Tufts Associated HMO, INC., H2256
Dual-Eligible Subset (Medicare Zero Cost-sharing) Special Needs Plan

Model of Care Score: 98.75%
3-Year Approval **January 1, 2014 – December 31, 2016**

Target Population

Tufts Associated HMO, Inc. (THP) serves a fully integrated dual eligible population that includes a subset of dual eligible members who are 65 years of age and older and reside in the THP's Medicare Advantage HMO ten county service area in Massachusetts. 87 percent of members live in the community and not an institutional setting. The conditions of poverty can result in poor access to medical services with concomitant poor health outcomes. The THP D-SNP product is structured to address language barriers, lack of mobility, social issues, chronic mental illness, and multiple chronic illnesses. In addition to high prevalence of chronic conditions, members have mental health diagnoses, and high prescription drug utilization.

Provider Network

THP's current Medicare Advantage network includes primary care physicians (PCPs) and specialty physicians in areas such as cardiology, nephrology, endocrinology, pulmonology, psychiatry and immunology. THP contracts with acute care hospitals, a variety of outpatient services including radiology, high technology imaging services (e.g., MRI, CT scans, PET scan, Nuclear Radiology), oncology and rehabilitative services, sub-acute facilities including skilled nursing, long-term acute care and inpatient rehabilitative services. THP contracts with allied health services including but not limited to clinical psychologists, LICSWs and other behavioral health clinicians, physical and occupational therapists, free standing laboratory providers, durable medical equipment providers, chiropractic services, and free-standing imaging and ambulatory surgical centers.

Care Management and Coordination

A health risk assessment (HRA), also referred to as the care level assessment, serves as an initial high level screen that helps the care management team identify the member's care needs. The THP care coordinators and the member complete the tool by phone within the first 30 days of initial effective date with the plan. An annual reassessment is completed within one year of the last assessment. The HRA identifies issues pertaining to dementia, mental health, chronic medical conditions, as well as dietary and environmental factors and/or the need for assistance at home. It also captures advanced directive status, transportation needs, preventive health measures and a medication review.

Following the HRA and initial comprehensive assessment, the members of the interdisciplinary care team (ICT) collaborate to create the plan of care (POC), with the complex care clinician becoming involved for the most complex members. Either the care manager or the complex care clinician facilitates the development of the POC, obtaining input from members of the ICT, including the PCP, the member and their caregivers, and other participants as needed, such as a behavioral health clinician, specialists and/or the geriatric support services coordinator. The care manager is always the primary point of contact for the members throughout the POC development process and is responsible for coordinating the ICT meeting, updating the POC, documenting revisions and communicating changes to stakeholders.

The goal of the ICT is to coordinate and manage all aspects of the member's needs: medical, behavioral, social and community. The actual composition of the ICT varies from member to member depending upon their health status and care management needs. The member is the center of the ICT design with the PCP, health plan care management team, the geriatric support services coordinator, and other medical specialists. If the member requires additional support, the ICT will be augmented with additional key resources such as: a complex care clinician (Nurse Practitioner, Physician Assistant or RN with geriatric expertise), a behavioral health clinician, a pharmacist employed by THP and other experts and specialists involved in developing the member's plan of care.

This MOC summary is intended to provide a broad overview of the SNP's MOC. Although the full extent of any MOC cannot be conveyed in a short summary, this summary provides the reader with a general overview of how the SNP addresses beneficiary needs.

For more information about this health plan refer to the Special Needs Plan's website at: http://www.thpmp.org/sco