Tufts Health Plan
Senior Care Options (SCO)
Model of Care Training

For PCPs and Providers
2019 Annual Training
Purpose of the Training

To update providers on developments in Tufts Health Plan SCO’s Model of Care, inclusive of its Care Management Program.

➢ While meeting the CMS requirement which mandates annual provider training
Outline of Training

• What is the Model of Care?
• What’s changed for 2019?
• Review of the Model of Care
  ➢ Description of Special Needs Population (SNP)
  ➢ Roles and responsibilities of members of the interdisciplinary care team
  ➢ Care coordination and transitions in care
  ➢ Quality measurement and performance improvement
• General reminders and information
Tufts Health Plan SCO Overview

Tufts Health Plan SCO is a benefit plan offered through a three-way contract between Tufts Health Plan, the Commonwealth of Massachusetts Executive Office of Health and Human Services (EOHHS) and the Centers for Medicare and Medicaid Services (CMS).

Tufts Health Plan SCO provides MassHealth Standard (Medicaid) and Medicare coverage plus additional benefits. It is a Dual Special Needs Plan (D-SNP).

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

All members are required to choose a PCP participating in the network.
Who is eligible?

Individuals are eligible to enroll if they:

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

Also DO NOT reside in an intermediate care facility for mental health conditions or in a chronic or rehabilitation hospital as an inpatient.
The Model of Care
What is the Model of Care?

“In accordance with CMS, a **Special Needs Plan (SNP)** **Model of Care (MOC)** must provide the structure for care management processes and systems that will enable the **Medicare Advantage Organization (MAO)** to provide coordinated care for special needs individuals.”

➢ Tufts Health Plan’s Model of Care is approved for three years.
CMS Requirements for Special Needs Plans

As an SNP, Tufts Health Plan SCO is required by CMS regulation to have a comprehensive care model, which must include the following elements:

1. Description of the SNP population served

2. Care coordination
   - Health Risk Assessment Tool (HRA)
   - Individualized Care Plan (ICP)
   - Interdisciplinary Care Team (ICT)
   - Care Transition Protocols

3. Comprehensive provider network
   - Provider expertise to support population
   - Clinical practice guidelines for providers and care transition

4. Quality measurement and performance improvement
What’s Changed for 2019?

Added new roles:
- BH Care Manager as primary Care Manager for Level 3 member
- Pharmacy Technician
- Community Health Worker

Clarified the Transition Management Processes, including who will share what information when:

- Indicated that a Tufts Health Plan Advanced Practice Nurse may conduct rounds and be the primary treating provider for members in short- and long-term Skilled Nursing Facility/Institutional Settings.
- Added the Part D Medication adherence and Statin Therapy measures to the quality improvement measures.
Levels of Care (Rate Cells)

• All members are enrolled as Community Well until they are evaluated by a On-boarding Nurse or RN Care Manager, who will submit an MDS-HC to MassHealth to determine their Rate Cell.
  ➢ Members who do not have an initial MDS remain Community Well
  ➢ Members who do not have an annual MDS are changed to Community Well
• Members are separated into Levels of Care based on their Rate Cell to determine the most appropriate Care Manager, services, and touch point frequency.
• Rate Cells drive revenue which pays for medical expenses.

Non-complex
  • Community Well
    • Level 1 – no Home/Community Services
    • Level 2 – with Home/Community Services

Complex
  • Alzheimer’s Dementia/Chronic MI
  • Nursing Home Certifiable
    • Level 3
    • Level 4

Institutional
Description of SNP Population

Based on the stratification of the population, the following is the distribution of Tufts Health Plan D-SNP membership by Care Level:

<table>
<thead>
<tr>
<th>Care Level</th>
<th>% of Members</th>
</tr>
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<tbody>
<tr>
<td>Level 1</td>
<td>15%</td>
</tr>
<tr>
<td>Level 2</td>
<td>6%</td>
</tr>
<tr>
<td>Level 3</td>
<td>4%</td>
</tr>
<tr>
<td>Level 4</td>
<td>70%</td>
</tr>
<tr>
<td>Institutional</td>
<td>5%</td>
</tr>
</tbody>
</table>
Description of SNP Population

Of the Tufts Health Plan SCO beneficiaries:

➢ 3% are disabled, and
➢ 84% have incomes at or below 100% of the federal poverty level

The top 5 co-morbid conditions impacting members are:

45% Diabetes
19.6% Chronic Obstructive Pulmonary Disease
16% Depression
11% Congestive Heart Failure
7.7% Dementia
The Most Vulnerable: Complex Members

- 69% female, with an average age of 77.

- Majority of beneficiaries are Caucasian/White (37%), while the remaining beneficiaries are 20% African American/Black, 26% Asian, 11% Hispanic/Latino.

- 36% live alone in a private home/apartment or in a senior housing building.

- 57% live with a family member, paid caregiver or in an Assisted Living Facility.

- 7% are reported to be homeless or have other living conditions.

- 39% speak English as their primary language. The remaining beneficiaries report their primary languages as: 10% Spanish, 7% Cape Verdean Creole, 14% Chinese, 5% Haitian, 3% Portuguese, and the remaining 22% being reported as Other.
The Most Vulnerable: Complex Members

- 39% report they do not speak English “at all” and 11% report not speaking English “well.”
- 45% do not have a high school education, with 9% having no schooling at all.
- 56% report needing help reading health-related materials “always” or “often.”
- 53% have no identified communication preferences, while 32% prefer interpreter services.
- 19% are hard of hearing, 24% have low vision, and 6% are disabled.
- The most significant difference between the two populations is the need for assistance with activities of daily living (ADLs.)
  - 91% of the most vulnerable population requires assistance with ADLs in comparison to 68% of the total population.
  - The majority of complex members have a caregiver/someone to help if they become ill.
Roles and Responsibilities of The Interdisciplinary Care Team
The Interdisciplinary Care Team (ICT)

The ICT consists of a group of Tufts Health Plan SCO network providers, including at least a PCP, a care coordinator, a geriatric support services coordinator (GSSC) and a Tufts Health Plan Care Manager.

The ICT works to help ensure effective coordination and delivery of covered services to all SCO members. The ICT roles and responsibilities follow.
RN Care Manager (RNCM)

Healthcare Professional (RN) responsible for managing the care of members with complex needs:

- Completes initial assessments for community members
- Secondary Care Manager for Level 3 assessments. Conducts annual assessments and assessments for change in condition for Level 3.
- Assigned Care Manager for Level 4 and Institutional members
- Ongoing assessments for Level 4
  - Leads ICT meetings
  - Develops and implements the care plan
  - Initiates Home- and Community-Based Services
  - Coordinates care with the PCP and medical specialty providers
  - Manages transition post hospitalization
  - Implements disease management programming as needed
- Completed annual MDS-HC for Level 3 and 4 members
- Supports paraprofessional members of the care team
Nurse Practitioner

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

- Consults to the ICT for members, regardless of Level, regarding medical conditions as needed
- Acts as a liaison to providers; giving updates on the member’s condition and recommendations for treatment
- Provides comprehensive assessments, palliative consults, and medication reviews
- Visits members in-home or at a SNF and treats in place
- Performs rounds and serves as primary treating provider for members at select preferred SNF/LTC facilities
Advanced Practice Nurse Clinical Care Delivery Program

Members can be referred to the program when needing oversight by a Nurse Practitioner (NP). These members will continue to be managed by an RNCM, but will have ongoing NP oversight with face-to-face visits as frequently as needed for an episode of care. Members can be referred for:

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

- **On-Call/After-Hours Clinical Support Process**
  1. Member calls Tufts Health Plan SCO Member Services after-hours
  2. Member holds the line if they wish to speak to a Nurse
  3. Call is forwarded to on-call Nurse Practitioner

- Between 5 p.m. and 8 p.m., Member Services is able to address member issues they are equipped to handle
- Tufts Health Plan Nurse Practitioners are on call on a rotating basis
Behavioral Health Care Managers (BHCM)

- Assists with early identification and intervention of mental health and substance use needs
- Serves as primary care manager for Level 3 members rated with Alzheimer’s Dementia/Chronic Mental Illness (AD/CMI)
- Collaborates with RN Care Manager on coordination of care and with the Department of Mental Health as needed
- Assists with referrals to behavioral health providers
- Collaborates with ICT on coordination of care for members with serious and persistent mental illness and substance use disorders
Geriatric Support Services Coordinator (GSSC)

Community resource contracted through Aging Services Access Point (ASAP)

- Serves as assigned Care Manager for Community Well members
  - Biannual telephonic assessments for Level 1 members
  - Biannual face-to-face assessments for Level 2 members
  - Can perform a quarterly face-to-face assessment for Level 3
- Coordinates Home- and Community-Based Services (HCBS)
- Collaborates with RNCM and BHCM on care coordination and Plan of Care implementation
- Participates in Interdisciplinary Team (ICT) meetings
- Assists with Medicaid eligibility issues (MassHealth)
Community Health Worker (CHW)

- Serves as RN CM extender/support, particularly when GSSC assistance is not available, with the main focus being working in the home with members to implement care plan interventions as assigned by an RNCM.

- Assists RNCMs with completion of care plan interventions for high-risk (complex) community-based members requiring assistance with activities of daily living (Care Level 4).

- Works collaboratively with the RNCM and providers to increase member knowledge, motivation and treatment participation through targeted interventions that address the member’s holistic needs from a psychosocial, medical and socio-economic perspective.
Care Coordinator (CC)

• Works in close collaboration with RN Care Managers to assist in:
  ➢ Calling MD offices for clinical information
  ➢ Faxing clinical information to providers

• Sets up services and transportation

• Orders supplies

• Sends written communications to members and providers
Clinical Pharmacist or Pharmacy Technicians

The Clinical Pharmacist supervises a group of pharmacy technicians, embedded in the Tufts Health Plan SCO Interdisciplinary Care Team, which improves quality of care through:

- Medication management programs
- Consultative services
- Quality initiatives
- Comprehensive medication management reviews to improve outcomes, reduce drug-related problems, and reduce admissions and readmission

For example:

- Advises member and ICT on the selection, dosages, interactions, and side effects of medications
- May teach member how to administer medications
- May perform medication reconciliation and review post inpatient discharge
The Dementia Care Consultant is a Tufts Health Plan employee who sits at the Alzheimer’s Association.

The Dementia Care Consultant provides information to beneficiaries and/or caregivers to develop a better understanding of the disease and develop strategies for symptom management.

The Dementia Care Consultant screens beneficiaries for changes in cognitive function and provides tools, education, support, and care planning. Care is coordinated with Care Manager, family, PCP, and other members of the ICT.
Primary Care Providers (PCP)

The role of the PCP is to provide primary care and participate in the development of each member’s Individual Plan of Care. Key tasks of the PCP include the following:

- Provides overall clinical direction and serves as the central point for integration and coordination of all covered services
- Provides primary medical services, including acute and preventive care
- Participates in ICT meetings, during which changes to a complex member's IPC are reviewed and approved
  - ICT meetings are organized to discuss the status and plan of care for each member. The frequency of these meetings depends on the member’s acuity and level of need.
- Promotes independent functioning of the member in the most appropriate, least restrictive environment with the proper supports in place
- Assists in the designation of a health care proxy, if the member wants one
- Communicates with the member and member’s caregiver(s) about their medical, social and psychological needs
Disease Management Program

The disease management program focuses on 5 diseases:

- Diabetes
- Depression
- Dementia
- Chronic Obstructive Pulmonary Disease
- Congestive Heart Failure

The program includes the provision of educational materials, disease-specific assessments and beneficiary coaching and referrals to specialty programs, as needed.

Tufts Health Plan’s Chronic Care Improvement Program is for members with COPD to identify and refer members who have concurrent Depression for treatment.
Comprehensive Assessment

A Comprehensive Assessment is conducted by a Tufts Health Plan Care Manager initially and at select intervals in order to evaluate the medical, functional, cognitive, psychosocial and mental health needs of each member.

The assessment review living arrangements, family and social supports, function, current health status, cognition, behavioral health, substance use/abuse, preventive health measures, medication and health history, and lab data, as well as advance directive status and goals of care.

It also identifies factors that may be contributing to illness and/or the need for support services.
Care Management Assessments

• Tufts Health Plan D-SNP Care Management Staff perform supplementary assessments as indicated by the member’s identified level of risk as well as their complexity, diagnoses, or health care utilization.
  - The Minimum Data Set-Home Care (MDS-HC)-A Functional Assessment
  - Disease Management Assessment
  - Behavioral Health Assessments

• In addition to regularly scheduled ongoing assessments, members are reassessed more frequently if certain trigger events occur, suggesting a change in functioning.
Core Care Model

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

- A Tufts Health Plan SCO member’s Interdisciplinary Care Team (ICT) includes a Primary Care Provider (PCP), a Registered Nurse Care Manager (RNCM) and/or a Behavioral Health Care Manager (BHCM), a Care Coordinator, and a Geriatric Support Services Coordinator (GSSC) from an Aging Services Access Point (ASAP).

- Based on the member’s needs, the ICT may also include, a Clinical Pharmacist or Pharmacy Technician, a Nurse Practitioner, a Community Health Worker (CHW), and/or other health specialists.

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

- The ICP includes a care plan and a service plan.
- The plan is updated as the member’s condition and needs change.
- Initial ICP and at minimum annual update is mailed to member/caregiver and PCP.
- A Centralized Enrollee Record (CER), accessible to all members of the care team, contains all activity related to the member’s care.
1. Initial clinical assessments are conducted by the RNCM.
2. After assessment, each member is assigned an appropriate Care Manager.
3. The CM uses these assessments to develop an service plan and an individually tailored care plan (ICP):
   - Problem list
   - Member-centric goals
   - Interventions
4. Short- and long-term member goals are established.
5. Plan is reviewed with member/caregiver(s).
6. An ICP Letter is mailed to the member for signature and the PCP. Signed letter is returned to Tufts Health Plan from the member.
7. Care Plan revisited and updated at each assessment.
8. At minimum re-mailed to member and PCP annually.
Interdisciplinary Care Team

- APN SNF/LTC Rounder
- Clinical Pharmacist/Technician
- Primary Care Provider
- Community APN
- RN Care Manager
- BH Care Manager
- Dementia Care Consultant
- Community Health Worker
- Care Coordinator
- GSSC
- Palliative Care APN

Member
The member’s Tufts Health Plan SCO Care Manager will:

- Initiate telephonic contact with the PCP in developing the Plan of Care and to coordinate care (no less than annually).
- Mail initial and annual care plan to the PCP.
- Notify the PCP of transitions of care.
- Notify the PCP of changes in functional status.
- Contact the PCP’s office and request assistance if the member is refusing care management intervention or is unable to be reached.
Planned Transitions (Prior to the Transition)

Clinical Administrative Staff Person:

- Notifies members of the ICT via the Central Enrollee Record (CER) of the upcoming admission.
- Calls the inpatient facility on the scheduled admission date to confirm that member has been admitted.
- If the member is not admitted to the inpatient facility because the inpatient admission is rescheduled or cancelled, CER is updated to reflect the change, including the new scheduled date of admission where applicable.

The Care Manager then:

- Provides the member and/or caregiver with a consistent person responsible for supporting them during the transition.
Planned and Unplanned Transitions (During the Transition)

Clinical Administrative Staff:

- Requests clinical information from the admitting facility.
- Send information about the member’s Individualized Care Plan (ICP) to the admitting facility upon notification of the admission.
- Ensures that the facility has the PCP contact information, and prompts their making contact.

Clinical Nurse Liaison:

- Monitors progress during inpatient stay and communicates with the admitting inpatient facility to review clinical information about the member’s progress during the inpatient stay.
- Plans for and coordinates the discharge to the next setting, beginning at the time of admission, in collaboration with the Care Manager.
- Updates the CER with information about the admission.
- Facilitates the sharing of information between the facility and the PCP if it has not otherwise occurred.
Planned and Unplanned Transitions (During the Transition)

The Care Manager:

- Contacts the caregiver within 1 business day of the admission to:
  - Communicate the care transition process
  - Confirm any changes to the member’s health status
  - Provide the caregiver a consistent person responsible for support during the transition
- Notifies community-based service providers to suspend services while beneficiary is away from home
- Communicates the discharge plan to the member and/or caregiver
- When necessary, convenes an ICT meeting
- Reviews and updates the service and care plan

For inpatient mental health/substance abuse admissions:
The Behavioral Health Department and Behavioral Health Care Manager work directly with the facility and communicate care plan information.
When discharge from an inpatient facility is to the member’s home:

**The Clinical Nurse Liaison:**

- Updates the CER with the discharge information which automatically generates a task to the Care Manager to conduct the Day 2 post-hospital assessment and intervention (PHA)

**The Care Manager:**

- Arranges for community providers to resume home- and community-based services and orders new services, as needed
- Shares ICP information with the home care agency for members being discharged with home health care services; in addition, the home care agency receives a discharge summary from the discharging facility
- Completes Day 2 PHA with member and/or caregiver to:
  - Assess member’s health status and plan of care
  - Ensure that PCP and/or specialist follow up appointment is scheduled
  - Identifies if the member is high risk for readmission (ensures an action plan or crisis plan is in place)
  - If the member is high risk, communicates with PCP and updates, as well as potentially referring, the member to the Nurse Practitioner Program
Planned and Unplanned Transitions (After the Transition)

The Care Manager (cont.)
Completes (or asks a pharmacy staff person to complete) the Day 7 Post Hospitalization Assessment and Intervention with the member to:

- Reassess health status
- Ensure that PCP and/or specialist follow up appointment is scheduled or has been completed
- Complete a medication review and reconciliation
- Ensure all the member’s needs are being adequately met

When a member is discharged from an inpatient facility to a skilled nursing facility, the Care Manager:

- Communicates with the PCP and Care Team updates ICP accordingly
- Coordinates with the skilled nursing facility about the member’s health status, risk for readmission, and care plan on an ongoing basis
- Continues to outreach to the member and/or caregiver for ongoing assessments and care plan updates
Specialized Network Expertise

Tufts Health Plan contracts and credentials in the Service area with over:

- 1,200 primary care practitioners
- 5,000 specialists
- 40 acute care hospitals
- 350 sub-acute facilities
- 15,000 individual, group, and facility providers encompassing many ancillary services:
  - including but not limited to clinical psychologists, Licensed Independent Clinical Social Workers (LICSWs), and other behavioral health providers; physical and occupational therapists and speech pathologists; durable medical equipment providers; chiropractic service providers; and free-standing laboratory facilities, imaging facilities, dialysis centers, and ambulatory surgical centers.
- 800 dentists
- 1,500 routine vision care providers
- ASAP for Home- and Community-Based Services (HCBS)
Tufts Health Plan endorses existing evidenced-based guidelines and distributes them to plan providers via the provider website, Provider Update newsletter, and provider training, including:

1. Preventive health guidelines, involving screening for disease
2. Clinical practice guidelines, outlining a recommended treatment path or use of ancillary services

Tufts Health Plan’s clinical practice and preventive health guidelines are designed to support preventive health, behavioral health, acute disease treatment protocols, and/or chronic disease management programs.

Tufts Health Plan standard guidelines and practice protocols are customized for the geriatric population.

The Care Management Team receives alerts and reminders for individual beneficiaries if there are gaps in care per the guidelines.

Providers are expected to maintain continuity of care during transitions.
Some Expectations of Tufts Health Plan SCO PCPs

- Review the Individual Care Plan (ICP) sent by Tufts Health Plan after the initial assessment and at minimum annually thereafter; Contact the Care Manager for suggested changes
- Respond to Nurse Care Manager requests to coordinate care and/or attend Interdisciplinary Care Team meetings when able
- Provide EMR access or submit annual history and physical annually
- Review assessments sent by Tufts Health Plan Nurse Practitioner staff; Contact the APN when needed to coordinate care
- Review Medication Reviews performed by Tufts Health Plan Pharmacy Staff: Contact the Pharmacy Staff when needed to coordinate care
- If requested by Tufts Health Plan: Provide latest available member contact information and attempt to bridge the gap in communication with members refusing Tufts Health Plan assessments and/or unable to be reached
- Recall members to fill gaps in care on quality measures
- Complete required model of care training and continuing education annually
Primary Care Access Standards

Primary care providers have the responsibility of monitoring the care of their Tufts Health Plan SCO members by providing them with medical management that is both high quality and cost-efficient. One important aspect of this requirement is being available to members **24 hours a day, 7 days a week** via direct contact or through a PCP-arranged network provider alternative.

<table>
<thead>
<tr>
<th>Appointments for...</th>
<th>Should be Seen/Scheduled</th>
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<tbody>
<tr>
<td><strong>Emergency care</strong></td>
<td>Same day</td>
</tr>
<tr>
<td><strong>Urgent care</strong></td>
<td>Within 24 hours</td>
</tr>
<tr>
<td><strong>Non-urgent symptomatic care</strong></td>
<td>Within 1 week</td>
</tr>
<tr>
<td><strong>Preventive/routine care</strong></td>
<td>Within 30 days</td>
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Annual Tufts Health Plan SCO Provider Continuing Education

Tufts Health Plan SCO Primary Care providers are expected to have annual continuing education in the following areas:

• Depression
• Alcohol and substance use
• Dementia, including Alzheimer’s disease
• Identification and treatment of incontinence
• Preventing falls
• Identification and mandatory reporting of abuse, neglect and exploitation of elderly individuals
• Chronic obstructive pulmonary disease (COPD)
• Congestive heart failure (CHF)
• Diabetes

Links to the free CEUs can be accessed on line at: tuftshealthplan.com/provider
Current Model of Care Quality Goals

1. Improve access to care for medical, social and behavioral health services
2. Improve access to affordable care
3. Improve coordination of care and appropriate delivery of services through alignment of the HRAT, ICP and ICT
4. Promote and enhance transitions of care
5. Improve access to and utilization of preventive services
6. Promote appropriate utilization of services
Current MOC Provider Performance Measures

• Care of Older Adults - Annual Pain Assessment and Functional Status Assessments

• % of members discharged from acute inpatient hospital setting and return to any hospital with any admission diagnosis within 30 days of discharge

• COPD admission and COPD readmission rates

• CHF admission and readmission rates

• % of members who are seen by their PCP/specialist for a post-discharge visit within 7 calendar days of discharge from an acute facility

• % of members who receive a medication reconciliation within 30 days of discharge from an acute facility to the home setting
Current MOC **Provider** Performance Measures

- Breast cancer screening rates 65-74
- Colorectal cancer screening rates
- Immunization rates for influenza and pneumococcal vaccines
- Osteoporosis management in women who have had a fracture
- Disease modifying anti-rheumatic medications for members with rheumatoid arthritis
- Initiation of statin therapy for diabetes and for CVD
- STARS Part D medication adherence rates:
  - 80% compliance with fills for oral diabetic, statins and hypertensive medications
Helpful Information
To contact a Tufts Health Plan SCO member’s Care Manager call:

888.766.9818
Centralized Enrollee Record

The centralized enrollee record (CER) is a single, centralized electronic record with the primary purpose of documenting Tufts Health Plan SCO member status.

The CER is used to facilitate communication among members of the Care Team.

The CER or a summary abstract is available to any provider who requires access 24 hours a day, 7 days per week.

To obtain access, contact:

Provider_Education@tufts-health.com
Tufts Health Plan online resources

Tufts Health Plan SCO member website:
- tuftsmedicarepreferred.org/plans/senior-care-options-plan

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

Tufts Health Plan SCO provider website:
- tuftshealthplan.com/provider

Available on the provider website:
- ✓ Provider Manual
- ✓ Payment Policies
- ✓ Medical Necessity Guidelines
Tufts Health Plan SCO Contact Information

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

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

Appeals and Grievances: 855.670.5934

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

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

We appreciate your attention and participation.

Please click here to attest to the completion of this training and to take the Tufts Health Plan SCO Provider Satisfaction Survey.