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Medical Management Program

The goal of the medical management program is to monitor and manage the delivery of health care services to ensure that all services meet Centers for Medicare and Medicaid Services (CMS) and/or MassHealth Standard (Medicaid) coverage criteria, as applicable. The Tufts Medicare Preferred or Tufts Health Plan Senior Care Options (SCO) Care Management and Utilization Management (UM) departments are an integral part of the Tufts Health Plan medical management program. Physicians and other providers are responsible for:

- Sharing clinical information (including, but not limited to, discharge summaries, test results and medication records) in a timely manner to facilitate coordination and continuity of care
- Abiding by plan inpatient notification policies providing timely notification of acute inpatient and skilled nursing facility (SNF) admissions
- Collaborating with the Tufts Medicare Preferred or Tufts Health Plan SCO care manager or UM clinician to coordinate and oversee the delivery of each member's medical services
- Responding promptly to quality of care concerns raised either concurrently or retrospectively
- Participating fully with the Interdisciplinary Care Team (ICT) and Tufts Health Plan SCO care manager to share clinical information concerning members under their care (for Tufts Health Plan SCO members)
- Collaborating with the Tufts Health Plan SCO care manager to review, approve, and help manage the care plan for Tufts Health Plan SCO members

The medical management program's scope encompasses all health care delivery activities across the continuum of care, including inpatient admissions to hospitals, acute rehabilitation facilities and SNF, home care services, outpatient care and office visits.

For Tufts Medicare Preferred HMO, the medical group and their associated health care team facilitate the medical management of members assigned to their group. Each medical group is responsible for developing their individual group's medical management program.

Roles and Responsibilities

Health Care Team

The health care team consists of a group of health care professionals including:

- The group's medical director
- PCPs and their office staff

- All other providers associated with the medical group, including specialists, preferred SNF and home health care providers
- The Tufts Health Plan Senior Products Care Manager
- The Tufts Health Plan Senior Products Utilization Management Clinician
- The Interdisciplinary Care Team for Tufts Health Plan SCO members also includes a host of clinical professionals from the health plan that include but is not limited to, medical directors, nurse practitioners, behavioral health care managers, community health workers, pharmacists, dementia care consultants and others.

Care Management

Tufts Medicare Preferred care managers may be internally or externally managed (i.e., by the PCP's medical group); Tufts Health Plan SCO care managers are hired by the health plan and work with the entire Health Care Team. The care manager collaborates with each member's medical group to provide a standardized, comprehensive, and integrated care management experience.

Tufts Medicare Preferred and Tufts Health Plan SCO BH clinicians and care managers, along with providers, work together to help members receive optimal health care by:

- Ensuring members have timely and easy access to appropriate behavioral health care
- Encouraging more direct involvement of members in their treatment planning and recovery
- Finding opportunities for members to receive more effective behavioral health and substance use recovery care
- Enhancing continuity and coordination of care among the member's providers

Tufts Medicare Preferred and Tufts Health Plan SCO does this by:

- Monitoring treatment compliance
- Reviewing ongoing service needs
- Assisting with discharge planning
- Providing members and their providers with information on community-based services
- Coordination of post discharge support services for safe and appropriate care

Tufts Medicare Preferred and Tufts Health Plan SCO recognize more than one provider may contribute to the care of members. Providers, particularly primary care and BH providers, who are caring for members should explain to members the benefits of care coordination and integration and make their best efforts to secure member consent to share relevant information with all of their providers regarding diagnoses, medication and/or treatment to help improve their health outcomes. If consent is not granted, this fact should be recorded in the member's record.

The Tufts Medicare Preferred and Tufts Health Plan SCO care managers follow best practice delivery of care and service using the Case Management Society of America's Standards of Practice for Case Management.

For more information on how Tufts Health Plan works with medical groups, refer to the Senior Products Provider Manual and Care Management Resource Guide.

Medical Management Program Activities

The medical group organizes and conducts ongoing medical management meetings, and the care manager is an integral part of these meetings. The care manager and medical management team are instructed to consult Medicare coverage guidelines as well as the member's Evidence of Coverage (EOC) when determining coverage of benefits, and MassHealth coverage guidelines (where appropriate) for Tufts Health Plan SCO members.

The care manager and UM clinician, in collaboration with the health care team, ensures that the member receives appropriate care and services in a timely, cost-effective manner by conducting concurrent and retrospective review for the following services (unless in scope for the Home and Community Care Transitions Program outlined in the section below):

- Acute inpatient hospitalization, utilizing InterQual® criteria
- Acute inpatient rehabilitation

- Extended care and skilled nursing services
- Home care services
- Hospice care
- Community-based services

Home and Community Care Transitions Program for Tufts Medicare Preferred

Tufts Health Plan has a partnership with Home and Community Care Transitions, who oversee utilization management review processes for skilled nursing facility (SNF), inpatient rehab facility (IRF)/acute inpatient rehab (AIR), and long-term acute care (LTAC) services, as well as home health care services. This review applies to Tufts Medicare Preferred members in Massachusetts unless they are included in a designated care management agreement with a professional medical group as indicated in this document.

For applicable members, Home and Community Care Transitions manages the prior authorization and concurrent/continued stay review processes in SNF, IRF/AIR, and LTAC settings. Providers can request authorization using Access (Home and Community Care Transitions' online provider portal). Home and Community Care Transitions will then conduct the appropriate medical necessity review. In addition, providers must submit notification of their patients' start of care (SOC) for home health care services to Home and Community Care Transitions. After the initial 30 days of home health treatment, prior authorization is required through Home and Community Care Transitions, who perform concurrent review, which includes clinical assessments for continued medical necessity.

Refer to the Home and Community Care Transitions page in the Vendor programs section of Point32Health's provider website for more details.

Medical Management Meetings

Medical management meetings are held weekly as a means for the medical group and care managers to regularly discuss member care, with the goal being ongoing communication between the group medical director, PCP and care manager to provide updates and discuss individual issues. In addition, the group medical director is responsible for communicating with PCPs, as necessary. For groups that may not participate formally, a medical director and/or nurse practitioner hired by the health plan will lead these medical management meetings.

Committee members include the medical group's medical director, PCPs, as well as office staff and Tufts Health Plan care managers. Other attendees may include hospitalists, SNF rounders (physicians/nurse practitioners) and other Tufts Health Plan staff, as appropriate.

Medical Management meetings intend to:

- Develop concurrent plans of care that use a team approach to manage specific high-risk members
- Identify obstacles to effective care and developing mitigation strategies
- Provide clinical input for individual member-centric plan of care
- Improve process and outcome of care
- Monitor group performance
- Identify opportunities for improvement
- Develop strategies to work with providers such as, preferred SNFs and homecare agencies
- Provide information regarding regulatory changes, provider updates, and topics from Tufts Health Plan Medical Directors meetings
- Integrate quality metrics, monitoring and reporting

Utilization Review

Federal and state regulatory agencies and accrediting bodies establish regulations and standards that govern utilization management (UM) functions. Tufts Health Plan conducts concurrent review during a member's inpatient hospital stay or course of treatment to evaluate the medical necessity of patient care. Tufts Health Plan utilizes initial utilization reviews and continued stay utilization reviews on an ongoing basis. When utilization review is conducted, the decision time frame and notifications must adhere to the requirements outlined in the Utilization Review Determination Time Frames for Senior Products members.

This resource for staff engaged in the UM decision-making process outlines the required time frame for rendering coverage decisions and providing verbal and written notifications to the member and provider. Tufts Health Plan UM policies and plan documents assist the utilization management clinician, physicians and other providers in planning and managing care with efficiency and high-quality standards.

Urgent and Emergency Care

Although prior authorization is not required, both inpatient and outpatient urgent or emergency care involves coordination by the PCP/medical group/care manager. Emergencies and urgent care that occur out of the service area should be reported to Tufts Health Plan.

Urgent Care

"Urgently needed services" are nonemergency but unforeseen medical illnesses, injuries or conditions that require immediate medical care. Urgently needed services may be provided by network providers, or by out-of-network providers when network providers are temporarily unavailable or inaccessible (e.g., if the member is temporarily outside of the plan's service area).

Urgent Care Inside the Service Area

Members should try to obtain urgently needed care from their PCP or specialists within their network when in the Tufts Medicare Preferred or Tufts Health Plan SCO service area. If a member believes they require urgently needed care, they should first contact their PCP. Hearing or speech-impaired members with TTY/TDD machines may also call the MassRelay at 711 (TTY/TDD 800-439-2370) for assistance contacting their PCP after hours.

In the event that providers are temporarily unavailable, and it is not reasonable for the member to wait until the provider becomes available, Tufts Health Plan will provide coverage for the member to obtain urgently needed care from providers who are outside the member's network.

Urgent Care Outside of the Service Area

Authorization is not required for urgently needed care outside the Tufts Medicare Preferred or Tufts Health Plan SCO service area. If the member is treated for an urgent care condition while out of the service area, Tufts Health Plan prefers that they return to the service area to receive follow-up care through their PCP. However, Tufts Health Plan will cover follow-up care provided from out-of-network providers outside the Tufts Medicare Preferred or Tufts Health Plan SCO service area as long as the care the member is getting still meets the definition of "urgently needed care."

Urgently needed care may be rendered in any Medicare-certified (or Medicaid-certified if services are rendered to Tufts Health Plan SCO members) clinical setting (e.g., a provider's office or outpatient clinic). Tufts Health Plan will refer members to their PCPs if they call requesting clinical guidance prior to receiving urgent or nonurgent out-of-area care.

Urgent care that occurs outside the service area should be reported to Tufts Health Plan so that an inpatient medical management clinician can assist with discharge planning services and follow urgent cases that occur outside the service

area (i.e., the 30-mile radius from the PCP's home hospital[1]) while the member remains inpatient. Members who call with questions regarding follow-up care more than two weeks after receiving urgent care will be referred back to their PCP.

Emergency Services

Emergency care that occurs outside the service area should be reported to Tufts Health Plan. The inpatient medical management services department will follow all emergency cases that occur outside the service area within the first two weeks of the member receiving emergent or urgent out of area care. Refer to the Emergency Services payment policy.

Post-stabilization Care

Post-stabilization services are covered services that are related to an emergency medical condition and that are provided after a member is stabilized, and provided either to maintain the stabilized condition, or under certain circumstances, to improve or resolve the member's condition. Tufts Health Plan must cover post-stabilization care services in accordance with Chapter 4, Section 20.5 of the Medicare Managed Care Manual.

InterQual Criteria

InterQual criteria are applied to all medical and surgical acute inpatient admissions and subsequent inpatient days. The criteria may be applied to assist in determining the most appropriate level of care for Tufts Medicare Preferred and Tufts Health Plan SCO members.

These criteria are based on the use of the severity of illness and/or the intensity of service being provided. In general, the severity of illness criteria is used for the day of admission and the intensity of service criteria are applied to continued stay days. However, both sets of criteria are flexible and can be used at any point during an acute stay.

InterQual criteria are used to facilitate communication with the provider about a member's health status for the coordination of care. InterQual criteria are also used for medical necessity determinations related to inpatient admissions and continued stays.

These criteria do **not** replace Medicare or MassHealth (Medicaid) coverage guidelines. Where available, Medicare and/or Medicaid coverage guidelines must be used when making coverage determinations.

Coverage Resources

Tufts Health Plan provides coverage for all services and items covered by Original Medicare for Tufts Medicare Preferred members; additional coverage for all services and items covered by MassHealth Standard (Medicaid) is provided to Tufts Health Plan SCO members. When making coverage determinations for services, providers should refer to the applicable CMS and/or EOHHS coverage guidelines.

There are additional services covered for members that are not covered under traditional Medicare and/or Medicaid. To determine which services/items are covered as supplemental benefits, providers should also refer to the most current version of the member's Summary of Benefits and Evidence of Coverage.

Medicare Coverage Guidelines

At a minimum, Tufts Health Plan provides coverage for all services and items covered by Medicare.

Tufts Health Plan uses Local Coverage Determinations (LCDs), National Coverage Determinations (NCDs), and Medicare interpretive manuals (e.g., the Medicare Benefit Policy Manual) to make coverage determinations for Tufts Health Plan members.

[1] Some medical groups may have an alternative arrangement.

Tufts Health Plan medical necessity guidelines do not replace Medicare coverage guidelines, unless specifically indicated by Tufts Health Plan, and are not to be used by providers when making coverage determinations, except for services that are covered by Tufts Medicare Preferred as a supplemental benefit. For SCO members, if the benefit is not a Medicare benefit or a Medicare-approved supplemental benefit, the MassHealth Guidelines for Medical Necessity Determinations should be followed.

Local Coverage Determinations (LCDs)

An LCD is a decision issued by a carrier or fiscal intermediary to cover (or not cover) a particular service on an intermediary-wide or carrier-wide basis.

Note:

- LCDs cannot restrict or conflict with NCDs or coverage provisions in interpretative manuals
- LCDs are binding on Medicare Advantage Organizations (MAOs)
- LCDs are accessible through the Medicare Coverage Database

Providers must adhere to the LCDs associated with the following contractors that have jurisdiction in Massachusetts:

- Durable Medical Equipment (DME MAC): NHIC as of 7/1/06; DME MAC LCDs
- Part B carrier: National Government Services
- Part A fiscal intermediary: jurisdiction is dictated by which contractor the hospital bills for fee-for-service

National Coverage Determinations (NCDs)

National Coverage Determinations (NCDs) are developed by CMS to describe the circumstances for Medicare coverage nationwide for a specific medical service, procedure or device. NCDs are binding on all Medicare Advantage plans as well as other Medicare contractors (such as carriers and fiscal intermediaries).

NCDs are contained in the Medicare NCD Manual, which is updated via NCD Transmittals. NCDs are also accessible through the Medicare Coverage Database.

Interpretive Manuals

Coverage provisions in interpretive manuals are instructions that are used to further define when and under which circumstances services may be covered (or not covered). Coverage information may be found in the following CMS interpretive manuals:

- Medicare Benefit Policy Manual
- Medicare Claims Processing Manual
- Medicare Program Integrity Manual
- Medicare Managed Care Manual

Case-by-Case Review

If there is no national policy or the national policy is purposefully vague and the applicable contractor does not have an LCD, providers or Tufts Health Plan staff should review the case on an individual case basis using Medicare's existing national guidance and any other LCDs in Massachusetts, if available. If there are no other LCDs in Massachusetts, contact the Medical Policy Department, who will contact the applicable contractor for input.

MassHealth Guidelines for Medical Necessity Determinations for Tufts Health Plan SCO Members

The MassHealth guidelines for medical necessity determination contains clinical information recommended by MassHealth to determine medical necessity for certain products and services that require prior authorization. MassHealth developed these guidelines and the associated forms using an ongoing process that includes a rigorous review of the most current evidence-based literature and input from clinical and program staff, as well as frequent input from external clinical experts.

Tufts Health Plan SCO uses these guidelines to clarify specific medical information that MassHealth requires to determine medical necessity. The Tufts Health Plan SCO care manager works with the PCP to recommend services that are covered under these guidelines.

PUBLICATION HISTORY

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04/10/25	administrative edits
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10/01/26	update for consistent use of term, “care plan”