



a Point32Health company

Tufts Health One Care

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

January 2024

Training Agenda

Overview

- Tufts Health Plan
- One Care
- Tufts Health One Care

Tufts Health One Care Model of Care

- Overview
- Care Team
- Member Care Plan (ICP)

Provider's Role in the Care Planning Process

- Expectations

Doing Business With Us

- Checking Member Eligibility
- Submitting Claims
- Provider Checklist
- Provider Resources

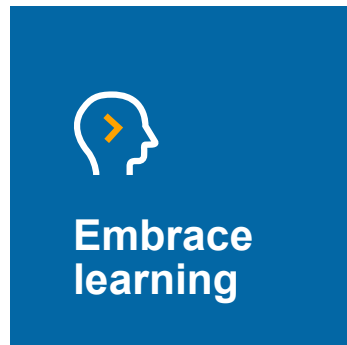
About Tufts Health Plan

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.

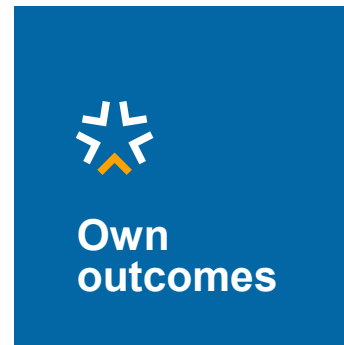
- In 2021, Tufts Health Plan completed a merger with Harvard Pilgrim Health Care to form the Point32Health parent company. Tufts Health Public Plans is now a division within Point32Health.
- Tufts Health Public Plans, Inc. is a licensed health maintenance organization but does business under the name “Tufts Health Plan.” Tufts Health Public Plans is the legal name of a division within Point32Health.
- 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 2021 and 2022
- THP currently offers four plans in Massachusetts:
 - Tufts Health Direct – Health Connector
 - Tufts Health Together – Includes MassHealth MCO Plan and Accountable Care Partnership Plans (ACPPs)
 - Tufts Health One Care – One Care plan
 - Tufts Health SCO – Senior Care Options Plan

Point32Health's Mission and Vision

- To guide and empower healthier lives for everyone
- We will be the leader in connecting all people in our communities to personalized solutions that empower healthier living



We **embrace learning** because we believe continuous learning produces continuous impact.



We **own outcomes** because we believe real results come from real commitment.



We **grow together** because we believe when our people thrive, our organization thrives.



We **build community** because we believe serving each other helps us better serve others.

About One Care

- One Care is a Massachusetts Medicare-Medicaid plan for dual eligible beneficiaries under age 65.
- One Care is a demonstration (MMP) which delivers integrated care to enhance functional status, improve health outcomes and promote independent living:
 - Medical care
 - Behavioral health
 - Long-Term Services and Supports (LTSS) and
 - Care management services
- One Care creates value for its members by offering
 - Enhanced benefits
 - No cost sharing
 - Streamlined experience
- For more information about One Care or provider trainings, please visit <https://www.mass.gov/one-care>

One Care History

- 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 as a Demonstration and Tufts Health Plan launched its One Care product Tufts Health Unify.
 - In 2024, Tufts Health Unify changed its name to Tufts Health One Care.
- One Care simplifies care delivery by merging enrollees' Medicaid and Medicare benefits into one plan
 - One Care enrollees have one card and one care manager 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:
<https://www.mass.gov/one-care>

Tufts Health One Care – 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
- Offered to members in Middlesex, Suffolk, Worcester, Bristol, Norfolk, Plymouth, Essex, and Barnstable counties.

Key Product Features

- Initial and Ongoing Member Assessments to inform member benefits and supports
- Individualized Care Plan
- Integrated care team model furthered by collaboration with Cityblock Health for care management services

Effective Care Integration

- Establish and enhance care coordination by meeting needs of members and care providers
- Improve health and functional outcomes by addressing care needs holistically
- Promote independent living and member connection to community.

One Care Contract Requirements

- One Care has significant care management requirements, which Tufts Health One Care currently operationalizes in collaboration with Cityblock Health (CBH).
- This involves close partnerships with community based providers to meet the needs of our members.

Examples of contract requirements include:

Member Engagement	<ul style="list-style-type: none">• All members must be outreached and offered a care manager; expect ~75% engagement• Cityblock completes all initial outreach and engagement work, in collaboration with community providers
Comprehensive Assessments	<ul style="list-style-type: none">• All members must be assessed by an RN upon enrollment and annually thereafter• Cityblock care managers complete the comprehensive assessment
Integrated Care Team Engagement	<ul style="list-style-type: none">• 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	<ul style="list-style-type: none">• Outreach following admission is required within 24 hours; outreach following discharge is required within 48 hours; currently led by Cityblock transitions of care team

Tufts Health One Care Model of Care

Overview

Tufts Health One Care works with Cityblock Health (CBH) to provide care management services to our members.

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

Using a wrap-around approach of comprehensive interdisciplinary services, Cityblock's care team supports members in navigating their complex and often interwoven needs including medical care, behavioral health services, and social and environmental supports.

Cityblock's care team meets members where they are; in home, in the community, or in an acute care setting to support a safe and positive transition plan.

Benefits and Capabilities

Benefits

- Optimized for Dual Medicaid & Medicare Beneficiaries
- A 24/7/365 personalized care system
- Ability to care for members anywhere, with the 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

Capabilities

- 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

Engagement and Improvement

Cityblock leverages personalized care teams and technology including phone, video, in-person visits; ED at home, Virtual Urgent Care and ED navigators designed to engage members and improve outcomes

Personalized Care Teams	Touchdown Spaces	Purpose-Built Technology
<p>Cityblock Health’s integrated care teams include MD, NP/PA, RN, BH, licensed social workers and Community Health Partners who deliver advanced primary, behavioral health (including SUD), and palliative care, and connect members with social services.</p>	<p>Multi-functional office spaces allow members of the care team to have access to resources (paperwork, documentation, medical and clinical supplies) which prepare them to best meet member’s needs in the community.</p> <p>These spaces also support our virtual urgent care and mobile integrated care programs, allowing the medical team to triage and dispatch as needed from a central space.</p>	<p><i>Commons</i>, 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.</p>

Pillars of Care

- Cityblock believes that the Member is CEO of their care, and the Care Team is the engine
- The Cityblock Team is easy to reach whenever and however
- Community drives health; There is no health without social, mental and physical health
- Cityblock helps catalyze change in serving communities
- What we say (and how we say it) matters

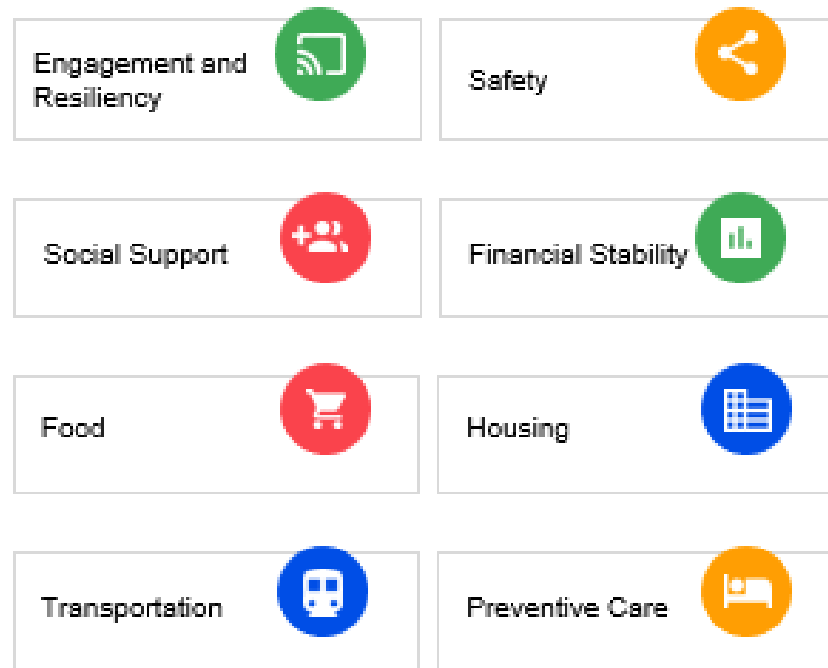


Care Teams Role Highlights

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
Registered Nurse or CHP	Primary Contact based on medical need/complexity

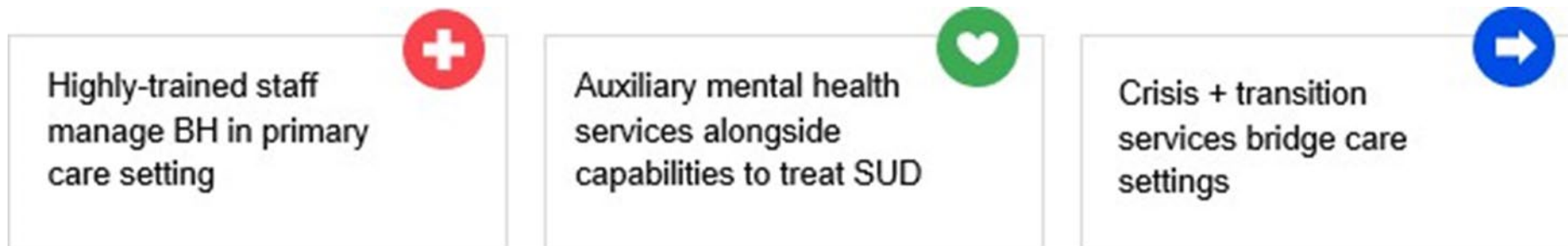
Analyzing Social Determinants

Cityblock Health's model of care identifies, tracks, and addresses the social determinants that impact health.



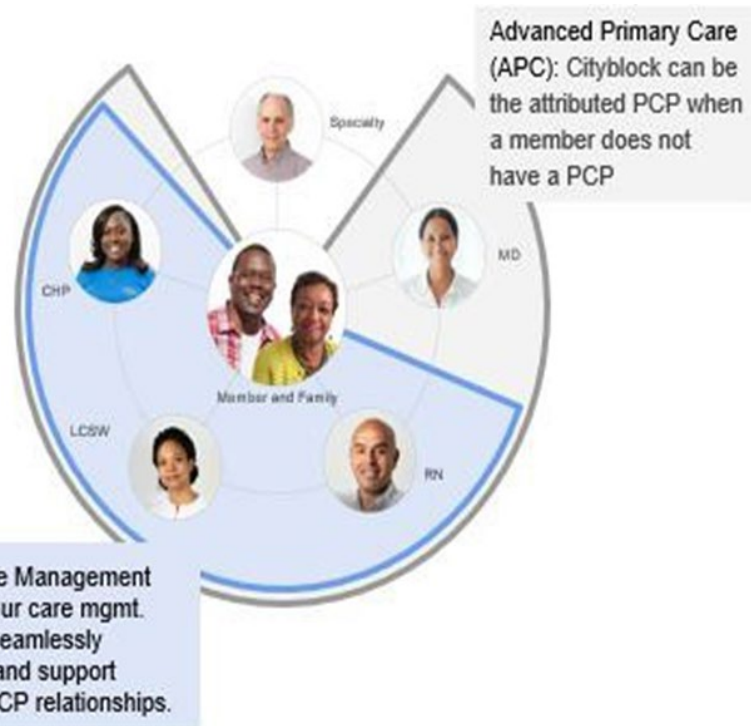
Behavioral Health Services

- 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.
- Cityblock aims to foster a collaborative, multidisciplinary environment where experts, caregivers and peers deliver evidence-based and trauma-informed care.



The Care Team is the Engine

Cityblock Health's flexible care teams meet members wherever and whenever they need care



- Each member is assigned a **Community Health Partner** to learn a member's story, support them in creating a personalized **Care Plan** to ensure they are connected with supports, 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.

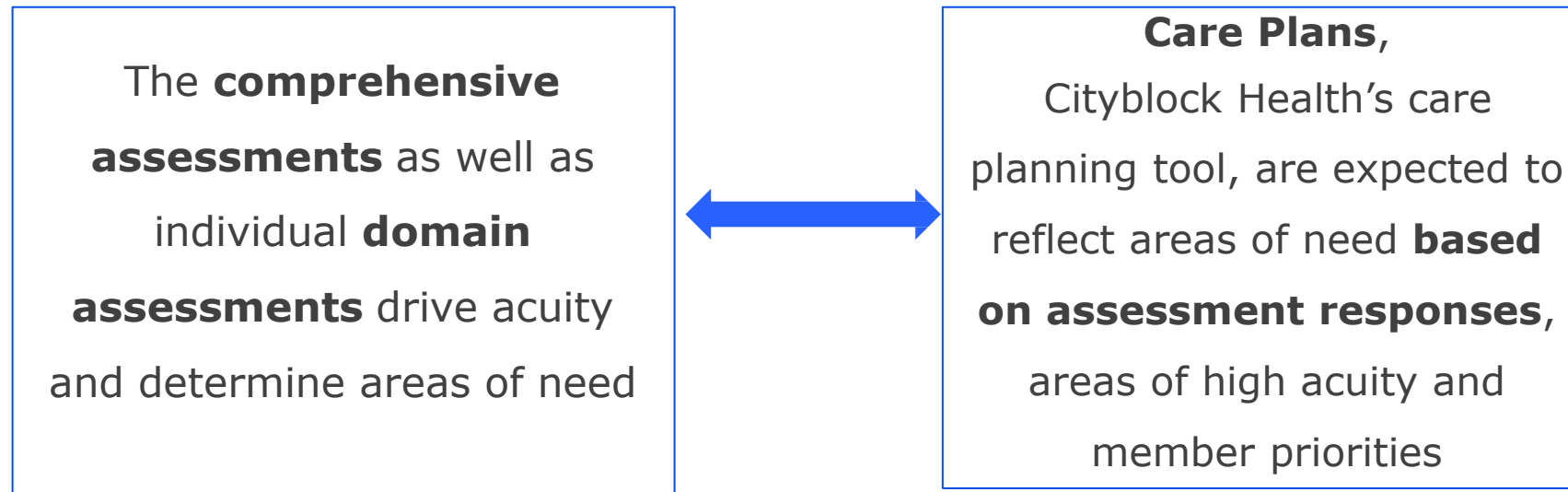
The Care Team Philosophy

1. Care teams are collectively responsible for moving members toward achieving their goals
2. Setting goals is a collaborative effort between the member and their team, ensuring that the most important and relevant goals are prioritized
3. Progress is made by using (and evolving) the structures and tools in place to work collaboratively towards 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



Comprehensive Assessment

Through a comprehensive assessment called the Health Risk Assessment (HRA) Cityblock Health understands a member's story in their own words. After the completion of the assessment the care plan is developed with the member taking the lead in identifying goals.



The final product is an Individualized Care Plan (ICP) that is reviewed and updated with the member throughout their journey with Cityblock. ICPs are customized to each individual member based on their unique needs, and reviewed with the Interdisciplinary Care Team (ICT) at regular intervals based on member level of complexity.

Member Individualized Care Plan (ICP)

Cityblock Health creates Individualized Care Plans for all members, also called the ICP.

ICPs are a collection of goals that documents the members' uniquely identified opportunities, interventions, barriers and expected outcomes.

Care plan goals are updated and documented during points of contact with members, as well as in the course of significant changes in care or status (such as transitions of care or acute utilizations).

Initial care plans are completed within 90 days of enrollment, and members must agree to the inclusion of any and all goals. Members are encouraged to be active participants in addressing their care plan goals.

Summary

- The Care model promotes comprehensive and holistic care management and care coordination across team members
- The Cityblock Health approach leverages person centered care planning processes based on comprehensive assessment and risk identification
- Cityblock Health care management team leverages a team-based model comprised of both licensed and non-licensed staff, allowing team members to work at the top of their license
- The model is designed to support the complexities of this population with specific focus on behavioral health needs
- It is crucial for care management and PCPs to work together to manage complex members to ensure best in class care
- Performance metrics drive accountability and ownership at the team level
- Both THP and Cityblock Health are fully committed to evaluating the model of care to ensure One Care members receive high quality, innovative care that best meets their needs

Provider's Role in the Care Planning Process

Expectations for Providers

- PCP will receive and review a care plan from Cityblock. Providers can also view a copy on the provider portal.
- 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
- Reasonably accommodate members and ensure that programs and services are equally accessible to an individual with disabilities, including diverse linguistic and cultural competence needs, as they are to an individual without disabilities.

Doing Business With Us

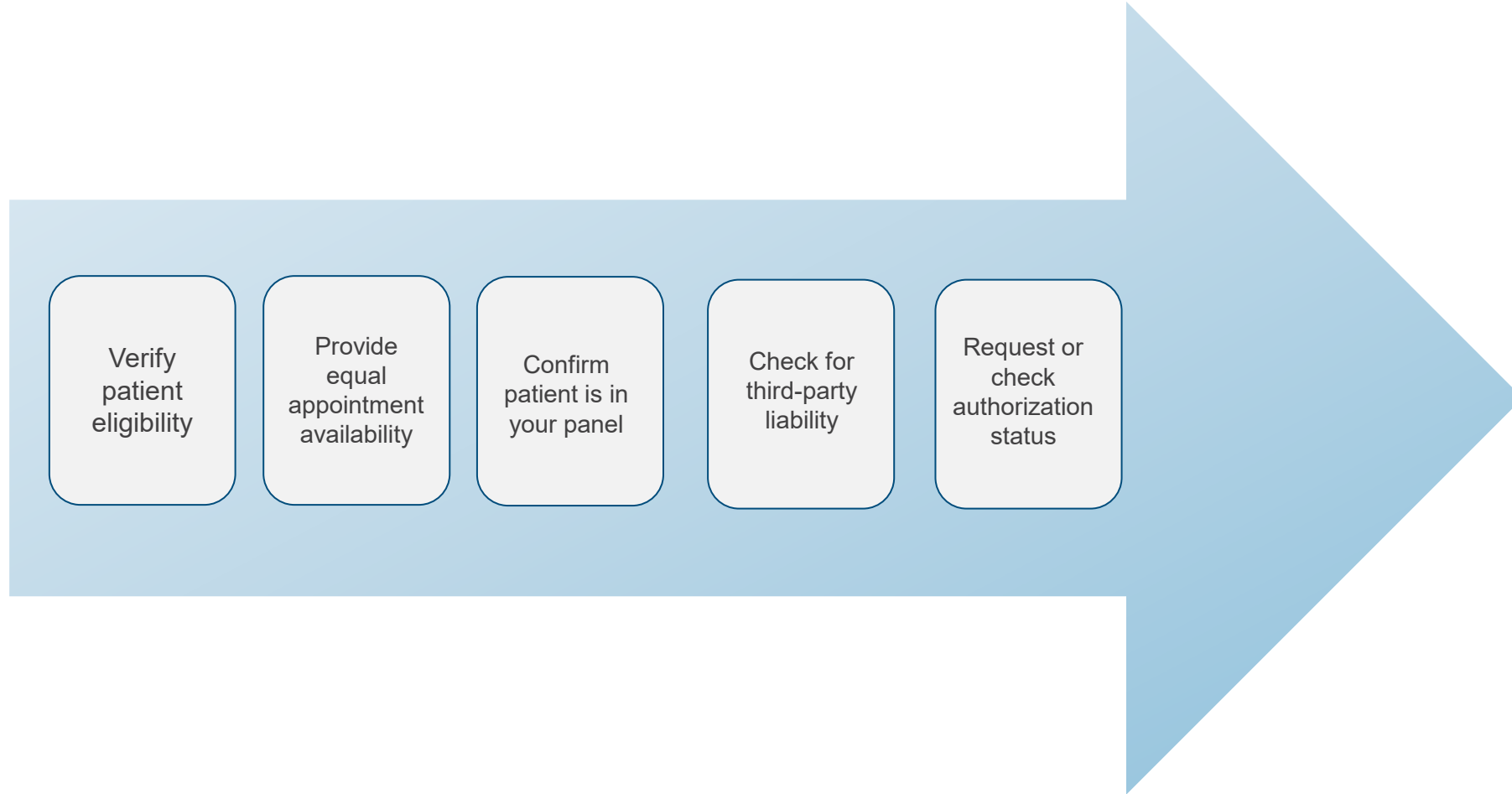
Doing Business With Us

As a Tufts Health One Care contracted provider, you get:

- A comprehensive approach to care for your Tufts Health One Care patients
- Support from Cityblock Health for member management and care coordination
- Ability to check (view integrated care plans), 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



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 <i>NEHENNet</i>
Call THP	Our 24/7 member eligibility line, 888.257.1985
Call MassHelath	24/7 automated line, 888.665.9993

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 Public 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 Public Plans – Paper Claims Submissions
c/o Health eConnex
25381 Commercentre Dr., Suite 225
Lake Forest, CA 96230
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 [Claims Requirements, Coordination of Benefits and Dispute Guidelines](#) of the [Tufts Health Public Plans Provider Manual](#) for additional information.

Provider Checklist

Have you taken the following actions?

- Register for **Provider Update**, THP's monthly newsletter; tuftshealthplan.com/provider/provider-email-capture
- Register to access THP's secure Provider portal and enjoy one-stop access for member eligibility claims, authorizations and panel reports; tuftshealthplan.com/provider/provider-register-for-secure-access
- Fill out the **Medical or Behavioral Health Provider Information Form**
 - Available in the Provider Resource Center; tuftshealthplan.com/provider/resource-center/resource-center
- Set up **direct deposit** and get paid faster: <https://tuftshealthplan.com/provider/provider-information/electronic-services> for instruction on how to enroll in Electronic Fund Transfer (EFT) with Payspan
- Review the **Tufts Health Public Plans Provider Manual** available in the Provider Resource Center; <https://tuftshealthplan.com/provider/provider-information/provider-manuals/tufts-health-public-plans>
- One Care trainings - <https://www.point32health.org/provider/training/>
- Call Provider Services if you have any questions: **888.257.1985**
- Call Cityblock Health if you have questions about the member's care management: **833.904.2273**

Please Remember

- Always bill THP, not MassHealth or the member.
- Quarterly, providers will receive a notification from CAQH requesting that they verify whether their information is accurate. Provider must attest to accuracy of information every 120 days. Be sure to take the time to update your information in CAQH if it is inaccurate.
- Be sure to register your email with THP to receive important updates.
(<https://tuftshealthplan.com/provider/provider-email-capture>)
- Call Cityblock Health if you have questions about the member's care management: 833.904.2273

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
/provider

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 monthly 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).