Tufts Health Unify

A One Care plan (Medicare-Medicaid Plan) for people ages 21-64

August 2020

TUFTS Health Plan

Training Agenda

Overview

- Tufts Health Plan
- One Care
- Tufts Health Unify

Tufts Health Unify Model of Care

- Key Principles
- Provider's Role in the Care Planning Process

Doing Business With Us

- Checking Member Eligibility
- Submitting Claims
- Provider Resources

About Tufts Health Plan

Founded in 1979, Tufts Health Plan (THP) is a nonprofit organization nationally recognized for its commitment to innovative, high-quality health care coverage. THP plans offer an array of health management programs, which support evidence-based approaches to health and wellness.

- Tufts Health Public Plans, Inc. is a licensed health maintenance organization but does business under the name "Tufts Health Plan." Tufts Health Public Plans is the legal name of a division within THP.
- THP's headquarters is located in Canton, Massachusetts.
- Tufts Health Public Plans was rated 4.5 out of 5 among health insurance plans in NCQA's Medicaid Health Insurance Plan Ratings in 2015-2016 and was the No. 1 Medicaid Health Plan in the U.S. for 2014-2015.
- THP currently offers three plans in Massachusetts:
  - Tufts Health Direct – Health Connector
  - Tufts Health Together – Includes MassHealth MCO Plan and Accountable Care Partnership Plans (ACPPs)
  - Tufts Health Unify – One Care plan

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Tufts Health Plan's Mission and Vision

Our mission

- To improve the lives of the diverse communities we serve

Our vision

- Every life improved through access to high-quality, affordable health care

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About One Care

- Medicare-Medicaid plan for dual eligible under age 65
- Demonstration to deliver integrated medical, behavioral health, Long-Term Services and Supports (LTSS) and care management services to enhance functional status, improve health outcomes and promote independent living
- Enhanced benefits
- No cost sharing
- For more information about One Care or provider trainings, please visit: mass.gov/eohhs/consumer/insurance/one-care/

About One Care (continued)

- In 2011, Massachusetts was one of 14 states awarded a design contract to develop a service delivery and payment model to integrate care for beneficiaries dually eligible for Medicare and Medicaid
- In 2013, One Care was launched in Massachusetts
- One Care simplifies care delivery by merging enrollees' Medicaid and Medicare benefits into one plan
- One Care enrollees have one card and one person to coordinate their care, in addition to their health care providers
- One Care plans contract with Independent Living LTSS coordinators from community organizations to work with participating beneficiaries
- For more information about One Care or provider trainings, please visit: mass.gov/eohhs/consumer/insurance/one-care/

Tufts Health Unify, a One Care plan

Leadership in Under 65 Duals

- One of the first Massachusetts plans to serve under 65 duals
- Active engagement in demonstration and contributor to the dialogue on how to strengthen support for the One Care program
- Commitment to One Care through next One Care contract cycle
- Offered to members in Middlesex, Suffolk and Worcester counties

Key Product Features

- Initial and Ongoing Member Assessments
- Individualized Care Plan
- Integrated Care Team

Effective Care Integration

- Establish and enhance care coordination with care providers
- Improve health and functional outcomes
- Recognize and address care needs holistically
- Promote independence within the community

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Tufts Health Unify Model of Care

Dual-Track Care Management

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Dual-Track Care Management Strategy

To address EOHHS' call for innovative and comprehensive care management, Tufts Health Unify is executing a dual-track care management strategy.

Track 1: THP-led model of care in **Middlesex and Suffolk** counties

Track 2: Cityblock Health-led model of care in **Worcester** county

While each model has some differences, they both share the following core principles in alignment with the One Care contract:

- Both models are compliant with all One Care requirements
- Member-centric: focused on the needs, values and preferences of individual members
- The care planning process includes an Interdisciplinary Care Team (ICT) and key support roles identified as important in achieving members' care plan goals
- Efforts focus on areas where a meaningful difference can be made
- Care planning is inclusive and based on principle of shared decisions between members and their ICT
- Care coordination is designed around a collaborative and inter-professional model of care management

Navigating the Dual-Track Strategy

THP aims to ensure a seamless member and provider experience, regardless of which organization is providing care management services

Core operational elements of THP's dual-track strategy:

- All members, regardless of location, will have a single point of contact for their care management
- All members' care manager and ICT information can be found on THP's centralized enrollee record portal (HealthTrio Portal)
- All members have the same benefits regardless of care manager
- All utilization management activities are handled centrally by THP
- Members who have a residential address in Suffolk and Middlesex counties are managed by THP care managers
- Members who have a residential address in Worcester county are managed by Cityblock care managers

Tufts Health Unify Model Overview

Suffolk and Middlesex Counties

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Key Principles

Initial Health Risk Screen	By screening for members with acute needs, THP can provide access to comprehensive care management sooner to those who need it most.
Stratification	A scoring guide assigns associated risk categories per relevant criteria.
All Members Assigned to ARN • <14 days for high risk • <30 days for moderate to low risk	**Assessment RN (ARN):** • Completes Minimum Data Set (MDS) and Comprehensive Assessment • Attributes member to relationship lead to draft care plan based on initial Problems, Goals, and Interventions (PGIs) • Reassessments are conducted to ensure ongoing attention to members' changing needs
Care Plan Process	**Accountable Care Manager (ACM):** • ICT Team Lead, reviews and approves all care plans • Relationship Lead for high acuity members **Primary Care Provider (PCP):** • Reviews and signs off on related care plans **Member:** • Reviews and approves personal care plans

Key Principle: Brief Health Risk Screen Tool

By screening for members with acute needs, THP can provide access to comprehensive care management sooner to those who need it most.

1 **PRIORITIZE**

Prioritize members into high and medium/low risk and reduce the time from enrollment into Tufts Health Unify to completion of the comprehensive assessment

2 **ESCALATE**

Where appropriate, provide an escalation pathway to members who need immediate assistance and get them the support they need

3 **INFO**

Provide an additional touchpoint for information gathering prior to assessment nurse's arrival into the home

4 **SAVINGS**

Prevent unnecessary utilization by engaging members in care management through prioritizing engagement for those at the greatest risk of hospitalization

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Key Principle: Member Risk Stratification

Based on the available data, chronic complexity and historical utilization metrics were strong predictors of avoidable spend.

Risk Stratification	Definition	% of Total Membership	% of Total Spend	% of Avoidable Spend
High Risk	Members with 3 or more chronic conditions AND - 2 or more IP admits OR - 3 or more ED visits OR - 175 or more PCA hours/month	12.0%	33.5%	45.6%
Medium Risk	Members with 3 or more chronic conditions AND - less than 2 IP admits OR - less than 3 ED visits OR - less than 175 PCA hours/month	35.5%	33.8%	29.3%
Low Risk	Members with less than 3 chronic conditions	52.6%	32.7%	25.1%

Model Enhancements:

- Incorporate recency of medical events (e.g., IP or ED utilization within past 90 days)
- Flag members who have been prescribed antipsychotics
- Include number of distinct medications prescribed
- Flag members who receive community-based adult services

Key Principle: Integrated Care Team Roles

Position	Roles and Responsibilities
Enrollment Specialist (ES) 	• Outreach and engagement to new members • Informs members on offered services/programs • Conducts brief health risk screen
Assessment RN (ARN) 	• Conducts comprehensive and MDS assessments in home, hospital, and ambulatory care settings • Develops initial care plan PGIs • Performs crisis intervention
MDS RN 	• Reviews and maintains MDS assessments and submissions with the state • Completes member attribution to the care team • Collaborate with care management team to clarify diagnoses and member status
Accountable CM (ACM) 	• Relationship lead for high-risk members • Reviews and approves care plan • Develops personal relationship with member and is key point person for high-risk members
BH Care Manager (BH) 	• Relationship lead for BH-primary members • Counseling and support for members with behavioral health and social determinant of health needs • Provides behavioral health consulting services
Care Coordinator (CC) 	• Supports members with social determinants of health needs • Relationship lead for low-risk members • Facilitates access to community-based organization (CBO) resources • Supports high-risk care manager as needed

Key Principle: Integrated Care Team Roles (continued)

Position	Roles and Responsibilities
Clinical Pharmacist 	• Provides medication reconciliation, adherence and education support
Community Health Worker (CHW) 	• Supports care team with outreach and engagement • Relationship lead for moderate-risk members • Connects engaged members to care team • Conducts home visits to potential or disengaged members
Peer Specialist (PS) 	• Outreach and engagement • Group facilitation • Emotional support, coaching and mentoring • Referral and escort to community services
Transitions Care Coordinator (TCC) 	• Supports care transitions care management • Supports key administrative functions and coordinates care for low acuity members
Transitions Care Manager (TCM) 	• Leads care transitions care management • Engages with facility care management staff and supports time-bound transitions

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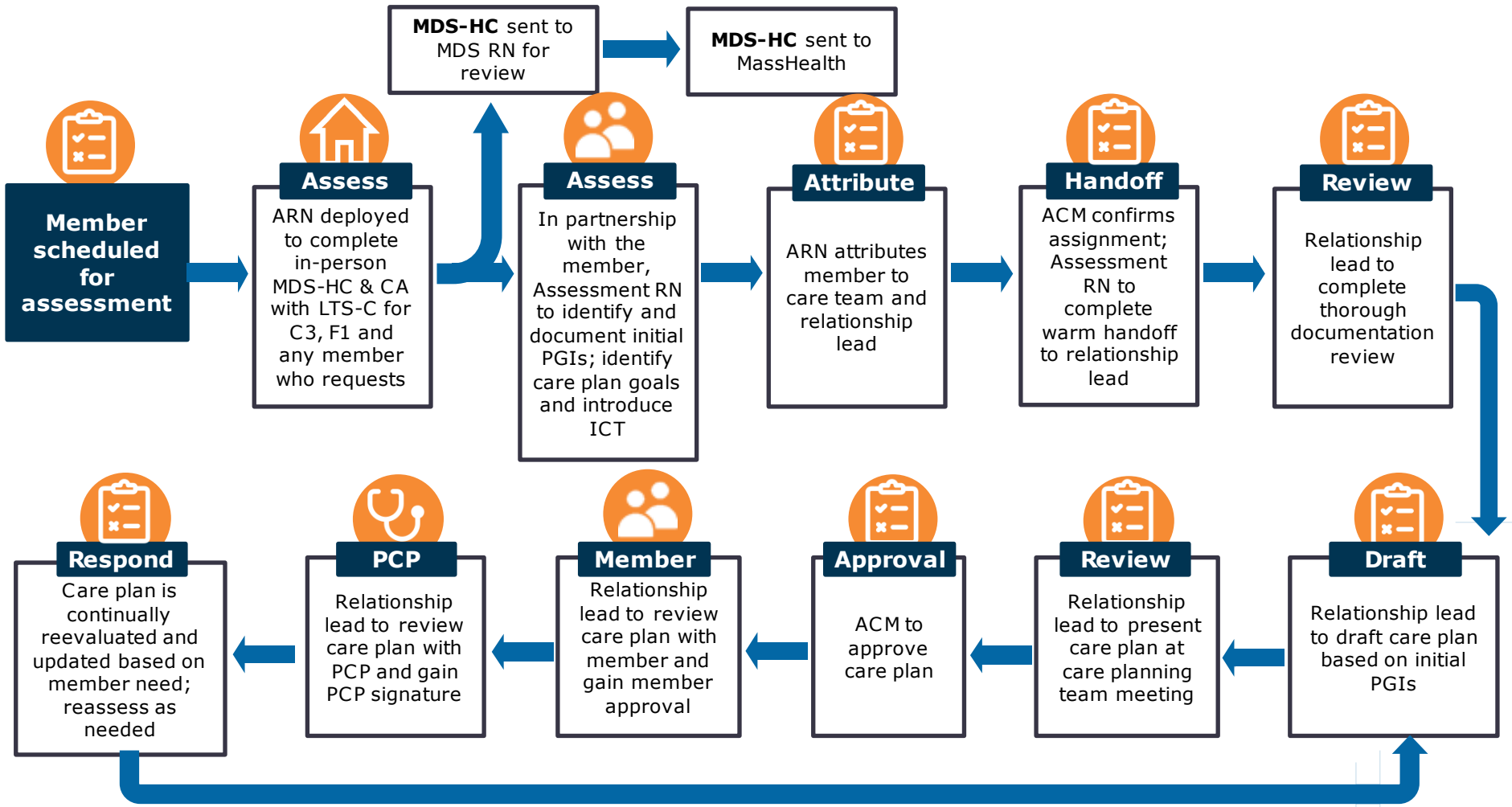
Key Principle: Care Plan Process



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Cityblock Health Model Overview

Worcester County

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Overview

Cityblock Health unites primary care, behavioral health and social services with custom-built technology to improve individual and community health in lower-income neighborhoods.

Benefits and Capabilities

There is enormous opportunity to improve outcomes and capture value by delivering a new model of care

Benefits	Capabilities
• Optimized for Medicaid and Duals • A 24/7/365 personalized care system • Majority of care in-home or virtual • Built to take full, two-sided total cost of care risk • Scalable tech enables low cost base • Business model flexibility; delegated staff-model provider and/or MSO capabilities • Built by experienced healthcare + tech team	• Primary care • Behavioral health (Psych + SUD) • Care transitions with facility rounding • In-home urgent and post-acute services • Palliative & EOL care • Tailored programs for populations with special needs • Direct social services delivery • CBO network build and management • Structured needs assessment • 24 / 7 / 365 clinical access with remote triage (voice / text / video) + in-home care • Social isolation programming • Real-time reporting • 360° member view • Network & referral management • Outreach & field engagement

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Engagement and Improvement

Cityblock leverages personalized care teams, Neighborhood Hubs and technology designed to engage members and improve outcomes

Personalized Care Teams	Neighborhood Hubs	Purpose-Built Technology
Cityblock Health's integrated care teams include MD, NP/PA, RN, BH, LSW, and Community Health Partners who deliver advanced primary, behavioral health (including SUD), and palliative care, and connect members with social services.	Multi-functional Hubs anchor integrated care teams and provide a community space for members. Field-based and home-based care teams flex out from the Hub, meeting members wherever is most convenient for them.	*Commons*, our care delivery platform, provides a 360° view of individual health and social needs, enabling inclusive care planning, multiple and integrated modalities of care delivery, protocolized alerts and seamless care team workflows.
		

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Principles of Care

Member is CEO of their care

The Care Team is the engine

Easy to reach whenever, however

Family and friends are central

Going for help should feel good

Community drives health

Cityblock helps catalyze change in serving communities

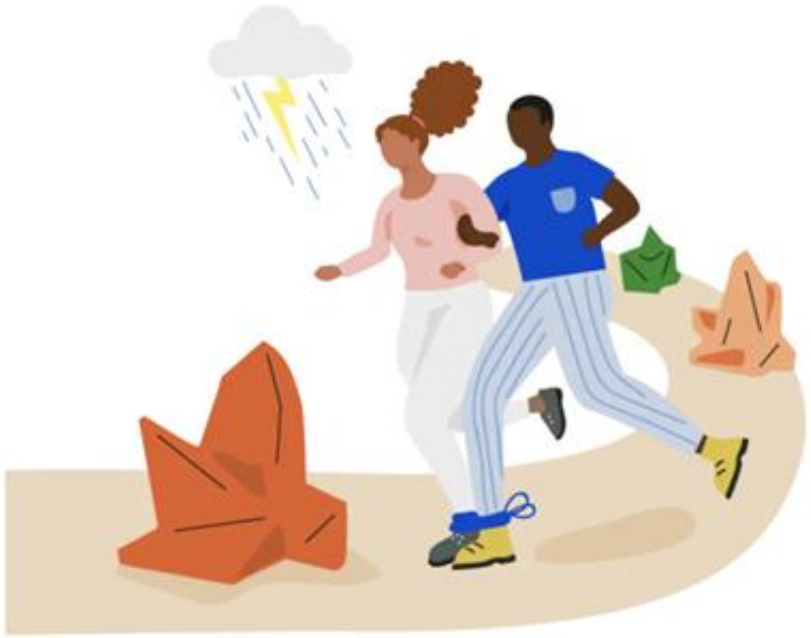
There is no health without social, mental and physical health

What we say (and how) matters

Cityblock's Care Team is our most important member

Analyzing Social Determinants

Cityblock Health's model analyzes and addresses the social determinants that impact health



- Engagement and Resiliency
- Safety
- Social Support
- Financial Stability
- Food
- Housing
- Transportation
- Preventive Care

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Behavioral Health Services

Cityblock Health integrates behavioral health (BH) services as a critical component of their care model.

Cityblock care teams' seamless integration of BH enables members to access services through numerous touch points. Beyond co-location, Cityblock fosters a collaborative, multidisciplinary environment where experts, caregivers and peers deliver evidence-based and trauma-informed care.

Highly-trained staff manage BH in primary care setting

Auxiliary mental health services alongside capabilities to treat SUD

Crisis + transition services bridge care settings

The Care Team is the Engine

Cityblock Health flips the hierarchy of traditional healthcare, putting all care team members as equal but distinct partners in the member's care. Each care team member is a professional with specific skills and contributions that are valuable to the member's health goals. Working together they drive trusting relationships with members that allow for true engagement and health behavior-change.

Members are further supported by Community Health Partners (CHPs). CHPs are trained in behavioral coaching and chronic disease management, they anchor the care teams and spend considerable time in the field taking calls, meeting families and building relationships for our most chronically ill members.

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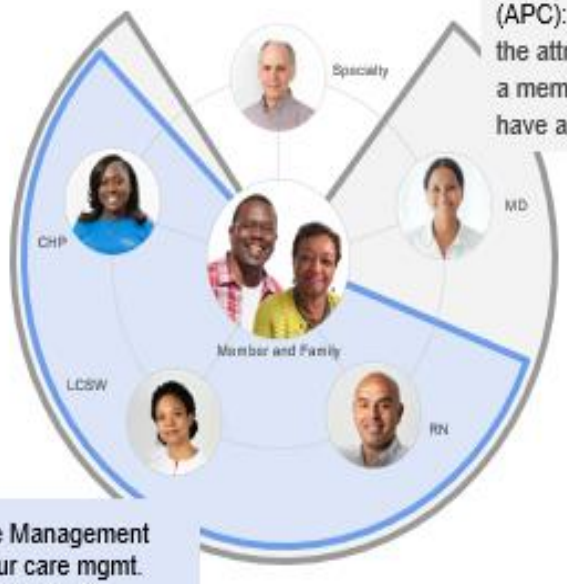
The Care Team is the Engine (continued)



Advanced Primary Care (APC): Cityblock can be the attributed PCP when a member does not have a PCP

Wrap Care Management (WCM): Our care mgmt. services seamlessly augment and support existing PCP relationships.

Cityblock Health's flexible care teams meet members wherever and whenever they need care, serving as PCP when necessary

- Each member is assigned a **Community Health Partner** to learn a member's story, support them in creating a personalized **Member Action Plan** and to ensure they are connected with care and services.
- Cityblock Health's **fully integrated care teams** collaborate closely on every member's care, coordinating delivery, **seamlessly integrating behavioral health** needs and wrapping around existing member relationships.
- These flexible care teams **meet members wherever and whenever is convenient**, be it in their home, at a community spot or via phone/text.
- Cityblock Health's **care model and technology are flexible** enough to adjust between their wrap model and their advanced primary care model.

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The Care Team Philosophy

1. Care teams are collectively responsible for moving members toward achieving their goals

2. Success metrics hold the hub accountable as a team

3. Use structures and tools in place (and help us improve them) to work collaboratively towards hub and member goals.

4. Learn from and with care teams via experience research (interviewing, shadowing, usability testing), core committee and care champions, data analysis and leadership experience, observation and challenges.

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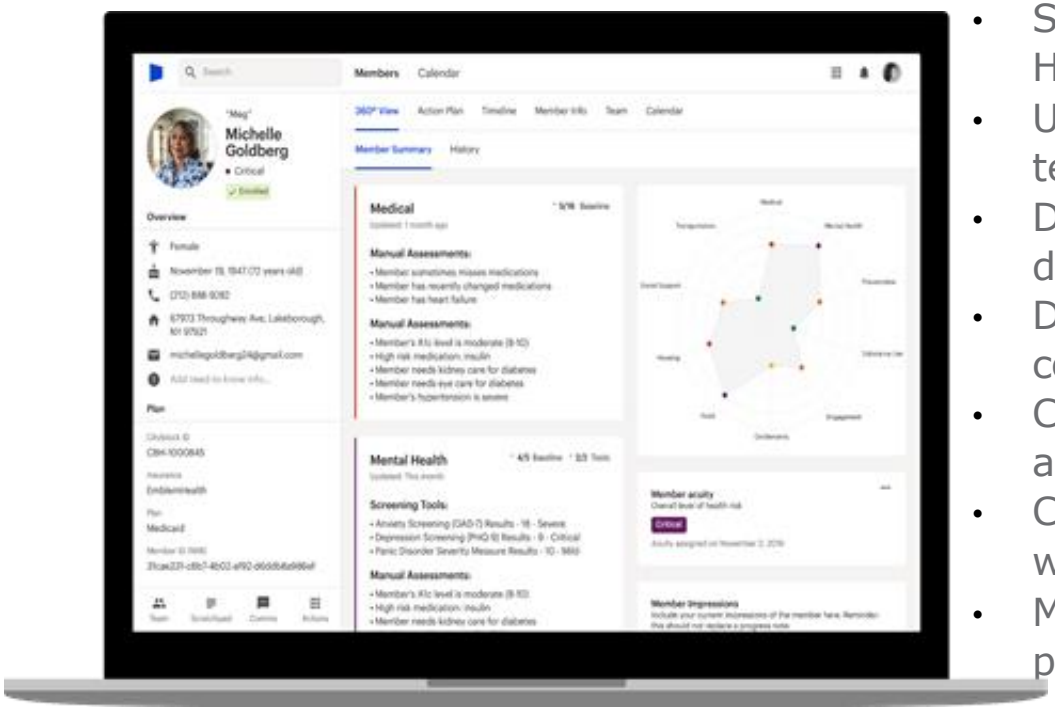
Care Teams Role Highlights

Roles	Accountable for…
Medical Director	Medical-Clinical Care and Outcomes
Psychiatrist	Behavioral Health Care and Outcomes for Panel
PCP	Medical-Clinical Care and Outcomes for Panel
Benefits Specialist	Redeterminations and entitlements
RN Care Manager	Chronic Disease Goal Execution, Triage and transitions of care for POD
Community Health Partner	Member Experience & Engagement, and Mission Achievement of Panel
Behavioral Health Specialist	Behavioral Health Outcomes for Panel and Pod
Outreach Specialist	Consenting members into the Cityblock model and re-engaging lost-to-contact members
Care Team Leads	Member Experience, Engagement and Mission Achievement of their POD

Commons

Commons, Cityblock Health's care delivery platform, enables care teams to deliver personalized care at scale

Ultimately, Cityblock's product is better health and social service delivery for members with complex needs, but technology is a key enabler and differentiator. *Commons* closes major gaps in technology infrastructure for community-based care.



- Support the engagement of Cityblock Health's members
- Understand a member's story as a care team
- Determine a member's acuity as a mean to drive intensity of intervention
- Drive action through decision support for collective accountability
- Collaboratively develop personalized and achievable goals with members
- Create efficiencies in Cityblock Health's work and collaborations
- Measure and evaluate Cityblock Health's processes and outcomes

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Comprehensive Assessment

Through a comprehensive assessment, Cityblock Health understands a member's story in their own words and begins to develop goals together.

The **comprehensive assessments** as well as individual **domain assessments** drive acuity and determine areas of need

Member Action Plans, Cityblock Health's care planning tool, are expected to reflect areas of need **based on assessment responses**, areas of high acuity and member priorities

Member Action Plan (MAP)

Cityblock Health creates MAPs to assure effective and efficient care and to empower members to manage their health care

A MAP is a living breathing tool that tells Cityblock Health how they and the member intend to work together over the upcoming 3- 4 months so that the member may achieve living in health.

A MAP…

- Is Individualized (based on each member's unique needs, provides choice) and reflects:
  - Conditions, concerns, abilities, routines, needs, wants and goals
- Is **organized around** 1 - 4 month Goals (MAP should always be person-centered; highlighting where the person is today and where they want to be or want to accomplish)
- Reflects tasks for care team members (both internal to Cityblock and external existing provider relationships) as well as member self-management tasks
- Is updated routinely
- Helps tell each member's story and reflects the partnership between the care team and the member

Decision Support

Cityblock Health promotes care consistent with scientific data and member preferences through decision support.

Decision support provides Cityblock Health's care team with knowledge and suggestions on how to create care plans for members. Cityblock Health wants to provide their non-clinical team members with a resource that gives them a basic understanding of Cityblock Health's most prevalent physical, social and behavioral conditions. This resource assists Cityblock Health's care teams in creating goals and missions for a member's Member Action Plan.

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Provider's Role in the Care Planning Process

Expectations for Providers

- PCP will review, approve and sign the Care Plan within 30 days of receipt
- Engage in Interdisciplinary Care Team meetings, as appropriate, including delegating function to qualified personnel
- Collaborate with THP and Cityblock Health care managers and medical directors

Summary

- Both models of care promote comprehensive and holistic care management and care coordination across team members
- Both models of care leverage person centered care planning processes based on comprehensive assessment and risk identification
- THP and Cityblock Health leverage a team-based model comprised of both licensed and non-licensed staff, allowing team members to work at the top of their license
- Both models are specifically designed to support the complexities of this population with specific focus on behavioral health needs
- THP and Cityblock Health are very interested in supporting PCPs in managing complex members to ensure best in class care
- Performance metrics drive accountability and ownership at the team level
- THP is fully committed to evaluating the efficacy of these models to ensure Unify members receive high quality, innovative care that best meets their needs

Doing Business With Us

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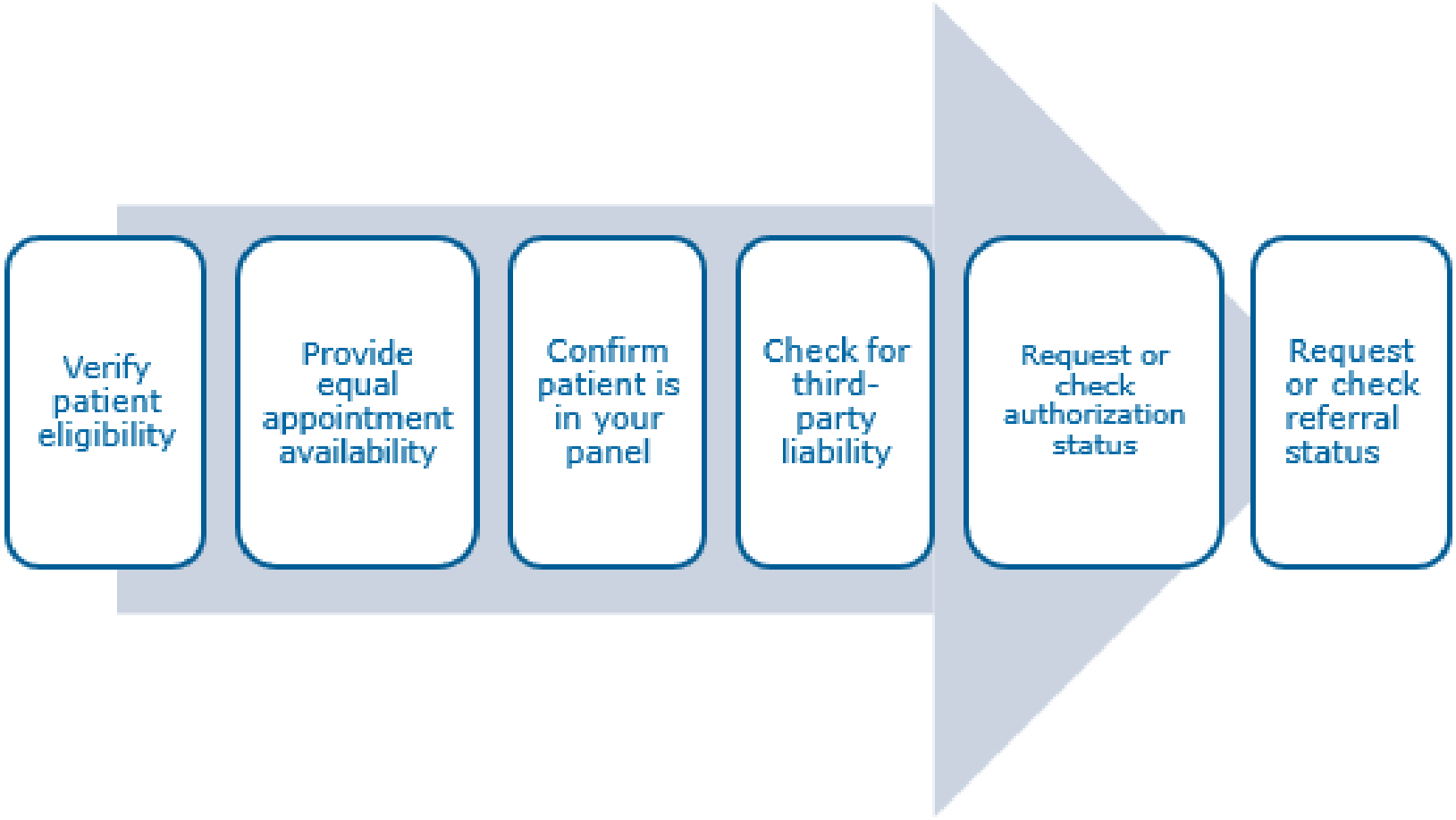
Doing Business with Us

As a Tufts Health Unify contracted provider, you get:

- A comprehensive approach to care for your Tufts Health Unify patients
- Ability to check member eligibility, authorization status, claims status and current member panels through Tufts Health Plan's secure Provider portal.
- Access to the Tufts Health Public Plans **Provider Services** team is available by calling THP at **888.257.1985**
- Multilingual, multicultural customer service for your patients is available by calling THP at **855.393.3154**

* To access Tufts Health Plan's secure Provider portal, go to: https://providers.tufts-health.com/

What to Do Before Patient Care



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How to Verify Eligibility on Date of Service

Check the Eligibility Verification System (EVS)	MassHealth's EVS, 800.554.0042 Have your MassHealth provider number or National Provider Identification (NPI) number and password ready. You may also access this information via the MassHealth Provider Online Service Center
Go online	Tufts Health Plan's secure Provider portal
NEHEN	New England Healthcare Exchange Network (NEHEN) or NEHEN*Net*
Call THP	Our 24/7 member eligibility line, **888.257.1985**
Call MassHealth	24/7 automated line, **888.665.9993**

* To access Tufts Health Plan's secure Provider portal, go to: https://providers.tufts-health.com/

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What to Do After Patient Care

1. File claims no later than 90 days after service
2. Providers are encouraged to submit claims electronically via one of the following methods:
   - Tufts Health Plan's secure Provider portal
   - Direct electronic data interchange (EDI) submission
   - New England Healthcare Exchange Network (NEHEN)
   - NEHEN*Net*
   - Clearinghouse submission
   - ABILITY
3. THP also accepts initial paper claims mailed to the following address:

   Tufts Health Plan
   P.O. Box 8115
   Park Ridge, IL 60068-8115
4. Check the claim's status by going to Tufts Health Plan's secure Provider portal
5. File a request for the claim's review within 60 days of the Explanation of Payment (EOP). Providers can find the Request for Claim Review form in the Resource Center on THP's public Provider website at tuftshealthplan.com/provider.

See **Chapter 8 Claims Requirements and Dispute Guidelines** of the Tufts Health Public Plans Provider Manual for additional information.

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Provider Checklist

Have you taken the following actions?

- Register for ***Provider Update***, THP's quarterly newsletter
  - Go to: tuftshealthplan.com/provider/provider-email-capture
- Register to access THP's secure Provider portal and enjoy one-stop access for member eligibility clams, authorizations and panel reports
  - Go to: tuftshealthplan.com/provider/provider-register-for-secure-access
- Fill out the **Medical or Behavioral Health Provider Information Form** available in the Provider Resource Center
  - Go to: tuftshealthplan.com/provider/resource-center/resource-center
- Set up **direct deposit** and get paid faster:
  - Go to changehealthcare.com to enroll or call Change Health at **866.506.2830** for instructions on how to enroll by mail or fax
- Review the ***Tufts Health Public Plans Provider Manual*** available in the Provider Resource Center
  - Go to: tuftshealthplan.com\provider\resource-center\resource-center
- Call Provider Services if you have any questions: **888.257.1985**

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Provider Resources

Provider Resource Guide	The *Tufts Health Public Plans Provider Resource Guide* to help providers get the information needed to do business with THP.
tuftshealthplan.com	*Read* payment policies and coverage guidelines; use THP's searchable preferred drug list; find a doctor, hospital, or pharmacy; and download benefit summaries, coverage area maps, forms and clinical practice guidelines.
Provider Update	Read THP's quarterly e-newsletter to get updates about pharmacy policies and coverage guidelines, pharmacy and preferred drug list changes, important business changes and regulatory requirements. Go *here* to sign up for *Provider Update*.
Provider Manual	The annually updated *Tufts Health Public Plans Provider Manual* is a tool to keep providers updated on policies and procedures, as well as information about federal and state regulatory requirements that may affect participating providers.
Secure Provider Portal	THP's secure Provider portal allows providers to check the status of a claim, verify member eligibility, check panel assignments, get remittance advice and view and download Explanations of Payment (EOPs).

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Please Remember

- Always bill THP, not MassHealth or the member.
- Quarterly, providers will receive a notification from THP requesting that they verify whether their information is accurate. Be sure to take the time to update your information if it is inaccurate.
- Be sure to register your email with THP to receive important updates.
  - Go to: https://tuftshealthplan.com/provider/provider-email-capture

Thank you.
Any questions?

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