medication, and treatment regimens
Primary Care Team
Roles and Responsibilities
Care Coordinator (CC)

Coordinates intake process for all new members:

- Serves as assigned Care Manager for all Level 1 members
- Works in close collaboration with RN Care Managers to assist in:
  - Calling MD offices for clinical information
  - Faxing clinical information to HCBS providers
- Coordinates welcome letters to all new members
- Assists with special projects
SCO CM Administrators

Coordinates intake process for all new members:

- **Disease Management Program**
  - Enroll new members from Quarterly Actuarial report
  - Mail Educational Materials
- **Schedule CHAs for Per Diem NPs**
- **Works in close collaboration with RN Care Managers to assist in:**
  - Fax referral documents to HCBS providers
  - Administer vaccine vials to RNs/NPs and daily monitoring of vaccine temperatures
  - Mail vaccination notification letters to PCPs
- **Creates HCBS Outpatient Events (OPEs) for RN Care Managers**
RN Care Manager (RNCM)

Health care Professional (RN) responsible for managing care for members with complex care needs:

- Assigned Care Manager for Level 3, 4, 4A members
  Institutional members usually have a Nurse Practitioner (NP) assigned
  - Completes initial assessments for all community members, and ongoing assessments for Level 3, 4, 4A
  - Development and implementation of IPC
  - Key player in IDT and PCT meetings
  - Initiates HCBS in collaboration with GSSC
  - Care coordination and planning in collaboration with PCP
  - Post-Hospitalization Assessments (PHAs) and follow-through
  - Disease Management Program assignment and implementation

- MDS-HC completion for Levels 3, 4, 4A members
- Resource and support for GSSC and CC
Clinical Manager

Member of the Care Management Team and is responsible for the development and implementation of the SCO clinical model

- Oversight and monitoring of the day-to-day care management functions
- Collaboration with the SCO Care Management leadership team to manage and implement initiatives to improve performance
- Partners with Network Providers and Allied Health departments to optimize the critical relationships with our community partners (physicians, ASAPs, health care facilities, vendors, etc.
- Oversees the ASAP Performance Consultant Team
- Clinical consultant to the Care Managers and Supervisors on individual cases
Geriatric Support Services Coordinator (GSSC)

Community resource contracted through Aging Services Access Point (ASAP)

- Serves as assigned Care Manager for Level 2 members
  - Ongoing assessments every 6 months
- Coordination of Home and Community-Based Services (HCBS)
- Annual assessments for Level 3, 4, and 4a members
- Collaborates with RNCM on care coordination, IPC, and Plan of Care implementation
- Participates as needed for Interdisciplinary Team (IDT) and PCT meetings
- Assists with Medicaid eligibility issues (MassHealth)
- Works jointly with RN/NP on an annual basis
Community Nurse Practitioner

Licensed Nurse Practitioner (NP) serving as a consultant for high-risk members and those with complex conditions

- Secondary owner to the most complex high-risk members (Level 4a)
- Consult to PCT for all members, regardless of Level, regarding medical conditions
- Act as a liaison to the providers, providing updates to member condition and recommendations for treatment
- Provide palliative consults, medication reviews, and collect annual health and physical reports (H&P)
- Visit members in-home or in SNF
- Member of PCT
Behavioral Health Clinician

Licensed Clinical Social Worker (LCSW) serving as a consultant for members requiring behavioral health services

- Assists with early identification and intervention of behavioral health needs
- Member of PCT
- May serve as primary Care Manager for members with Chronic Mental Illness (CMI)
- Collaborates with RN Care Manager on coordination of care with Department of Mental Health as needed
- Assists with referrals to behavioral health providers
- Collaborates with PCM on coordination of care and medications for members with serious and persistent illness
Dementia Care Consultant provides care consults and advanced expertise and resources. Conducts a needs based assessment and develops plan of care to be shared with the CM, PCP, and member/caregiver.

Primary Care Provider provides overall clinical direction and serves as the central point for integration and coordination of Covered Services.

Pharmacist advises member and PCT on the selection, dosages, interactions, and side effects of medications.

Geriatric Support Services Coordinator care manages a subset of members, authorizes the provision of appropriate HCBS, a key resource to the PCT around community-based supports.

Care Coordinator responsible for developing care plans for a subset of Community Well members, arranging and tracking appointments, educating members, and coordinating other aspects of members’ wellbeing.

Registered Nurse/Nurse Practitioner Care Manager provides care to members with complex care needs via the development, implementation, and evaluations of individualized plans of care.

Behavioral Health Clinician serves as a consultant to the PCT with a focus on members’ behavioral health needs. May serve as primary Care Manager for members with CMI. Augments a multidisciplinary approach to care planning.
Individualized Plan of Care (IPC) Process

1. Upon enrollment, each member chooses a PCP and is assigned a Care Manager.
2. Initial clinical assessments are conducted by the member’s PCP and an RNCM.
3. The CM uses these assessments to develop an individually tailored care plan (IPC).
4. Plan is reviewed with the member and member’s caregivers.
5. An IPC Letter is mailed to the member for signature and the PCP. Once the signed letter is returned to THP from the member, it is stored in CaseTrakker.

Members are regularly assessed for risk by multiple members of the PCT.
Role of Tufts Health Plan Customer Relations

Customer Relations:

- Acts as a enrollee service representative (ESR), working in an incoming call center environment
  - Must have access to the CER
  - Conducts Welcome Calls
  - Assists members if they choose to file an appeal or grievance
  - Assists members with billing questions
  - Assists members with lost ID cards
  - Connects with the Care Manager as needed

Per EOHHS requirements, ESRs must be available during normal business hours on a daily basis, and must answer 90 percent of all calls within 20 seconds or less.
Role of Tufts Health Plan Provider Relations

Provider Relations: 800.279.9022
- Serves as the main point of contact for provider inquiries
- Addresses inquiries regarding covered benefits, claims and Explanations of Payment (EOP)
- Confirms member eligibility
- Answers general and specific provider questions

Provider Education: Provider_Education@tufts-health.com
- Educates providers about products, policies and procedures and self-service technology solutions
- Offers educational programs in the form of webcasts, webinars and onsite meetings

For self-service information and forms, visit the Tufts Health Plan Provider website: tuftshealthplan.com/provider.
Tufts Health Plan SCO Contact Information

Provider Relations: 800.279.9022
• Providers can call with inquiries about claims, benefits, policies and care management.

Member Services: 855.670.5934
• Members can call for information about their health care coverage.
• Translation services are available: 855.670.5936

Appeals and Grievances: 855.670.5934

Provider Education: Provider_Education@tufts-health.com
• Educates providers about products, policies and procedures and self-service technology solutions

Tufts Health Plan Provider Website: tuftshealthplan.com/provider
• For technical inquiries, email: Network_Tech@tufts-health.com.
• For assistance with website navigation, registration and account maintenance, call Provider Web Support at 888.880.8699, ext. 35956.
Thank You!

We appreciate your attention and participation.

Please click here to complete a brief evaluation and attest to the completion of this training.