



Delegated Care Management

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1 Delegated Care Management

Tufts Health Plan prides itself on working collaboratively with its providers¹ to arrange the best managed care for its members, and the best overall health program to those who purchase Tufts Health Plan coverage. In the spirit of collaboration, Tufts Health Plan developed a delegation program in response to a request from numerous provider units to locally perform significant portions of care management.

Delegated Care Management:

- Grants the provider a lead role in medical management. This is a logical step, following the acceptance of increased responsibility for financial performance.
- Encourages the provider's understanding of its local community resources.
- Promotes the development of a quality communication process among a provider's participating physicians.
- Supports Tufts Health Plan's goal to increase provider and member satisfaction.
- Lowers the administrative cost of caring for members.

This chapter discusses the participation criteria and the process to qualify for Tufts Health Plan's delegated care management program. Presently, Tufts Health Plan delegation programs are:

- Commercial and Tufts Health Plan Medicare Preferred.
 - Medical Management.
- Tufts Health Plan Medicare Preferred only.
- Special Population Management.
 - Complex Care Management.
 - Disease Management.

Definition of Delegated Care Management

Tufts Health Plan defines delegated care management as a program in which the provider's clinical staff is responsible for a specified group of care management functions for a defined population, where previously, Tufts Health Plan performed these care management functions. The provider is the responsible entity and does not subcontract any delegation functions.

When care management is delegated, Tufts Health Plan retains ultimate accountability and responsibility, and ensures that the delegated functions meet Tufts Health Plan's regulatory requirements and accreditation

¹ For this manual's purpose, a provider is a contracted entity with Tufts Health Plan and is limited to the following: integrated delivery networks (IDN), Physician Hospital Organization (PHO), Medical Group, or Physician Organization (PO).

standards, including policies and standards required by credentialing entities. These entities include, but are not limited to, the following:

- Centers for Medicare and Medicaid Services (CMS)².
- National Committee for Quality Assurance (NCQA).
- Applicable state and federal regulatory agencies and departments.

Because of continuing contractual obligations to its various customers, Tufts Health Plan reserves sole discretion to define the services and functions to be delegated and the specific requirements that must be met by the provider performing the delegated functions.

In addition, Tufts Health Plan performs defined oversight functions that evaluate and monitor the delegated functions to ensure the continued delivery of high-quality health care to its members. A provider's delegation status is determined by Tufts Health Plan and is dependent upon the provider's adherence to participation criteria.

Participation Criteria

A provider must meet an initial minimum set of criteria to be considered for delegated medical management. The following list is a high-level summary of these criteria:

The provider must:

- Participate in an enhanced risk arrangement with Tufts Health Plan.
- Be in full standing with the Quality Improvement (QI) department and not subject to QI monitoring.
- Be able to demonstrate financial solvency.
- Be delegated for Medicare Preferred Medical Management prior to requesting Delegation for Medicare Preferred Special Population Management.
- Have established care management processes, e.g., decision-making processes that reflect an understanding of managed care and discussion of utilization and QI issues.
- Assemble a management team that includes physicians and non-physicians.
- Maintain a formalized and adequate infrastructure, including space, standard office equipment, system interface capability, and personnel.
- Submit the following written plans:³
 - Medical Management Plan.
 - Case Management Plan.
 - Disease Management Plan (as applicable).
 - Complex Care Management Plan (as applicable).
 - QI Plan.
 - Authorization Processing Plan⁴.

² Payments, if any, for these activities or services that relate to Tufts Health Plan Medicare Preferred HMO members are derived, in whole or in part, from federal funds. Receipt of any such funds is subject to certain laws applicable to individuals and entities receiving federal funds.

³ See details in [Chapter 4, Care Management Delegation Assessment](#).

⁴ Required with commercial medical management delegation.

- Comply with Tufts Health Plan policies, procedures, and oversight standards that are based on the following:
 - federal and state regulatory requirements.
 - CMS and NCQA policies and standards.
- Agree that the written requirements:
 - May be modified from time-to-time by the Plan without any other party's consent.
 - May include other terms and conditions as CMS deems necessary and appropriate to implement the applicable requirements under state and federal law, including, but not limited to, the Federal Medicare Advantage regulations.
- Demonstrate the ability to change systems and processes upon Tufts Health Plan's request, as necessary. This includes, but is not limited to, changes required by Tufts Health Plan systems upgrades and compliance with HIPAA X.12 ANSI format.

Assessment Process

The process for a provider to assume delegated medical management, including the additional delegated functions of disease management and complex care management, is outlined below.

1. A provider expresses interest in delegated services to Tufts Health Plan.
2. The Tufts Health Plan Delegation Team coordinates an internal review process to ensure the provider fulfills the participation criteria.
3. Tufts Health Plan provides this manual and schedules an initial intake session to orient the provider to delegation.

The purpose of the orientation meeting is to review the overall requirements for delegation. The provider's key medical and administrative leadership must attend the meeting.

4. The provider uses the assessment tool contained in this manual to submit an assessment packet to the Tufts Health Plan Assessment/Oversight Team.

The tool consists of the following:

- Surveys.
 - Written plans.
 - An agreement for delegated services that must be signed by a provider's authorized representative. The agreement also contains Business Associate language designed to address the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and its implementation regulations.
5. The Assessment/Oversight Team reviews the assessment packet, requests additional information if necessary, and consults with the provider until all documentation complies with Tufts Health Plan policies, procedures, and delegation standards.
 6. The Tufts Health Plan Assessment/Oversight Team makes a recommendation to the Delegation Steering Committee.

7. The Tufts Health Plan Delegation Steering Committee, as the governing body for delegated medical management, determines the Provider's delegation status:
 - **Full delegation.**
 - **Delegation with provisional status** - Delegation is contingent upon specific actions and modifications being completed within a specified time frame.
 - **No delegation** until specific modifications are made.
8. After Tufts Health Plan informs the provider of the decision to approve the provider for delegated medical management, the Delegation Team and the new delegate co-negotiate a plan detailing the transition of Medical/Complex Care Management functions to the delegatee.

Oversight Program

Tufts Health Plan's oversight program is designed to ensure equitable and efficient medical management for all of its members. The program incorporates compliance with Tufts Health Plan contractual agreements, policies and procedures, regulatory requirements, and accreditation standards.

To facilitate the delegates' and Tufts Health Plan's success with delegated medical management, Tufts Health Plan assigns a Delegation Nurse Consultant (DNC) to each delegatee. The DNC's two primary roles are:

- **Communicator** - This role encompasses the functions of liaison, resource, advocate, and educator.
- **Surveyor** - This role encompasses auditing the delegatee's performance against Tufts Health Plan's delegation standards.

The oversight program, through a review of a set of deliverables, assists Tufts Health Plan and the delegatee to document their compliance with all standards.

The deliverables are categorized into daily, weekly, monthly, quarterly, biannual, and annual submission requirements. Analysis of the deliverables may result in specific plans for remedial action, up to and including revocation of delegation. These plans, developed jointly with the delegatee, are monitored and evaluated over a specific time frame.

Daily Requirements

Submission of Commercial Precertification log(s).

Weekly Requirements

- Submission of the following information to Tufts Health Plan:
 - Medicare Preferred Precertification log(s).
 - Home Care and durable medical equipment (DME) authorizations (electronic or paper log submission).
 - Quality Occurrence reports.
- Denial decision information/letters.
- Conduct weekly Tufts Health Plan Medicare Preferred HMO (Tufts Medicare Preferred HMO) Medical Management meetings, and record minutes.

Monthly Requirements

- Submission of the following information to Tufts Health Plan:
 - Institutional, Hospice, and Denial Letter logs.
 - Key changes in delegate and delegated provider unit (DPU) personnel.
 - Requested documentation for audit by the DNC.
- Conduct Tufts Medicare Preferred HMO and Commercial QI meetings. Record and maintain minutes, including the peer review statement.
- Tufts Health Plan informs the delegate of appropriate Quality Improvement/Quality Assurance (QI/QA) incident reports that Tufts Health Plan receives.

Quarterly Requirements

- Conduct Commercial Utilization Management/Medical Management meeting. Record and maintain minutes.
- Attendance at Hosted Complex Care Management Meeting.
- Submission of Hosted Complex Care Management Audit Summary.
- Ad hoc performance review meetings scheduled at the request of either party.

Biannual Requirements

- Discussion of QI work plan reflected in QI meeting minutes.
- Participation in delegation performance review meetings with Tufts Health Plan representative.
- Submission of enrollment statistics with analysis.
- Upon request, submission of:
 - Medical Management meeting minutes.
 - Disease Management Summary Reports.

Annual Requirements

- Discussion of Risk Management issues reflected in QI meeting minutes.
- Provider unit representation at Advanced Delegation training.
- Submission of:
 - Completed Assessment⁵ (or Re-Assessment) packet ninety (90) days prior to the last day of the delegation anniversary month. The Assessment (or Reassessment) deliverables are detailed within the tools in chapters 4 and 5 for medical surgical and Disease Management.
 - Complex Care Management Program Evaluation.
 - Analysis of Member Satisfaction Survey.
 - Analysis of Member Complaints and Inquiries.
 - Member participation rates.

⁵ Submission of an Assessment packet is required every 3 years. Reassessment packets may be submitted during the intervening 2 years.

Off-Cycle Review

Tufts Health Plan may conduct an off-cycle review of the provider's delegated arrangement if Tufts Health Plan believes that such a review is appropriate under Tufts Health Plan policies, applicable law, and accreditation standards.

Revoking Delegated Status

If Tufts Health Plan and/or CMS⁶ determines that the provider is not performing any of the delegated services or functions consistent with the terms of the applicable assessment tool and manual, Tufts Health Plan and/or CMS may revoke the delegation in whole or in part.

If revocation occurs, Tufts Health Plan resumes performing any, or all, of the delegated services or functions upon written notice to the provider. Tufts Health Plan has the option of revoking the provider's responsibility for delegated services/functions if:

- Delegation is not functioning effectively as evidenced by member or provider complaints, or issues identified through Tufts Health Plan oversight. This includes, but is not limited to, its QI Program.
- Tufts Health Plan believes that continued delegated medical management would jeopardize its NCQA or other such accreditation, or state or federal licensure, certification, or qualification.
- An administrative contact and/or medical director acceptable to Tufts Health Plan are not available to perform delegated functions.
- A provider does not correct an identified issue within 30 days from written notification by Tufts Health Plan.

⁶ As it relates to Tufts Medicare Preferred HMP delegation.

2 Quality Improvement

The Tufts Health Plan Quality Improvement (QI) Program includes identifying and reporting QI Occurrence and Member Grievances to identify quality of care issues and to take steps to enhance care. Tufts Health Plan looks at all places of service where care is provided, and has a process for reviewing and recording member quality issues.

Tufts Health Plan QI Occurrence Screens are used to review inpatient medical records to identify potential quality events. When an occurrence is identified, the Provider Unit's (PU) Case Manager completes an Occurrence Report Form, including documenting circumstances of the event, follow-up, and outcome.

Tufts Health Plan QI Member Grievance screens are used to review member complaints about the care and/or services that they received. When a grievance is identified, the member should be advised to call Tufts Health Plan Member Services. The Case Manager completes a Grievance Form, including documentation of the event, follow-up, and outcome.

The PU's Case Manager will forward identified QI Occurrences and Grievances to the Tufts Health Plan Clinical QI Department. A Tufts Health Plan Medical Director or designee (designated physician or RN reviewer) reviews the cases. Severity and prevention ratings are assigned, and the cases are then presented to the Tufts Health Plan Quality of Care Committee (QOCC). The QOCC, chaired by a Tufts Health Plan Medical Director, oversees member complaints, physician credentialing, risk management activities, and QI occurrences.

Tufts Health Plan has a responsibility to its members to arrange a provider network capable of providing accessible quality care and to use uniform screening criteria to evaluate quality issues. Aggregate data are used to identify trends, and Tufts Health Plan works with the provider network to adopt clinical practice guidelines and other measures to improve care.

PU's/Medical Groups are expected to have QI Committee meetings at least monthly. For the records to be protected under medical peer review privilege law, the minutes from these meetings should be documented separately from those of the Medical Management meetings. (Sample QI Committee agenda and minute formats are included at the end of this chapter. Refer to [Figure 2 on page 2-13.](#))

Forward all QI Occurrence and Grievance Reports to:

Kim Botan, RN
Clinical Quality Improvement Department (3E)
Tufts Health Plan
705 Mount Auburn Street
Watertown, MA 02472-1508

FAX: (617) 972-9474
Phone: (888) 766-9818, ext. 2048

Review of QI Occurrence Screens

The PU's Case Manager applies Tufts Health Plan QI Occurrence Screens to each received case. When a QI Occurrence Screen is identified, the case is reported to the Tufts Health Plan Clinical QI department on a monthly basis.

The case manager must:

1. Apply relevant QI Occurrence Screens to each case during review.
2. Using Tufts Health Plan QI Occurrence Report form, complete all information, including the screen number and nature of the issue specific to the patient.
3. Provide detailed narrative on the QI event, identifying the date when the event occurred.
4. Record the physician's full name and the facility for the identified QI Occurrence. The names provided are the providers who will be held accountable for the event. If you are unsure of the provider (e.g., anesthesiologist or surgeon), do not guess.
5. Include all of the following:
 - Member full name.
 - Tufts Health Plan Member number.
 - Tufts Health Plan precertification number (Inpatient admissions).
 - Name and phone number (including area code) of PU Case Manager submitting the QI Occurrence Report.
 - Physician for QI Occurrence (first and last name).
 - Facility for QI Occurrence (indicate which site or campus, if more than one exists).
 - Facility Medical Record number.
 - Admission and Discharge dates of admission when the event occurred.
 - Date of the QI Occurrence.
 - Tufts Health Plan QI Occurrence Screen number (if there is more than one event, use a separate report for each)
 - Diagnosis,
 - Procedure and date of procedure,
 - Narrative of QI Occurrence (should not be a duplication of the QI Occurrence screen wording, but should include a summary of the situation).
 - Case notes (notes that outline the course of events preceding the quality event, the event, follow-up actions and outcome).
 - Additional Information (as described on the QI Occurrence Screens Documentation Requested sheet, including admission notes, discharge summary, OR reports, if available).
 - This information should be comprehensive and sufficient enough to create an understanding of the event and allow the reviewer to assign a severity and prevention rating.s
6. If information is not complete when received by Tufts Health Plan CQI Department, the PU Case Manager may be contacted for additional information.

Tufts Health Plan QI OCCURRENCE REPORT

Forward all QI Occurrence reports to:

Kim Botan, RN
Clinical Quality Improvement Department (3E)
Tufts Health Plan
705 Mount Auburn Street
Watertown, MA 02474-1508

Member Name: _____ Member ID#: _____
Medical Record #: _____ Precertification #: _____
MD for QI Event: _____ Facility for QI Event: _____
Admission Date: _____ Discharge Date: _____
Date of QI Event: _____ Event Code #: _____ (1 event per sheet)

*ATTACH COPY OF CASE NOTES and
SUPPORT DOCUMENTATION (see Documentation Requested information)*

Diagnosis(es): _____
Procedure(s) and Date(s): _____
Date(s): _____
Past Medical History: _____
Narrative of QI Event: _____

(Use additional sheets as needed)

Case Manager Reporting: _____

Phone: (____) _____

Document Status: The TAHP/TAHMO/Tufts Health Plan Patient Care Assessment/Quality Improvement Committee designates this letter/document(s) and any accompanying materials as minimum necessary protected health information for proceedings, reports, and records of a medical peer review committee, quality assurance program, professional competence committee or peer review board under applicable state law and, as such, all letters and accompanying materials shall be kept strictly confidential.

Clinical Quality Improvement Department Occurrence Screen Program 2009

TUFTS HEALTH PLAN		
CLINICAL QUALITY IMPROVEMENT DEPARTMENT OCCURRENCE SCREEN PROGRAM 2008 CODES & CRITERIA FOR CASE MANAGER IDENTIFIED EVENTS		
Category	Code	Examples
Readmission following discharge from a hospital, ED, or MH/SA setting	0700	<ul style="list-style-type: none"> • Within 72 hours of discharge from ED or observation status • Within 1 week of outpatient or day surgery
Inadequate coordination of care: any instance in which care was not coordinated adequately	0710	<ul style="list-style-type: none"> • Discharge plan inadequate, not initiated, or completed • Inadequate coordination of care with outpatient provider(s) - includes delay in diagnosis +/- treatment • Inadequate coordination of care among inpatient providers - includes delay in diagnosis +/- treatment • Inadequate communication between facilities +/- providers/practitioners
Serious adverse medical outcome secondary to care or lack thereof	0760	<ul style="list-style-type: none"> • Serious medication errors • Falls with injury • Severe surgical complications • Harm to self • Catastrophic events - unexpected outcome resulting in life threatening situation, severe impairment, or serious loss of functional levels. Examples: <ul style="list-style-type: none"> - Unexpected death - Paralysis - Hemodialysis - Coma - Loss of limb - Ventilator dependence
<p>Please feel free to contact us for assistance in determining occurrence eligibility and/or category.</p> <p>Tufts Health Plan Clinical Services 888-766-9818</p> <p>Clinical Quality Improvement Department:</p> <p>Kim Botan, RN, Manager, CQI (ext. 2048)</p> <p>Tracy Menza, RN, Clinical QI Coordinator (ext. 3294)</p> <p>Jean Clapp, RN Clinical QI Coordinator (ext. 2844)</p>		

Member-Generated Grievances

Reporting Process

Under the overall umbrella of our member satisfaction services, Tufts Health Plan has a process to receive and review member complaints or 'grievances'. This process was designed to meet Tufts Health Plan's mission to provide quality service to our members, as well as to comply with external regulatory requirements. Tufts Health Plan always reviews member complaints that are related to the quality of care and services that a member receives.

When members complain to a Delegated Case Manager about the healthcare services that they received, a grievance should be filed (see the specific category examples below). Upon receipt of the complaint, the Case Manager is expected to:

- Respond to any ongoing member needs.
- Explain to the member that Tufts Health Plan is interested in hearing about their concerns.
- Explain that Tufts Health Plan has a process to review member concerns about their healthcare services.

Once the grievance process is explained, the Case Manager should ask the member for consent to file the grievance with Tufts Health Plan.

Procedure

1. Complete the Grievance Report Form, and include the following information:
 - Date that the grievance (complaint) was brought to the Case Manager's attention.
 - Name and phone number of the PU Case Manager referring member's grievance.
 - Member's full name.
 - Member's Tufts Health Plan or Tufts Medicare Preferred HMO ID number.
 - Provider's full name (relative to event).
 - Provider's PU or Tufts Medicare Preferred HMO Group identification number.
 - Confirmation that the Member was given his/her grievance rights, and that the member consents to filing the grievance.
 - Explain the situation in as much detail as possible, including dates, times, and names of individuals involved. Use additional sheets as needed.
 - Document immediate follow-up action taken by the PU Case Manager. If available, document the member outcome.
2. Fax the Grievance Report Form to Kim Botan, Clinical Quality Improvement Department at (617) 972-9474, as soon as a member complaint is reported to the Case Manager. Be aware that Tufts Health Plan (including Tufts Medicare Preferred HMO) is required to complete the review of member grievances within 30 days of the members' complaint).

Figure 2: Sample QI Committee Meeting Minutes

Medical Group				
Quality Improvement Committee Meeting Minutes				
Attendees:				
Date:				
Time meeting began:				
Time meeting adjourned:				
Next meeting:				
Issue	Discussion	Follow-up	Resolution	Timeline for Resolution

Respectfully submitted,

QI Committee Chairperson

Document status: The _____ Quality Improvement Committee designates this information and record as proceedings, reports, and records of a medical peer review committee under applicable state law.

3 Standards

NCQA Standards

The National Committee on Quality Assurance (NCQA) annually publishes Standards for Accreditation, which outlines utilization management requirements. You can order copies of the current document from NCQA at 1-800-839-6487, or you can access the website: www.ncqa.org.

Tufts Health Plan Decision Timeframes

The Plan's utilization review determination timeframes are available on the Provider page of the Tufts Health Plan website: <http://www.tuftshealthplan.com/providers>.

The document titles are:

- Utilization Review Determination Timeframes Applies to all Products Except for Tufts Health Plan Medicare Preferred.
- Utilization Review Determination Timeframes For Tufts Medicare Preferred HMO Members.

4 Care Management Delegation Assessment

Overview

This chapter assists interested providers in enhancing their Medical Management Plan to meet the requirements of the Tufts Health Plan delegated medical management model. When completed, the new Medical Management Plan becomes the provider's delegated medical management assessment packet, which includes Tufts Health Plan Medicare Preferred Special Population Delegation when applicable. When the Tufts Health Plan Delegation Steering Committee approves the Plan, the document becomes the provider's delegation agreement with Tufts Health Plan.

To ensure submission of a complete assessment packet, the entity must use the Assessment Tool. This Tool consists of the following seven categories of information:

- Demographics.
- Infrastructure.
- Medical Management Plan.
- Case Management Plan.
- Quality Improvement (QI) Plan.
- Technical Communication Plan.
- Signatory Page.

Medical Management Delegation

Tufts Health Plan currently delegates management of Tufts Medicare Preferred HMO and Commercial HMO members to clinical staff of select integrated delivery networks (IDNs) and provider units (PUs). The Plan does not delegate all functions of medical management. The following section lists the functions delegated to the IDN/PU, and those retained at Tufts Health Plan.

Commercial

- Medical/Surgical Management.

Medicare Preferred

- Medical/Surgical Management.
- Special Population Management:
 - Complex Care Management.
 - Disease Management.

Integrated Delivery Network's/Provider Unit's Responsibility

Delegated medical management functions include the following:

- All clinical staff is available to receive communication from providers and members during the normal business day (8:30 am to 5 pm) and after hours by fax and/or voice mail.
- Prospective, concurrent, and retrospective review of requested services.
- Discharge planning.
- Case management.
- QI occurrence and grievance identification and reporting.
- Claims/encounter data submissions.
- Medical Management and QI committee meetings.
- Member identification and referral into the Plan's specialty care management and/or delegates Special Population Management programs.
- Adoption of a nationally recognized level of care review criteria based on sound clinical evidence, and reviewed and approved annually by the IDN/PU Board of Directors.
- Notification to Tufts Health Plan of any changes in leadership or shifting of the delegated group.

Delegated Special Population Management functions for Tufts Medicare Preferred only, including:

- Program design, including:
 - Member identification process,
 - Member interventions and stratification processes,
 - Program evaluation processes, including quarterly and annual data analysis.
- Practitioner outreach and education methodologies, including:
 - Program staffing management.

Tufts Health Plan's Responsibility

Medical management functions retained by the Plan under this program include the following:

- Grievance/appeals for members and providers.
- Commercial disease state management programs, including:
 - Healthy Birthday (high-risk pregnancy).
 - Diabetes program.
 - Others as developed.
- QI, including:
 - Occurrence rating and follow-up.
 - Periodic record audit.
- Wellness benefits.
- Assisted reproductive technologies.
- Early intervention.
- Benefit interpretation decisions, including:
 - Exceptions.
 - Extensions.
 - Clinical guidelines.

- Out-of-Area.
- Precertification.
- Prior Authorization/Central Authorization.
- Oversight.

Medical management functions not delegated by Tufts Health Plan frequently require data submission from the delegated entity and/or collaboration between the Plan and the delegated entity.

Product-Specific Definitions

Product-specific policies and regulations govern several delegated medical management functions; thus, operational differences exist between the Tufts Medicare Preferred and Commercial delegation programs. The table below presents key examples of differences between the two delegation programs.

Function	Tufts Medicare Preferred HMO	Commercial
Definition of Out-of-Area	<ul style="list-style-type: none"> • Outside the 30-mile radius from the members home hospital, except for Harvard Vanguard Medical Associates (HVMA). • For HVMA, out-of-area is defined as outside of the state of Massachusetts. 	Outside the Plan's service area ¹ .
Authorizing Agent	Medical group and/or Medical director of the member's PU, the member's PCP, or Tufts Health Plan Medicare Preferred staff.	The member's PCP or Tufts Health Plan staff.
Concurrent Review of acute medical/surgical admissions	A delegated PU is responsible for all in-area admissions at facilities contracted with Tufts Medicare Preferred HMO within Massachusetts.	<ul style="list-style-type: none"> • A delegated PU is responsible for all their delegated members' admissions to the PU's primary admitting (home) hospital. • Any delegated PU's delegated members admitted to a non-home hospital are reviewed either by the Plan's Case Manager or the non-home hospital's Delegated Case Manager (DCM). • Delegated PUs encompassing a "present to" function are also responsible for all Tufts Health Plan commercial members, except PPO members, admitted to the PUs' home hospital.

1. See *Tufts Health Plan Directory of Health Care Providers* for Tufts Health Plan's Service Area

Developing the Assessment Packet

To create your Assessment Packet, use the Assessment Tool and refer to the instructions below.

You use a copy of the Assessment Tool as the index to your Assessment Packet. Please number all pages.

In your packet, identify where the information that addresses each requirement is found. Record the page number on which the requirement's material is found in your Assessment Packet within the Location/Comments column of the Tool.

Example:

D	Submit a copy of each Case Manager's resume demonstrating fulfillment of the following:	Section G Pages 12-16
	<ol style="list-style-type: none"> 1. Active case management/discharge planning experience, <u>or</u> 2. Minimum of 5 years of recent medical/surgical clinical experience*. 	
	*The DPU must provide a 6-week, minimum case management education/preceptorship orientation program.	

Note: Only those Tufts Health Plan providers requesting Special Population Delegation need to submit the corresponding "*Complex Care/Disease Management*" information.

Step 1 - Medical Group Demographics

The purpose of the demographic page is to document key leadership and contact information. The number of demographic pages submitted is determined in the following manner:

- One page describing the requesting entity, e.g., IDN, Physician Hospital Organization (PHO), Medical Group.
- One page describing each Tufts Medicare Preferred HMO provider unit number.
- One page describing each Commercial HMO provider unit number.
- One page describing any subset organizations (e.g., pods, teams) for Tufts Medicare Preferred HMO and/or Commercial.

Line	Description
A	Check the box(es) to indicate for which product(s) your entity is requesting delegation/redelegation. For example, when an IDN requests delegation/redelegation for Tufts Medicare Preferred HMO and Commercial, check both boxes.
B	Enter the name and phone number of the Organization's Executive Director.
C	List the Special Population Program(s) for which you are currently requesting delegation. For example, Congestive Heart Failure (CHF), Chronic Obstructive Pulmonary Disease (COPD), Complex Care Management.
D	Enter the name and phone number of the Contact Operations person on the requesting entities page only . The Contact Operations person is defined as the "owner" of the Delegated Medical Management process and the key contact for communications from the Health Plan. If the contact information is different for the delegated Special Population program(s), list each program contact information separately, indicating program name.

Line	Description
E	Enter Provider Units (PU) full name and Provider Unit Number.
F	Enter PU's mailing address.
G	Enter PU/group's business hours (minimal requirement 8:30 am to 5 pm Monday - Friday).
H	Enter PU's business phone number(s), at which a person can be reached between 8:30 am to 5:00 pm.
I	Enter fax number for PU entered in line G.
J	Enter one name and phone number as the Case Manager contact. Indicate that whether this contact is available both during and after business hours. For after hours, indicate a fax number or an available voice mail answering service number, if different.
K	Enter Case Management Fax number.
L	Enter PU's Medical Director's name and phone number.
M	Enter Special Population Program(s) contact for each program. Enter the telephone number. Enter the fax number, if different from the Group.
N	Enter Medical Management Committee Chairman's name and phone number.
O	Enter frequency, day, and time of PU's Medical Management meeting.
P	Enter QI Committee Chairman's name and phone number.
Q	Enter frequency, day, and time of PU's QI meeting.
R	Enter the primary admitting hospital for the PU. The primary admitting hospital is the hospital(s) to which the provider unit's PCPs usually admits their patients.

Medical Group Demographics Plan

Medical Group Demographics		
A.	Commercial HMO <input type="checkbox"/>	Tufts Medicare Preferred HMO HMO <input type="checkbox"/> Special Population Management <input type="checkbox"/>
B.	Executive Director/Phone:	
C.	List the Special Population Programs for which you are currently requesting delegation	
D.	Contact/Operations Person/Phone: Med/Surg and Special Population Management, if different	
E.	Full Name of Group / Tufts Health Plan Provider Unit #:	
F.	Address:	
G.	Office Business Hours: (Minimal requirement: M-F 8:30-5:00)	
H.	Business Telephone Number: Additional Number if necessary:	
I.	Business Fax Number:	
J.	Case Manager (CM)/PU Telephone Number for CM Listing:	
K.	Case Manager Fax Number:	
L.	Medical Director/Phone:	
M.	Each Special Population(s) Program Contact Name: Telephone Number: Fax Number, if different from the Group's (list for each program)	
N.	Medical Management (MM) Committee Chairperson/Phone:	
O.	Day and Frequency of MM Meetings:	
P.	QI Committee Chairperson/Phone:	
Q.	Day and Frequency of QI Meetings:	
R.	Primary Admitting Hospital:	

Step 2 - Infrastructure

This section describes the IDN/Group organizational structure. The structure may include policies and procedures, roles of committees, budgets, and reports necessary to make delegated medical management operational.

Line	Description
A.1-4	Submit an agreement statement to comply with these four requirements derived from Centers for Medicare and Medicaid Services (CMS) and National Committee for Quality Assurance (NCQA). For example, the IDN/group creates an agreement statement by constructing a page with the following heading: “ <i>IDN/Group name' agrees to comply with the following,</i> ” and then copies and pastes the exact verbiage from the tool onto this page.
B.1	Submit delegation requesting the entity's (IDN/PU) organizational chart. The chart must depict the interrelationships between the IDN, the PUs, the key leadership committee, and business functions (e.g., Board of Directors, Case Management, each Special Populations program, Complex Care/Disease Management, major committees).
B.2	Submit a list of the Board of Directors and their specialty areas.
B.3	Submit two budgetary reports, the actual budget for the prior fiscal year, and the current year's projected budget. The report must include the entity's operating costs, (e.g., rent, salaries, office expenditures, income sources). OR Submit a copy of the statement within the annual auditors report addressing the financial solvency of the company, including the name and contact information of the auditing company.
B.4	Submit the methodology and criteria used to hire physicians.
B.5	Submit an explanation about how information is disseminated to physician members, including samples.
B.6	Submit the process to orient new physicians to delegation policies and workflows that are related to Medical Management and/or Special Population Management.
B.7	Submit the educational plan to keep physicians current with delegated medical and each Special Population management requirements. Example of Special Population management: <ol style="list-style-type: none"> 1. All practitioners will be required to attend one of three educational programs explaining each program component, including how to use program services, how to enroll members in the program, and how the program will provide feedback to the physicians on their patients' status while enrolled. 2. A copy of the above presentation will be sent to all practitioners for future reference. 3. The Delegated entity's intranet will include a link to the disease management program and its component.
B.8.a-d	Submit a confidentiality policy encompassing all forms of communication (verbal and written): <ul style="list-style-type: none"> • Detail the procedure to ensure the accuracy and the protection of all information, and to ensure that the procedure complies with HIPAA requirements. • Describe the ramifications of breaching the policy. • Submit Conflict of Interest policy detailing the groups' expectations of the delegated entity and employees.
B.9	Submit a policy detailing how services are delivered in a culturally competent manner; e.g., consider issues with communication/language barriers and mobility barriers.

Infrastructure Plan

Infrastructure	√	Location/Comments
Provide page numbers and section numbers for all attached materials. Use the Location/Comments column to note the location and any other pertinent information related to the requested materials.		
A	Submit a statement agreeing to do the following:	
A.1	Submit the following documents to Tufts Health Plan: <ul style="list-style-type: none"> • All proposed Tufts Medicare Preferred HMO member mailings to facilitate CMS review and approval before actual use. • All commercial member correspondence that incorporates benefit interpretation statement(s) before actual use. 	
A.2	Retain records pertinent to delegated services for audit and inspection in accordance with applicable state law or with respect to Tufts Medicare Preferred HMO (according to rights set forth by the U.S. Department of Health and Human Services and Comptroller General, or their respective designees ¹)/	
A.3	Certify that any data or information pertinent to the activities or services provided under the delegation agreement that is submitted to the Plan or to CMS is accurate, complete, and truthful.	
A.4	Comply with all state and federal laws and regulations that prohibit discrimination, including but not limited to discrimination based upon health status.	
B.	Attach the following:	
B.1	The Organizational Chart for delegated services, reflecting the governing structure(s) and relationship(s) of the entities requesting delegated functions. Include all that is applicable: <ul style="list-style-type: none"> • The provider units/risk units (if no IDN, submit Board of Directors information at this level). • The case management reporting relationship(s). • Special Population Management program(s). 	
B.2	A list of Board of Directors names and their medical specialties.	

Infrastructure		√	Location/Comments
B.3	Financial report and/or business plan for current and past year, or a copy of the statement within the annual auditors report addressing the financial solvency of the company. Include the name and contact information of the auditing company.		
B.4	Description of process to evaluate and accept new physician members.		
B.5	Description of method of communicating to physician members, including frequency of communication and samples.		
B.6	Description of mechanism to orient new physician members to the initiation of delegated medical and/or special population management.		
B.7	Description of mechanism to continuously educate physician members about delegated medical and/or special population management.		

Infrastructure		√	Location/Comments
B.8	<p>Submit policies and procedures, including a copy of the attestation statements as appropriate. Detail the processes that will be used to perform the following tasks:</p> <ul style="list-style-type: none"> a. Safeguard the privacy of any information (electronic and hard copy) that identifies a particular member ensuring that information from, or copies of records, may be released only to authorized individuals and unauthorized individuals cannot access or alter member records. (Original medical records must be released only in accordance with federal or state laws, court orders, or subpoenas. b. Maintain member records and information in an accurate and timely manner. c. Ensure the confidentiality of all member information. d. Affirm the following: <ul style="list-style-type: none"> • Utilization management (UM) decision making is based only on appropriateness of care and service. • The delegated entity does not specifically reward practitioners or other individuals conducting utilization review for issuing denials of coverage or service. • Financial incentives for UM decision-makers do not encourage decisions that result in underutilization. • Conflict of Interest expectations for delegated entity and employees. 		
B.9	<p>Submit policies and procedures detailing the processes that ensure services are provided in a culturally competent manner.</p>		

1. The Department of Health and Human Services, the Comptroller General, or their designees have the right to inspect, evaluate, and audit any pertinent contracts, books, documents, and records involving transactions related to the contract between Tufts Health Plan and CMS, including those of subcontractors, and:

- Such right shall exist for any particular contract period through ten (10) years from the end of the final contract period or completion of audit, whichever is later unless (i) CMS determines there is a special need to retain a particular record or group of records for a longer period and notifies Tufts Health Plan at least thirty (30) days before the normal disposition date; (ii) there has been a termination, dispute, or allegation of fraud or similar fault by Tufts Health Plan, in which case the retention may be extended to six (6) years from the date of any resulting final resolution of the termination, dispute, fraud, or similar fault; or (iii) CMS determines that there is a reasonable possibility of fraud or similar fault, in which case CMS may inspect, evaluate, and audit Tufts Health Plan at any time, and
- All pertinent contracts, books, documents, and records, as described above, shall be maintained by the applicable party or subcontractor to facilitate such right.

Step 3 - Medical Management Plan

This section details the clinical process(es) which delegates will use to fulfill their delegated functions. The Plan will include:

- Descriptions of the responsibilities of key clinical leadership positions and committees.
- Details on the operational methodology to achieve the care of their assigned members.
- Descriptions of processes to evaluate operational methods.

Depending on the complexity of the prospective delegate's organization, each assessment tool requirement may have several hierarchical levels. The Medical Management Plan must describe the role of each hierarchical level in fulfilling the delegated functions.

For example, IDN X consists of four (4) individual physician groups. Their medical management plan states, *“the purpose of the IDN medical management committee is to review and determine medical practice policies for all their physician groups.”* The committee membership consists of the Medical Directors from each physician group, as well as the IDN Physician and Case Management leaders. Also, each physician group will have a medical management committee to determine how to make the IDN policies operational. This local committee is also responsible for reporting specific operational issues to the IDN committee.

Line	Description
A.1	<ul style="list-style-type: none"> • Submit verification that the Medical Director has a current unrestricted clinical license and is board-certified. • Submit the procedure, or process description, outlining the Medical Director role. The procedure must include information on how the Medical Director is appointed and his/her major job functions and duties, including guidance over all clinical aspects of the program and consultation with practitioners in the field.
A.2	<ul style="list-style-type: none"> • Submit the policy detailing which physician, or organizational title, is responsible to hear escalated coverage cases and mediate to a final coverage decision. The policy/description must include the physician's role as a resource for complex coverage decisions and the primary contact for the Health Plan on expedited appeal cases. • Submit MD coverage schedules including coverage during normal business hours and after hours.
A.3	<p>Submit a detailed description of the provider's Medical Management (MM) Committee. The description must include the following:</p> <ul style="list-style-type: none"> • How often the committee will meet and that formal meeting agendas and minutes will be filed. The required frequency of MM meetings is product-specific. For Tufts Medicare Preferred HMO, meetings must be weekly. For Commercial HMO, meetings must be quarterly.
A.4	<ul style="list-style-type: none"> • Submit a description of the Committee membership, specifically detail how members are chosen/appointed, and list membership roles, e.g., chairman, minute recorder. • The provider's case management leadership/staff must be an active participant on each committee level. • Physician membership involved in determining processes that impact Tufts Health Plan members must be Tufts Health Plan providers. Tufts Health Plan staff maintains ad hoc membership to the committee. <p>Note: Within the commercial HMO delegation program, those delegates who will be under a “Present - To” model must also describe the methodology to demonstrate utilization management consistency for all Tufts Health Plan members; i.e., the delegates' risk members and non-risk members who access care within the delegate's primary admitting hospital.</p>

Line	Description
A.5	<p>Submit a list of the committee's major goals and functions, and describe the processes to be used to accomplish them. In particular, the description must address:</p> <ul style="list-style-type: none"> • The techniques by which the delegate will identify if there are issues; e.g., over/under utilization or deficiencies with the established medical management policies and procedures. • Who is accountable for the analysis and evaluation of medical care practices and coverage decision information. • The method to develop action plans when opportunities for improvement are identified.
A.6	<ul style="list-style-type: none"> • Submit the policy/procedure detailing the process(es) the physicians and Case Managers will use to make and document coverage decisions. The procedure needs to: <ul style="list-style-type: none"> - Ensure that all authorized or denied services meet Tufts Health Plan, Tufts Medicare Preferred HMO, and/or Commercial HMO coverage requirements. - Include a statement that the IDN/physician group will abide by Tufts Health Plan standards should there be a difference between their routine processes and the Plan's standards. • Submit the policy with the following items: <ul style="list-style-type: none"> - The procedure detailing how a denial decision and a request for reconsideration will be made operational. The procedure must include the expected actions, decision timeframes, responsible parties/titles, documentation, and denial letter content requirements. The provider must include a statement indicating that all utilization review (UR) decisions to deny coverage are made by qualified, licensed physicians with clinical expertise appropriate for the case. <p>Example:</p> <p>The denial decision process steps may include the following actions:</p> <ul style="list-style-type: none"> - Case manager provides the pertinent parts of the medical or case record to the primary care provider (PCP) for review and determination of medical necessity. - PCP communicates medical necessity decision to the Case Manager. - Case manager validates the member's eligibility with the Plan and the member's specific benefit. - Case manager documents the pertinent facts of the decision process, including the date and time that the request was made, the medical necessity and coverage decisions, and the date and time the member is notified of the decision. <p>For delegates requesting delegation for both products, the submitted policy must include information on the product-specific timeframes for decisions, including notification of appropriate parties (e.g., for Tufts Medicare Preferred HMO, all standard pre-service determinations must be completed within 14 calendar days of the request. For Commercial HMO, all urgent pre-service determinations must be completed within 48 hours of receiving all pertinent clinical information).</p> <p>Tufts Health Plan developed utilization review timeframes based on regulatory requirements and accreditation standards. The Tufts Health Plan UR decision and notification timeframe requirements are available on the Tufts Health Plan provider web site: http://www.tuftshealthplan.com/providers.</p>

Line	Description
A.6 (cont.)	<ul style="list-style-type: none"> - A clause describing the delegate's process for using board-certified physician consultants for case review to ensure medical necessity decisions are reviewed by appropriate experts. For example, the delegate consults a pediatrician for coverage decisions concerning a pediatric member. - The procedure detailing how a decision for a coverage request meeting the criteria for an expedited decision will be made operational. The procedure must include the expected actions, the responsible parties/titles, and documentation requirements. <p>The Department of Labor's definition, adopted by NCQA, for processing "urgent" requests for coverage determination is:</p> <p>UR performed for requests for coverage of medical care or treatment with respect to the application of the time periods to make non urgent coverage determinations: 1) could seriously jeopardize the life or health of the member or the ability of the member to regain maximum function, or 2) in the opinion of a physician, with knowledge of the member's medical condition, would subject the member to severe pain that cannot be adequately managed without the care or treatment that is the subject of the coverage request.</p> <ul style="list-style-type: none"> - Within the procedure, describe which clinician is responsible for completion of each step/action, and who is accountable for the oversight of the overall process. - A procedure outlining the documentation requirements for coverage decisions made by an individual PCP and/or the Medical Director during a utilization/MM committee meeting. Items to address are: the pertinent facts to include in the note/meeting minutes, and where and how the documents will be stored. - Specific assignment of whom, by title, is responsible for assisting the Health Plan's Appeals and Grievance processes.
A.7.a	Submit the name of the nationally recognized criteria (e.g., Interqual, Milliman, and Robertson or M-Cap), the IDN/Medical Group uses for each level of care (e.g., acute care, rehab, long-term acute care (LTAC), skilled nursing facility (SNF), home care).
A.7.b	<p>Submit a policy detailing the process to select the utilization review criteria. The policy must include:</p> <ul style="list-style-type: none"> • A statement that some services are managed centrally by the health plan and require prior authorization. • The procedure to accomplish the governing bodies annual review, and revision and approval of the utilization review criteria. • A statement attesting the criteria will be disclosed to enrollee and providers upon request. • The fact that when denial decisions are communicated, the decision criteria will be included/attached. • A description of the process the delegate uses to inform their physicians that they may request a copy of the criteria.
A.8.a	Submit the policy/procedure detailing the process through which the IDN/Medical Group completes an inter-rater reliability study. The study must be completed every 12 months, and include all physicians and nurses involved in utilization management decisions.
A.8.b	Submit summary statistics on the 12-month inter-rater reliability review of all clinical professionals involved in utilization management decisions (not needed for initial Delegation Assessment).

Line	Description
A.9	<p>Submit a document, that can be formatted as policies, procedures, workflows, or a narrative outline, detailing the following aspects of the delegates system to study and evaluate their medical management practices:</p> <ul style="list-style-type: none"> • The annual process of how the delegate will determine the specific medical management processes they will evaluate that year. <p>For example, the UVW Medical Management Committee receives the following annual reports:</p> <ul style="list-style-type: none"> - From the financial manager, the cost and volume of outpatient referrals, and admissions to tertiary and home hospitals. - From the QI chair, the volume and scope of that year's occurrences. <p>After analyzing the reports, the MM Committee votes on which specific aspects of medical care/medical trends they will focus for prospective, concurrent, and retrospective review during the next business year.</p> <ul style="list-style-type: none"> - A list (the work plan) of the specific issues to be reviewed prospectively, concurrently, and retrospectively. Information on all levels of care, acute inpatient, SNF, rehabilitation hospitals, home care, and outpatient are to be considered for inclusion. - A description of those who will be involved in the current year's process and their responsibilities. - A description of how the reviews will be conducted and evaluated, including: <ul style="list-style-type: none"> - Instructions to staff to follow Medicare Coverage Guidelines to manage members. - Timeframe to analyze data and report to MM Committee. <p>Example:</p> <p>Provider Unit Z submits a plan to conduct prospective review on all GI patients with a questionable diagnosis of QRS, whose PCP request a UGI. The prospective review will include:</p> <ul style="list-style-type: none"> - A record review by Dr. X, a gastroenterologist, to determine the effectiveness of an initial MRI versus UGI/LGI procedures. - A case management telephone assessment of the member's needs by the PU's DCM. - A discussion with the PCP to determine the final treatment plan. <p>Quarterly, a summary of the findings that includes the number of members reviewed, the initial test (UGI versus MRI) conducted, the subsequent treatments required (Medical, Home Care, Rehabilitative therapies), the time to reach conclusive diagnosis, and a cost:benefit analysis of initial MRI versus UGI for diagnosing QRS.</p>
A.10	<p>Submit the policy requiring the delegate's governing body/Board of Directors to conduct an annual review and revision of the MM plan and the Special Population management programs.</p>

Line	Description
B.1 and B.2	<p>Submit an agreement statement to comply with these requirements. Refer to the instructions within the Infrastructure section; Line A 1-4, page 29, for assistance with developing the statement.</p> <p>Notes:</p> <ul style="list-style-type: none"> • This is a one-time submission requirement for item B2g. In the delegate's original assessment packet, a copy of the proposed Preregistration Log must be submitted for prior approval. The proposed log must include all Tufts Health Plan Preregistration data elements; however, the log may be formatted to meet the individual delegate's electronic systems. • The Tufts Medicare Preferred Disease Management report consists of: <ul style="list-style-type: none"> - Quarterly program statistics on member identification and enrollment. - Biannual reports that includes analysis of enrollment statistics and evaluation of the program, including program changes with an implementation plan. <p><i>Example of Disease Management Quarterly Report:</i> Medical Group CHF program: 1/1/07-6/30/07 timeframe 46 new members identified</p> <ul style="list-style-type: none"> • 3 based on hospital admission. • 4 physicians referrals. • 12 claims only. • 3 self referrals. • 24 from claims and pharmacy data. <ul style="list-style-type: none"> • 38 patients received introductory telephone calls. • 4 patient deemed in eligibility (1 expired, 3 at MD discretion). • 4 unable to reach letter. • 32 enrolled in program. • 6 opted out of program. <ul style="list-style-type: none"> • 298 assessment call completed to enrolled members. • 61 incoming calls received from enrolled members. • 12 calls referred to MD resulting in medication changes. • 1/76 enrolled members hospitalized with CHF during this period.
C.	<p>Submit a policy or procedure that instructs staff on how to respond to the threat of harm by a member to himself/herself or to another. The policy must include:</p> <ul style="list-style-type: none"> • Who to notify within delegates organization and how Tufts Health Plan is notified. • Documentation requirements.
D	<p>Submit a policy detailing the process to manage Tufts Medicare Preferred HMO members who have complex or serious medical conditions, as identified through the Plan's Health Risk Appraisal. The policy must include:</p> <ul style="list-style-type: none"> • A description of how the delegate will use the Health Risk Appraisal information received from the Plan. • A list of responsible parties and their roles in the delegate's process.

Line	Description
E.1	<ul style="list-style-type: none"> • For each Disease Management program, submit a detailed program description. <p><i>Example:</i></p> <ul style="list-style-type: none"> - X Medical Group is designing a CHF program to partner with our patients to improve the quality of their life, as evidenced by self-reports of improved overall satisfaction with their lifestyle and a decreased rate of emergent admissions to the acute hospital.... - The program Medical Director is a board-certified cardiologist who is responsible for - The program is staff with 1 RN per 5,000 enrolled patients whose major functions are.... - The program is supported by 1 secretary whose major functions are.... - On admission to the CHF program, the patient’s PCP will supply a complete health history that will be reviewed by the program medical director to determine eligibility for program interventions. Depending on patient medical status and desire to engage in the program, the member will be assigned to a program level A, B, or C. In a program level A; patients will be educated on weighing themselves twice daily, on the significance of X lbs of weight gain, and when to notify the MD or program coordinator. Patient will be educated on the importance of notifying the MD/program coordinator at the onset of symptoms, such as shortness of breath or decreased ability to perform activities of daily living. The program will monitor medication refills to ensure that the patient is taking medication. Program will monitor member attendance at MD appointments. The education component will consist of literature from the American Heart Association and two self-study education programs that are reviewed with the RN at their following appointment. The education is directed at assisting the member with setting realistic goals and who to contact when problems or questions arise. After the first educational meeting, the program RN will communicate the results to the member’s PCP and group Case Manager by completing the assessment within the computerized medical record. If an enrolled member is treated in the Emergency Department (ED) or is admitted to the hospital, the group’s Case Manager will contact the program RN to - Members in program Level C will be supplied with the Coaching Scale which sends urgent messages to the Program Coordinator: after patient fails to meet two scheduled weigh-in times; experiences weight gains of three or more pounds; or experiences a daily weight variance of three or more pounds. This scale along with the daily diuretic dose chart along with ... are the major methodologies for measuring member adherence to their treatment plan... • Program Interaction with Enrollees PCP <ul style="list-style-type: none"> - On a biannual basis, the Program Medical Director reports to the Medical group at the MM meeting on the program identification and enrollment statistics and annually on the program results, including the planned changes for the next year. - The Program Coordinator sends a “Member Enrollment” Notice to the PCP after one of their members has agreed to participate in the program. This letter includes a description of the program, the clinical updates the PCP will receive, and information on how to contact the Program Coordinator.

Line	Description
E.2	<ul style="list-style-type: none"> • For each Tufts Health Plan Medicare Preferred Disease Management Delegation program, submit the policy and procedures detailing the member identification process, including frequency of process and utilization of at least five of the data sources. <p>Example:</p> <p>On a monthly basis, X Medical group uses the following data sets to identify members for the CHF Management program:</p> <ul style="list-style-type: none"> - From the Paid Claims report - Member will have two or more office claims for a diagnosis of CHF in a three-month period. - From the Case Manager's Preregistration Log - A hospital admission with a primary diagnosis of CHF within the last six months. - From the Scheduler - One office visit for CHF and two prescriptions for classes of identified medications. - From the Computerized Medical Record - PCP documentation of the disease of a Cardiologist referral for CHF. - Self reports problem with CHF on Health Risk Assessment (HRA). - Referred to program by group's Case Manager and PCP, or member self refers. <p>Example:</p> <p>For the Tufts Health Plan Medicare Preferred Complex Care Management Delegation program, XYZ PU encourages the referrals from the following:</p> <ul style="list-style-type: none"> - A health information line refers members who are looking for information on chronic conditions and community resources. - Our disease management program refers members to the complex care management program who are ready for discharge or are not eligible for their program. - The hospital utilization program and discharge planner refer patients that believe would benefit from a comprehensive care management services. - Members who call and request a Care/Case Manager will be evaluated for enrollment in the program. <ul style="list-style-type: none"> • Physicians and other healthcare practitioners are encouraged to refer members to the program.
E.3	<p>Submit a copy of each Disease Management program's member letter, which includes information on:</p> <ul style="list-style-type: none"> • How the patient was identified. • The program, including a brief description of the services available and how the member will use the services. • How the patient may opt in or out of the program (optional if delegate submits a policy addressing this process). • Program contact information and process. • Program enrollment process.

Line	Description
E.4	<ul style="list-style-type: none"> • For the Complex Care Management program, submit a detailed program description, including a Program description. <p><i>Example:</i></p> <ul style="list-style-type: none"> • X Medical Group is designing a Complex Care Management program to partner with our patients to improve the quality of their lives, as evidenced by self-reports of improved overall satisfaction with their lifestyles and a decreased rate of emergent admissions to the acute hospital... • Staffing <ul style="list-style-type: none"> - The program Medical Director is a board-certified internist who is responsible for ... - The program is staff with 1 RN per 75 -100 enrolled patients whose major functions are... - The program is supported by 1 secretary whose major functions are... - Provider Unit X uses the following methodology to contact members eligible for the program. - An introduction letter is sent to the member within ... days of identification. - ...days after the letter is sent and initial call will be made to the member. - ...calls will be made to attempt to reach member. If the Care Manager is unable to reach the member, they will send an unable to reach letter. • Prior to admission to the program, the member will be notified of his/her right to decline participation. • Provider unit X Medical Group used the evidence-based guidelines from as a resource in designing our complex care management program, including the assessments, care plans, follow-up activities, and evaluations. • The methodology used to complete the assessment an electronic Care Management system purchased to allow us to access standardized assessments questions and care plans based on the member's conditions. Each question is based on the member's answer to the previous question. The assessment includes the following areas: <ul style="list-style-type: none"> - To determine cultural and linguistic needs/limitations, the Case Manager asks the following questions: <ul style="list-style-type: none"> - What language did you first speak as a child? - How may languages are you fluent in? - What do you consider your primary language? - Do you fill out your own health forms or does someone complete them for you? - Questions to determine caregiver resources include: <ul style="list-style-type: none"> - Do you live alone? - If you are ill, who helps buy your food? - Are you active in any clubs or religious organizations? - Functional status with activities of daily living...

Line	Description
E.4 (cont.)	<ul style="list-style-type: none"> • The program’s annual evaluation by X Medical Group consists of evaluating three relevant processes or outcomes for the Complex Care Management program. Our review for the next year will consist of: <ul style="list-style-type: none"> - Quarterly evaluation of member enrollment data. Data set consists of: <ul style="list-style-type: none"> - Member identified letter sent/returned. - Outreach calls. - Made unable to reach letters sent. - Members enrolled. - Member declined. For example, 48 members were identified for the program, 78 calls were made, and 25 members were enrolled in the program... • Annual evaluation of admission rate for members in the Complex Care Management Program. The PU will compare the admission rate for these members to the overall admission rate for the groups Tufts Health Plan Medicare Preferred members. The PU expects to see a lower admission rate for the members enrolled in the Complex Care Management Program. <ul style="list-style-type: none"> - The third process measure is ... • On a biannual basis, the PU will analyze all data and report to the organization based on policy and procedure. Adjustments to the program are made as needed based on this analysis. • Case Manager documentation and audits are completed based on the organizations policies and procedures
E.5	<p>For the Complex Care Management program, submit the following policies and procedures:</p> <ul style="list-style-type: none"> • Care Plan Development <p><i>Example:</i></p> <p>PU decided to follow the standards developed by the ... as a frame work for their Comprehensive Care Plan polices and procedures. These policies include: what the Care Manager will document, the frequency of documentation and ...</p> • Documentation Standards <p><i>Example:</i></p> <ul style="list-style-type: none"> • All care plans are maintained in an electronic medical record accessible only to authorized personnel. Only approved medical abbreviations will be used by the Care Managers... • The date and time of all calls to the member will be recorded in the electronic record... • The care management assessment including goals and barriers will be updated with each call... • Team Leader/Supervisors will complete audits on a quarterly basis and report findings to both the Care Managers and Tufts Health Plan. Opportunities for improvement in documentation will be noted at the time of the audits...

Line	Description
E.5 (cont.)	<ul style="list-style-type: none"> • Member Identification Process <p>Example:</p> <p>On a monthly basis, the X PU uses the following criteria to identify members:</p> <ul style="list-style-type: none"> • Claims or encounter data - Member will have two or more claims with a diagnosis of failure to thrive submitted by the PU. • Case Manager Preregistration log - A hospital admission with a diagnosis of compression fracture within the past three months. • Pharmacy data - Member on designated classes of medication; e.g., post-transplant medications, self-injectable medication. • Members referred based on the UM process - Referred to program by group's Case Manager and PCP based on hospital or outpatient (OP) utilization. <p>On an ongoing basis, X medical group accepts the referrals from the following:</p> <ul style="list-style-type: none"> • From Z's health information line, members who are looking for information on chronic conditions with available community resources. • From Medical Group X's disease management program, members who are not eligible for or are being discharged from their program. • From hospital utilization programs and discharge planners, members who they believe would benefit from a comprehensive care management services. • Members calling to request a Care/Case Manager will be evaluated for enrollment in the program. • From Physicians and other healthcare practitioners. <p>4. Annual Program Evaluation Process</p> <p>Example:</p> <ul style="list-style-type: none"> • Each November, X medical group's Care Management Committee determines the processes to be measured; the goals to be achieved, frequency of reporting...

Medical Management Plan

Medical Management Plan		√	Location/Comments
A	Submit a MM Plan which must include provisions for all of the following:		
A.1	Appointment of a medical director and description of the Medical Director's role and responsibility: <ul style="list-style-type: none"> • Current unrestricted license. • Board certified. 		
A.2	Appointment of specific physician coverage plan to assume responsibility for day-to-day MM issues and address any expedited appeals during and after normal business hours.		
A.3	Regular MM meetings, per product standard, with written minutes and agenda.		
A.4	MM Committee participants, including Tufts Health Plan representation (include names of committee members and/or positions).		
A.5	MM committee roles and responsibilities, including a system to identify and manage: <ul style="list-style-type: none"> • Overutilization of services. • Denial of services. • Underutilization. • Deficiencies in utilization of services (inpatient and outpatient). 		

Medical Management Plan		√	Location/Comments
A.6	<p>An organizational determination methodology that conforms to Tufts Health Plan, CMS, NCQA (or other regulatory) requirements, with turnaround times and processes for decisions and notifications to members and provider, and includes, but is not limited to:</p> <ul style="list-style-type: none"> • Denial and reconsideration procedures, including the relevant clinical information to be collected to make coverage decisions. • The use of qualified licensed physicians with the appropriate clinical expertise must render all medical necessity denial of coverage determinations. • Expedited initial determination procedure, including statement referencing Tufts Health Plan turn-around time grids and decision-making procedure. • Roles of each licensed professional. • Documentation processes (e.g., tracking of decision timeframes, recording MD review, and decision and maintenance of letters). • Facilitating Tufts Medicare Preferred Appeals and Grievances processes. 		
A.7	<p>For Clinical Review Criteria, submit the following:</p> <ul style="list-style-type: none"> • The name of a nationally accepted clinical review criteria to be used for medical necessity reviews. • A policy describing in detail the following: <ul style="list-style-type: none"> - The governing body's review and revision process for the criteria (to take place every 12 months). - How the criteria can be disclosed to enrollee and provider upon request and, in the case of a denial criteria, must be attached to communications. - How the delegate communicated the criteria is available to their physicians. 		
A.8	<ul style="list-style-type: none"> • Submit a policy mandating that every 12 months an inter-rater reliability analysis is completed for all clinical professionals involved in utilization management decisions. • Submit summary statistics on the 12-month inter-rater reliability review of all clinical professionals involved in utilization management decisions (not needed for initial Delegation Assessment). 		

Medical Management Plan		√	Location/Comments
A.9	A description of the prospective, concurrent, and retrospective review plans.		
A.10	A policy mandating that every 12 months the Delegation Care Management Plan, including Disease Management programs, when applicable, is reviewed, revised (if needed), and approved by the Board of Directors/Governing Body.		
B.	Submit the following agreement statements:		
B.1	To participate in Tufts Health Plan-sponsored programs, includes participation in Tufts Health Plan MM leadership meetings (e.g., medical director/physician reviewer meetings, network-wide delegation operations meetings, and educational sessions, such as, physician and DCM).		
B.2	<p>To supply Tufts Health Plan with timely, relevant data, including, but not limited to, the following areas:</p> <ul style="list-style-type: none"> • Appeals and Grievances. • Claims Adjudication. • Coordination of Benefits. • Approvals and denials. • Exception to benefit/Experimental cases. • Oversight program. • Precertification. • Specialty and catastrophic cases managed or co-managed by Tufts Health Plan. • Tufts Health Plan Medicare Preferred Disease Management reports: <ul style="list-style-type: none"> - Quarterly Member Identification and Enrollment Statistics. - Biannual Program Status Update or Annual Evaluation. 		
C.	Submit a policy addressing a threat of harm by a member to himself or to another.		
D.	Submit a policy for managing Tufts Medicare Preferred HMO members with complex or serious medical conditions, as identified through the Plan's triage process (Health Risk Appraisal).		

Medical Management Plan		√	Location/Comments
E.1	<p>Tufts Health Plan Medicare Preferred Special Population Delegation:</p> <ul style="list-style-type: none"> • For Disease Management Delegation, submit E.1-E.3. • For Complex Care Management Delegation, submit E.4-E.6. • For each Disease Management program, submit a detailed program description, including: <ul style="list-style-type: none"> - Program purpose and goals, - Staffing, including qualifications and responsibilities of: <ul style="list-style-type: none"> - Medical Director. - Clinical Staff - minimal staffing 1 RN to 75-100 enrolled members). - Administrative Staff. - Clinical indicators to be monitored with frequency. - Program Interventions, including alternate interventions to factor in co-morbidities, life style conditions, and cultural requirements. - Program intervention implementation plan. - Interventions based on stratification processes. - Methodologies to monitor patient adherences to the programs treatment plan(s). - Process to provide enrolled patient's PCP with information on the program. - Annual program evaluation process, including: <ul style="list-style-type: none"> - Annual member participation rate. - Member Satisfaction Survey. - Annual analysis of member complaints and inquiries. 		

Medical Management Plan		√	Location/Comments
E.2	<ul style="list-style-type: none"> • For each Tufts Health Plan Medicare Preferred Disease Management Delegation program, submit the policies and procedures detailing the member identification process, including frequency of process (minimal requirements is monthly) and utilization of at least five of the following data sources: <ul style="list-style-type: none"> - Claims or encounter data. - Pharmacy data. - Health risk appraisal results. - Laboratory results. - Data collected through the medical management process (Utilization Management or Case Management). - Member and practitioner referral. • The policy and procedure needs to describe how the program will integrate information from the following resources: <ul style="list-style-type: none"> - A health information line. - Other Disease Management programs. - The Case Management program. - The Utilization Management program. 		
E.3	Submit a copy of each Disease Management program's member letter.		
E.4	<p>For the Complex Care Management program, submit a detailed program description, including:</p> <ul style="list-style-type: none"> • Program purpose and goals, • Staffing, including qualifications and responsibilities of: <ul style="list-style-type: none"> - Medical Director. - Clinical Staff. - Administrative Staff. • Confirmation that members will be offered the right to disenroll in the program. 		

Medical Management Plan		√	Location/Comments
E.4	<ul style="list-style-type: none"> • Methodology for conducting a comprehensive initial and subsequent assessment of members health status within 30 days of enrollment, which includes the following areas¹: <ul style="list-style-type: none"> - Cultural and linguistic needs/limitations. - Caregiver resources. - Functional status with activities of daily living. - Clinical History, including medication for each identified condition/medication, note individual's concerns or challenges. - Life planning activities. - Health Plan coverage eligibility and benefits. • Description of annual program evaluation, including: <ul style="list-style-type: none"> - Program components a minimum of three - "The quantitative methodology - "Frequency of analysis - "Annual identification of opportunities for improvement 		
E.5	<p>Submit the following policies and procedures:</p> <ul style="list-style-type: none"> • Develop a comprehensive care management plan, including: <ul style="list-style-type: none"> - Long- and short-term goals. - Schedule for follow-up with specific time frames. - Documentation of barriers with mitigation plan. • Document members self-management plan with specific individual intervention barriers. • Develop documentation standards, including: <ul style="list-style-type: none"> - Whether the record is maintained in an electronic or paper format. - Each member contact note is dated and timed. - Audits conducted at least quarterly. 		

Medical Management Plan		√	Location/Comments
E.5	<ul style="list-style-type: none"> • Develop member identification processes, including: <ul style="list-style-type: none"> - Frequency of process (at least monthly). - Utilization of at least the following four data sources: <ul style="list-style-type: none"> - Claims or encounter data. - Hospital discharge data. - Pharmacy data. - Data collected through the UM process. - The policy and procedure needs to describe how the program will integrate information from the following resources: <ul style="list-style-type: none"> - Health Information Line. - Disease Management Program. - Discharge Planner referral. - UN referral (if indicated). - Member self-referral. - Practitioner referral. - Complex Care Management Program Evaluation to include relevant program components to be addressed (a minimum of three): <ul style="list-style-type: none"> - Performance goal(s) to be achieved. - Measurement process and frequency. - Methodology for analysis and evaluation. - Plans for continued re-measurement, analysis and evaluation. - Member satisfaction, including: <ul style="list-style-type: none"> - Process and frequency to obtain feedback from members with frequency. - Procedure and frequency for analysis and evaluation of member. - Feedback. - Complaints. - Inquiries. 		

1. Delegate may submit a copy of the program assessment tool as evidence of their comprehensive assessment process.

Step 4 - Case Management Plan

The purpose of this section is to design your Case Management Model. This model should include:

- Case Management philosophy, mission, or definition.
- Case Manager Roles and Responsibilities.

- Operational methodology.
- Case Management Model polices and procedures.
- Method of communication to Case Management staff.
- Case Manager information, including experience, assignments orientation, education, job description, and evaluation.

Line	Description
A.	<p>Submit a description of the Case Management Model, including:</p> <ul style="list-style-type: none"> • Case management philosophy or mission. • The roles/functions of each position. A statement that the DCM is responsible for case management and following delegated functions. • An overview of the communication and documentation workflows. Specifically address how you manage members' care across the continuum and, where applicable, transfer of care to another Case Manager. Explain communication expectations to providers and members. Explain how on-site and telephone staff should identify themselves. • Methodology to case manage all requested products, e.g., Tufts Medicare Preferred HMO and/or commercial HMO, and commercial present-to members. Policies and procedures must address product differences, including approvals and denials. <p><i>Example</i></p> <p>(partial description), PU XYZ's case management team consists of a Manager, two Supervisors (one for inpatient services and one for outpatient services), eight Case Managers, four Inpatient Care Facilitators, two Outpatient Care Coordinators, and two Extended Care Reviewers. The manager's role is.... The Supervisor's role and functions are: ... The Outpatient Care Coordinator's role and functions include: 1) to notify the inpatient care facilitators of all elective admissions with their expected discharge services, 2) to review the hospital census daily and contact the inpatient facilitators to begin discharge planning, 3) to contact the extended care reviewers of a planned admission to their assigned extended care facilities, and 4) to obtain care updates from the Inpatient Care Facilitators and/or the Extended Care Fiewers for presentation at the weekly Medical Management Committee.</p> <ul style="list-style-type: none"> • Description of documentation requirements. <p><i>Example</i></p> <p>Specify which citations need to be entered in the member's record when:</p> <ul style="list-style-type: none"> - A member does or does not meet UR clinical review criteria. - A Case Manager discusses the case with appropriate MD to establish medical necessity. - Long- and short-term goals are established.
B.	<p>Submit Case Management policies, including prospective, concurrent, and retrospective review process for the following levels of care:</p>

Line	Description
B.1	<p>Acute medical/surgical hospital:</p> <ul style="list-style-type: none"> • Commercial Members: <ul style="list-style-type: none"> - Submit a description of concurrent review procedure. Include initial review timeframe and frequency of reviews. - For delegates under a present-to model, the plan must include a description of the concurrent review process for all Tufts Health Plan patients. Include who will complete the review, and where the review will be documented. • Tufts Medicare Preferred HMO Members: <ul style="list-style-type: none"> - Submit a description of concurrent review process, including initial review timeframe and frequency of reviews (minimal requirements with 24 hours of notification of admission (excluding weekends/holidays).
B.2 - 3	<p>Acute Rehabilitation/SNFs:</p> <ul style="list-style-type: none"> • Commercial Members: <ul style="list-style-type: none"> - Submit a description of Rehab/SNF concurrent review procedure. Include initial review timeframe and frequency of reviews (minimal requirement within seven days of admission or as needed for family meeting/discharge planning and process for on-site attendance for family/team meetings). • Tufts Medicare Preferred HMO Members: <ul style="list-style-type: none"> - Submit a description of Rehab/SNF concurrent review procedure, including initial review timeframe and frequency of reviews (minimal requirement description of process for meeting on-site review requirement and Case Management attendance at family/team meeting as needed. - Description of process used to track member's benefit periods.
B.4	<p>Custodial Setting:</p> <ul style="list-style-type: none"> • Tufts Medicare Preferred HMO Members: <ul style="list-style-type: none"> - Submit a description of Non-Skilled Review/Institutional process, including documentation of monthly review, and workflow followed when skilled needs are identified. - Description of process used to track member's benefit periods.
B.5	<p>Homecare, including durable medical equipment (DME):</p> <ul style="list-style-type: none"> • Submit a description of Homecare/DME concurrent review process (minimal requirement within 24 hours of notification of request (excluding weekends/holidays) and, thereafter, prior to each re-authorization. <ul style="list-style-type: none"> - Commercial Members: <ul style="list-style-type: none"> - Benefit tracking process, e.g., to identify if DME is subject to co-pay (if an integral component of a Home Care plan) and to identify the maximum benefit reached.
B.6	<p>Specialty/Catastrophic Case management for the following:</p> <ul style="list-style-type: none"> • Commercial Members: <ul style="list-style-type: none"> - Submit a statement about how delegate will use the Tufts Health Plan program.
B.7	<p>Community Resource Referral:</p> <ul style="list-style-type: none"> • Describe how the delegates refer members to community services (e.g., local senior services, elders at risk, meals on wheels, or other local agencies) when plan benefits are exhausted.

Line	Description
C.	<p>Submit a staff assignment grid for each provider unit that depicts the following:</p> <ul style="list-style-type: none"> • Provider/medical group for which each Case Manager is responsible. • Product for which each Case Manager is responsible. • Coverage plan for scheduled and unscheduled absences. • In addition, when notified by Tufts Health Plan that your commercial HMO delegation will be as a “present to” model, submit a staff assignment grid that demonstrates adequate staffing to perform case management functions for non-risk (present-to) members admitted to the home hospital. <p>Note: This information needs to reflect Tufts Health Plan minimum staffing requirements as detailed on the assessment tool.</p>
D.	<p>Submit a copy of each DCM’s resume at the time of hire.</p>
E.	<ul style="list-style-type: none"> • Submit your provider's process to verify and document RN staff's clinical experience and licensure. Include a description of provider's biannual verification process, e.g., the delegatee's Human Resource department checks three references, verifies education and active licensure for each prospective DCM candidate prior to hiring. • Within a month of expected licensure renewal, the delegate must also verify active license status by accessing the Massachusetts Board of Registration in Nursing web site, and ensure that job functions do not violate any restrictions imposed by the Board of Registration.
F.1	<p>Submit a copy of the outline of the formal orientation and training program(s). The training outline must include the topics, topics related to delegation, and timeframes.</p>
F.2	<p>Submit the DCM’s job description.</p>
F.3	<p>Submit a description of the provider's annual Case Manager performance evaluation process and/or a copy of the evaluation tool, including who is responsible for performing the evaluation.</p>
F.4	<p>Submit a description of the provider's ongoing education process for their Case Management staff.</p> <p>Example:</p> <p>Provider Q recognizes the importance of ongoing case management education by providing two educational days per year for each Case Manager to attend job-related educational programs. IDN B has an educational department staffed by two RNs and one MD who provide monthly educational programs for physicians, Case Managers, and therapists employed by their respective risk units. Tufts Health Plan utilization timeframe policies are reviewed and accessed on the Tufts Health Plan website.</p>
G.	<p>Submit a description of the provider’s method of communication to Case Management staff. Include frequency of communication(s) and samples.</p>

Case Management Plan

	Infrastructure	√	Location/Comments
<p>Provide page numbers and section numbers for all attached materials. Use the Location/Comments column to note the location and any other pertinent information related to the requested materials.</p>			
A.	Submit a description of Case Management Model.		
B.	<p>Submit policies detailing case management processes, responsibilities, and documentation in the following areas:</p> <p>Note: Documentation standards must address that the patient plan of care is oriented toward short- and long-term goals.</p> <ul style="list-style-type: none"> • Acute medical/surgical hospital. • Acute rehabilitation hospital. • SNFs. • Custodial setting. • Home care setting. • Specialty/catastrophic. • Community resource referral. 		
C,	Submit a Case Manager assignment grid demonstrating the following:		
C.1	PU's/medical groups for which each Case Manager is responsible.		
C.2	Product for which each Case Manager is responsible.		
C.3	<p>Fulfillment requirements, including:</p> <ul style="list-style-type: none"> • A minimum of one full-time equivalent (FTE) Case Manager per 1,700 Medicare members or 24,500 commercial members (or reasonable equivalent as determined by Tufts Health Plan). • Coverage for scheduled and unscheduled absences. • For commercial HMO delegated medical management, PU's delegated under a "Present-To" model must demonstrate adequate staffing to perform case management functions for non-risk members. 		

	Infrastructure	√	Location/Comments
D.	Submit a copy of each Case Manager's resume demonstrating fulfillment of: <ul style="list-style-type: none"> • Active case management/discharge planning experience, or • Minimum of five years of recent medical/surgical clinical experience¹. 		
E.	Submit a policy or description of the process to verify and document RN staff's clinical experience and licensure.		
F.	Submit the following case management information: <ul style="list-style-type: none"> • Outline of the formal orientation and education program(s), including how staff are taught and updated on Medicare Coverage Guidelines. • Job description(s). • Evaluation process/evaluation tool. • Description of ongoing staff development program. 		
G	Submit a description of the method of communication to Case Management staff, including frequency of communications and samples.		

1. At a minimum, the Delegated Provider Unit (DPU) must provide a six-week case management education/preceptorship orientation program.

Step 5 - Quality Improvement Program

This section guides the prospective delegates to identify and detail the roles, responsibilities, and processes of their QI program.

Line	Description
A.	<p>QI Plan</p> <ul style="list-style-type: none"> • Describes an organizational structure that identifies quality as a separate organizational function reportable to the Board of Directors, who oversees the integration of quality and safety of clinical care throughout the provider network. The Board of Directors or the policy-making body must submit a signature page documenting the date of the annual review of the QI Plan. • Submit a copy of the Confidentiality Policy. A provider may reference the same location noted under the Infrastructure section (B.8) of the tool.

Line	Description
A.4	<p>QI Committee Meetings</p> <ul style="list-style-type: none"> • The QI meeting must be a separate from the medical management meeting to ensure Peer Review Privilege protection under Massachusetts law. If these meetings are held in sequence on the same day, the medical management meeting must be adjourned. Each of the two meetings must have their separate minutes. • In addition, all elements listed must be included, e.g., timelines for resolution of a problem. If objectives and resolution are not achieved, there must be documentation and analysis of barriers that were encountered.
B.1	<p>QI Work Plan</p> <ul style="list-style-type: none"> • The QI Work Plan is a written program with specific goals, objectives, and activities aimed at developing, implementing, and evaluating new initiatives. The QI Work Plan needs to include indicators that pertain to the objectives identified, the responsible individuals or group, and the timelines necessary to achieve the goals set forth. • The Board of Directors or the policy-making body must include a signature page documenting the date of the annual review of the QI Work Plan.

Quality Improvement Plan

Infrastructure	√	Location/Comments
<p>Provide page numbers and section numbers for all attached materials. Use the Location/Comments column to note the location and any other pertinent information related to the requested materials.</p>		
<p>A. Written <u>QI Plan</u>:</p>		
<p>1. Submit a written QI Plan and/or QI Workplan with the following components:</p> <p>Note: These requirements may be met in one combined document or two separate documents.</p>		
<ul style="list-style-type: none"> • Description of program, which may include a philosophy statement, purpose statement, objective, and scope. 		
<ul style="list-style-type: none"> • Plan QI Projects for the year. 		
<ul style="list-style-type: none"> • Organizational structure, including resources devoted to QI Program. 		
<ul style="list-style-type: none"> • Planned QI monitoring of previously defined issues, 		
<ul style="list-style-type: none"> • Description of how patient safety improvement is addressed, 		
<ul style="list-style-type: none"> • Documentation that QI Plan/Workplan is reviewed, updated, and approved annually by the Board of Directors or appropriate policy-making body, • Signature of chairperson (medical director), • Date of meeting, 		
<ul style="list-style-type: none"> • Authority from and accountability to PU's senior executive. 		
<p>2. Submit a description of organizational structure of QI Program:</p>		
<ul style="list-style-type: none"> • Physician involvement required in all QI activities. 		
<ul style="list-style-type: none"> • A specific physician has overall responsibility for QI activities. 		
<ul style="list-style-type: none"> • The Medical Director has substantial involvement in QI activities. 		
<p>3. Attach a description of QI Committee, including:</p>		
<ul style="list-style-type: none"> • Role. 		
<ul style="list-style-type: none"> • Structure and function. 		
<ul style="list-style-type: none"> • Meeting frequency. 		

Infrastructure	√	Location/Comments
<ul style="list-style-type: none"> • Function - description of the process of coordinating/analyzing data from other PU and Tufts Health Plan monitoring activities, such as: 		
<ul style="list-style-type: none"> - UM Monitoring. 		
<ul style="list-style-type: none"> - Assessment of member satisfaction. 		
<ul style="list-style-type: none"> - Medical record review. 		
<ul style="list-style-type: none"> - Risk management. 		
<ul style="list-style-type: none"> - Membership (both PCPs <u>and</u> Specialists must be included in QI Committee membership). 		
<ul style="list-style-type: none"> - QI Meetings (held per Tufts Health Plan requirement, at least monthly). 		
4. Submit template/description or sample of QI Committee Meeting minutes, and include the following elements:		
<ul style="list-style-type: none"> • Agenda. 		
<ul style="list-style-type: none"> • Members present. 		
<ul style="list-style-type: none"> • Problems identified. 		
<ul style="list-style-type: none"> • Action plans with timelines to address QI problems. 		
<ul style="list-style-type: none"> • Review of patient care across the clinical spectrum, including hospital, office, SNFs, rehab, and homecare. 		
<ul style="list-style-type: none"> • A review of the policies and procedures involved in the case (attach the policy/procedure to the minutes, when pertinent). 		
<ul style="list-style-type: none"> • Review of instruments used to monitor quality of care in minutes, when applicable. 		
<ul style="list-style-type: none"> • Signature of chairperson (Medical Director). • Date of meeting. 		
<ul style="list-style-type: none"> • Recorded monthly and retained on file for Tufts Health Plan and regulatory agencies to access, if necessary. 		
<ul style="list-style-type: none"> • Peer review activities must be reported to the QI Committee at least quarterly, and are linked to individual providers, as appropriate. 		
<ul style="list-style-type: none"> • Documentation that any actions taken are reviewed by the Board of Directors or policy-making body. 		

Infrastructure	√	Location/Comments
5. Submit the following:		
<ul style="list-style-type: none"> Documentation that the QI Plan is reviewed, updated, and approved annually by Board of Directors or appropriate policy-making body. 		
<ul style="list-style-type: none"> Signature of chairperson (Medical Director). Date of meeting. 		
B. Reporting/Participation Requirements (submit an agreement statement to do the following:		
<ul style="list-style-type: none"> PU must use Tufts Health Plan generic quality screening criteria to identify and report occurrences. 		
<ul style="list-style-type: none"> PU must use Tufts Health Plan occurrence screen tool or must submit current tool for review. 		
<ul style="list-style-type: none"> Provide requested medical records within required timeframe (as requested by Tufts Health Plan, MassPro, or CMS). 		
<ul style="list-style-type: none"> Participation in Tufts Health Plan QI projects as required by Tufts Health Plan and/or its designee. 		

Step 6 - Technical Requirements for Medical Management Authorizations

This section assists prospective delegates in identifying and detailing the roles, responsibilities, and processes of their electronic interface with Tufts Health Plan. The instructions and tools within the Assessment and Reassessment chapters detail each element to be documented.

Refer to the Tufts Health Plan Delegated Authorization Data Transfer Specification document for further explanations. This document is provided to the DPUs on request.

Technical Requirements for Medical Management Authorizations

Technical Staff		
Commercial <input type="checkbox"/>	Tufts Medicare Preferred HMO <input type="checkbox"/>	
Operations contact for authorizations: _____		
Phone number: _____		
Fax number: _____		
IS contact(s): _____		
Phone number: _____		
Fax number: _____		
Number of IS staff assigned to authorizations: _____		
Technical Assessment	√	Comments
<ul style="list-style-type: none"> • Central facility has appropriate staff to process authorization volume. 		
<ul style="list-style-type: none"> • Central facility has technology to communicate electronically with Tufts Health Plan (must be able to transmit by Tufts Health Plan pre-defined format¹). 		
<ul style="list-style-type: none"> • Provider Unit is able to transmit test data for EDI assessment. (File transmission testing is part of the assessment process for delegation.) 		
<ul style="list-style-type: none"> • Attach Authorization Processing Plan. The plan must: <ol style="list-style-type: none"> a. Describe your plan to interface with Tufts Health Plan's IS department. b. Describe your communications protocol. c. Identify the IS/Practice Management system used. d. Describe, in detail, your disaster recovery program. e. Describe the process for obtaining member and provider eligibility. f. Describe the process for resolving file layout data discrepancies, including key provider unit contacts. g. Describe the operational workflow for processing authorizations. 		

1. Refer to Tufts Health Plan's *Delegated Authorization Data Transfer Specification*. This document is provided to the DPUs on request.

Step 7 - Signature Page

This page documents each year's delegation agreement between Tufts Health Plan and the delegate. The delegate must submit the completed and signed original page within their assessment packet.

Once approved for delegated medical management for the med/surge population, the delegate will receive a copy of the page signed by the Tufts Health Plan Medical Director for Delegation. If the delegate needs an original, then two signature pages must be submitted within the assessment packet.

Signature Page

Delegated Medical Management	
Commercial <input type="checkbox"/>	Tufts Medicare Preferred HMO <input type="checkbox"/> Disease Management <input type="checkbox"/> (list programs here) Complex Care Management <input type="checkbox"/>
_____ Hereinafter known as Provider Unit, agrees/represents:	
<ul style="list-style-type: none"> • To perform the delegated services listed above on behalf of Tufts Health Plan as outlined in the Tufts Health Plan Delegated Services Manual, subject to any limitations or contingencies that might be outlined by Tufts Health Plan as part of the delegation assessment and approval process. 	
<ul style="list-style-type: none"> • To comply with Tufts Health Plan requirements set forth in the Health Services Agreement. 	
<ul style="list-style-type: none"> • To comply with Tufts Health Plan policies and procedures, federal and state regulatory requirement, and accreditation standards (such as NCQA). 	
<ul style="list-style-type: none"> • To comply and cooperate with all applicable Medicare laws, appeals procedures, regulations, CMS instructions and reporting requirements, and Tufts Health Plan's contractual obligations to CMS, all as amended from time-to-time. 	
<ul style="list-style-type: none"> • That no individual performing any of the delegated services or activities, either directly or under a subcontracted arrangement, has been excluded from participation in Medicare or Medicaid under sections 1128 and 1128A of the Social Security Act. 	
<ul style="list-style-type: none"> • To abide by all agreements regarding confidentiality which are outlined in the Business Associate Agreement. 	
Failure to comply with Tufts Health Plan requirements may result in a corrective action plan or revocation of delegation.	
_____ Signature of Provider Unit Authorized Representative	_____ [Date]
_____ [Print name and title]	
Tufts Health Plan has reviewed Provider Unit's delegation assessment tool and the results of the site visit, and agrees to delegate the above service(s) to Provider Unit, subject to any contingencies or limitations as noted in the acceptance letter (attached) on the effective date of _____	
_____	_____ [Date]
_____ [Print name and title]	

Step 8 - Submission to Tufts Health Plan

Submit three copies of the completed Assessment Packet to:

Tufts Health Plan, Case Management Department
c/o Jennifer Cody
705 Mt. Auburn Street
Watertown, MA 02472

5 Care Management Delegation Reassessment

Overview

The purpose of the Reassessment process is to:

- Assist the delegated entity in conducting their review and evaluation of their Delegation Care Management Plan every 12 months.
- Ensure any proposed changes to the delegates' plan are submitted to Tufts Health Plan for approval.
- Comply with National Committee for Quality Assurance's (NCQA) standard, UM 15, for the Health Plan to evaluate all delegated entities every 12 months.

This chapter guides the interested Integrated Delivery Network (IDN) or Provider Unit (PU) in completing the required reassessment documentation. To ensure the submission of a complete reassessment packet, the delegate uses a copy of the current Delegated Care Management Manual and the Reassessment Tool (see [page 20 through page 56](#)) as the index to their reassessment packet.

The Reassessment Tool consists of the same seven categories of information found within the Assessment Tool. The Reassessment Tool is designed to build upon the plans (e.g., Medical Management, Case Management) within the previously submitted Assessment Packet. After reviewing the current Delegated Care Medical Management Manual, the delegated group completes a review checklist to indicate that there are no changes to the previously submitted documents, and submits the 12-month reassessment requirements following the tools outline.

However, if the previously submitted Assessment Packet meets one of the following criteria, the delegate must use the reassessment tool (see [page 20](#)) for this year's packet submission:

- Did not encompass all the products which the delegate is requesting this year.
- Required multiple revisions during the 12-month review process.

Since the details of a Quality Improvement (QI) Plan and Workplan are expected to change each year, completing this section of the Reassessment Tool is a requirement every 12 months.

A submission of the contact demographics is required every 12 months to complete the technical section of the Reassessment.

Instructions

Refer to [Chapter 4, Care Management Delegation Assessment](#) if a detailed description of a requirement is needed.

1. Complete a copy of the Medical Group Demographics as described in [Chapter 4, Care Management Delegation Assessment](#).
2. Submit a packet comprised of the agreement statements, documents, samples, summary statistics, work plans, and grids as outlined in the tool.
3. Attach your QI Plan and work plan as outlined on [page 48](#).
4. If applicable, complete the *Technical Requirements for Medical Management Authorizations* demographic section on [page 52](#).
5. Use the Reassessment checklist to assist your review of all delegated medical management requirements not included within the reassessment tool. A checkmark in the second column confirms that no changes were made to your previously submitted assessment packet during this year's review. If you are unable to attest that there were no changes, the third column indicates the information to be submitted with this year's reassessment packet. The fourth column indicates the page number where that requirement's materials are found in your reassessment packet.
6. Provide the required signature on the Signature Page on [page 55](#).
7. Use a copy of the reassessment tool as the index to your reassessment packet. Within the location/comments column of the tool, specify the page number where that requirement's materials are found in your reassessment packet.
8. Submit three copies of the completed Reassessment packet, including forms and attachments to:

Tufts Health Plan, Case Management Department c/o Jennifer Cody 705 Mt. Auburn Street Watertown, MA 02472
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Medical Group Demographics

Medical Care Demographics	
A.	<p>Commercial <input type="checkbox"/></p> <p>Tufts Medicare Preferred HMO</p> <p>HMO <input type="checkbox"/></p> <p>Special Population Management <input type="checkbox"/></p>
B.	Executive Director/Phone:
C.	List the Special Population Programs for which you are currently requesting delegation
D.	<p>Contact/Operations Person/Phone:</p> <p>Med/Surg and Special Population Management, if different</p>
E.	Full Name of Group/Tufts Health Plan PU#
F.	Address
G.	<p>Office Business Hours:</p> <p>(Minimal requirement: M-F 8:30-5:00)</p>
H.	<p>Business Telephone Number:</p> <p>Additional Number if necessary</p>
I.	Business Fax Number:
J.	Case Manager/PU Telephone Number for Case Manager listing:
K.	Case Manager Fax Number
L.	Medical Director/Phone:
M.	<p>Each Special Population(s) Program Contact Name:</p> <p>Telephone Number:</p> <p>Fax Number, if different from the Group's (list for each program)</p>
N.	Medical Management (MM) Committee Chairperson/Phone
O.	Day and Frequency of MM Meetings
P.	QI Committee Chairperson/Phone
Q.	Day and Frequency of QI Meetings
R.	Primary Admitting Hospital

Infrastructure

Infrastructure		√	Location/Comments
<p>Provide page numbers and section numbers for all attached materials. Use the Location/Comments column to note the location and any other pertinent information related to the requested materials.</p>			
A	Submit a statement agreeing to do the following:		
A.1	Submit the following documents to Tufts Health Plan: <ul style="list-style-type: none"> • All proposed Tufts Medicare Preferred HMO member mailings to facilitate Centers for Medicare and Medicaid Services (CMS) review and approval before actual use. • All commercial member correspondence that incorporates benefit interpretation statement(s) before actual use. 		
A.2	Retain records pertinent to delegated services for audit and inspection in accordance with applicable state law or with respect to Tufts Medicare Preferred HMO, according to rights set forth by the U.S. Department of Health and Human Services, and Comptroller General, or their respective designees ¹ .		
A.3	Certify that any data or information pertinent to the activities or services provided under the delegation agreement that is submitted to the Plan or to CMS is accurate, complete, and truthful.		
A.4	Comply with all state and federal laws and regulations that prohibit discrimination, including but not limited to discrimination based upon health status.		

1. The Department of Health and Human Services, the Comptroller General, or their designees, have the right to inspect, evaluate and audit any pertinent contracts, books, documents and records involving transactions related to the contract between Tufts Health Plan and CMS including those of subcontractors, and:
 - a) Such right shall exist for any particular contract period through ten (10) years from the end of the final contract period or completion of audit, whichever is later unless (i) CMS determines there is a special need to retain a particular record or group of records for a longer period and notifies Tufts Health Plan at least thirty (30) days before the normal disposition date; (ii) there has been a termination, dispute, or allegation of fraud or similar fault by Tufts Health Plan, in which case the retention may be extended to six (6) years from the date of any resulting final resolution of the termination, dispute, fraud, or similar fault; or (iii) CMS determines that there is a reasonable possibility of fraud or similar fault, in which case CMS may inspect, evaluate, and audit Tufts Health Plan at any time, and
 - b) All pertinent contracts, books, documents, and records, as described above, shall be maintained by the applicable party or subcontractor to facilitate such right.

Infrastructure		√	Location/Comments
B.	Attach the following:		
B.1	The Organizational Chart for delegated services, reflecting the governing structure(s) and relationship(s) of the entities requesting delegated functions. Include all that is applicable: <ul style="list-style-type: none"> a. The provider units/risk units (if no IDN submit Board of Directors information at this level). b. The case management reporting relationship(s). c. Special Population Management program(s). 		
B.2	A list of Board of Directors names and their medical specialties.		
B.3	Financial report and/or business plan for current and past year, or a copy of the statement within the annual auditors report addressing the financial solvency of the company, including the name and contact information of the auditing company.		
B.4	Description of process for evaluating and accepting new physician members.		
B.5	Description of method of communication to physician members (include frequency of communication and samples).		

Medical Management (MM) Plan

Medical Management Plan		√	Location/Comments
	Provide page numbers and section numbers for all attached materials. Use the Location/ Comments column to note the location and any other pertinent information related to the requested materials.		
A	<p>Does previous plan encompass all products that PU is requesting to perform delegation for?</p> <ul style="list-style-type: none"> • If yes, indicate that there are no changes to the previously submitted plan with a copy of the Board of Directors meeting minutes demonstrating 12-month review and approval of: <ul style="list-style-type: none"> - The MM Plan. - The Clinical Review Criteria. - The QI Plan and Work plan - The Authorizations Processing Plan - Special Population Program(s): <ul style="list-style-type: none"> - Complex Care management. - Disease Management. • If no, attach new plan (refer to Chapter 4, Care Management Delegation Assessment and use the MM tool to submit the new plan). 		
A.8	Submit summary statistics on the 12-month inter-rater reliability review of all clinical professionals involved in utilization management (UM) decisions.		
A.9	Submit the current year's prospective, concurrent, and retrospective workplan (including specific issues, responsible personnel, and evaluation timelines).		
B.1	<p>Indicate agreement to continue:</p> <ul style="list-style-type: none"> • To participate in Tufts Health Plan-sponsored programs, includes participation in Tufts Health Plan medical management leadership meetings (e.g., medical director/physician reviewer meetings, network-wide delegation operations meetings, and education sessions, such as physician and Delegated Case Manager (DCM)). 		

Medical Management Plan		√	Location/Comments
E.1	Submit annual evaluation of the Disease Management program, including: <ul style="list-style-type: none"> • Annual member participation rate. • Member Satisfaction Survey. • Annual analysis of member complaints and inquiries. • Changes with implementation plan. 		
E.6	Submit annual evaluation of the Complex Care Management program, including: <ul style="list-style-type: none"> • Annual member participation rate. • Member Satisfaction Survey. • Annual analysis of member complaints and inquiries. • Summary of process measures evaluated. • Changes with implementation plan. 		

Case Management Plan

Case Management Plan		√	Location/Comments
	Provide page numbers and section numbers for all attached materials. Use the Location/ Comments column to note the location and any other pertinent information related to the requested materials.		
A	Submit a Case Manager assignment grid demonstrating the following:		
A.1	PU's/medical group for which each Case Manager is responsible.		
A.2	Product for which each Case manager is responsible.		
A.3	Fulfills the staffing requirements, including: <ul style="list-style-type: none"> • A minimum of one FTE Case Manager per 1,700 Medicare members or 26,250 commercial members (or reasonable equivalent as determined by Tufts Health Plan). • Coverage for scheduled and unscheduled absences. • For commercial HMO delegated medical management, PU's delegated under a "Present-To" model must demonstrate adequate staffing to perform case management functions for non-risk members. 		
B.1	Submit a sample list of ongoing staff development programs attended by the Case Management staff.		

Quality Improvement

Infrastructure	√	Location/Comments
<p>Provide page numbers and section numbers for all attached materials. Use the Location/Comments column to note the location and any other pertinent information related to the requested materials.</p>		
<p>A. Written <u>QI Plan</u>:</p>		
Written QI Plan and/or QI Workplan. (These requirements may be met in one combined document or two separate documents.)		
<ul style="list-style-type: none"> • Description of program, which may include such things as philosophy statement, purpose statement, objective, and scope: 		
<ul style="list-style-type: none"> • Planned QI Projects for the year. 		
<ul style="list-style-type: none"> • Organizational structure, including resources devoted to QI Program. 		
<ul style="list-style-type: none"> • Planned QI monitoring of previously defined issues. 		
<ul style="list-style-type: none"> • Description of how patient safety improvement is addressed. 		
<ul style="list-style-type: none"> • Documentation that QI Plan/Workplan is reviewed, updated, and approved annually by the Board of Directors or appropriate policy-making body. • Signature of chairperson (Medical Director). • Date of meeting. 		
<ul style="list-style-type: none"> • Authority from and accountability to PU's senior executive. 		
Submit a description of the organizational structure of the QI Program, including:		
<ul style="list-style-type: none"> • Physician involvement required in all QI activities. 		
<ul style="list-style-type: none"> • An attestation that a specific physician has overall responsibility for QI activities. 		
<ul style="list-style-type: none"> • An attestation that the Medical Director has substantial involvement in QI activities. 		
Attach a description of QI Committee, including:		
<ul style="list-style-type: none"> • Role. 		
<ul style="list-style-type: none"> • Structure and function. 		
<ul style="list-style-type: none"> • Meeting frequency. 		

Infrastructure	√	Location/Comments
<ul style="list-style-type: none"> Function - description of the process of coordinating/analyzing data from other PU and Tufts Health Plan monitoring activities, such as: 		
<ul style="list-style-type: none"> - UM Monitoring. 		
<ul style="list-style-type: none"> - Assessment of member satisfaction. 		
<ul style="list-style-type: none"> - Medical record review. 		
<ul style="list-style-type: none"> - Risk management. 		
<ul style="list-style-type: none"> - Membership (both PCPs <u>and</u> Specialists must be included in QI Committee membership). 		
<ul style="list-style-type: none"> - QI Meetings (held per Tufts Health Plan requirement, at least monthly). 		
Submit a template/description or a sample of QI Committee Meeting minutes, including the following elements:		
<ul style="list-style-type: none"> Agenda. 		
<ul style="list-style-type: none"> Members present. 		
<ul style="list-style-type: none"> Problems identified. 		
<ul style="list-style-type: none"> Action plans with timelines to address QI problems. 		
<ul style="list-style-type: none"> Review of patient care across the clinical spectrum, including hospital, office, SNFs, rehab, and homecare. 		
<ul style="list-style-type: none"> A review of the policies and procedures involved in the case (attach the policy/procedure to the minutes, when pertinent). 		
<ul style="list-style-type: none"> Review of instruments used to monitor quality of care in minutes, when applicable. 		
<ul style="list-style-type: none"> Signature of chairperson (Medical Director). Date of meeting. 		
<ul style="list-style-type: none"> Recorded monthly and retained on file for Tufts Health Plan and regulatory agencies to access, if necessary. 		
<ul style="list-style-type: none"> Peer review activities must be reported to the QI Committee at least quarterly, and are linked to individual providers, as appropriate. 		
<ul style="list-style-type: none"> Documentation that any actions taken are reviewed by the Board of Directors or policy-making body. 		
Submit the following:		

Infrastructure	√	Location/Comments
<ul style="list-style-type: none"> Documentation that the QI Plan is reviewed, updated, and approved annually by Board of Directors or appropriate policy-making body 		
<ul style="list-style-type: none"> Signature of chairperson (Medical Director). Date of meeting. 		
B. Reporting/Participation Requirements (submit an agreement statement to do the following:		
<ul style="list-style-type: none"> PU must use Tufts Health Plan generic quality screening criteria to identify and report occurrences. 		
<ul style="list-style-type: none"> PU must use Tufts Health Plan occurrence screen tool, or must submit current tool for review. 		
<ul style="list-style-type: none"> Provide requested medical records within required timeframe (as requested by Tufts Health Plan, MassPro, or CMS). 		
<ul style="list-style-type: none"> Participation in Tufts Health Plan QI projects, as required by Tufts Health Plan and/or its designee. 		

Technical Requirements for Medical Management Authorizations

Technical Staff	
Commercial <input type="checkbox"/>	Tufts Medicare Preferred HMO <input type="checkbox"/>
Operations contact for authorizations:	_____
Phone number:	_____
Fax number:	_____
IS contact(s):	_____

Phone number(s):	_____
Fax number(s):	_____
Number of IS staff assigned to authorization:	_____

Review Checklist

Assessment Chapter #s	Assessment Packet Requirement	"X" Indicates no changes	OR Submit	Location/Comments
	Within Infrastructure			
B.4	Process to evaluate and accept new physician members		Submit new process	
B.5	Method of communication to providers (include frequency of communication)		Submit new method	
B.6	Mechanism to orient providers to the initiation of delegated medical management and/or special population management		Submit new mechanism	
B.7	Mechanism to continuously educate providers about delegated medical management and/or special population management		Submit new mechanism	

Assessment Chapter #s	Assessment Packet Requirement	"X" Indicates no changes	OR Submit	Location/Comments
B.8	<p>Policies and procedures, including a copy of the attestation statements as appropriate, detailing the processes that will be used to perform the following tasks:</p> <ol style="list-style-type: none"> a. Safeguard the privacy of any information (electronic and hardcopy) that identifies a particular member, so that information from, or copies of records may be released only to authorized individuals, and unauthorized individuals cannot access or alter member records. (Original medical records must be released only in accordance with federal or state laws, court orders, or subpoenas.) b. Maintain member records and information in an accurate and timely manner. c. Ensure the confidentiality of all member information. d. Affirms: <ul style="list-style-type: none"> • UM decision-making is based only on appropriateness of care and service. • The delegated entity does not specifically reward practitioners or other individuals conducting utilization review for issuing denials of coverage or service. 		Submit new policies	

Assessment Chapter #s	Assessment Packet Requirement	“X” Indicates no changes	OR Submit	Location/Comments
	<ul style="list-style-type: none"> • Financial incentives for UM decision-makers do not encourage decisions that result in underutilization. • Outlines expectations of delegated entity and employees on matters of conflict of interest. 			
B.9	Policies and procedures detailing the processes that ensure services are provided in a culturally competent manner.		Submit new policies and procedures	
Within the Medical Management Plan				
A.1	The medical director's role and responsibility.		Submit new MM plan	
A.2	The specific physician coverage plan to assume responsibility for day-to-day MM issues, and address any expedited appeals during and after normal business hours.		Submit new MM plan	
A.3	MM meetings structure, roles, responsibilities, and participants.		Submit new MM plan	
A.6	Organizational determination methodology.		Submit new policies	
A.8	A policy mandating that, every 12 months, an inter-rater reliability analysis is completed of all clinical professionals involved in UM decisions.		Submit new policies	
A.9	A description of the prospective, concurrent, and retrospective review plans.		Submit new policies	

Assessment Chapter #s	Assessment Packet Requirement	"X" Indicates no changes	OR Submit	Location/Comments
A.10	A policy mandating that, every 12 months, the Delegation Management Plan is reviewed, revised (if needed), and approved by the Board of Directors/ Governing Body.		Submit new policies	
C.	Policy addressing a threat of harm by a member to himself/herself or to another.		Submit new policies	
D.	Policy for managing Tufts Medicare Preferred members with complex or serious medical conditions, as identified through the Plan's triage process (Health Risk Appraisal).		Submit new MM plan	
E.1	Disease Management program content.		Submit new MM plan	
E.2	Disease Management policies and procedures detailing member identification process.		Submit new policies	
E.3	Disease Management program letter.		Submit new policies	
E.4	Complex Care Management program contents.		Submit new program	
E.5	Complex Care Management policies and procedures.		Submit new policies	
Within the Case Management Plan				
A.	The case management model.		Submit new Case Management Plan	

Assessment Chapter #s	Assessment Packet Requirement	"X" Indicates no changes	OR Submit	Location/Comments
B.	Case Management review policies for: <ul style="list-style-type: none"> • Acute medical/surgical hospital. • Acute rehabilitation hospital. • SNFs. • Custodial setting. • Home care setting. • Specialty/Catastrophic. • Community resource referral. 			
E.	The process to verify and document RN staff's clinical experience and licensure.		Submit new policies	
F.	The following case management information: <ul style="list-style-type: none"> • Outline of the formal orientation and education program(s). • Job description(s). • Evaluation process/evaluation tool. • Description of ongoing staff development program. 		Submit new information	
G.	The method of communication to Case Management staff, including frequency of communications.		Submit new method	
Within the Technical Requirements for MM Authorizations				
1.	Central facility has appropriate staff to process authorization volume.		Submit new plan	

Assessment Chapter #s	Assessment Packet Requirement	“X” Indicates no changes	OR Submit	Location/Comments
2.	Central facility has technology to communicate electronically with Tufts Health Plan (must be able to transmit by Tufts Health Plan pre-defined format).		Submit new plan	
3.	PU is able to transmit test data for electronic data interchange (EDI) assessment. (File transmission testing is part of the assessment process for delegation).		Submit new plan	
4.	<p>Attach Authorization Processing Plan. The plan must address the following items:</p> <ul style="list-style-type: none"> • Describe your plan to interface with Tufts Health Plan's Information Systems (IS) department. • Describe your communications protocol. • Identify the IS/Practice Management system used. • Describe, in detail, your disaster recovery program. • Describe process to obtain member and provider eligibility. • Describe process to resolve file layout data discrepancies, including key PU contacts. • Describe operational workflow to process authorizations. 			

Signature Page

This page documents each year's delegation agreement between Tufts Health Plan and the delegate. The delegate must submit the completed and signed original page within their assessment packet.

Once approved for delegated medical management for the med/surge population, the delegate will receive a copy of the page signed by the Tufts Health Plan Medical Director for Delegation. If the delegate needs an original, then two signature pages must be submitted within the assessment packet.

The following is an example of a signature page.

Delegated Medical Management	
Commercial <input type="checkbox"/>	Tufts Medicare Preferred HMO <input type="checkbox"/> Disease Management <input type="checkbox"/> (list programs here) Complex Care Management <input type="checkbox"/>
<p>Hereinafter known as Provider Unit, agrees/represents:</p> <ul style="list-style-type: none"> To perform the delegated services listed above on behalf of Tufts Health Plan as outlined in the Tufts Health Plan Delegated Services Manual, subject to any limitations or contingencies that might be outlined by Tufts Health Plan as part of the delegation assessment and approval process. To comply with Tufts Health Plan requirements set forth in the Health Services Agreement. To comply with Tufts Health Plan policies and procedures, federal and state regulatory requirement and accreditation standards (such as NCQA). To comply and cooperate with all applicable Medicare laws, appeals procedures, regulations, CMS instructions and reporting requirements, and Tufts Health Plan's contractual obligations to CMS, all as amended from time-to-time. That no individual performing any of the delegated services or activities, either directly or under a subcontracted arrangement, has been excluded from participation in Medicare or Medicaid under sections 1128 and 1128A of the Social Security Act. To abide by all agreements regarding confidentiality which are outlined in the Business Associate Agreement. <p>Failure to comply with Tufts Health Plan requirements may result in a corrective action plan or revocation of delegation.</p>	
_____ Signature of Provider Unit Authorized Representative	_____ [Date]
_____ [Print name and title]	
Tufts Health Plan has reviewed Provider Unit's delegation assessment tool and the results of the site visit, and agrees to delegate the above service(s) to Provider Unit, subject to any contingencies or limitations as noted in the acceptance letter (attached) on the effective date of	
_____	_____ [Date]
_____ [Print name and title]	

