

Care Management Resource Guide 2024

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I. INTRODUCTION

A. Introduction to Integrated Care Management

The integrated care management model for Tufts Medicare Preferred (TMP) includes inpatient utilization management (UM), transition management across the continuum, and population management. The model relies on a targeted, focused approach utilizing interdisciplinary care teams (ICT) which incorporate healthcare professions including transition managers (TM), registered nurse care managers (RNCM), behavioral health care managers (BHCM), dementia care consultants (DCC), community health workers (CHW), care coordinators (CC), nurse practitioners (NP), and pharmacists and pharmacy technicians (Pharm). The goal is to provide holistic care to the members with the goal of improving health and wellness.

The guiding principles of this model include:

- The Primary Care Provider (PCP), ICT and member interacting as a team
- Use of the most current evidence-based guidelines to manage geriatric patients with multiple chronic conditions to avoid redundant services and prevent avoidable admissions and readmissions
- A focus on developing geriatric expertise with a strong commitment to medication adherence, fall prevention, advanced life planning, social determinants of health (SDoH) and other challenges that seniors face
- A standardization of the member experience across the entire TMP population
- A measurement of standard outcomes and process metrics across the network
- Coordination of all health care providers, including hospitals, emergency departments, specialty clinics, rehabilitation facilities, home care agencies, hospice programs, and social service agencies
- Smooth transitions between sites of care with an intensive focus on transitions in and out of hospitals and extended care facilities.
- Education and support of family caregivers
- Facilitation of access to community resources

The Tufts Health Plan (THP) TMP Care Management Model is designed to improve transitions and coordination of care using:

- Early identification of high-risk members through a segmentation and stratification process
- Clinical guidelines
- Care Managers as educators and coaches
- Member self-management of chronic illness

B. Members of the Interdisciplinary Care Team

Using a team approach, the model aims to increase member self-management and decrease avoidable admissions and readmissions to the hospital for complex and chronic members who can be managed in their home. Ongoing education and support through telephonic and face to face care management can reinforce member independence. The use of self-management tools can reduce avoidable admissions that are prevalent in this population. The TMP RNCM works with each identified member, the PCP, and other members of the care team to create a member-focused plan of care. To be successful, medical groups must be skilled in managing members with multiple chronic and complex conditions. The ratio of care managers to members will depend on the severity score, demographics, and acuity of the population, which will also drive the resources needed for positive outcomes. There are several supporting resources to the RNCM and the TM to “wrap around” the members:

- Pharmacy Technicians and Pharmacists
- Behavioral Health Care managers
- Dementia Care Consultants
- Community Health Workers
- Care Coordinators
- Nurse Practitioners

II. CARE MANAGEMENT PROGRAMS OVERVIEW

A. Complex Management

The Complex Program uses the latest clinical guidelines and educational material to manage members with multiple chronic conditions, co-morbidities, and co-existing functional impairments. This program also aims to improve overall medical care delivery, outcomes, and psychosocial support from family, friends, community outreach programs, and home healthcare providers. Constantly moving members toward healthier living, the issues addressed in the program include those related to education, transportation, access to healthcare providers, clinical evaluations, needs assessments, and disease management. The Complex Program achieves its goals through a partnership between a Care Manager, a member, and a PCP. Members who agree to participate in the program are assessed for geriatric conditions and psychosocial issues that could impact quality of life and medical cost. These issues include, but are not limited to, the following:

- Cultural and linguistic needs/limitations
- Caregiver resources
- Social Determinants of Health
- Functional status with activities of daily living
- Clinical history
- Mental health status, including cognitive functions
- End-of-life planning and goals of care

- Health plan coverage eligibility and benefits
- Geriatric condition management
- Medication adherence and reconciliation
- Fall risk

These assessments can be either face-to-face member interactions or through telephonic care management. Care Managers use the assessment results in collaboration with the member to create a member-centric care plan that includes:

- Member-identified and prioritized problems, goals and interventions
- Schedule for follow-up with specific time frames
- Documentation of barriers with a solution-focused plan

Member action plans are available to the member and family for continued reference. The care plan is a working tool that will change and adapt as member needs arise or resolve and should include assessment and referral for palliative care or hospice needs as appropriate. Complex Program Adherence is monitored through specific measures identified and discussed during interaction with the member.

B. Rising Risk Chronic Illness Management

The Rising Risk Chronic Illness Management Program uses the latest clinical guidelines, member educational materials, motivational interviewing, and self-management support strategies to educate, counsel, and empower members and their caregivers to play a more central role in managing their health. Members who agree to participate in the program are assessed for geriatric conditions and the ability to self-manage their chronic illness. The program includes:

- Co-developing individualized action plans to assist members in making lifestyle and behavioral changes to manage their conditions
- Coaching members to follow an action plan when they have symptoms (i.e., adjust medications, initiate a call to their PCP, make physician office appointments, and follow their medication regimen)
- Coaching members to make appropriate lifestyle changes to achieve their goals (i.e. modifying diet, stopping smoking, participating in exercise, or losing weight)

The Chronic Illness Program conducts telephonic assessments and care management, uses community resources, skilled home care interventions, and other identified needed interventions. Some members may also benefit from a referral to palliative care for assistance with goals of care discussions and symptom management. Evidence-based educational materials that Tufts Health Plan has vetted can be shared with members.

During telephonic care management, motivational interviewing techniques and health coaching is used to:

- Help members follow their treatment plans set in place by their PCP and specialists
- Help members relate these plans to their personal goals
- Help members overcome barriers to effective treatment.

C. Transitional Care Management

Members that have had a hospitalization or admission to a skilled nursing facility (SNF), are identified for the ToC program due to being at greater risk for readmission because of the disruptions caused by the hospitalization. Within an inpatient event, there can be ensuing changes in medications, deconditioning, decline in health status, and other related challenges for geriatric members. These changes can make transitioning to home a challenge. All members transitioning from inpatient to home will be followed for post discharge follow up, medication reconciliation and to ensure the member has a PCP/Specialist follow up appointment. The screening for a “transitions” intervention includes, at a minimum, a standardized phone call assessing the member's confidence in his/her ability to manage his/her post-discharge needs.

After a member is identified for Transitional Intervention, a Care Manager conducts a transition of care assessment and identifies member-specific needs in such areas as:

- Medication adherence
- Fall risk
- Lack of understanding of red and yellow flags of worsening condition
- Self-management deficits
- Psychosocial deficits

The Care Manager collaborates with the Member to identify a Plan of Care to address identified needs. The Care Manager continues to oversee the plan of care to support a successful transition. This is achieved through a series of phone calls lasting up to 45 days, during which the Care Manager re-assesses member needs and determines if the risks are being mitigated by coaching, hands-on help from family or community support, and whether the member's ability and confidence to self-manage his/her care has improved. In an effort to prevent readmission, the Care Manager reinforces the signs and symptoms that warrant a call or visit to the PCP or the Care Manager. In addition, the Care Manager identifies other parties and community resources that address members' specific needs. This may include a visiting nurse, a hospital program, Aging Services Access Points (ASAPs), clinical pharmacists or clinical social workers. The members' readiness for self-management is measured using objective questions, including “confidence” in the ability to manage care and the ability to “teach back” understanding of medication regimes, symptom identification, and action plans. Members are ready to be discharged when the above measures indicate an ability to self-manage. Members not independent within the 45-day time frame should be referred for enrollment in the Complex or Chronic.

D. Emergency Department (ED) Transitions

The ED Transitions Program focuses on members who may have been able to seek care in an alternative setting as well as members who utilize an ED frequently. Interventions include education related to early signs and symptoms of decline, appropriate alternatives to the ED, and assessing and identifying member-specific needs for more intensive care management and community supports and services. This program targets members in the top 20% of the population at risk who need their ED transition managed. Members are identified by daily Admission Discharge Transfer (ADT) notifications and referred to care management. The duration and modality of the program is up to 7 days of telephonic care management. The program is managed by the RNCM along with the CHW and other internal specialist resources if needed.

E. Wellness Supportive Care

This Wellness Supportive Care program focuses on members not currently engaged in a CM program but have been identified as needing assistance with care coordination, potentially require more intensive services (unrelated to a recent ED or hospitalization) or may benefit from outreach to address gaps in care related to quality measures or other health promotion outreach campaigns. Referrals for this program come from PCPs, Member Services, Health Risk Assessment Surveys, Star Measures, and Population Health Analytics. The duration and modality of the program 7-45 days of telephonic care management. The program is managed by the RNCM along with the CHW, CC, and other internal specialist resources if needed.

F. Landmark Health (*Not applicable for Externally Managed Groups*)

The Landmark Health program is a healthcare organization THP has partnered with to provide in-home care for complex, chronic patients. Services include but are not limited to 24/7 In-Home concierge level care for those who need it the most, and in-home diagnostics and interventions to stabilize and treat in place. Members are identified via Landmark's proprietary algorithm which uses a point system for select chronic and complex conditions. Landmark includes select counties in Massachusetts and New Hampshire. This is a longitudinal care model utilizing telephonic care management and in-home scheduled and urgent care visits. This program is managed by Geriatricians, Advances Practice Registered Nurses (APRN), RNCMs, CHWs, Social Workers, Palliative Care Specialists, BHCMS, and Pharm.

G. Behavioral Health (BH) Severe and Persistent Mental Illness (SPMI)

The BH SPMI program integrates behavioral and medical care management, providing holistic care that addresses BH and physical health, including BH transitions management. The SPMI program focuses on supporting members with SPMI with strategies for long-term self-management. Referrals for this program come from PCPs, Member Services, and Internal CMs. The duration and modality of this program is 7-45 days of telephonic care management. This program is managed by BHCMS, Social Workers, CHWs, and BH APRNs.

H. Social Care

The Social Care program involves a care team conducting psychosocial assessments to identify needs and risks, address psychosocial determinants of health, provide information about available resources, and participate in proactive and comprehensive care planning. Referrals for this program come from PCPs, Member Services and Internal CMs. The duration and modality of this program is 7-45 days of telephonic care management. This program is managed by Social Workers and CHWs.

I. Behavioral Health Transitions Program

The Behavioral Health Transitions Program conducts telephonic and/or in-person care management to members who have been hospitalized for behavioral health treatment and are returning home. Eligibility is open to members who are at risk of readmission, as evidenced by:

- A recent psychiatric readmission
- A history of noncompliance either with outpatient services or taking medication as prescribed
- Ineffective self-management
- Co-occurring conditions that can make self-management more challenging

Enrolled members are followed through their 30 to 45 day post-hospitalization period, and telephonic support is provided to attend aftercare appointments and complete their provider's recommendations for care. Care management goals include:

- An assessment and review of the discharge plan and the member's/caregiver's ability to follow the plan
- Support of the member/caregiver to follow through on outpatient specialty services and adhere to the medication directions prescribed by his/her provider
- Education regarding the member's condition
- Conversations with the member and caregiver regarding the coordination of care
- Identification of barriers to successfully following the treatment plan

Sources of referrals to the program include:

- Tufts Health Plan-contracted and non-contracted facilities with psychiatric inpatient services
- TMP Care Managers
- Providers who are currently working with members diagnosed with a psychiatric disorder and who have assessed their patient to be at risk for an inpatient hospitalization

J. Dementia Care Consultation Program (DCC)

The Dementia Care Consultation program is coordinated between Tufts Health Plan and the Alzheimer's Association Massachusetts/New Hampshire chapter.

Dementia care consultation is an in-depth, personalized service for individuals and families facing the many decisions and challenges associated with Alzheimer's disease or related dementia. The goal of the Dementia Care Consultation program is for each family to develop an understanding of a dementia diagnosis; make plans to maximize the independence of the person with memory loss; secure needed resources; and develop strategies for the best possible symptom management and communication.

Dementia Care Consultants have expertise directly related to dementia, as well as training from the Alzheimer's Association. In addition, these consultants have direct access to the Alzheimer's Association's training and programs.

Any member who has or cares for someone with concerns regarding memory or cognitive changes can be referred to this program; formal diagnosis is not needed. The RNCM will assess the member/caregiver and refer to the Dementia Care Consultation Program as appropriate.

To complete the initial consultation, the Dementia Care Consultant contacts the identified caregiver by phone or in person at the Alzheimer's Association office within two weeks. During this consultation, the following areas are assessed:

- Exploration of diagnosis (if there is one) and caregiver/member understanding of the diagnosis
- Presenting symptoms and behaviors
- Level of functioning: activities of daily living (ADL) and instrumental activities of daily living (IADL)
- Level of structure and engagement
- Safety concerns, e.g., driving, wandering, financial, home safety
- Supports, services, and respite
- Approach to care
- Caregiver capacity to provide needed care
- Future planning needs

In addition, the Dementia Care Consultant can offer assistance related to:

- Education about the disease process
- Connection to Alzheimer's Association programs and services
- Management of challenging behaviors
- Communication
- Approach to care
- Accessing and introducing new services
- Safety concerns
- Future care planning
- Recommendations provided to caregivers, care manager, and PCP

The Dementia Care Consultant either emails or faxes written feedback highlighting the assessment and areas discussed to the referring Care Manager. The Care Manager is responsible for sharing this information with member's PCP. In addition, the Dementia Care Consultant sends a personalized care plan to the caregiver. This care plan outlines the recommendations and any resources that were discussed during the assessment. Follow-up is provided until the identified needs are met.

NOTE: Caregivers can be re-referred at any time. The Dementia Care Consultant is also available to consult on cases as needed.

In addition to direct referrals, Tufts Health Plan partnered with the Alzheimer's Association Massachusetts/New Hampshire chapter to provide dementia caregiver education programs on-site for interested medical groups. For medical groups interested in hosting a program, Tufts Health Plan will assist in planning, facilitating, and promoting the program.

K. Clinical Pharmacy (Pharm)

The Clinical Pharmacy team provides consultation to members regarding their medication and pharmacy needs, including information related to medication cost resources, improving awareness of treatment plans, monitoring treatment response, and improving member understanding and compliance with medication regimens. Referrals for this program come from PCPs, Member Services and Internal CMs. The duration and modality of this program is 7-45 days of telephonic care management. This program is managed by Clinical Pharmacists and Pharmacy Technicians.

III. CARE MANAGER COMPETENCIES

A. Care Manager Roles

The Care Manager's role includes Comprehensive care management and care coordination for a panel of frail elderly patients that includes the following services:

- Providing a comprehensive geriatric assessment and managing geriatric conditions
- Developing and communicating (with member, caregiver, and PCP/health care team) a comprehensive care plan based on evidence-based best practice for chronic illness
- Collaborating and presenting with interdisciplinary care team members, when necessary
- Ensuring that the member Action Plan is available to the member, family, and other care providers
- Providing proactive management and follow-up (home visits and telephone calls) according to the care plan
- Managing and coordinating all transitions of care for complex members, including:
 - Communicating the care plan to all providers in all settings of care (i.e., emergency department, hospital, rehabilitation facility, nursing home, home care, specialty care)
 - Assuring relevant providers receive timely clinical data for care treatment decisions in all care settings (i.e., emergency department, hospital, rehabilitation facility, nursing home, home care, and specialty care)
 - Providing direct caregiver support, as needed
 - Facilitating member and caregiver access to community resources relevant to member's needs, including referrals to transportation programs, Meals on Wheels, senior centers, chore services, etc.
 - Incorporating self-care and shared decision-making in all aspects of member care

Care Manager Competencies Include:

- The ability to be a creative problem solver
- advanced clinical experience
- advanced understanding of geriatric conditions
- understanding of goals, medications, exercise, and dietary needs related to chronic illness and common geriatric conditions
- ability to work with all stakeholders to improve member quality of life
- understanding of Tufts Health Plan Medicare Preferred benefits and how to help members use these benefits appropriately
- understanding of member benefits external to Tufts Health Plan Medicare Preferred
- understanding of appropriate resource utilization of internal specialists (Social Worker, Palliative Care, Dementia Care, Behavioral Health, and Pharmacy)
- understanding of Motivational Interviewing and the ability to incorporate into practice
- understanding of teach-back principles and the ability to incorporate these principles into practice
- ability to facilitate goals of care discussions and assist with end-of-life planning
- transitions management - discharge planning/care coordination

Education and Disease Self-Management

Education and disease self-management focuses on the disease process or condition and the steps that the member can take to help control the progress of the chronic condition and manage their symptoms. The education includes discussion about how the members' co-morbid conditions, lifestyle, and cultural needs affect their chronic disease. Using a teach-back communication method to confirm that the member understands what he/she has learned can help improve health literacy. This teach-back technique involves asking members to verbally state, in their own words, what they learned from their health care provider. Teach-back is one of the 11 top evidence-based patient safety practices endorsed by the following groups: The National Quality Forum, American Academy of Family Physicians, American College of Surgeons, American Hospital Association, American Nursing Association, and Joint Commission. Additional information regarding teach-back principles is available on the following [Web site: Agency for Healthcare Research and Quality](#).

NOTE: To view teach-back information on this Web site, enter teach back in the Search field, and then press Enter. Teach-back information is displayed in the search results.

Evidence-based educational materials that Tufts Health Plan has vetted can be shared with members. Tufts Health Plan's list of these materials is available on request.

B. Geriatric Condition Management

1. Geriatric Conditions

The prevalence of geriatric conditions, such as dementia and falling, are like those of chronic diseases in older adults and are associated with physical and psychosocial

disability. Although prevalent, geriatric conditions are not part of healthy aging and potentially can be prevented or treated. Individuals impacted by various geriatric conditions can experience a decline in activities of daily living and a decline in overall well-being.

In geriatric care management, it is essential to assess the individual using a multifaceted approach, with the goal of promoting independent function and wellness. To prevent or minimize further decline in functional and cognitive functioning, screening and assessment for common geriatric conditions should be conducted to identify those who can benefit from care management intervention. Although there are numerous conditions that are common in the geriatric population, Tufts Health Plan Medicare Preferred identified the following conditions for assessment and intervention by Care Managers.

2. Falls

According to the Centers for Disease Control and Prevention (CDC), falls are the leading cause of death in individuals who are 65 years and older. In addition, falls are the most common cause of non-fatal injuries and hospital admissions related to trauma (for additional information regarding falls, see [Important Facts about Falls](#) on the CDC Web site). Fall prevention is a joint responsibility between the primary care provider (PCP) and the Care Manager. Tufts Health Plan Medicare Preferred recommends certain elements be included in a member's physical exam to screen for fall risk and to treat potential causes.

3. Incontinence

Urinary incontinence in the elderly is not considered a condition of normal aging; however, it is common, and the prevalence of incontinence increases with age. Multi-factorial causes include age-related factors, co-morbid conditions, medications, and functional and cognitive impairments. Because urinary incontinence is often under-diagnosed and under-treated, it is essential to assess this condition because of the significance associated to morbidity and quality of life impact.

Care Managers should assess members for urinary incontinence and encourage them to address it with their PCP.

- [Urinary Incontinence Assessment in Older Adults: Part I – Transient Urinary Incontinence](#)
- [Urinary Incontinence Assessment in Older Adults: Part II - Established Urinary Incontinence](#)

4. Cognition

The risk for age-related cognitive decline increases with age. Decline in cognition/memory often leads to poor treatment compliance, safety, decision-making, and psychosocial well-being. A decline in cognition directly impacts quality, cost, and utilization. Screening and identification of cognitive decline in the early stages can identify those individuals who may require a change in their medical treatment plan and/or those who may be at risk of developing delirium or functional impairments.

Care management staff are required to use the Six-Item Screener to screen for potential cognitive decline for members enrolled in the chronic or complex programs. The Six-Item Screener is quick (less than five minutes), easy to administer, and validated for telephonic use. It has a sensitivity of 88.7% and specificity of 88%.

A positive screen is determined by two or more misses on the Six-Item Screener. After a positive screen is identified, a Care Manager is expected to notify the PCP for recommended follow up. This notification should be completed via fax, phone call, or electronic health record, and documented accordingly. (For additional information regarding the Six-Item

Screener assessment, see [Appendix A – Six Item Screener](#))

Follow up with the PCP to determine the etiology or whether the cognitive decline is reversible is imperative for the appropriate treatment planning. Effective interventions (i.e., Alzheimer’s Association, community supports, long-term care planning, advance directives) can be implemented by the Care Manager to assist the individual and his/her caregiver in dealing with the consequences of cognitive decline.

For additional information on age-related cognitive decline, use the following link: [Mental Status Assessment of Older Adults: The Mini-Cog](#)

5. Depression

Although depression is common later in life, it is not a normal part of aging and can be treated. Depression has been found to have an adverse effect on the course and outcome of individuals with chronic conditions, such as arthritis, chronic obstructive pulmonary disease (COPD), asthma, cardiovascular disease, cancer, diabetes, and obesity. If left untreated, depression can impact an individual physically and psychosocially, and can often lead to increased health care costs and decreased quality of life.

Screening older adults for depression is recommended and, when present, a collaborative care approach to improve condition management is recommended. This approach should involve the PCP, mental health specialists, and other providers. You can use measures from the Patient Health Questionnaire (PHQ) to determine if the individual is exhibiting depressive symptoms, i.e., “little interest or pleasure in doing things”, “feeling down, depressed, or hopeless”. For additional information and assessment tools, use the following links:

- [American Psychiatric Association Practice Guidelines](#)
- [The Geriatric Depression Scale \(GDS\)](#)

6. Medication Adherence

There are numerous reasons why an individual might not follow through on medication regimen, including inability to pay for medication, lack of knowledge regarding the need for the medication, and poor health literacy or cognition problems. An individual's inability to adhere to his/her treatment plan often leads to increased health care costs and decreased quality of life. Member-centered care plans should include assessment for medication adherence barriers or risk factors.

For additional information on assessment of medication adherence and tips on effecting change in the individual, use the following link: [Case Management Society of America \(CMSA\)](#).

7. Hearing

According to the [National Institute on Deafness and Other Communication Disorders \(NIDCD\)](#), hearing sensitivity declines progressively with age. Disabling hearing loss affects:

- 2% of 45 to 54-year-old adults
- 8.5% of 55 to 64-year-old adults
- 25% of 65 to 74-year-old adults

- 50% of adults who are 75 or older

It is estimated that less than one in three (30%) of adults aged 70 and older who could benefit from hearing aids have never used them. A significant impact of declining hearing sensitivity is the lack of the ability to understand speech, which can have a significant effect on quality of life. Depression, anger, loss of self-esteem, and social isolation are often associated with hearing loss.

A hearing loss assessment can assist in identifying those in need of treatment. To access a hearing loss screening tool, use the following link: [Hearing Screening in Older Adults](#)

8. Advanced Life Planning/Goals of Care

The aim for Advanced Illness management (Serious Illness Management) is to improve the quality of care as life comes to an end by providing care that matches what the member wants. To achieve this goal, efforts directed towards members, providers, and clinicians are needed. Members need to be able to express what matters most to them as they decline, and providers/clinicians need to be able to conduct and document these conversations so that members' wishes are honored when necessary.

In addition, members need an opportunity to express what matters most to them in the context of their cultural beliefs. Opportunities for these conversations should be created when members are well and should be reviewed as disease processes progress. The first step in this process is asking members what is important to them should a sudden event, medical or trauma. Family and provider participation in the conversation is very important. The second step in the process is members identifying a Health Care proxy with whom they have spoken, and who can honor their wishes should the member become unable to speak for themselves.

Some members may remain relatively healthy the rest of their lives; however, for those high-risk frail elders who are identified for care management, subsequent conversations to are necessary to uncover their understanding of their diseases, as well as the explanation from the provider about hopes and worries given the progress of their condition. Increasing functional decline is a significant indicator for the need to conduct a Serious Illness conversation. Depending on the individual circumstances, a Massachusetts Orders for Life Sustaining Treatment (MOLST) order set may be appropriate to ensure that members' wishes are clearly documented to ensure that these wishes will be honored when necessary.

The Advance Directives documentation has two parts:

- The Health Care proxy should be completed and available to all providers, and what matters most should also be available.
- Goals of Care is another way to express what matters most to a member/family and helps guide future conversations about prognosis and plans of care. These kinds of ongoing conversations with all the stakeholders will promote treatment plans that match members' wishes and promote living well.

The Tufts Health Medicare Program Advanced Illness initiative, Voice Your Choice, and Honoring Choices is a way to:

- Encourage members to express their wishes
- Create an open dialog with clinicians when members are well so that all members of the team, including family members, are able to participate in planning for the management of illness as it advances to its conclusion, resulting in high member satisfaction and high quality of care at end of life
- For additional information about Advanced Directives Resources on the Tufts Health Plan website by following the link: [Provider Resources Advance Directives Resources](#)

9. Palliative Care

Palliative care is comprehensive medical care to treat the symptoms and stress of serious illness. Palliative care consultation and services can benefit members with chronic disease or life-threatening illness who do not have a prognosis of less than six months but who need improved symptom management to improve quality of life and decrease the risk for readmission.

A palliative care consultation is also a good option when discussions regarding goals of care have been difficult to initiate with a member. In this situation, a palliative care specialist works collaboratively with the PCP and the member to initiate these difficult discussions and to integrate goals of care into the member's treatment plan.

NOTE: Members can continue to receive treatment for their disease while receiving the support and expertise of a Palliative Care team. This option might appeal to members who are not ready to forgo treatment, but who need additional end-of-life care and support. Members who move into the final stage of a terminal illness with a life expectancy of less than six months can transition to hospice care for medical services, emotional support, and spiritual resources.

Point32Health is partnering with Honoring Choices to cobrand materials for mailing and provide training. Honoring Choices is a partner with Ariadne Labs.

Find more information about Honoring Choices at the website and linked documents below.
<https://www.honoringchoicesmass.com/make-a-plan/getting-started-tool-kit/>

Key Takeaways
for Care
Managers

What Matters Most

10. Hospice Care

According to the National hospice and Palliative Care Organization Hospice is considered to be the model for quality, compassionate care for people facing a serious or life-limiting illness or injury. Hospice care involves a team-oriented approach to expert medical care, pain management, and emotional and spiritual support which is tailored to the individual patient's and caregiver's needs and wishes.

When adopted early, hospice care offers significant benefits for patients and families. Hospice is designed to reduce suffering and improve quality of life, but it can take time to get

symptoms under control. Continuous visits from the hospice team over weeks or months can bring comfort and relief. Some clinical research suggests that patients may even live longer when receiving hospice services.

There is also a financial benefit to the beneficiary and the health care system. Medicare covers all hospice related costs allowing patients to remain home, receive the full support of the hospice team, with no cost to them. A correlation has been found between hospice length of stay and reduced cost and utilization in the acute setting.

Hospice utilization continues to grow among the Medicare Population and remains a bit higher among decedents enrolled in Medicare Advantage (MA) plans than among Traditional Medicare users, while the trendline for hospice usage continues to increase in both groups. Medicare Advantage decedents who utilized the hospice benefit rose from 51.1 percent in 2015 to 53.2 percent in 2019. During the same period, Traditional Medicare decedents utilizing the hospice benefit rose from 47.6 percent in 2015 to 50.7 percent in 2019.

In 2019, 1.61 million Medicare beneficiaries who died were enrolled in hospice care for one day or more. This was a 3.9 percent increase from 2018 when 1.55 million Medicare beneficiaries were enrolled in hospice. This growth is seen in the increase of hospice agencies providing care to Americans. Over the course of 2019, there were 4,840 Medicare certified hospices in operation based on claims data. This represents an increase of 18.3% since 2014.

For additional information about the Tufts Medicare Preferred Hospice benefit, refer to the [Tufts Medicare Preferred HMO and Tufts Health Plan Senior Care Options Hospice Payment Policy](#).

IV. MEETINGS

A. Interdisciplinary Care Team Meetings

The purpose of the weekly Interdisciplinary Care Team (ICT)/Medical Management (MM) meeting is to intervene with members who require collaboration on discharge planning, addressing readmissions, multiple admissions, and preventable admissions. The goal of the meeting is to enable proactive and timely multidisciplinary communication regarding barriers to a safe and successful transition of care and improving both the quality of life and outcomes for members with complex needs. Using a structured case presentation format, the multidisciplinary team will apply their specific and collective expertise to problem solve discharge barriers and coordinate community resources. The ICT meeting also provides a unique opportunity for the multidisciplinary team to educate one another and engage in shared learning.

B. Medical Management Meetings

The Medical Management meetings are a vital means of communication for the medical group and Care Managers to regularly discuss member's care. To facilitate effective management of the high-risk population, interdisciplinary meetings with the PCP are

recommended. These meetings serve many purposes, including:

1. Developing concurrent plans of care that use a team approach to manage specific high-risk members
2. Identifying obstacles to effective care and developing mitigation strategies
3. Creating a learning environment by evaluating outcomes, conducting case reviews, facilitating discussion, and providing constructive, respectful feedback
4. Improving effectiveness of the Care Management role by providing clinical input for individual member-centric plan of care
5. Improving process and outcome of care
6. Identifying opportunities for improvement
7. Developing strategies to manage the population
8. Developing strategies to work with preferred SNFs and home care agencies
9. Creating an environment that facilitates discussion and learning
10. Establishing clear expectations, roles, and responsibilities of all participants
11. Attendees at these meetings could include the following:
 - a. Group Medical Director
 - b. PCPs
 - c. Hospitalist (if appropriate)
 - d. SNF rounder (physician/NP)
 - e. Care Managers from all programs
 - f. Ad hoc attendees (SNF/Home Care representative, Specialists, Hospital Care Management, other THP team members)

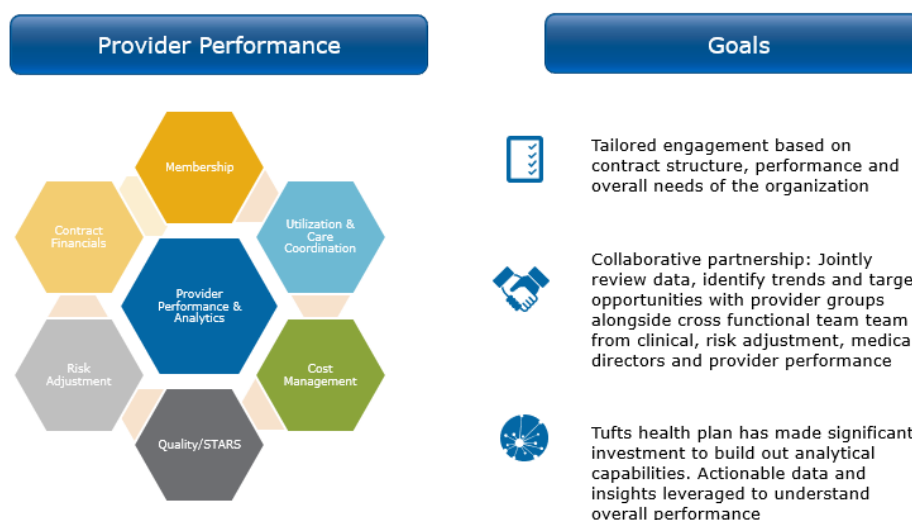
Best practice is ongoing communication between the Group Medical Director/Group Leader/PCP and Care Manager to provide updates and discuss individual issues. In addition, the Group Medical Director/Group Leader is responsible for communicating with PCPs as necessary.

V. PROVIDER PERFORMANCE OVERVIEW

Provider Performance Management is a critical function within Tufts Health Plan Medicare Preferred that helps provider groups succeed in our value-based care risk model while providing quality care to our members. It is comprised of a specialized team that provides a consultative approach helping Tufts Health Plan Medicare Preferred providers manage medical expenses and improve outcomes. The Provider Performance Team acts as the liaison between the TMP Internal and External network by sharing information to both parties to assure best practice standards are being met. This includes the following:

- Create a transparent and collaborative relationship and an optimal experience for the member and provider across the externally managed network
- Collaborate with providers and case management teams sharing processes to align full HMO network
- Conduct a joint review of cost and utilization data to understand drivers of performance

- Data-driven identification of group-specific opportunities for improvement, identify network trends, develop strategies to address areas of opportunity using Evidence-based Practice and Best Practice guidelines
- Develop innovative clinical programs and interventions to implement with groups in partnership with Care Management, Risk Adjustment, Provider Performance, Medical Directors, Product Strategy, Contracting and Product Strategy
- Recommend strategies to improve performance and improve member outcomes based on data analysis and alignment of group and network priorities
- Collaborate with provider groups to identify priorities, create an action plan, implement interventions and work with provider performance to monitor action plans with the goal of improving performance (adjust as necessary)
- Measure and monitor interventions (as necessary)



TMP Group Risk Types and Care Management Impact

Full Risk Groups: Provider is accountable for clinical and financial outcomes

- Provider drives initiatives/ programs; TMP members are allowed to participate
- Care Management supports provider initiatives/ programs while also supporting TMP initiatives/ programs
- Care Management has low to medium impact on outcomes

Shared Risk Groups: Provider and TMP are accountable for clinical and financial outcomes

- Provider and TMP collaborate to drive combined initiatives/ programs
- Provider may have additional programs/initiatives that TMP members can participate in
- Care Management supports both combined and TMP initiatives/ programs
- Care Management has medium-high impact on outcomes

No Risk Groups: TMP is accountable for clinical and financial outcomes

- TMP Provider Performance Team and TMP CM team drive initiatives/ programs

- Provider collaboration is very limited
- Members are usually excluded from any provider programs/ initiatives
- Care Management supports TMP initiatives/ programs
- TMP Care Management has high impact on outcomes

VI. OPERATIONS

A. Day of Admission Report

The DOAR is a daily report, run each morning, that shows new admissions, discharges, and transfers for internally managed members. This report can be used by care management to expedite outreach to members who have recently been admitted to or discharged from a facility. The report includes source data from utilization management and CMT PreManage (our vendor for ADT data). There are multiple tabs that allow care management teams to view the data in different ways.

Tab Name	Tab Description
Master Tab	All open prereg events, acute and extended care admissions and discharges, emergency room/observation, and future electives.
Acute New Admissions	Acute facility admits within the last 24hrs
Acute New Discharges	Acute facility discharges within the last 5 days
Extended Care New Admissions	Extended care facility admits within the last 24hrs
Extended Care New Discharges	Extended care facility discharges within the last 5 days
ED-OBS	Recent emergency room and observation discharges to home (up to 2 days prior Tuesday-Friday and up to 4 days prior on Monday)

B. Health Risk Assessment (HRA)

- Gives Tufts Health Plan a snapshot of actual/potential health needs of newly enrolled Medicare Preferred members
- Performed by newly enrolled members who answer a health risk assessment survey on the telephone, online, or on paper
- Results are sent to Primary Care Providers (PCP) and, if Care Manager flags are triggered, a Care Manager referral can be generated, and a Care Manager will be notified

C. Institutional Log (*Not applicable for Externally Managed Groups*)

The *Tufts Health Plan Institutional Log* uses information from CMS to identify members who are residents in long-term care facilities. CMS uses the information included in the Minimum Data

Set (MDS) that is reported by Medicare-certified skilled nursing facilities to determine long-term institutional status. Tufts Health Plan Medicare Preferred members residing in a long-term institution for 90 days prior to the payment month are classified as long-term institutional status. Tufts Health Plan Medicare Preferred members remain in long-term institutional status until they have been discharged to the community for a period longer than 14 days. A long-term institutional status is determined for Tufts Health Plan Medicare Preferred members and added as a factor in risk-adjusted payments.

Care Managers are expected to follow the SP-TMP hospice and Long-Term Care recording procedure.

D. Managing the Effectiveness of Care Management

The Tufts Health Plan leadership team will utilize the Team Performance File Review Processes and review tools, care management key performance indicators, and other data points to identify opportunities for improvement and address gaps in the care management program workflows and team performance. Member file review findings will help facilitate conversations between the leadership team using this tool to provide constructive feedback and foster professional development.

Care Management File Review is the process for Measuring Effectiveness of the TMP CM Team Performance. Below are some key points to consider while performing a file review for member cases:

- The assessment tool gathers information to determine the needs of the member.
- The initial note describes the members' holistic picture, including their clinical condition(s), recent events, home environment, transportation needs, and self-management plan.
- The care plan is an interpretation of the gathered information to identify actionable problems, goals, interventions, and barriers. The ongoing note/progress note provides information on progress towards goals and the care management services, including ongoing contact plan (ongoing member engagement) & action steps

DI. Frail Elder Report (FKA The High-Risk Report)

The *High-Risk Report* (see [Appendix B – ESS High Risk Member Report Sample](#)) is a working tool that will identify the top 10% of the group's high-risk members for Care Managers. The report flags internally managed members who are in organ failure or frail elder segments. Only members not currently engaged in a Care Management program and that have not been on in the past six months are included in the report. For a list of the high-risk definitions, see [Appendix C – High Risk Member Report Stratification](#). A Care Manager will be able to quickly identify these members to begin immediate interventions, with the goal of reducing the risk of readmission while working to provide members with the highest quality of life possible. The report also provides the probability of an admission within the next six months based on the indicators. The *Report* is updated monthly with new members appearing in bold blue. Inpatient utilization is based on ten months of claims and a two-month preregistration look back.

F. Evidence of Coverage

For information regarding evidence of coverage, use the following link on the Tufts Health Plan Medicare Preferred Web site: [Tufts Health Plan Medicare Preferred Documents](#).

G. Referrals

The *Referral Authorization Request Form* must be used to refer Tufts Health Plan Medicare Preferred members to a specialist. Tufts Health Plan Medicare Preferred members are encouraged to see specialists within their PCP's network. If a member requests to see a specialist outside of the PCP's network and the PCP's treatment decision is that the member can access the same care within the PCP's network, then the member should be informed that he/she has the option to contact Tufts Health Plan Medicare Preferred to request an organization determination.

For additional information, use the following link on the Provider Portal of Tufts Health Plan's Web site: [Tufts Health Plan Senior Products Provider Manual, Prior Authorizations](#).

H. Out-of-Area Benefit

The Tufts Health Plan Medicare Preferred Out-of-Area Benefit provides coverage of urgent and emergent events occurring 30 miles or more from the selected PCP's home hospital. Events and post-acute care services related to the out-of-area episode of care are managed by Utilization Inpatient Managers at Point32Health. When a medical group or PCP grants prior authorization for care/services outside of the service area (30 miles or more from the home hospital), the care is not covered under the Out-of-Area Benefit.

For the Externally Managed Groups, it is the medical group's responsibility to manage any prior authorized services or care outside of the service area.

For additional information, use the following link on the Provider Portal of Tufts Health Plan's Web site: [Tufts Health Plan Senior Products Provider Manual](#).

I. Payment Policies

To view Tufts Health Plan Medicare Preferred payment policies, access the [Provider Resource Center](#) on Tufts Health Plan's Web site.

J. Quality Assurance and Improvement

TMP Care Management continuously evaluates the quality of care in all health care settings that it serves and advocates for improvement when necessary. For standards and guidelines, refer to the forms below and department workflows:

- [Our Plans | Provider | Complaints, Grievances and Appeals | Tufts Health Plan](#)
- [Tufts Health Plan Quality Improvement Occurrence Report Form](#)

K. Grievances, Organization Determinations and Appeals

Tufts Health Plan Medicare Preferred members have the right to file both appeals and grievances, or to request organization determinations related to their care. A grievance is an expression of dissatisfaction with any aspect of the operations, activities or behavior of a plan or its delegated entity. An organization determination is a decision made by the Plan that is based on a request by the beneficiary/authorized representative (including a physician) to pay for goods or provide services. The request for an organization determination can be the result of 1) a disagreement with the Treatment Team or 2) a request for coverage by the Member or authorized representative. If an adverse organization determination is reached, a member has the right to appeal that decision.

Please refer to the Provider Manual for more information:

Referrals, Prior Authorizations, Notifications and Organizational Determinations: <https://tuftshealthplan.com/documents/providers/provider-manuals/sp-04-ran>

Member Appeals and Grievances: <https://tuftshealthplan.com/documents/providers/provider-manuals/sp-06-member-ag>

L. Treatment Team Definition

A Treatment Decision is a decision between the provider (Treatment Team) and a beneficiary/authorized representative without the Plan's direct involvement. The Treatment Team may be comprised of, but not limited to, the member's Provider, PCP, Medical Group Director, group nurse practitioner (NP), office nurse, and Care Manager. As a member of the Treatment Team, a Tufts Health Plan Medicare Preferred Care Manager participates in making treatment decisions/recommendations for members. If a member agrees with a treatment decision, the Care Manager should document the discussion/rationale in the medical record.

If the member disagrees with the treatment decision, the Care Manager should document the discussion/rationale for the decision in the medical record and offer the member the opportunity to contact Tufts Health Plan Medicare Preferred to request an organizational determination (for example, an acute inpatient member requests a discharge to acute rehabilitation, and the treatment team recommends sub-acute level of care).

NOTE: It is not necessary for the Care Manager or medical group representative to notify Tufts Health Plan Medicare Preferred.

M. Member Services Referrals

Member Service department staff members are trained regarding the Integrated Care Management model and Care Manager functions. They have been trained regarding what qualifies as areas of concern that may indicate the need for Care Manager involvement.

While answering calls in the Call Center, based on caller statements, a Member Service department staff member may identify a member who is in potential need of Care Manager outreach. The staff member will offer to forward the information to the Care Management department. When the caller agrees, the information is sent via email. Then, a Care Management department staff member reviews the member information and contacts the member within five business days.

NOTE: When the member belongs to an externally managed medical group, the information is forwarded via email to the appropriate medical group contact.

N. Pharmacy

For information on Tufts Health Plan Medicare Preferred pharmacy benefits, use the following link on the Provider Portal of Tufts Health Plan's Web site: [Tufts Health Plan Pharmacy Information](#).

O. Home Health

Home health services do not require prior authorization; for information about home health services for Senior Products, refer to the *Home Health Payment Policy* in the [Tufts Health Plan Provider Resource Center](#).

P. Part B Notification

Part B notification refers to services that SNFs' rehabilitation services provide for Tufts Health Plan Medicare Preferred custodial members. The appropriate UM reviewers will assess the requester's clinical rationale and ensure that member goals are being met.

NOTE: When the member belongs to an externally managed medical group, the request is processed by the external care manager.

Q. Use of Out of Plan Providers and Carve Outs

Infrequently, the UM Department will need to facilitate an admission to a non-contracted facility (i.e., SNF, Long-Term Acute Care, Acute Inpatient Rehabilitation) or a non-contracted home health care agency. In this instance, the UM Clinician will determine the medical necessity and appropriate level of care, then instruct the provider to notify the Tufts Health Plan Medicare Preferred In-Patient Notification department. Following discharge, the provider can bill Tufts Health Plan Medicare Preferred at the same billing rate as traditional Medicare or Medicaid.

If there is the need for a medication carve-out at SNFs or for durable medical equipment (DME) from non-contracted providers, the UM Clinician should contact the Allied Health Contract (AHC) Manager assigned to SNFs when requesting a medication carve-out. The UM Clinician should inform the AHC SNF contract manager of key elements (e.g., Care Manager name and number, member name, member ID, drug name, dosage, frequency, duration, member's weight).

If there is the need for DME, the UM Clinician should contact the AHC Manager assigned to DME and request the DME and key demographics referenced above.

Call Provider Services (1-800-279-9022) to contact both AHC Managers.

Note: External Care Managers refer to Use of Out of Plan Providers and Carve Outs in the External Management Section below.

R. Additional Resources

1. Non-Covered Items/Equipment List

For information on non-covered items/equipment, use the following link on the Provider Portal of Tufts Health Plan's Web site: [Tufts Health Plan Medicare Preferred Coverage Resources](#)

2. Quality Improvement Organization Fast-Track Appeal

Quality Improvement Organization (QIO) is designated by CMS to serve as the designated QIO for the Tufts Health Plan Medicare Preferred service. QIO receives appeal requests from members who disagree with the *Notice of Discharge* that they have received. In the hospital or other acute level-of-care settings, the *Important Message No. 2 (IM No. 2)* serves as the *Notice of Discharge or Important Message (IM)*. SNFs, Comprehensive Outpatient Rehabilitation Facilities (CORF), and HHAs use the *Notice of*

Medicare Non-Coverage (NOMNC). It is the responsibility of the UM Department to communicate to the QIO.

Note: External Care Managers refer to QIO in the External Management Section below.

VII. COMPLEX CARE MANAGEMENT POLICIES

A. Population Assessment

1. Purpose: The purpose of this policy is to ensure a process to provide ongoing assessment of the needs of the general population on, at minimum, an annual basis to adjust the procedures to facilitate linking members with care management services that meet their needs.
2. Policy: Tufts Health Plan Medicare Preferred will review the population at least annually to assess the characteristics and needs of its member population and relevant subpopulations. This assessment will be used to review and update care management processes and resources to address member needs.
3. Procedure: The Tufts Health Plan Medicare Preferred Management Team, in conjunction with analysts from the Actuarial department, routinely reviews information about the Tufts Health Plan Medicare Preferred population. These reviews determine eligibility for care management services in the Clinical Data work group and ad hoc meetings with the Tufts Health Plan Medicare Preferred Medical Director and management teams. Characteristics of specific population include, but are not limited to:
 - i. Ethnicity
 - ii. Social Determinants of Health
 - iii. Health Disparities
 - iv. Custodial members
 - v. Hospice members
 - vi. Members with:
 - a. Multiple chronic conditions
 - b. Psychiatric diagnoses
 - c. Geriatric conditions

B. Member Identification – Data Sources

1. Purpose: The purpose of this policy is to identify data sources used to identify potential members for Tufts Health Plan Medicare Preferred care management.
2. Policy: On a monthly basis, members will be identified as candidates for complex care management using the ESS process. Members will be identified by providers or other care managers during utilization management and discharge planning process.
3. Procedure:
 - a. The Population Health Analytics team analyzes data related to member identification. Tufts Health Plan medical and pharmacy claims history are gathered on a monthly basis to produce population segmentation with risk scoring.

- b. The clinical parameters for complex care are identified and reviewed monthly by the Tufts Health Plan Medicare Preferred Care Management leadership team and Medical Director.
- c. The clinical parameters for complex care are identified and reviewed monthly by the Tufts Health Plan Medicare Preferred Care Management leadership team and Medical Director.
- d. Identified members comprise a list of potential members for care management. A greater number of members will be identified than will be able to be assigned.
- e. When the member is an inpatient, the Care Manager will screen the member for an evaluation.
- f. When the member is an outpatient, the Care Manager will prioritize the evaluation of members based on their risk.

C. Access to Care Management

- 1. Purpose: The purpose of this policy is to ensure that members meeting the criteria for complex care management services are referred to the program by multiple sources in a timely way.
- 2. Policy: The Tufts Health Plan Medicare Preferred network uses multiple sources for referral to complex care management services, including, but not limited to:
 - a. Claims data
 - b. Information gathered through the utilization management (UM) or discharge planning process
 - c. Information gathered through the member's involvement with other programs or services provided (i.e., enrollment in the congestive heart failure program)
 - d. Member or caregiver self-referral
 - e. Provider referral
- 3. Procedure:
 - a. Claims data is reviewed on a monthly basis to determine if a member meets the criteria for care management prioritization.
 - b. Daily reports that identify all members with an open preregistration and their associated risk factors are sent to Care Managers. These reports are used to identify and prioritize the completion of the initial assessment by the Care Manager.
 - c. Members and/or caregivers can make a self-referral to the program, either by contacting the Plan, their providers, and/or Care Manager. Providers can also make ad hoc referrals for complex care management programs. Information about the programs is available to members, caregivers, and providers in a variety of mediums including, but not limited to, the Internet, mailings, and medical management meetings.
 - d. The Plan maintains a file that indicates the source of member referrals. The Tufts Health Plan Medicare Preferred management team and Medical Director routinely analyze this file.

D. Care Management Systems

- 1. Purpose: The purpose of this policy is to assure that the assessment and management of members is based on evidence-based decision support tools that minimize management

variability. Documentation is maintained in an electronic system that provides automatic documentation of member, provider, and caregiver interactions and reminders for the care plan.

2. Policy: The Tufts Health Plan Network uses a Care Management System that does the following:
 - a. Uses evidence-based clinical guidelines/algorithms and logic scripts to assess and manage Complex Care Management patients
 - b. Includes automatic documentation of staff member's ID, and is date- and time-stamped with each interaction with members, providers, or practitioner involved in the care
 - c. Includes automated prompts for follow-up with reminders for next steps as required by the care plan
3. Procedure: The Care Manager will use evidence-based and standardized tools to complete the following:
 - a. Minimize treatment variability
 - b. Improve health outcomes
 - c. Reduce health care costs
 - d. Increase patient involvement and adherence

E. Care Management Process

1. Purpose: The purpose of this policy is to establish a standardized process to assess the needs of each member referred to the program and to develop an effective and individualized member care plan.
2. Policy: The initial assessment covers a broad scope of health-related topics. Members and Care Managers explore these topics to identify the member's achievable health goals and opportunities to improve self- management of health conditions, as well as influence health-related behavior for optimal health and identify member-centric goals. The Care Manager will complete all activities involved in the member initial assessment period within 30 days of the receipt of a new care request or assignment of a direct referral. The following are the components of an initial assessment:
 - a. Health status and any condition-specific issues
 - b. Clinical history, including medications
 - c. Daily living activities
 - d. Mental health and cognitive status
 - e. Life planning activities
 - f. Cultural, linguistic, visual, and hearing needs, preferences, or limitations
 - g. Caregiver resources and involvement
 - h. Benefits within the organization and from community resources
 - i. Self-management ability

This process creates an individualized care management plan with the following:

- a. Provides prioritized goals that consider the member's and caregiver's goals, preferences, and desired level of involvement in the care management plan

- b. Provides a time frame for re-evaluation
- c. Identifies resources to be used, including appropriate level of care
- d. Includes planning for continuity of care, including transitions of care and transfers
- e. Provides collaborative approaches to be used, including family participation
- f. Provides educational materials that encourage member self-management
- g. Evaluates member social needs and personal preferences that drive activities to support the care management plan

3. Procedure: The process identifies the following:

- a. Available resources for member referral as part of benefits or other health organizations and a follow-up process to determine whether members act on referrals
- b. Barriers to member receiving or participating in the care management plan
- c. A follow-up plan and schedule
- d. Development and communication of a member self-management plan

The process assesses member progress against the care management plan, including the following:

- a. Overcoming barriers to care
- b. Meeting treatment goals
- c. Maintaining self-management
- d. Maintaining the desired level of involvement in care management activities

F. Measuring Effectiveness of the Care Management Program

1. Purpose: The purpose of this policy is to:

- a. Identify at least three measures that validate the effectiveness of the care management program across its entire population or subset of the population
- b. Ensure that these measures have significant and demonstrable bearing that enables the appropriate intervention that would result in significant improvement of the population

Additionally, based on the results of the measurement and analysis of care management effectiveness, the organization will do the following:

- a. Implement at least one intervention to improve performance
- b. Remeasure to determine change in performance

2. Policy: The Tufts Health Plan Medicare Preferred network measures care management activities that have significant influence in the improvement of the health of its membership.

The measures may include, but are not limited to:

- a. Fall risk
- b. Medication adherence
- c. Advance Directives
- d. Healthcare Effectiveness Data and Information Set (HEDIS)
- e. Readmission reduction
- f. Member satisfaction

Based on the results of the identified measures, the organization identifies opportunities for improvement and implements measures to improve performance, thereby improving the health of its population.

3. Procedure: The organization measures the effectiveness of its care management program using three measures. For each measure, the organization does the following:
 - a. Identifies a relevant process or outcome
 - b. Uses valid methods that provide quantitative results
 - c. Sets a performance goal
 - d. Clearly identifies measure specifications
 - e. Analyzes results
 - f. Identifies opportunities for improvement, if applicable
 - g. Develops a plan for intervention and re-measurement

VIII. Additional Resources and Information

For the External Care Manager

External Management Overview

“Externally managed” (formerly known as delegated) means that Tufts Health Plan designated another entity (an Integrated Delivery Network (IDN) or Medical Group) to perform certain functions on its behalf; however, responsibility and accountability for the functions being performed remain with Tufts Health Plan. Tufts Health Plan Medicare Preferred’s externally managed network is comprised of IDNs. These IDNs are networks consisting of medical groups in risk arrangements with Tufts Health Plan Medicare Preferred. The IDNs and medical groups are responsible for the implementation and management of the Integrated Care Management Program.

Integrated Care Management Program

Tufts Health Plan Medicare Preferred Care Management department adopted the Integrated Care Management Model to:

- Address the increasingly complex care needs of members
- Ensure a consistent member experience throughout the Tufts Health Plan Medicare Preferred network

To achieve external management status, IDNs or Groups must demonstrate adoption of the Integrated Care Management Model components and must cooperate with all Tufts Health Plan Medicare Preferred requirements as outlined in this guide. Tufts Health Plan Medicare Preferred’s Provider Engagement Clinical Consultants are available to groups who want to achieve external management status.

Medical Management

Tufts Health Plan Medicare Preferred Integrated Care Management Model relies on a foundation of strong medical management principles that require infrastructure for, and management of, the delivery of health care services to our members across the continuum. Medical management is led by a Medical Director and relies on preferred provider networks with systematic means of communication. The Care Manager also plays an important role in the medical management team. Key tenets for medical management infrastructure include:

- Medical Director:
 - Full-time preferred, but varies on size of group
 - Responsible for applying Medicare coverage criteria in case of a dispute with a provider
- Plan for home hospital inpatient management, including identification of daily rounder (Primary Care Provider (PCP) and/or Hospitalist)
- 24-hour medical coverage
- Access to inpatient medical record system
- Plan for preferred provider relationships, especially skilled nursing facilities (SNF) and home health providers, also including Acute Rehabs, and Long-Term Acute Care (LTAC)

- Plan for SNF management, including dedicated physicians or nurse practitioner (NP) rounders at preferred SNFs
- Plan to impact Emergency Department utilization
- Integrated Care Management program for high-risk members
- Plan for regular Medical Management meetings

Program Requirements (Specifications)

The Integrated Care Management Model for externally managed programs requires leadership of a Medical Director and Care Management Leadership staff. Externally managed IDNs/Groups must meet and maintain policies and procedures consistent with the Tufts Health Plan Medicare Preferred Care Management program. This includes, but is not limited to, the specific requirements of:

- Tufts Health Plan Medicare Preferred Care Management Resource Guide
- Centers for Medicare & Medicaid (CMS) Manual
- CMS Chronic Care Improvement Plan (CCIP)
- CMS Star requirements

Required components of the Integrated Care Management program include:

- Transitions management - discharge planning/care coordination
- Chronic illness management
- Complex care management
- Inpatient UM (Externally Managed Groups Only)
- Provider engagement and performance management, including:
 - Actionable data to medical groups and PCPs to facilitate management
 - Dashboards to monitor trends against benchmarks and best practice
 - Clinical collaboration and consultation to manage both individual members and targeted populations to improve outcomes
 - Joint efforts to identify opportunities and execute on initiatives to improve quality
 - Identification and engagement of both preferred and “best-in-class” providers

Tufts Health Plan Medicare Preferred Care Manager

Care Managers should have a professional license in a health care field with initial geriatric certification or the equivalent commitment to staff development (e.g. Certified Case Manager® -CCM®). In addition, Care Managers are required to complete 5 contact hours (CH) per year related to geriatric care management.

Competencies

The Care Manager’s competencies include demonstrating:

- The ability to communicate effectively with team members to facilitate successful transitions of care and prevent readmission
- Knowledge of Complex and Chronic Program criteria to enable member referral appropriately
- An understanding of referral responsibilities regarding community resources
- An understanding of levels of care and SNF benefits
- An understanding of a member’s denial process and appeal rights

- The ability to actively participate in relationship building with external providers
- An understanding of and ability to identify member psychosocial needs vs. medical needs, and the ability to identify associated Tufts Health Plan Medicare Preferred benefits
- An understanding of geriatric condition management
- An understanding of appropriate resource utilization of consultants as available (e.g., social worker/ palliative care, pharmacy)

Integrated Care Management Capabilities

The Integrated Care Manager is embedded within the medical group setting and has the ability to:

- Use assessment tools to create detailed care plans for targeted members
- Create an individual care plan to be shared with Primary Care Provider (PCP) and care team
- Create an individual action plan to be reviewed with the enrolled member
- Engage and coach member in self-management of chronic disease
- Use community resources to augment care plan
- Apply discharge criteria
- Demonstrate supporting systems to document care plans, track action steps, due dates, follow ups, and member utilization activity
- Demonstrate a capability to integrate care plans into members electronic medical record (EMR)
- Perform utilization care management
- Ensure adherence to Tufts Health Plan Medicare Preferred payment policies
- Ensure adherence to Interqual or equivalent criteria for Inpatient utilization
- Ensure adherence to CMS criteria for skilled nursing facilities (SNF) and home health agency (HHA) utilization management (UM)
- Identify opportunities to mitigate iatrogenic conditions or delays in care that may adversely impact quality
- Facilitate discharge planning/transition of care program for those admissions not enrolled in Integrated Care Management programs
- Identify members who may be appropriate for referral to Integrated Care Management programs
- Utilization review may be telephonic for acute setting; however, Care Management for SNF members should be provided on site when possible.

Complex & Chronic Population Description

The Complex Program targets the top 3 to 4% of membership that are at the highest risk for readmission. These frail members often suffer from chronic and/or multiple co-morbid conditions, as well as psychosocial issues that put them at risk.

The Rising Risk Chronic Illness Management Program focuses on the next 3.5 to 10% of members identified as having a geriatric condition and/or specific chronic illness (e.g., heart failure, chronic obstructive lung disease, Type 2 diabetes) that places them at higher risk for admission in the next six months. Other conditions include (but are not limited to): falls, incontinence, impaired cognition,

polypharmacy/ medication adherence issues, behavioral health issues, psychosocial concerns, and other syndromes that contribute to the risk of avoidable admissions.

Members are identified for the Complex & Chronic Programs in one of the following ways:

- Using the segmentation and stratification process
- Based on the Daily Census
- After meeting ad hoc admission criteria

Adherence to the program's treatment plan and identified goals is monitored through specific measures identified and discussed during each phone call to the member, repeat hospitalization or emergency room visits, and reports from the home care nurse.

Transitions of Care Management

The screening for a “transitions” intervention includes, at a minimum, a standardized phone call assessing the member's confidence in his/her ability to manage his/her post-discharge needs including:

- The reason for his/her hospitalization
- Ability to manage medication administration
- Signs or symptoms that warrant calling his/her Primary Care Provider (PCP)
- A treatment regimen

Inclusion Criteria for Ad Hoc referrals to Wellness, Complex, & Chronic

Ad Hoc Referral/ Case Guideline Tool			revised June 2020
Wellness	Chronic	Complex	
Members who do not meet Complex or Chronic Criteria but are in need of Care Management for assistance with self-management or <u>knowledge deficits</u> related to : <ul style="list-style-type: none"> • Functional decline • Disease management • Medications • Nutrition/ Diet • Community Resources • Specialist Resources 	1+ chronic conditions (CHF, COPD, Diabetes, ESRD, Parkinson's, etc.) WITH self-management deficits: <ul style="list-style-type: none"> • IADL and/or 1 ADL deficit • Medication adherence • Exercise/ diet OR 1+ chronic conditions AND 2 or more of the following: <ul style="list-style-type: none"> • 1+ admit in 6 <u>mo</u> • Medication adherence concerns • Altered mental status with teachable care giver • Living alone • 1-2 falls in 6 months • 7+ medications • Age 85+ • Psychosocial concerns • Community resource needs 	Catastrophic Injury (stroke, brain injury) OR 2+ chronic conditions with multiple ADL/ IADL deficits OR Cognitive Impairment and living alone OR New Oncology Dx OR 2+ Chronic Conditions AND 2 or more of the following: <ul style="list-style-type: none"> • 2+ admits in 6 <u>mo</u> • Medication adherence concerns • Altered Mental Status • Living alone • 3+ falls in 6 months • 10+ medications • Age 85+ • Psychosocial concerns • Community resource needs 	

THP SNF Rounding Model

Guiding Principles of Rounding in Skilled Nursing Facilities

The overall aim of this program is to assist the member/caregiver in navigating the transitions of care while providing a structure to ensure high quality outcomes. The guiding principles of this program include:

- Identified Medical Doctor (MD)/NP rounders who will actively participate in the short-term management of Tufts Health Plan's Health Maintenance Organization (HMO) members while in a preferred SNF. MD/NP rounders will:
 - Conduct a face-to-face admission assessment within 24 to 48 hours of admission
 - Actively participate in the multidisciplinary discharge planning process
 - Provide 24/7 call coverage with communication processes in place to ensure coordination of plan of care
 - Provide a minimum of weekly rounds, as well as any additional necessary rounds
 - The medical group will identify a subset of SNFs (preferred SNF referral circle) in their geographic area that meet the defined quality and performance standards. The medical group will:
 - Direct at least 80% of their admissions to this subset of preferred facilities.
 - Develop systems/processes for regular communication and, at a minimum, meet annually with preferred SNFs to share data/clinical outcomes
 - The group Care Manager will:
 - Actively participate in oversight and management of members in the SNF
 - Inform home hospitals and others of their preferred facilities to facilitate appropriate referral
 - Actively participate in the care planning and multidisciplinary discharge planning process
 - Identify and follow up on any readmissions to the acute setting or other quality events

Tufts Medicare preferred offers a SNF Rounding Service based on these principles

Monitoring group performance

- Providing information regarding regulatory changes, provider updates, and topics from the Tufts Health Plan Medicare Preferred Medical Directors meetings
- Developing an annual plan for medical management with goals and priorities, and incorporating metrics and reporting
- Integrating quality metrics, monitoring, and reporting
- NOTE: Attendees, and discussions, recommendations, follow ups and takeaways must be recorded at these meetings

Focuses on managing medical and rehabilitation services in the SNF at the sub-acute level

- The THP/vendor NP co-manages member with the receiving/attending MD at identified SNF's
- THP/vendor NP first call 24/7
- The member's plan of care is based on their individual functional improvement goals.

- Designed to enhance quality and functional status to promote positive outcomes
- Role of the THP Nurse Practitioner
 - THP NP/Attending SNF MD co-management model
 - THP NP provides “first call” coverage 24/7
- Returns calls within 15 minutes of receipt
- Completes Admission History and Physical w/i 48 hrs of admission. Conduct medication reconciliation.
- Identifies and aligns member, caregiver goals
- Coordinates care with member, family, attending physician, group case manager, other members of interdisciplinary team
- Participates in weekly team conferences and family meetings
- Monitors members’ progress toward goals
- Facilitates members’ transition to the next level of care
- PCP follow up visit is in place at time of discharge
- Provide prescriptions for new medications with 30-day supply
- Discharge summary note is faxed to PCP

Nurse Practitioner Interfaces

- NP admits pt, evaluates medical needs and begins to develop plan of care. Communicates with member /family to validate and document baseline function, anticipated d/c destination and support system.
- Participates in weekly team meetings, gains team consensus POC and d/c plan, communicates w/family and updates SNF rounder as necessary.
- Collaborates with facility team regarding progress/barriers toward goal and documents findings and plan.
- Based on team input, NP initiates discharge plan or change in level of care. Collaborates w/MD SNF rounder and group CM re: final discharge disposition. Documents episode of care and d/c plan writes d/c orders.
- NP provides d/c summary to PCP.
- Interfaces w/ Facility Staff
- Facility CM/SW communicate and collaborate w/NP on admission as to pt status, initial goals for treatment and tentative d/c destination and supports.
- Facility CM/SW initiate family contact to verify prior level of function, tentative d/c plan and support system. Arranges for family meeting w/i 72 hrs.
- Facility CM/SW facilitate weekly team meeting and family meetings.
- Facility staff communicates directly with NP regarding any concerns about medical management/ POC/d/c plan.
- Achieve team consensus for POC and d/c plan and ensure documentation supports POC, progress/barriers and team decisions.
- Facility CM communicates w/group CM re: authorizations and level changes.
- Facility CM collaborates w/ NP and other members of the team (SW, rehab, nsg) to initiate and implement d/c plan.
- Group CM is responsible to call Post Acute Program Coordinator with any potential SNF admissions
- When a member is admitted to a SNF the CM will:

- Meet the member/family, clarify/validate baseline functional status, member/family goals and anticipated discharge plan.
- Participate in weekly care planning meeting, family meeting.
- Collaborate/communicate w/ NP re: goals, barriers to progress and facilitates any change in LOC.
- Review cases with NP, as necessary, to facilitate plan of care. Communicates functional goals, progress and any barriers to plan of care to PCP/Med Group at medical management meetings.
- Collaborates/communicates w/NP re: discharge plan, identifies preferred providers for post-acute services/DME (as necessary).

Tufts Health Plan Medicare Preferred Responsibilities and Oversight

THPMP Responsibilities

- Identifying high risk/high-cost members, including:
 - Producing daily admission/high risk report
 - Providing ongoing predictive modeling reporting
 - Providing data from Health Risk Assessment
- Supporting the development of the Care Management role, including:
 - Providing competencies/sample job descriptions for Care Managers
 - Providing best practice “seminars” for Care Management Leadership for both clinical and regulatory requirements
 - Providing geriatric seminars for Care Managers for to complete 5 contact hour (CH) opportunities
- Reporting outcome metrics to facilitate performance monitoring, including:
 - Admissions and Readmissions trend reports
 - Cost per member trend reports
 - Inpatient length of stay
 - Home care utilization
 - Ambulatory sensitive conditions, Potentially Avoidable Admissions
 - Fall rate
 - Hospice rate
- Overseeing external management, including ensuring that the provider organization is meeting program specifications as outlined herein
- Performing fast-track appeals
- Maintaining Organizational Determination process, Notice of Denial of Medical Coverage (NDMC), and member appeal data

THPMP Oversight

Tufts Health Plan's oversight process includes meeting with the Tufts Health Plan Medical Director and/or Clinical Nurse Consultant at least quarterly and on an as needed basis to review the performance of program reporting and utilization. In addition, the Provider Engagement Clinical

Nurse Consultant may perform record reviews or discuss summary results of record reviews done in advance of meeting. These meetings may be held in person if warranted.

Annual evaluation of external management functions is conducted using documentation including, but not limited to:

- Meeting documentation
- Chart reviews
- Policy and procedure reviews
- Integrated Care Management program metrics

The externally managed groups are expected to supply documentation sufficient to meet Tufts Health Plan, accreditation, and regulatory requirements.

Integrated Delivery Network Responsibilities, Processes, & Requirements

IDN Responsibilities

- All externally managed medical groups are required to follow Tufts Health Plan Medicare Preferred's policies in accordance with the CMS rules and regulations
- Identified medical and care management leadership
- Administrative processes with accountability for completion of the end-to-end processes
- Workflows for all Care Manager functions
- Quality Improvement (QI) process and structure, including participating in Tufts Health Plan Medicare Preferred's QI work plan for CMS
- Medical group performance evaluation and improvement plan
- Compliance and regulatory guidelines and criteria and associated processes and workflow
- Benefit management - provide information updates and educational resources to group/Care Managers
- Orientation, education, and training
- Communication regarding product and regulatory changes
- Collaboration and support

IDN Processes

Administrative processes with accountability for completion of the end-to-end process

Claims payment processes such as review of 10-day claims report with timely resolution of claims discrepancies IDN intercedes as necessary to facilitate completion of these administrative processes.

Timely submission of authorization logs to facilitate claims payment

Identifies cases for potential "bridging" review, or other medical claims review triggers

IDN Requirements

- Facilitate/support development and implementation of Quality Improvement Plan with documented monthly Quality Improvement meetings. IDN oversight provides opportunity for sharing of “Best Practice” QI plans.
- Submission of Quality events
- Identified medical group leadership is available to care managers for clinical consultation/review
- Medical group identifies and develops collaborative relationship with selected referral circle and monitors utilization trends and leakage
- Compliance with regulatory guidelines and criteria and associated processes and workflows
- CMS policies and procedures: provide training, support, and oversight for all regulatory processes
- IDN will monitor performance trends and patterns and work collaboratively with THPMP to develop action plans as needed.
- IDN is responsible for oversight, training, and support of their provider network and will work with THP to monitor compliance to CMS policies
- IDN will demonstrate ability to use CMS manuals

Specific compliance tasks

- Member requests, organizational determinations, and appeals
- Fast track appeals and clinical reinstatements associated with NOMNC;
- Member non-compliance issues;
- IDN will identify a contact person to act as an intermediary to facilitate Organizational Determinations and appeal processes. Internal audits will be used to assess compliance with standards and provide direct feedback to the groups and IDNs on program outcomes.
- Benefit Management: provide informational updates and educational resource to groups and care managers

Specific updates include

- Annual changes in TMP Evidence of Coverage (EOC), Summary of Benefits, prior authorization, and referrals;
- CMS coverage guidelines;
- Access to CMS website
- IDN will provide updates and changes to their network.
-

Orientation, education, and training

- Leadership at each IDN is responsible for training and developing their Care Management staff. This includes orientation and training new staff regarding Tufts Health Plan Medicare Preferred’s policies and procedures.
- New group training
- IDN responsible for clinical training and competencies of all providers in its network.
- Ongoing education and training to meet compliance or regulatory requirements/standards

- Assess competency of all Care Managers on hire and annually
- Provide Floater Holiday coverage
- IDN is aware of Tufts Floater Holidays and early close days. Provides voice mail coverage messages for these times.
- CM to obtain 5 Contact Hours (CH) in Geriatric Content
- IDN maintains records of CM staff annual Contact Hours (CH) in Geriatric content (5 CH annually)

Communication

- Facilitate communication between THP MP and individual groups/care managers regarding changes or updates in process, administrative, coverage, compliance, or business policies
- IDN CM leadership will participate in TMP MP IDN Webinars and convey information to IDN medical groups and Care Managers.
- Collaborate with THP MP Clinical Consultants and medical group/care managers to:
 - Monitor performance toward targets.
 - Develop, revise plans to improve outcomes/performance.
 - Develop strategies for members who present Management or adherence challenges.
- IDN will participate and collaborate with Provider Engagement Clinical consultants at regularly scheduled consultant meetings and during Provider Performance Meetings.
- Tufts Health Plan's provider engagement consultants will offer informational IDN webinars/conference calls throughout the year. Representation from each IDN is expected to participate to ensure that important information and updates are received. The IDN leadership is responsible for disseminating updated information to their respective Care Managers.

OPERATIONS

Observation Program

Care Managers are encouraged to use the observation status when the member's problem related to an inpatient facility is reasonably expected to resolve within 48 hours. For detailed information on this program, use the following link on the Provider Portal of Tufts Health Plan's Web site:

<https://tuftshealthplan.com/documents/providers/provider-manuals/sp-11-obs-program>

<https://tuftshealthplan.com/documents/providers/payment-policies/observation-services>

Inpatient Notification Management

Acute inpatient level of care determinations rely on the use of a nationally recognized standard (e.g., Tufts Health Plan uses Interqual®) for acute hospital admissions. LTAC, acute inpatient rehabilitation (AIR), and SNF admissions and home health care services are guided by Centers for Medicare & Medicaid (CMS) definitions for each level of care. For additional information, refer to the following:

- Daily Census Report
- Daily Census Report Guide

- Home Health (Home Care Based Services HCBS Claims Data Report)

Prior Authorization

For a current list of procedures, services, medication, and items requiring prior authorization, use the following links on the Provider Portal of Tufts Health Plan's Web site:

<https://tuftshealthplan.com/documents/providers/lists/tmp-pa-and-inp-notif-list>

<https://tuftshealthplan.com/provider/pharmacy/senior-products/tufts-medicare-preferred>

<https://tuftshealthplan.com/documents/providers/payment-policies/referral-pa-notification-policy>

QIO Fast Track Appeal

Quality Improvement Organization (QIO) is designated by CMS to serve as the designated QIO for the Tufts Health Plan Medicare Preferred service. QIO receives appeal requests from members who disagree with the Notice of Discharge that they have received. In the hospital or other acute level-of-care settings, the Important Message No. 2 (IM No. 2) serves as the Notice of Discharge or Important Message (IM). SNFs, Comprehensive Outpatient Rehabilitation Facilities (CORF), and HHAs use the Notice of Medicare Non-Coverage (NOMNC).

For more information, please click the following link: <https://www.cms.gov/Medicare/Appeals-and-Grievances/MMCAG/BFCC-QIO-Review>

When QIO receives a call within the required time frame after the delivery of the IM No. 2 or NOMNC, QIO activates the fast-track appeal process.

1. After the process has been initiated, QIO notifies the Appeals and Grievances department at Tufts Health Plan. The Appeals and Grievances department representative then contacts the appropriate facility or provider to request that a copy of the Notice of Discharge be faxed to him/her.
2. An Appeals and Grievances Analyst determines if the NOMNC or IM was issued correctly and contacts the appropriate Care Manager to obtain the Discharge Summary document.
3. The Care Manager must return the completed Discharge Summary document to the Appeals and Grievances department within two hours of being notified by the Analyst or by the end of business that day, whichever comes first. This information is used to write the letter which goes from the Health Plan to the facility/provider. A copy is also mailed to the member's home on record and to the PCP's office. The acute setting letter is the Detailed Notice of Discharge (DNOD). The SNF/HHA letter is the Detailed Explanation of Non-Coverage (DENC).
4. The member's medical record from the hospital or SNF is sent directly to the QIO. The SNF and HHA record are sent to Tufts Health Plan Medicare Preferred for review before Appeals and Grievances forwards it to KEPRO (effective 6/8/2019).
5. If the Notice of Discharge is upheld, QIO notifies the provider, the member, and Tufts Health Plan. If the notice is overturned, QIO notifies the provider, the member, and Tufts Health Plan.

On occasion, the group's Care Manager performs a clinical reinstatement before the QIO decision has been rendered. When done, this halts the fast-track appeal process. For additional information, use the following links on Tufts Health Plan's Web site:

- Hospital Discharge Summary Form
<https://tuftshealthplan.com/documents/providers/forms/hospital-discharge-summary-form>
- Hospital Discharge Summary Form Instructions
<https://tuftshealthplan.com/documents/providers/forms/hospital-discharge-summary-form-instruct>
- SNF/HHA/CORF Discharge Summary Form
<https://tuftshealthplan.com/documents/providers/forms/snf-hha-corf-discharge-summary-form>
- Tufts Health Plan Medicare Preferred HMO SNF/HHA/CORF Discharge Summary Form Instructions
<https://tuftshealthplan.com/documents/providers/forms/snf-hha-corf-discharge-summary-form-inst>
- HMO Reinstatement of Services
<https://tuftshealthplan.com/Documents/Providers/Forms/H2229-2006-80-Reinstatement-of-Services>

NOTE: All Care Managers, both for internally and externally managed groups, are considered part of the Treatment Team and are not acting on behalf of the Plan.

For additional information on appeals and grievances, use the following link to the Provider Portal on the Tufts Health Plan Website: Tufts Health Plan Medicare Preferred Senior Products Provider Manual, Member Appeals and Grievances.

<https://tuftshealthplan.com/documents/providers/provider-manuals/sp-06-member-ag>

Use of Out-of-Plan Providers and Carve-Outs

Infrequently, a Care Manager will need to facilitate an admission to a non- contracted facility (i.e., SNF, Long-Term Acute Care, Acute Inpatient Rehabilitation) or a non-contracted home health care agency. In this instance, Care Manager will determine the medical necessity and appropriate level of care, then instruct the provider to notify the Tufts Health Plan Medicare Preferred In- Patient Notification department. Following discharge, the provider can bill Tufts Health Plan Medicare Preferred at the same billing rate as traditional Medicare or Medicaid.

For home health care, the Care Manager should request that the provider use the Universal Health Forms with the number of visits requested and supporting documentation.

If there is the need for a medication carve-out at SNFs or for durable medical equipment (DME) the Care Manager should contact the Allied Health Contract (AHC) Manager assigned to SNFs when requesting a medication carve-out. The Care Manager should inform the AHC SNF contract manager of key elements (e.g., Care Manager name and number, member name, member ID, drug name, dosage, frequency, duration, member's weight).

If there is the need for DME, the CNL/Care Manager should contact the AHC Manager assigned to DME and request the DME and key demographics referenced above.

Call Provider Services (1-800-279-9022) to contact both AHC Managers.

Exhaustion of Benefits

If a member is exhausting his/her SNF, acute inpatient rehabilitation, or long-term acute care hospital benefit, the Care Manager is required to:

1. Notify the member/member's authorized representative and the facility of the impending benefit exhaustion 15 calendar days prior to the date the coverage will end.
2. Complete and fax the Tufts Health Plan Medicare Preferred Extended Care Exhaustion of Benefit Notification Form to the Precertification department. This form enables the Care Manager to communicate specific information relative to the member's benefit exhaustion to the Precertification department.

After receiving the form, the Precertification department uses the information to generate the Notice of Denial of Medical Coverage and Payment (NDMCP) and then faxes it to the facility to be delivered to the member. In addition to serving as the formal Plan notification to the member of benefit exhaustion, the NDMCP provides the member with his/her appeal rights and the process to request an appeal if the member disagrees with the benefit exhaustion.

For additional information on the extended care exhaustion and benefit notification process, use the following links on the Provider Portal of Tufts Health Plan's Web site:

- Tufts Medicare Preferred HMO Extended Care Exhaustion of Benefit Notification Form <https://tuftshealthplan.com/Documents/Providers/Forms/instructions-extended-care-eob-tmphmo>
- Instructions for Tufts Medicare Preferred HMO Extended Care Exhaustion of Benefit Notification Form <https://tuftshealthplan.com/Documents/Providers/Forms/instructions-extended-care-eob-tmphmo>

Medication Reconciliation

Tufts Health Plan requires an improved comprehensive medication reconciliation documentation standard for all Tufts Medicare Preferred Health Maintenance Organization (HMO) members. This is to support the standardization of best practice across the network and increase the focus on avoidable admissions and readmissions, while addressing new expectations set forth by CMS. The required documentation and/or coding must be completed within 30 days of patient discharge from an acute or non-acute inpatient facility to the community. We must be able to review the member's discharge medications and the member's current outpatient medications in the documentation. Notification of completed medication reconciliation, as well as any identified concerns, must be shared with the member's PCP.

Documentation

One or a combination of the following evidence meets the criteria for best practice documentation:

- Notifications that the medications prescribed or ordered upon discharge were reconciled with the current medications
- A medication list in a discharge summary that is present in the outpatient chart and evidence of reconciliation with the current medications conducted by a registered nurse,

clinical pharmacist, or prescribing practitioner (e.g. nurse practitioner, physician assistant, or physician)

- Notation that no medications were prescribed or ordered upon discharge

NOTE: The date of member's discharge must be noted in the electronic medical record (EMR). In addition, a signature (electronic or written) of the clinician who completed the medication reconciliation must be included.

Medication reconciliations can be performed only by a registered nurse, clinical pharmacist, or prescribing practitioner (e.g. nurse practitioner, physician assistant, or physician).

Coding

- NCQA HEDIS rules for this measure: Medication reconciliations (using approved codes) must be conducted by a prescribing practitioner, clinical pharmacist, or registered nurse.
- Medical Providers: The submissions of transitional care management codes (TCM) 99495 or 99496 are appropriate and reimbursable. The submission of reporting code 1111F is also appropriate but not reimbursed.
- Care Management: If care managers are completing medication reconciliation post-discharge and coding is inappropriate or not applicable, documentation in accordance with specifications described above are required.
- Home Care Agencies: The submission of CPT code 1111F in combination with code G0299 on the same claim will comply with NCQA HEDIS measure requirements. Code G0299 confirms that a registered nurse completed the medication reconciliation.
- Audit: Verification is subject to audit by Tufts Health Plan.

Denial Letters

For a complete list of Tufts Health Plan Medicare Preferred denial letters, definitions, delivery method, time frames, and written notice requirements, use the following link on the Provider Portal of Tufts Health Plan's Web site: Tufts Health Plan Medicare Preferred Determination & Notice Instructions <https://tuftshealthplan.com/provider/resource-center/resource-center#?d=57413c&f=instructions>

Transplants

The medical group issues referrals for transplants and is responsible for ensuring that the transplants are performed at a Tufts Health Plan Medicare Preferred-contracted and Medicare-approved transplant facility. After the member is admitted, the group manages the inpatient care of transplants for the member. For a listing of Medicare-approved transplant facilities in the Tufts Health Plan Medicare Preferred network, use the following link on the Provider Portal of Tufts Health Plan's Web site:

Tufts Health Plan Medicare Preferred HMO Medicare Approved Facilities

COB/Subrogation

Coordination of Benefits/Subrogation (External only d/t MHK capabilities)

Tufts Health Plan is pleased to announce our new Subrogation and Third-Party Liability (TPL) Recovery program with The Rawlings Company LLC (Rawlings). Rawlings is recognized as the industry leader in the field of health insurance subrogation and reimbursement.

As part of the TPL program, Tufts Health Plan will receive information identifying potential recovery opportunities. It is important to send this information to Rawlings for the investigation process to begin.

If you receive a call or correspondence from

- Member
- Attorney
- Property/Casualty Insurance Carrier
- Medical Provider

And they are asking questions regarding

- Third party liability/other party liability
- Motor vehicle accidents (MVAs)
- Subrogation or reimbursement related to a lien for payments made by Tufts Health Plan
- Slip and fall or premises liability
- Workers' compensation

Then do any of the following

- **Refer the individual to The Rawlings Company at 888.846.4512.** This is the toll-free number designated for Tufts Health Plan members/patients, in addition to their groups' members/patients.
- **Fax the correspondence to the attention of Manual File Coordinator at 502.753.7064.** Please indicate your company name, Tufts Health Plan, and the member's identification number on all correspondence.
- **Complete the manual referral form and email it to The Rawlings Company at**

manualfilecoordinator@rawlingscompany.com through your secure email system.

Which departments receive this information?

- Claim and Overpayment Recoveries
- Member Services
- Legal Department
- Corporate Recoveries
- Workers' Compensation
- Medical and Pharmacy Claims

*When speaking with members/patients, please advise them to respond to The Rawlings Company regarding any investigation letter the member received.

<https://tuftshealthplan.com/documents/providers/forms/manual-referral-process>



Third Party Liability/Workers' Compensation Manual Referral Form Tufts Health Plan

Please complete as many fields as possible and send by either faxing 502.753.7064 (Attn: Manual File Coordinator) or emailing Manualfilecoordinator@rawlingscompany.com.

Insured name:	Member ID:
Patient name:	Patient date of birth:
Insured address:	City/State/ZIP:
Insured phone number:	Date of accident:
Attorney name:	Attorney address and phone number:
Employer name (if workers' compensation only):	Employer phone number and address (if workers' compensation only):
Third party insurance (TPL) carrier (at-fault party)/workers compensation carrier:	Third party claim number/workers' compensation claim number:
TPL adjuster name:	TPL address and phone number:
First party insurance carrier (insured/member's auto insurance):	First party claim number:
Name of person completing this form:	Phone number of person completing this form:

Please attach copy of correspondence and/or claim information.

BEHAVIORAL HEALTH

BH Designated Facility Program Discontinuation

Tufts Medicare Preferred HMO
November 01, 2022

Tufts Health Plan has operated a Behavioral Health (BH) Designated Facility program for members of fully insured Massachusetts Commercial HMO plans and Tufts Medicare Preferred HMO. As Tufts Health Plan and Harvard Pilgrim Health Care continue integration efforts and prepare for migration of Commercial membership from Tufts Health Plan to Harvard Pilgrim Health Care products, we conducted an evaluation of this program and made a determination that we will discontinue the BH Designated Facility program effective Jan. 1, 2023.

Under this program, Tufts health Plan used a network of designated facilities to provide assigned members (based on PCP/practice organization selection) with certain behavioral health and substance use disorder (BH/SUD) services, such as crisis stabilization, BH/SUD emergency services, level-of-care determination, and acute inpatient BH/SUD treatment. Currently, two facilities — Bournewood Hospital and Northeast Hospital Corporation — participate.

With this change, starting on Jan. 1, providers can refer patients for covered behavioral health services to any contracted BH facility within the Tufts Health Plan network. Providers should follow standard Tufts Health Plan claims submission guidelines. You can check member eligibility and benefits via the secure Provider portal.

As mental and physical well-being are interconnected, Tufts Health Plan's behavioral health program emphasizes highly coordinated care manager that supports the whole health of the member.

Clinical Management for Inpatient and Intermediate Levels of Care

To assist in coordinating care and discharge planning, the Tufts Health Plan Behavioral Health Utilization Manager is in contact with the inpatient facility periodically during the admission. Clinical management is focused on the member's discharge planning needs and readmission prevention. Facilities are expected to proactively communicate with PCPs regarding the member's admission, including medication reconciliation and health information exchange to inform treatment planning during the admission and post-discharge plans.

Accessing Outpatient Behavior Health and/or Substance Use Disorder Treatment

- The PCP approves and authorizes all outpatient specialty care, including outpatient behavioral health care. These services for Tufts Health Plan Medicare Preferred are not centrally managed at Tufts Health Plan.
- A representative from the PCP can call Tufts Health Plan's Behavioral Health department for assistance searching for contracted services, if needed.
- The PCP must authorize all outpatient psychological and neuro-psychological testing.

Substance Use Disorder

For members who have been recently hospitalized with Substance Use Disorder, per member's request our BHCMS can provide telephonic care management to members who have been recently hospitalized for substance use disorder treatment and are returning home, or who have been identified by an outpatient provider as needing support around substance use, sobriety, and recovery, with the member's permission to be contacted.

Eligibility is open to members with a substance use disorder, as evidenced by, but not limited to:

- A recent detoxification on a medical unit, hospitalized due to a medical condition during which substance use was identified, or hospitalized for medical problems that were caused or worsened by substance abuse
- Ineffective self-management
- Co-occurring conditions that can make self-management more challenging
- Enrolled members may be followed through their post-hospitalization period with telephonic support provided regarding:
 - Attending aftercare appointments and complete their provider's recommendations for care on their road to recovery. Care management goals can include:
 - An assessment and review of the discharge plan and the member's/caregiver's ability to follow the plan
 - Support of the member/caregiver to follow through on outpatient services and adhere to the medication directions prescribed by his/her provider
 - Education regarding the member's condition
 - Conversations with the member and caregiver regarding the coordination of care

Dementia Care Consultation Program

- *See Section 2, CM Programs Overview: Dementia Care Consultant Program for additional information*
- To access the Dementia Care Consultation Referral Form, use the following link on Tufts Health Plan's Web site: Dementia Care Consultation Referral Form
<https://tuftshealthplan.com/documents/providers/forms/alzheimer-s-association-referral-form>
- Email completed forms to the following Tufts Health Plan mailbox:
dementiaconsults@point32health.org

Tufts Health Plan's Dementia Care Consultation Program Referral Form

Please complete this form, save your answers, and attach a copy of your completed referral form in an email to DementiaConsult@point32health.org.

HPHC:

☐ Commercial ☐ USFHP ☐ Senior Care Options ☐ Medicare Preferred HMO

Member Name: _____ Member ID: _____

Type of Dementia: _____ CM Program: _____

Member's Primary Contact: _____ Relationship to Member: _____

Contact Primary Phone: _____ Alternate Phone: _____

PCP: _____ Neurologist/Geriatric Psychiatrist: _____

Referring Case Manager: _____ Phone: _____

HIPAA permission obtained from member? ☐ Yes ☐ No ☐ N/A

Caregiver Assessment Score: _____ ☐ N/A

Needs:

- | | |
|--|---|
| <input type="checkbox"/> Medical issues (dx, medication, etc.) | <input type="checkbox"/> Safety (driving, home alone, safe return etc.) |
| <input type="checkbox"/> Increase care/support at home | <input type="checkbox"/> Support groups/education programs |
| <input type="checkbox"/> Placement/care needs | <input type="checkbox"/> Future care planning |
| <input type="checkbox"/> ADLs | <input type="checkbox"/> Early stage issues |
| <input type="checkbox"/> Symptom management | <input type="checkbox"/> End-of-life issues |
| <input type="checkbox"/> Caregiver support | |

ADDITIONAL RELEVANT INFORMATION:

THPMP REPORTING

Overview, Description, Samples

Daily Census Report

The Daily Census Report is a working tool that will help Care Managers identify high risk, high priority inpatient members who will benefit from more immediate care management, and transition of care oversight. The report:

- Provides a snapshot of all Tufts Health Plan Medicare Preferred members with current medical admissions (acute, skilled nursing facility (SNF), and rehabilitation), future elective, and current mental health admissions in the Tufts Health Plan Medicare Preferred system
- Flags members with Complex, Chronic/Tier 2 status by member to allow the Care Manager to quickly prioritize their daily case load for intervention
- Provides information that may be used to report coordination of benefits (COB)/subrogation cases and cases being considered for bridging

Daily Census Report Guide: Overview

The Daily Census Report is a working tool that will help Care Managers identify high risk, high priority inpatient members who will benefit from more immediate care management and transition of care management. The report provides a snapshot of all Tufts Health Plan Medicare Preferred members with current medical admissions (acute, skilled nursing facility (SNF), and rehabilitation), future elective, and current mental health admissions in the Tufts Health Plan Medicare Preferred system. The report prioritizes members with Complex, Tier 2/Chronic status to allow the Care Manager to quickly prioritize their daily caseload for intervention.

The report is also intended to improve operational efficiency, as it contains a discharge date field and blank Admission Status field which will allow the external Care Manager to document the member's discharge date or admission status (i.e. change to observation or never admitted), and then email the report back to the TMP. Because the report is provided in Excel format, users may also manipulate the format to accommodate other needs, such as creation of a daily census or use for weekly management meetings.

The Daily Census Report is scheduled for email delivery daily (Weekdays ONLY). Please do not send questions to the email address on the auto-generated email.

Selection Criteria

The Admissions sheet of the report includes all open events in the TMP system

- Any open cases (on date of report run) awaiting final determination from IDN or TMP UM
- Includes future elective events
- Includes events with discharge date in TMP system awaiting final determination from IDN or TMP
- Includes Mental Health events: will appear at time of notification and stay on report until the TMP Mental Health dept closes case with discharge date.

- Includes Out of Area events: will appear at time of notification and stay on report until the TMP UM dept closes case with discharge date.

The Discharges sheet of the report includes all closed/completed events within the last 31 days.

- Includes events reviewed by IDN AND TMP (Externally Managed and Internally Managed)
- Excludes Cancelled events

Report Details

Field Name	Field Description
Member ID	Member ID
Member Name	Member Full Name
Member DOB	Member Date of Birth
Facility Name	Facility Name
	Note: Out of Area events are reviewed internally
Place of Service	Place of Service Description (examples: Inpatient Hospital, Skilled Nursing Facility, Inpatient Psychiatric Facility)
	Note: Mental Health (Inpatient Psychiatric Facility) events are reviewed internally
Diagnosis	Primary Diagnosis Description (Long Name)
Bed Type	Bed Type Code Name (examples: Medical, Surgical, SNF Level 1B)
Admission Type	Scheduled or Urgent/Emergent
Procedure Name	Primary Procedure Description (Long Name)
Received Date	Inpatient Notification Received Date
Requested Admission Date	System Request Admit date
Admission Date	System Actual Admission Date
Days In	Member Admission Date minus day report is ran
Discharge Date	System Discharge Date OR Used by External groups for sending information back to Tufts Health Plan
	Note: Discharge date on admissions sheet may have been obtained from clinical, EMR, or entered by facility via portal and need to be confirmed to close out the event
Admission Status (Admissions Sheet only)	Used by External groups for sending information back to Tufts Health Plan
	Leave blank (if member still in)
	Fill in discharge date or SDC – Surgical Day Center OBS - Observation for LOC change
	Never admitted (examples: ER only, cancelled admission)
	Notes for Clarifying/Correcting Data on the Report
Discharge Status (Discharges Sheet only)	System Discharge Disposition
Days Since Discharge (Discharge Sheet only)	Count from System Discharge date to day report is ran
Case Number	Authorization Number
PCP Name	System Case PCP Provider Full Name
PCP Group ID	System Case Provider Group ID
PCP Group Name	System Provider Group Name
PCP Phone Number	System PCP Phone Number
# Acute Admits	Number of admits to an Acute Facility within the last 12 months (Excludes Electives)
Last Acute Admit Date	Last Admission Date to an Acute Facility (Excludes Electives)
30 Day Acute Readmission	Y or N if this Acute Admission is a 30-day readmission from a previous Acute Admission (Excludes Electives)
CCS (Clinical Complexity Score)	Clinical Complexity Score (Tier 3, Tier2/Chronic, Complex)
	Tier 3: Clinical Complexity Score 0-2. Members can agree to participate in Proactive Programs (programs intended to prevent events that have not occurred yet)
	Tier 2/Chronic: Clinical Complexity Score 3-5. The member was identified as being in the top 3.5 – 10% for risk of an acute inpatient admission within the next 6 months. Members can agree to participate in Responsive Programs (programs intended to stabilize members and prevent chaotic care pattern)
	Complex (Tier 1): Clinical Complexity Score 6-10. The member was identified as being in the top 3.5% for risk of an acute inpatient admission within the next 6 months. Members can agree to participate in Intensive Programs (programs intended to reduce chaotic pattern of IP and ED utilization)

Daily Census Report Detail Description

Using the report

For Daily Management of Inpatient Members

- Care Managers should check the report first thing each morning to identify new, high-priority admissions. The report will be delivered daily (Weekdays ONLY)
- The report is sorted by Admission Date to allow the Care Manager to quickly identify new admissions.
- The CCS (Clinical Complexity Score) and Admitting Diagnosis columns will provide information to allow the Care Manager to quickly assess clinical severity and priority of the member.
- The Care Manager will synthesize the content of this report to prioritize their workload and determine whether to reach out to hospital Care Managers for individual members.

For Creating Weekly Management Meeting Census Reports

Because the report is in Excel format, Care Managers can use this format to create weekly management reports or census reports.

For Sending Discharge Date/Disposition to TMP

Care Managers will use the report to document discharge dates or other admission status by adding the information directly in the Discharge Date or Admission Status field and will **email discharge dates to TMP at a minimum of three times per week**. Sending discharge dates or up to date admission status on a timely basis will make the report more manageable, accurate, and will expedite claims payment.

Updating the report

Enter the discharge date if applicable, in the Discharge Date field or case status into the Admission Status field. Admission status field can be used to correct inaccurate information for accurate payment. Changes in admission status may be one of the following:

- SDC
- OBS
- Never admitted [ER only, cancelled admission, etc.]
- Clarifying/Correcting Data on the Report, Delay Days, Custodial status,
 - It is the responsibility of the facility to pre-register the case, however, to clarify or correct information on the report that is inaccurate type the accurate information in the appropriate column and/or write a clarifying note in the admission status field. (example: to correct dates for levels of care, to notify TMP a SNF member is becoming custodial or to identify delay days with identification of responsible party or that case is a coordination of benefit case). See next pages for Coordination of Benefits/Subrogation and Bridging policy

Bridging Policy

Email address: thmp_mcr_program@point32health.org

****MCR = Medical Claims Review**

Payment for a readmission to the same acute facility within 30 days may be denied if, through medical record review, the admission was deemed preventable, medically unnecessary or was due to a premature discharge of the prior admission.

Some of the common reasons for bridging the readmissions include but are not limited to:

a. Diagnostic errors including:

- i. Error of delay in diagnosis
- ii. Failure to employ indicated tests
- iii. Use of outmoded tests or therapy
- iv. Failure to act on results of monitoring or testing

b. Treatment mistakes:

- i. Error in performance of operation, procedure or test
- ii. Error in administration of treatment
- iii. Error in dose or method of using a drug
- iv. An avoidable delay in treatment or in responding to an abnormal test
- v. Inappropriate (not indicated) care

c. Prevention related failures:

- i. Failure to provide prophylactic treatment
- ii. Inadequate monitoring or follow up of treatment
- iii. Failure to get appropriate consultation

d. Hospital billing for two separate admissions for care that could have been provided during one admission:

- i. When a definitive treatment has been decided and the patient is discharged only to be readmitted for that definitive treatment, without a medical reason for such a delay
- ii. When a member is discharged for less than 48 hours with intention to resume treatment in the hospital upon the member's return; such breaks in care should be labelled as "leave of absence" and not billed as separate admissions

Summary: What Groups Must Do						
Readmission Interval	Notification of TMP	Clinical Information Provided	Notification Of Group	Effectuation	Appeals	Notification Of Group
0-14 Days	TMP copies group on request to the hospital for medical records for readmission review Group sends e-mail to MCR if case should not be reviewed	TMP requests Hospital Record Group provides any information to support decision to bridge	TMP sends group cc: of the letter to hospital with bridging decision either way	If bridged, claim denied retroactively deducted from future hospital payments. Deducted from HSF expense	Hospital has right to appeal decision to bridge	If overturned, hospital notified, group cc:d on notification
15-30 Days	Group sends e-mail to MCR to initiate review process Include rationale for bridging admissions	TMP requests Hospital Record Group provides any information to support decision to bridge	TMP sends group cc: of the letter to hospital with bridging decision either way	If bridged, claim denied retroactively deducted from future hospital payments. Deducted from HSF expense	Hospital has right to appeal decision to bridge	If overturned, hospital notified, group cc:d on notification

For more information on Bridging see <https://tuftshealthplan.com/documents/providers/payment-policies/bridging-policy-thmpmp>

End of Month Reconciliation Report

Overview

The End of Month Reconciliation Report is a working tool that will help Care Managers identify outstanding open cases at the end of the previous month that require a current admission status or discharge date. It does not include any future dated admissions.

The report is also intended to improve operational efficiency, as it contains a Discharge Date field and blank Admission Status field which will allow the external Care Manager to document the member's discharge date or admission status (i.e. change to observation or never admitted), and then email the report back to the TMP.

The End of Month Reconciliation Report is run on the second business day of the month and sent out via email to the IDN. It includes a deadline on when TMP is expecting an update on all members in the report. Send out date from TMP and deadline depends on what day of the week the second business day falls on. It is typically sent same day or within 1 day of receipt and expected back within a week. Please be advised there may be some overlap with members sent back on the daily reports on that same day.

Updated admission status or discharge date is REQUIRED. TMP cannot accept "blank" replies

Note: If “still in” written in admission status field on daily report on the first of the month this will make the End of Month Reconciliation report more manageable, accurate, and will expedite claims payment.

Medicare EOM Group (IPA) Template						
Reference #	Member ID	Member Name	Date of Birth	LOB	Facility	Request Admit Date
*****	S00***** 01	MOUSE, MINNIE	MM/DD/YYYY	HMO MEDICARE	WINCHESTER HOSPITAL - IN PT	10/6/2020
*****	S00***** 01	MOUSE, MINNIE	MM/DD/YYYY	HMO MEDICARE	MELROSEWAKEFIELD HEALTHCARE-IN	9/30/2020
*****	S00***** 01	MOUSE, MICKEY	MM/DD/YYYY	HMO MEDICARE	BEAR HILL HEALTHCARE AND REHA	10/11/2020
*****	S00***** 01	DUCK, DONALD	MM/DD/YYYY	HMO MEDICARE	BOSTON MEDICAL CENTER INPT	10/8/2020
*****	S00***** 01	MERMAID, ARIEL	MM/DD/YYYY	HMO MEDICARE	BRIGHAM AND WOMENS HOSP-INPT	10/14/2020
*****	S00***** 01	FLINTSTONE, FRED	MM/DD/YYYY	HMO MEDICARE	BETH ISRAEL DEACONESS MED-INPT	10/13/2020
*****	S00***** 01	FLINTSTONE, WILMA	MM/DD/YYYY	HMO MEDICARE	THE ELMHURST HEALTHCARE	10/15/2020
*****	S00***** 01	RUBBLE, BARNEY	MM/DD/YYYY	HMO MEDICARE	ANNA JAKUES HOSPITAL - INPTNT	10/15/2020
*****	S00***** 01	RUBBLE, BAM BAM	MM/DD/YYYY	HMO MEDICARE	TUFTS MEDICAL CENTER - INPT	10/16/2020
Actual Admit Date	Actual Discharge Date	Admission Status	Admission Type	Bed Type	Provider Group ID	Provider Group Name
	10/8/2020		Scheduled	Surgical	*****	*****
9/30/2020	10/4/2020		Urgent/ Emergen	Medical	*****	*****
10/11/2020			Scheduled	SNF Level 1B	*****	*****
10/8/2020	10/10/2020		Scheduled	Surgical	*****	*****
10/14/2020	10/18/2020		Urgent/ Emergen	Medical	*****	*****
10/13/2020	10/18/2020		Urgent/ Emergen	Medical	*****	*****
10/15/2020			Urgent/ Emergen	SNF Level 1B	*****	*****
10/15/2020			Urgent/ Emergen	Medical	*****	*****
10/16/2020			Urgent/ Emergen	Medical	*****	*****

Updated 12/30/2020

Report Details

Field Name	Field Description
Reference #	Authorization Number
Member ID	Member ID
Member Name	Member Full Name
Date of Birth	Member Date of Birth
LOB	Member Line of Business
Facility	Facility Name
Request Admit Date	System Request Admit date
Actual Admit Date	System Actual Admission Date
Actual Discharge Date	System Discharge Date OR Used by External groups for sending information back to Tufts Health Plan Note: Discharge date may have been obtained from clinical, EMR, or entered by facility via portal and need to be confirmed to close out the event
Admission Status	Drop Down List including most utilized options (Discharged, Still In, Status Changes to Obs, Cancelled/Never Admitted, and allows free text for any other options Note: Discharge date and/or Admission status MUST be filled in on returned report. TMP cannot accept “blank” replies.
Admission Type Code Name	Scheduled or Urgent/Emergent
Bed Type	Bed Type Code Name (examples: Medical, Surgical, SNF Level 1B)
Provider Group ID	System Case Provider Group ID
Provider Group Name	System Provider Group Name

Using the report

- Care Managers will use the report to document discharge dates or other admission status by adding the information directly in the Discharge Date or Admission Status field and will email to TMP by the deadline in the original email. Sending discharge dates or up to date admission status on a timely basis will make the report more manageable, accurate, and will expedite claims payment.

Updating the report

- Enter the discharge date if applicable, in the Discharge Date field and select “Discharged” in the admission status
- Select “Still In” in the admission status for any members who are still in house.
- Admission status also can be used to correct inaccurate information for accurate payment. Changes in admission status may be one of the following:
 - SDC
 - OBS
 - Never admitted [ER only, cancelled admission, etc.]
 - Clarifying/Correcting Data on the Report, Delay Days, Custodial status,
 - It is the responsibility of the facility to pre-register the case, however, to clarify or correct information on the report that is inaccurate type the accurate information in the appropriate column and/or write a clarifying note in the admission status field. (example: to correct dates for levels of care, to notify TMP a SNF member is becoming custodial or to identify delay days with identification of responsible party or that case is a coordination of benefit case).

Note: Updated admission status or discharge date is REQUIRED. TMP cannot accept “blank” replies

Returning the report to TMP

- Save the document with the IDN name or #, EOM, and today’s date.
- Attach the updated document to your secure email. Using the secure domain name between Tufts Medicare Preferred and your IDN will ensure the email is secure.
- In the subject line type your IDN name or #.
- Email the edited document to the following email address to assure correct payments
- preregistration_case_close_out@point32health.org

End Stage Renal Disease

ESRD notification is handled internally by the enrollment department. This function no longer resides within Care Management.

Chart Audits

Tufts Health Plan Medicare Preferred requires externally managed IDNs to audit 15 charts per quarter where a member has experienced a readmission. The goal is to identify any gaps in care along the continuum as well as look at clinical outreach, documentation, and timeliness with the expectation of improving member care and service.

[Click Here: Sample Readmission Chart Review Tool](#)

This tool assesses the engagement, resources, and quality of the documentation for members who have experienced a readmission, it also prompts the reviewer to look for gaps and strategies to mitigate those gaps. 15 audits per IDN will be completed quarterly and completed tools are submitted quarterly to Tufts Health Plan Medicare Preferred Clinical Consultant Team. These submissions are reviewed, trends are gathered, and findings are brought to the external groups to discuss trends, educational needs, and strategies to reduce readmissions

ESS High Risk Report

The ESS High-Risk Report is a working tool that will identify the top 10% of the group's high-risk members for Care Managers. The report flags members with a Complex (Tier 1) or Chronic (Tier 2) status based on an aggregate of indicators (for a list of the high risk definitions, see Appendix B, High Risk Member Report - Stratification). Only members not currently engaged in a Care Management program and that have not been on in the past six months are included in the report. A Care Manager will be able to quickly identify these members to begin immediate interventions, with the goal of reducing the risk of utilization while working to provide members the highest quality of life possible. The report also provides the probability of an admission within the next six months based on the indicators. The High-Risk Report is updated monthly with new members appearing in bold blue. Inpatient utilization is based on ten months of claims and a two-month preregistration look back.

The Tufts Health Plan Medicare Preferred – Enterprise Segmentation and Stratification
Tufts Health Plan employs an Enterprise Segmentation and Stratification (ESS) process to target and prioritize members for care management intervention. The process incorporates over 220 member variables (17 clinical and non-clinical data sources and 25 billion data points). Machine Learning (ML) models support the segmentation and stratification analysis and provide predictive inputs in assessing patients future level of risk.

All THP members are segmented based on their clinical and social needs. There are seven segments ranked in the order of increasing illness, and 26 sub-segments. Once segmented, members are stratified using a Clinical Complexity Score (CCS) to rank order members based on recent utilization, reducible utilization, and Social Determinants of Health (SDOH). The CCS is defined on a 0 to 10-point scale, with 0 indicating no identified needs and 10 indicating the most complex member need profile.

The following table illustrates the populations and how this model targets these populations:

CCS 6 – 10	Complex members, many of whom have chronic diseases with multiple co-morbidities	<ul style="list-style-type: none"> Individualized care planning, including: Psychosocial issues Careful management of care transitions Frequent face-to-face interactions Home and nursing home visits
CCS 3-5	Chronic disease and other variables that increase the risk for admission	<ul style="list-style-type: none"> Early intervention Closely monitor and manage conditions Develop individual care plans Manage admissions and transitions of care
CCS 0-2	Rest of the population mainly healthy, increasing risk over time	<ul style="list-style-type: none"> Preventative care Annual health assessment Ongoing monitoring for change in health status

Sample ESS High Risk Report

member_id	NEWLY_IDENTIFIED	FIRST_NAME	LAST_NAME	DOB	EXTERNALLY_MANAGED_GRP	pcp_ipa	PCP_FUL_L_NAME	PCP_LEV_EL1	ccs	oppscr_amt	SEGMENT
S00***** 01	Y	MOUSE, MINNIE		MM/DD/YYYY	Y	123				8.4	ADVANCING ILLNESS
S00***** 01	Y	MOUSE, MINNIE		MM/DD/YYYY	Y	123				8.4	ADVANCING ILLNESS
S00***** 01	Y	MOUSE, MICKEY		MM/DD/YYYY	Y	123				7.8	FRAIL ELDER
S00***** 01	Y	DUCK, DONALD		MM/DD/YYYY	Y	123				7.4	ADVANCING ILLNESS
S00***** 01	Y	MERMAID, ARIEL		MM/DD/YYYY	Y	123				7.4	ADVANCING ILLNESS
S00***** 01	Y	FLINTSTONE, FRED		MM/DD/YYYY	Y	123				7.4	ADVANCING ILLNESS
S00***** 01	Y	FLINTSTONE, WILMA		MM/DD/YYYY	Y	123				7.4	ADVANCING ILLNESS
S00***** 01	Y	RUBBLE, BARNEY		MM/DD/YYYY	Y	123				7.3	ADVANCING ILLNESS
S00***** 01	Y	RUBBLE, BAM BAM		MM/DD/YYYY	Y	123				6.9	ADVANCING ILLNESS
MED_SC											
BH_ADM BH_ADM HED_AD											
TOTAL_3 MONTHS HS TOTAL_12MONT ED_3MO ED_12M ITS_3MO ITS_12M MIT_3M MED_UNSCHEAD MIT_3MO											
SUBSEGMENT	funcnt_impair	chf	copd								
Organ failure (ESRD, ESLD, CHF Level 4, End Stage COPD)	1	1	1	1	17075	45258.77	48744.8	101762	2	2	2
Organ failure (ESRD, ESLD, CHF Level 4, End Stage COPD)	1	1	1	1	19848.6	70013.04	105769	130661	2	5	1
Older Adults with Functional Impairment and Major Comorbi	1	1	1	1	10860.2	20726.75	22685.1	23241.9	1	3	0
Organ failure (ESRD, ESLD, CHF Level 4, End Stage COPD)	0	0	1	1	4377.68	36367.36	18728	31821	3	6	0
Organ failure (ESRD, ESLD, CHF Level 4, End Stage COPD)	1	1	1	1	6541.75	24437.12	8757.3	94579.7	1	5	0
Organ failure (ESRD, ESLD, CHF Level 4, End Stage COPD)	1	1	1	1	11080.1	51723.31	12487	14029.6	3	5	1
Organ failure (ESRD, ESLD, CHF Level 4, End Stage COPD)	1	1	0	0	8501.31	64485.54	17172.2	45741.4	2	7	3
Organ failure (ESRD, ESLD, CHF Level 4, End Stage COPD)	0	0	1	1	25401.2	35832.02	45775.8	85337.9	2	2	3
Organ failure (ESRD, ESLD, CHF Level 4, End Stage COPD)	1	1	1	1	46512.6	29482.05	24874.9	53057.8	2	8	3

Other Reporting

Tufts Health Plan Medicare Preferred reserves the right to require reporting mandated by CMS. Tufts Health Plan Medicare Preferred strives to give as much notice as possible for CMS-required changes

THPMP REPORTING: Outcomes & Measures

The reporting metrics for the Integrated Care Management Program include both process and outcome metrics. Data tracking and reporting are required for the entire Tufts Health Plan Medicare Preferred membership enrolled in care management programs. Standard reporting requirements will provide the ability to identify and track opportunities for improvements in the delivery of the Integrated Care Management Program. Outcome measures will demonstrate effectiveness of programs and opportunities for improvement.

	Complex Care Management	Tier 2/Chronic Management	Transitions Management	Wellness
Process Metrics	<ul style="list-style-type: none"> Quarterly Process Metrics (including Goals of Care and Cog screen) 	<ul style="list-style-type: none"> Quarterly Process Metrics (including Goals of Care and Cog screen) 		
	<ul style="list-style-type: none"> Monthly Member Level Variable Report 	<ul style="list-style-type: none"> Monthly Member Level Variable Report 	Monthly Member Level Variable Report	Monthly Member Level Variable report

Quarterly Process Metrics

This reporting is conducted on members in the Complex Care Management Program. Reporting should include all members who have agreed to participate and have a disposition code of ENROLLED ACTIVE.

Reporting Objectives

The objectives of this report include ensuring that:

- Members who are newly enrolled in the Complex Care Management Program receive timely assessments, care plans, and actions plans
- The initial assessment is completed within 30 days of being assigned to a Care Manager
- Members with a completed Depression Screen
- Members with Goals of Care answered
- Members are screened for declining cognitive function and action is taken

Monthly Process Metrics (Complex, Chronic, Transitions, Wellness)

This reporting file provides Tufts Health Plan Medicare Preferred with a monthly data feed for all members who have a new or changed disposition code for the Complex, Chronic, Transition, or Wellness program within the reporting month.

Reporting Objectives

The objectives of these reports include:

- Tracking referral source into Complex, Chronic
- Reconciling status of members sent to the Integrated Delivery Network (IDN)/Medical Groups on the Tufts Health Plan Medicare Preferred Complex and Chronic Tier 2 Lists and Custom Care Wellness
- Allowing Tufts Health Plan Medicare Preferred to know which members are enrolled in Integrated Management Programs
- Allowing Tufts Health Plan Medicare Preferred to track duration of members enrollment in programs

Process Metric Specifications

I. 2023 Process and Outcome Metric Reporting Requirements

A. Reporting Objective

The objective of the complex member quarterly report is to ensure that members who are newly enrolled in the Complex Care Management Program receive timely assessments, care plans and actions plans. Note: It is expected that members who are enrolled in care management Complex or Chronic Program will 1) have a completed initial assessment, care plan and action plan within 30 days of being assigned to a Care Manager, 2) be asked about goals of care during the first 60 days of enrollment into the Complex program and 3) receive a depression screening.

B. Quarterly Process Metrics

Quarterly process metrics are reported on Complex members who have a disposition code of ENROLLED ACTIVE. The report should include:

1. Numerator for each metric and total denominator (Please note, total denominator for percent of Complex and Chronic/Tier 2 Members with documented goals of care differs from the denominator for the remainder of the goals of care metrics.; (Please see Specifications section for specifics)
2. Percentage of Complex Members with a completed Initial Assessment within 30 days of case assignment to care manager
3.
 - a. Percentage of Complex and Chronic/Tier 2 Members with documented answers to Goals of Care question
 - b. Of the Complex / Chronic Tier 2 Members who are enrolled:
 - i. Percent of Complex Members with a documented Longevity goal
 - ii. Percent of Complex Members with a documented Function goal
 - iii. Percent of Complex Members with a documented Comfort goal
 - iv. Percent of Complex Members who did not wish to answer
4. Percentage of Complex Members with a documented Care Management Plan
5. Percentage of Complex Members who have received a Member Action Plan
6. Percentage of Complex Members who have received a Depression Screen

C. Specifications

1. Denominator for calculating percentages for all metrics (except metrics for specific member answers to Goals of Care question – see below), includes the following:

- a. Members who are Enrolled active in Complex and Chronic Tier 2 care management program regardless of referral source
- b. Members who hit their 60th day of enrollment during the reporting period (i.e. If member is enrolled active in Q1 but hits 60th day during Q2, then the member should only be included in the Q2 report)
- c. Members with a current disposition code of Enrolled Active as of last day of the reporting period
- d. Members who have been in program for at least 60 days (since date member became enrolled active)

2. Denominator for calculating percentages for specific member answers to Goals of Care question is the total number of Complex members with goals of care specified

NOTE: Given the definition of the denominator (1a and 1b), those members that were open at least 60 days and discharged before the last day of the quarter are exempt from quarterly reporting

3. Multiple medical groups can either be rolled up to the IDN level or reported individually

4. File Format and naming convention

- a. The preferred format is a tab delimited text file with the following naming convention:
- b. TMP_Complex_Mbr_Quarterly_Q#_yyyy_XXX.txt**
- c. Please substitute the 'XXX' with the medical group number or IDN name.
- d. The second preference for file format is an Excel file with the same naming convention (.xls).

D. Definitions

- 1. Initial Assessment
- 2. Depression screen: PHQ2
- 3. Goals of Care: 1) Members who respond to Goals of Care question and 2) Members who report goal of Longevity, Function or Comfort or Members who did not wish to answer
- 4. Care Management Plan: Medical and behavioral plan for managing and monitoring the member's condition
- 5. Member Action Plan: Member centric document created and sent to member

II. **Process Metrics Quarterly Cognitive Screening report (new 2016) separate file**

A. Reporting Objective

The reporting objective is to perform dementia screening on all new Complex and Tier 2 members and measure the incidence of positive screens that lead to PCP, MSW or Dementia Care Consultant referrals.

A second objective is measure caregiver strain for those members who have positive screen and to measure completion of Goals of Care discussion for all members with positive screening.

B. Quarterly Cognitive Screen Process Metrics

Quarterly process metrics are reported on Complex and Tier 2 (chronic) members who have a disposition code of ENROLLED ACTIVE. The report should include:

1. Numerator for each metric and total denominator (Please note, total denominator for percent of Complex or Chronic/Tier 2 Members with documented completed cognitive screens differs from the denominator for the remainder of the cognitive screen metrics.; (Please see Specifications section for specifics)
2. Number and percentage of Complex members with completed Cognitive Screen
3. Number and percentage of Complex members with positive screen
4. Number and percentage of members with positive screen with referral to PCP or medical provider
5. Number and percentage of members with positive screen with referral to MSW
6. Number and percentage of members with positive screen with referral to Dementia Care Consultant
7. Number and percentage of members with positive screen with completed Goals of Care
8. Number and percentage of members with positive screen with completed Caregiver Strain
9. Repeat same measures for Tier 2/Chronic members

C. Specifications

1a. Denominator for calculating percentages for all metrics (except metrics for specific actions made as a result of a positive cognitive screen see below), includes the following:

- a. Members who are Enrolled active in Complex and Chronic Tier 2 Care management program regardless of referral source
- b. Members who hit their 60th day of enrollment during the reporting period (i.e. If member is enrolled active in Q1 but hits 60th day during Q2, then the Member should only be included in the Q2 report)
- c. Members with a current disposition status of Unassigned or disposition code of Enrolled Active as of last day of the reporting period
- d. Members who have been in program for at least 60 days (since date member became enrolled active)

1b. Denominator for calculating percentages for Positive Cognitive screen with referrals or Goals of care or caregiver strain completed is the number of Complex and Chronic members with a Positive Cognitive Screen.

NOTE: Given the definition of the denominator (1a and 1b), those members that were open at least 60 days and discharged before the last day of the quarter are exempt from quarterly reporting

2. Multiple medical groups can either be rolled up to the IDN level or reported individually
3. File naming convention

The preferred format is a tab delimited text file with the following naming convention:

- a) Quarterly_COGNITIVE_Q#_yyyy_IDN.txt
- b) Please substitute the 'XXX' with the medical group name of IDN name,
- c) The 2nd preference for file format is an xls with the same naming convention (.xls)

D. Definitions

- a. Cognitive Screen: 6 Item Screener: Cognitive Screen (Used with Permission): Christopher M. Callahan, MD, Frederick W. Unverzagt, PHD, Siu L. Hui, PHD, Anthony J. Perkins, Ms, And Hugh C. Hendrie, Mb, Chb: Medical Care: Volume 40, Number 9, Pp 771–781©2002 Lippincott Williams & Wilkins, Inc. please insert this statement into your Documentation system
- b. Positive Screen: 2 or more questions are missed
- c. Referral to PCP (medical provider) documentation in system expect this for all positive screens
- d. Referral to MSW and or Dementia Care Consultant documentation in system this is as indicated by assessment
- e. Goals of care as documented in system
- f. Caregiver Strain as documented in system

III. Process Metrics: Monthly Metrics for Complex, Tier 2/Chronic, Transition Management and Wellness

A. Reporting Objectives

The monthly member level process metrics report will provide Tufts Health Plan Medicare Preferred a monthly data feed for all members who have a new disposition code for either the Complex, Tier 2/Chronic, Transitions or Wellness programs within the reporting month. The report also allows Tufts Health Plan Medicare Preferred to:

1. Track referral source for members enrolled in Complex, Tier 2/Chronic programs
2. Reconcile members' status, as identified on the Tufts Health Plan Medicare Preferred High Risk Complex and Tier 2/Chronic lists, which are sent monthly to the IDN/ Medical Groups
3. Identify which members are enrolled in Integrated Care Management Programs
4. Track duration of members' enrollment in programs

B. Specifications

1. File format and naming convention
 - a. The preferred format is a tab delimited text file with the following naming convention: TMP_Member_Level_Detail_XXX_MonYR.txt.
 - b. Please substitute the 'XXX' with the med group number or the IDN name. The second preference for file format is an Excel file with the same naming convention (.xls).
2. Report is required to be sent to Tufts Health Plan Medicare Preferred every month
3. Report file format must match exactly
4. Use of Disposition Codes: Pre enrollment disposition status should only be used to relay why a member was not enrolled in a program:
 - CLINICALLY NOT APPROPRIATE
 - INELIGIBLE
 - MEMBER DECLINED
 - MIN REQUIREMENT NOT MET
 - UNABLE TO CONTACT

- For an enrolled member, with a disposition status of ENROLLED – ACTIVE, a disposition status of ENROLLED – DISCHARGED should be used if the member is discharged from the program, regardless of the reason
- Transitions reporting ENROLLED – ACTIVE disposition and enrolled date, then, at time of discharge, ENROLLED-DISCHARGED followed by discharge date
- Wellness reporting Enrolled active same as above, Only discharge if moving to Complex or Tier 2 level of CM or member opt out after being enrolled



As of January 2021, highlighted fields are the only fields that will need to be completed

Variable Name	Type	Length	Format	Values	Description
TMP_MID	Char	9			TMP Member ID
DATE_CASE_ASSIGNED	Date	8	DDMMYY*		Date the data is loaded and available to CM
REF_DATE	Date	8	DDMMYY		Date the file is received from THP or ad hoc referral received
REF_SOURCE	Char	50		TMP MEMBER REPORT	Complex or Tier 2
				DM PROGRAM	DM Program (Complex to Tier 2 or Tier 2 to Complex)
				UM PROGRAM	Referred via discharge planning or transition of care
				MEMBER OR CAREGIVER PRACTITIONER	
PROGRAM_REFERRED	Char	50		COMPLEX	
				TIER2	
PROGRAM_FOCUS_REFERRED				CHF	
				COPD	
				NOT CLASSIFIED	
PROGRAM_ENROLLED	Char	50		COMPLEX	
				TIER2	
				TRANSITIONS	
				WELLNESS	Those members that have opted into Custom Care and do not meet Complex or Tier 2 criteria
PROGRAM_FOCUS_ENROLLED				CHF	
				COPD	
				NOT CLASSIFIED	
DATE_MBR_AGREED	Date	8	DDMMYY		Date the member agrees to participate (begin/schedule assessment)
DATE_ASSESSMENT_COMPLETE	Date	8	DDMMYY		Date initial assessment completed, and initial care plan generated
DISPOSITION_CODE	Char	50		ENROLLED_ACTIVE	Assessment complete and initial care plan generated
				ENROLLED_DISCHARGED	
				MEMBER DECLINED	
				UNABLE TO CONTACT	
				CLINICALLY NOT APPROPRIATE	
				MIN REQUIREMENT NOT MET	I.e. custodial, hospice, unable to communicate
DISPOSITION_DATE	Date	8	DDMMYY	INELIGIBLE	I.e. deceased, termed with the plan
					Only changes when disposition is updated

2023 IDN Reporting Schedule

Monthly Member Level File		Quarterly Process Metrics File	
Reporting Month	Due Date	Reporting Quarter	Due Date
December 2022	January 12, 2023	Q4 2022	January 19, 2023
January 2023	February 9, 2023	Q1 2023	April 20, 2023
February 2023	March 9, 2023		
March 2023	April 13, 2023		
April 2023	May 11, 2023	Q2 2023	July 20, 2023
May 2023	June 8, 2023		
June 2023	July 13, 2023		
July 2023	August 10, 2023	Q3 2023	October 19, 2023
August 2023	September 14, 2023		
September 2023	October 12, 2023		
October 2023	November 9, 2023	Q4 2023	January 18, 2024
November 2023	December 14, 2023		
December 2023	January 11, 2024		

Appendix A – Six Item Screener

Script:

I would like to ask you some questions that ask you to use your memory. I am going to name three objects. Please wait until I say all three words, and then repeat them.

Remember what they are because I am going to ask you to name them again in a few minutes.

Please repeat these words for me: APPLE—TABLE—PENNY.

(Interviewer may repeat names 3 times if necessary, but repetition not scored.)

Did patient correctly repeat all three words? Yes ☐ No ☐

	Correct	Yes	No
What is the year?		<input type="checkbox"/>	<input type="checkbox"/>
What is the month?		<input type="checkbox"/>	<input type="checkbox"/>
What is the day of the week?		<input type="checkbox"/>	<input type="checkbox"/>

Before asking member to repeat the words Apple, Table, Penny, ensure that at least three minutes have passed from the time you provided these names to the member. Example: Ask additional questions such as validation of address and phone number.

What were the three objects I asked you to remember?

		Yes	No
Apple	Recall	<input type="checkbox"/>	<input type="checkbox"/>
Table	Recall	<input type="checkbox"/>	<input type="checkbox"/>
Penny	Recall	<input type="checkbox"/>	<input type="checkbox"/>

Six Item Screener: Number of objects missed (only choose one).

1. ☐ 2. ☐ 3. ☐ 4. ☐ 5. ☐ 6. ☐

Do responses indicate cognitive impairment?

Scoring: A score of greater than 2 missed indicates a need for further screening and diagnostic evaluation

Appendix B – ESS High Risk Member Report Sample

member_id	NEWLY_IDENTIFIED	FIRST_NAME	LAST_NAME	DOB	EXTERNALLY_MANAGED_GRP	pcp_ipa	PCP_FUL_L_NAME	PCP_LEV_EL1	ecg	oppscr_amt	SEGMENT
S00***** 01	Y	MOUSE, MINNIE	MM/DD/YY YYY	Y		123			8.4		ADVANCING ILLNESS
S00***** 01	Y	MOUSE, MINNIE	MM/DD/YY YYY	Y		123			8.4		ADVANCING ILLNESS
S00***** 01	Y	MOUSE, MICKEY	MM/DD/YY YYY	Y		123			7.8		FRAIL ELDER
S00***** 01	Y	DUCK, DONALD	MM/DD/YY YYY	Y		123			7.4		ADVANCING ILLNESS
S00***** 01	Y	MERMAID, ARIEL	MM/DD/YY YYY	Y		123			7.4		ADVANCING ILLNESS
S00***** 01	Y	FLINTSTONE, FRED	MM/DD/YY YYY	Y		123			7.4		ADVANCING ILLNESS
S00***** 01	Y	FLINTSTONE, WILMA	MM/DD/YY YYY	Y		123			7.4		ADVANCING ILLNESS
S00***** 01	Y	RUBBLE, BARNEY	MM/DD/YY YYY	Y		123			7.3		ADVANCING ILLNESS
S00***** 01	Y	RUBBLE, BAM BAM	MM/DD/YY YYY	Y		123			6.9		ADVANCING ILLNESS
MED_SC											
SUBSEGMENT	funct_impair	chf	copd	TOTAL_3 MONTHS	TOTAL_12MONT HS	ED_3MO NTHS	ED_12M ONTHS	ITS_3MO NTHS	ITS_12M ONTHS	HED_AD MIT_3M O	MED_UNSED_AD MIT_3MO
Organ failure (ESRD, ESLD, CHF Level 4, End Stage COPD)	1	1	1	17075	45258.77	48744.8	101762	2	2	2	0
Organ failure (ESRD, ESLD, CHF Level 4, End Stage COPD)	1	1	1	19848.6	70013.04	105769	130661	2	5	1	0
Older Adults with Functional Impairment and Major Comorbi	1	1	1	10860.2	20726.75	22685.1	23241.9	1	3	0	0
Organ failure (ESRD, ESLD, CHF Level 4, End Stage COPD)	0	0	1	4377.68	36367.36	18728	31821	3	6	0	1
Organ failure (ESRD, ESLD, CHF Level 4, End Stage COPD)	1	1	1	6541.75	24437.12	8757.3	94579.7	1	5	0	0
Organ failure (ESRD, ESLD, CHF Level 4, End Stage COPD)	1	1	1	11080.1	51723.31	12487	14029.6	3	5	1	0
Organ failure (ESRD, ESLD, CHF Level 4, End Stage COPD)	1	1	0	8501.31	64485.54	17172.2	45741.4	2	7	3	0
Organ failure (ESRD, ESLD, CHF Level 4, End Stage COPD)	0	0	1	25401.2	35832.02	45775.8	85337.9	2	2	3	0
Organ failure (ESRD, ESLD, CHF Level 4, End Stage COPD)	1	1	1	46512.6	29482.05	24874.9	53057.8	2	8	3	0

Appendix C – High Risk Member Report Stratification

Definition

The Clinical Complexity Score (CCS) is a process to rank order all THP members based on recent utilization, reducible utilization, and Social Determinants of Health (SDOH). The CCS is defined on a 0 to 10-point scale, with 0 indicating no identified needs and 10 indicating the most complex member need profile.

CCS Calculation

1. All members have a CCS that is updated monthly.
2. CCS calculation employs data from 5 consecutive quarters:
 - The most recently finished quarter (Q0);
 - 4 quarters prior the most recently finished quarter (Q1-Q4).

The quarter is considered finished on a last day of the quarter. For example, Q2 2019 is finished on June 30, 2019. The data for the quarter will change over time as claims are adjudicated.
3. Machine Learning (ML) algorithm provides a one quarter forecast for four clinical variables: inpatient medical scheduled utilization, inpatient medical unscheduled utilization, inpatient behavior utilization, emergency department utilization.
4. The ML forecasts are used in the utilization-based components CCS calculation and is made for the most recently finished quarter (Q0). CCS for historic quarters (Q1, Q2, Q3, Q4) uses actual values.
5. Calculation of Paid Claims, ED visits, inpatient visits for Q0 relies on blending actual and predicted values.
6. Prediction for medical spend is made by applying the average change of total spend across three completed quarters Q1, Q2, Q3 to the most recent completed quarter Q1.

$$Q1\text{actual} + \text{MAX}(0, \text{AVG}(Q2\text{actual} - Q3\text{actual}, Q1\text{actual} - Q2\text{actual}))$$

For Q1 and other historic quarters, percentile of medical spend for Segment 6 is calculated using actual Q1 medical claims.

7. Prediction for IP and ED utilization is made by applying ML forecasted values to the cost mapping file generated from historic values. A sample values for the cost mapping file are presented below:

Business	Measure	Average Visits	Members	Prob	Cost
Comm	ED	0	3739443	0.933294	\$0
Comm	ED	1	204121	0.984215	\$352.630
Comm	ED	3.25	63180	0.997674	\$1606.67

If ML predicted percentile of ED visit for Commercial product member is greater than 0.984215 (the percentile value from the mapping file for average visits '1') and lower or equal to 0.997674 (the percentile value from the mapping file for average visits '3.25'), then a member is predicted to have 2-

3.25 ED visits with cost of \$1606.67.

Prediction for inpatient visits is made similar with ML forecasted IP visits being the maximum of forecasted medical scheduled, forecasted medical unscheduled, forecasted behavioral visits.

8. Blended medical spend, IP and ED utilization for Q0 is then calculated as follows:

$$Q0_{\text{actual}} + \text{MAX}(0, Q0_{\text{predicted}} - Q0_{\text{actual}}) * (\# \text{ full months left in current quarter} / 3)$$

For example, if the model is updated in October 2019 and Q0 corresponds to the third quarter of 2019, medical spend will be calculated as

$$\text{Third quarter 2019 Actual} + \text{MAX}(0, \text{Third quarter 2019 Predicted} - \text{Third quarter 2019 Actual}) * (2/3).$$

If the model is updated in November 2019 and Q0 corresponds to the third quarter of 2019, medical spend will be calculated as

$$\text{Third quarter 2019 Actual} + \text{MAX}(0, \text{Third quarter 2019 Predicted} - \text{Third quarter 2019 Actual}) * (1/3).$$

9. Opportunity Values are calculated as a sum of ED and inpatient paid claims for the last 4 finished quarters. The claims are removed from the calculation if any of the following conditions is satisfied:

- Revenue code: 114, 116, 124, 126, 905, 906 or 911;
- CPT code: H0010, H0011, H0015, H0019, H0037, H0037HH, H2015, S9485TG, 1001, 1002;
- Service types: Acute Treatment Services/Level 3.7, Enhanced Acute Treatment Services, Clinical Stabilization Services/Level 3.5, Dual Diagnosis Acute Residential Treatment, RRS, Community Based Acute Treatment, Intensive Community Based Acute Treatment, Community Crisis Stabilization, Community Support Program. The following service types were also removed for commercial and TMP members: Psychiatric Inpatient, Detox, SUD Acute Residential Treatment, Psychiatric Acute Residential Treatment.

Opportunity values are then grouped into Low, Moderate and High categories based on their percentile within a subsegment:

- Low: member's opportunity value is less or equal to 75th percentile;
- Moderate: member's opportunity value is greater than 75th percentile and less or equal then 90th percentile;
- High: member's opportunity value is greater than 90th percentile.

10. CCS composition for most recently finished quarter (Q0) is outlined in the table below.

CCS Element	Weight	Data Input	Comment
Total Paid Claims	20%	100% if ≥ 98 percentile of blended paid claims 75% if ≥ 94 percentile of blended paid claims 50% if ≥ 90 percentile of blended paid claims 25% if ≥ 85 percentile of blended paid claims	Forecast is made for one quarter only. Use blended formula.
Inpatient Utilization	15%	100% if 2+ blended IP visits	Forecast is made for one quarter only. Use blended formula.
ED Utilization	10%	100% if 2+ blended ED visits	Forecast is made for one quarter only. Use blended formula.
Opportunity Value	10%	100% if (Opportunity Value \geq \$4k) 50% if (Opportunity Value \geq \$1k)	Utilization cost for last 4 finished quarters.
Medical Chronic Comorbidities	10%	100% if (3+ conditions) OR (1+ high risk condition) OR (1+ catastrophic condition) 50% if (2+ conditions not in high risk/catastrophic group) 25% if (1 condition not in high risk/catastrophic group)	The value is fixed and will not vary by quarter.

Mental Health Chronic Comorbidities	10%	100% if SPMI=1 OR High MH: (Mental_Health=1) AND (BH admits in Q0 or Q1 or Q2 or Q3 or Q4>=1) 50% if Mod MH: (Mental_Health=1) AND (Rx claim count in Q0 or Q1 or Q2 or Q3 or Q4>=3) OR (Mental_Health=1) and (Count of CNS fills in Q0 or Q1 or Q2 or Q3 or Q4>=2) 25% if Low MH: (Mental_Health=1)	SPMI flag is fixed and will not vary by quarter. MH flag will vary by quarter.
Substance Use Disorder Indicator	10%	100%: (SUD_ Alcohol or Opioid or Other=1) AND (ATS37 for Q0 or Q1 or Q2 or Q3 or Q4>=1) 100%: (SUD_ Alcohol or Opioid or Other =1) AND (CSS35 for Q0 or Q1 or Q2 or Q3 or Q4>=1) 50%: (SUD_ Alcohol or Opioid or Other =1) AND (ED Visit for Q0 or Q1 or Q2 or Q3 or Q4>=1) 25%: (SUD_ Alcohol or Opioid or Other =1)	The value will vary by quarter.
Composite SDOH Risk #1	6%	100% if SDoH Composite #1 Econ and Housing Instability =1	The value will vary by quarter.
Composite SDOH Risk #2	6%	100% if SDoH Composite #2 Low Health Literacy=1	The value will vary by quarter.
Composite SDOH Risk #3	3%	100% if SDoH Composite #3 Access Limitations=1	The value will vary by quarter.

11. CCS calculation for quarters Q1, Q2, Q3, Q4 shifts input data by one quarter back dynamically. For example, for quarter Q1: predicted values and Q0 values are replaced with Q1 data, Q1 values are replaced with Q2 data and so on.
12. CCS scores are recalculated in each data refresh monthly. Since each data refresh updates claims and medical history information, quarterly CCS scores may differ from the last iteration.

Reviewed 1/2023 by: Colleen Sterianos RN, Tristan Diaz RN CCM, Martha MacDougall RN BSN CCM, Maggie Dwyer LICSW. Approved by Audrey Sefakis, RN BSN CCM.