TUFTS Health Plan

a Point32Health company

Tufts Health One Care

A One Care D-SNP Plan

January 2026

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One Care Overview

In 2011, Massachusetts was awarded a contract to develop a service delivery and payment model that would integrate care for beneficiaries (21-65 years of age) who are dually eligible for Medicare and Medicaid.

One Care delivers integrated care to enhance functional status, improve health outcomes, and promote independent living through:

- Medical and behavioral health care
- Long-Term Services and Supports (LTSS)
- Care management services

One Care creates value for its members by offering:

- Enhanced benefits
- No cost sharing
- Streamlined experience

One Care simplifies care delivery by merging Medicaid and Medicare benefits:

- One member plan identification card and one care manager
- Contracts with Independent Living LTSS coordinators

About Tufts Health One Care

Launched as Tufts Health Unify in 2013 and renamed Tufts Health One Care in 2024

Transitioned to a Dual Eligible Special Needs Plan (D-SNP) in 2026

Among the first MA plans to serve dually eligible individuals under age 65

Available to members in Middlesex, Suffolk, Worcester, Bristol, Norfolk, Plymouth, Essex, and Barnstable counties

Collaborates with Cityblock to coordinate and provide medical care, behavioral health care, and social and environmental supports at home, in acute care settings, and in the community

Strives to improve functional outcomes by holistically addressing care needs

One Care Contract Requirements

In collaboration with Cityblock, One Care partners with community-based providers to meet the significant care management needs of our members. Examples of contract requirements pertaining to member engagement, comprehensive assessments, integrated care team engagement, and transitions of care follow.

Member Engagement	• All members must be outreached to and offered a care manager. • Cityblock completes all initial outreach and engagement work in collaboration with community providers.
Comprehensive Assessments	• All members must be assessed by an RN upon enrollment, with a major change in condition as defined, and annually thereafter. • Cityblock care managers complete the comprehensive assessment.
Integrated Care Team Engagement	• All members must have a care team, and the team must meet to review members' care. • Care teams are led by members and their care manager; collaboration is critical from providers, advocates, etc.
Transitions of Care	• Cityblock outreach to inpatient facility is required with 24 hours of notification of admission. • Cityblock outreach to member is required within 48 hours of discharge notification.

Cityblock Capabilities

Cityblock leverages care teams and technology to provide phone, video, and in-person visits as well as ED navigators, ED services at home, and Virtual Urgent Care — all designed to engage members and improve health outcomes.

Commons, Cityblock's Centralized Enrollee Record (CER), provides a 360-degree view of individual health and social needs, enabling inclusive care planning, protocol alerts, and seamless care team workflows.

Cityblock Capabilities

Structure

- Optimized for dual Medicaid and Medicare beneficiaries
- A 24/7/365 personalized care system
- Ability to care for members anywhere, with most of the 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 management services organization (MSO) capabilities
- Built by experienced healthcare and tech team

Capabilities

- Primary care
- Behavioral health (psych & substance use disorder)
- Care transitions with facility rounding
- In-home urgent and post-acute services
- Palliative and end-of-life (EOL) care
- Tailored programs for population with special needs
- Direct social services delivery
- Community-based organization (CBO) network build and management
- Structured needs assessment
- 24/7/365 clinical access with remote triage (voice/text/video) and in-home care
- Social isolation programing
- Real-time reporting
- 360-degree member view
- Network and referral management
- Outreach and field engagement

Best-in-Class Programs

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Mobile Integrated Care

- **24/7/365** urgent care services
- **Virtual** urgent care and ED@Home
- **Dispatch** team answers 86% of calls within one minute
- **1,800** urgent care visits for Tufts Health One Care members in 2023

Advanced Behavioral Health

- **Long-acting** injectable anti-psychotics (LAI), IM Vivitrol, and in-home buprenorphine induction for members with SMI and/or SUD
- **16%** decrease in hospitalizations in Washington, D.C. market
- **Launched** in Massachusetts in Oct. 2022, with early promising results

Care Pathways

- **Tailored** evidence-based interventions delivered by Cityblock providers across variety of chronic conditions (asthma, CHF, etc.)
- **Geriatric** and **palliative** care programs
- **Powered by** tech-enabled workflows to guide care teams
- **Early** analyses show double-digit percent reduction in per member per month (PMPM) costs

Social Determinants of Health

Community drives health; There is no health without social, mental, and physical health.

Cityblock's Model of Care identifies, tracks, and addresses social determinants that impact health:

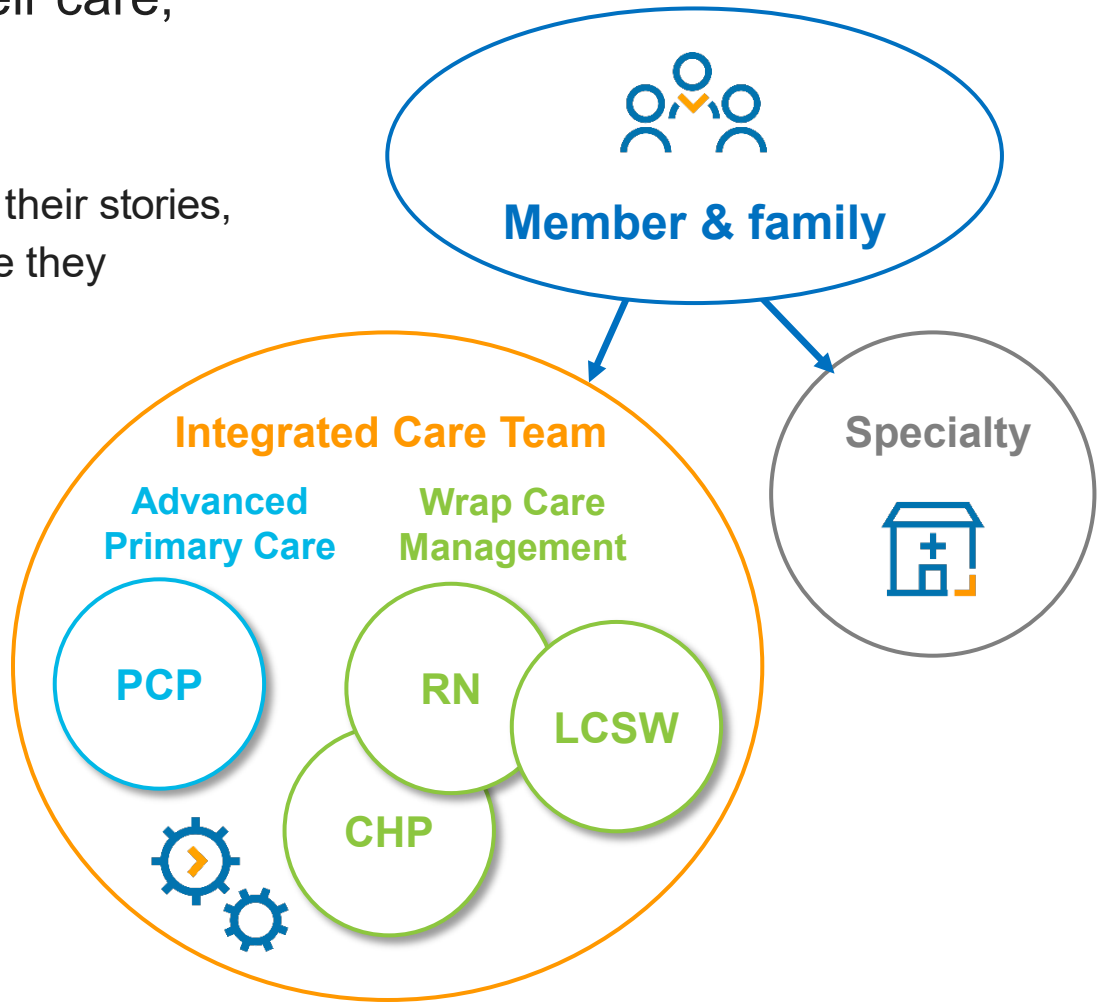
- Engagement & resiliency
- Social support
- Food
- Transportation
- Safety
- Financial security
- Housing
- Preventive care

What we say, and how we say it, matters.

Integrated Care Team

Cityblock believes that each Member is CEO of their care, and that the Care Team is the engine.

- **Members** are assigned community health partners to learn their stories, support them in creating personalized care plans, and ensure they relate to the supports and services they need.
- **Cityblock's Integrated Care Teams** (ICTs) coordinate care delivery, seamlessly integrating behavioral health needs and wrapping around existing member relationships.
- **Care teams** meet members where and when it's convenient (at home, in the community, or by phone/text).
- **Health care delivery** accommodates both advanced primary care and wrap care management.



Care Team Roles

Care teams are **collectively responsible** for setting and prioritizing goals with each member and moving them toward achieving their goals.

Accountable for ...

1. **PCP**
   Medical-clinical care and outcomes for panel
2. **Psychiatrist**
   Behavioral health care and outcomes for panel
3. **Benefits Specialist**
   Redeterminations and entitlements
4. **RN Care Manager**
   Chronic disease goal execution, triage and transitions of care for POD
5. **Community Health Partner**
   Member experience & engagement, and mission achievement of panel
6. **Behavioral Health Specialist**
   Behavioral health outcomes for panel and POD
7. **Outreach Specialist**
   Consenting member into Cityblock model and re-engaging lost-to-contact members
8. **Care Team Leads**
   Member experience, engagement and mission achievement of their POD
9. **Registered Nurse or CHP**
   Primary contact based on medical need/complexity

Assessment and Individualized Care Plan

After completing a comprehensive Health Risk Assessment (HRA) based on each member's story, Cityblock develops an **Individualized Care Plan (ICP)** – with members taking the lead in identifying goals.

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

Care Plans are expected to reflect areas of need based on assessment responses, areas of high acuity, and member priorities.

Individualized care plans are a collection of goals that document members' opportunities, interventions, barriers, and expected outcomes. ICPs will be completed within 90 days of conducting the initial HRA or within 90 days after the effective date of enrollment, whichever is later. Care plan goals are updated and documented during points of contact with members, as well as during significant changes in care or status (such as transitions of care or acute utilizations).

Behavioral Health Services

Behavioral health (BH) services are a **critical component** of Cityblock's care model which aims to foster a collaborative, multidisciplinary environment where experts, caregivers, and peers deliver evidence-based and trauma-informed care at numerous points during treatment.

Highly trained staff manage BH in primary care setting

Auxiliary mental health services alongside capabilities to treat SUD

Crisis and transition services bridge care settings

One Care Provider Responsibilities

- **Receive and review** care plan from Cityblock. (PCPs can also view care plans on the provider portal.)
- **Participate** in interdisciplinary care team meetings and delegate tasks to qualified personnel as appropriate.
- **Collaborate** with Tufts Health Plan and Cityblock care managers and medical directors as needed.
- Reasonably **accommodate** members and ensure that programs and services are accessible to individuals with disabilities, as well as those with diverse linguistic and cultural needs.

Refer to Tufts Health Plan Public Plans Provider Manual for a complete list of provider responsibilities.

What to do before patient care

- ✓ **Verify** patient eligibility
- ✓ **Provide** equal appointment availability
- ✓ **Confirm** patient is in your panel
- ✓ **Check** for third-party liability
- ✓ **Request** or check authorization status

Verifying Eligibility on Date of Service

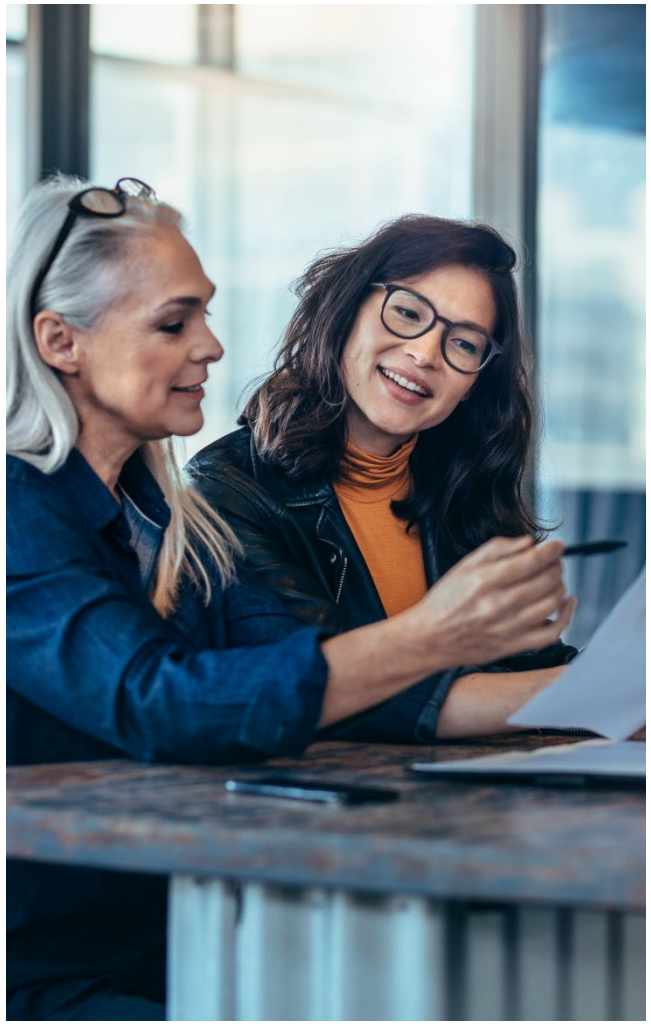
Check the online MassHealth Eligibility Verification System (EVS) or call 800-841-2900. Have your MassHealth provider number or National Provider Identification (NPI) number and password ready.

Visit Tufts Health Plan's online Secure Provider Portal. If you are a member, check New England Healthcare Exchange Network (NEHEN) or NEHEN*Net*.

Call:

- Tufts Health Plan at 888-257-1985
- MassHealth at 888-665-9993

Filing Claims



- Be sure to file claims no later than **90 days** after date of service.
- Submit claims **electronically** via one of the following:
  - Tufts Health Plan's secure Provider Portal
  - Direct electronic data interchange (EDI) submission
  - NEHEN (New England Healthcare EDI Network) if you are a NEHEN member
  - Clearinghouse submission
  - ABILITY
- **Mail** initial paper claims to:

  Tufts Health Public Plans – Paper Claims Submissions
  P.O. Box 189
  Canton, MA 02021-0189
- Check the **status** of a claim on Tufts Health Plan's secure Provider portal.
- To file a request for a **claim review** within 60 days of the Explanation of Payment (EOP), access the Request for Claim Review form in forms section of our Provider website.
- **Refer** to the Claims Requirements, Coordination of Benefits and Dispute Guidelines within the Tufts Health Public Plans Provider Manual for additional information.

Provider Reminders

- **Review** and bookmark the Tufts Health Public Plans Provider Manual for easy access to up-to-date Tufts Health One Care plan information.
- **Always bill** Tufts Health Plan. Never bill MassHealth or a member.
- Take the time to **review and update** your information in CAQH. On a quarterly basis, you will receive a CAQH notification requesting verification of whether your provider information is accurate. Providers must attest to the accuracy of information every 120 days.
- If you need to make changes to your provider information, complete the appropriate **Provider Information Form** found within the Forms section of the provider website.
- **For questions** regarding a member's care management, call Cityblock at 833-904-2733 and select option 3, or email providers@cityblock.com.
- **Call** Tufts Health Plan Provider Services at 888-257-1985 if you have any other questions.

Provider Checklist

New to Tufts Health Plan? Be sure to take the following steps:

- ❑ Register for ***Insights and Updates for Providers***, Point32Health's monthly newsletter featuring important Tufts Health One Care updates and information.
- ❑ Register for Tufts Health Plan's secure **Provider portal** to access information on member eligibility, benefits, referrals, authorization, notification, claims inquiries, and panel reports.
- ❑ Set up direct deposit to assist with timely payment. Refer to the Electronic Services section of the provider website for information on **Electronic Funds Transfer** (EFT) enrollment with Payspan.

Attestation of Tufts Health One Care training completion

Please confirm that you have completed your review of Tufts Health Plan's One Care Model of Care training by filling out and submitting the attestation form.

*For information on additional **One Care training** – required by the Executive Office of Health and Human Services (EOHHS) and the Centers for Medicare & Medicaid Services (CMS) – refer to the Tufts Health One Care provider training section of our website.*

Thank you for your partnership in caring for our Tufts Health One Care members!