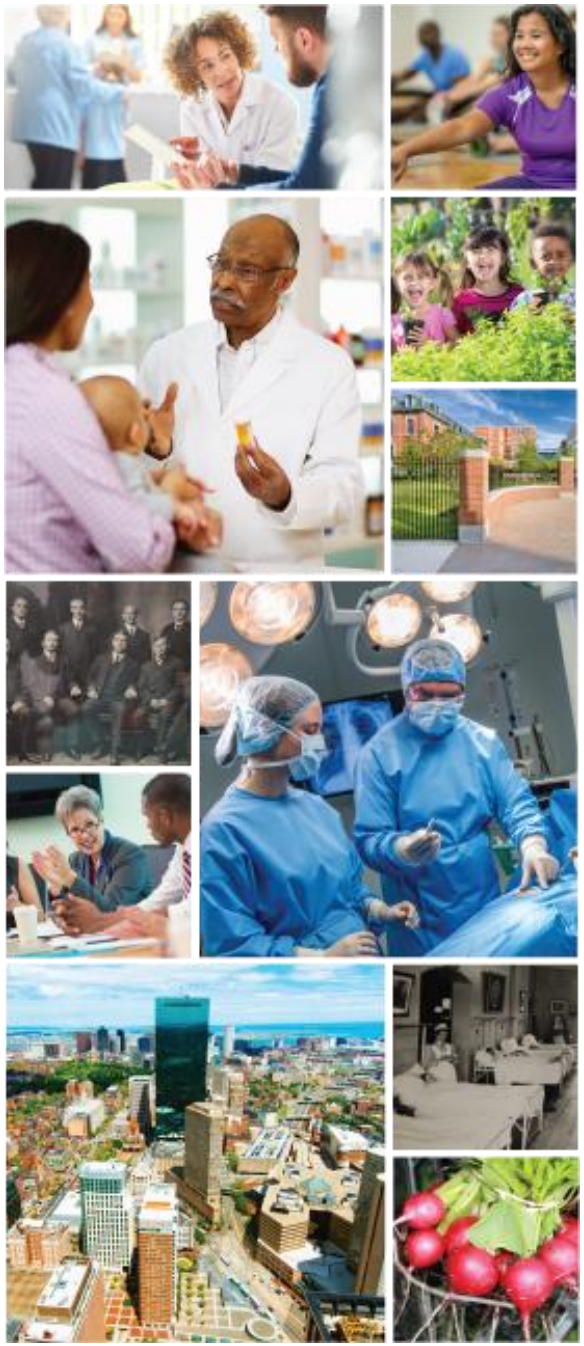

Boston Medical Center
HEALTH SYSTEM

MassHealth Primary Care Sub-Capitation: Payment Logic

WellSense Care Alliance

March 1, 2023

Questions/Concerns:
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Goals for today

- Review the basics of primary care sub-capitation
- Briefly review **primary care sub-capitation program payment reporting tools, and claims suppression logic**
- Discuss steps that your ACO can take to:
  - Reconcile payment against FFSE and audit suppressed claims
  - Ensure clean data with WellSense

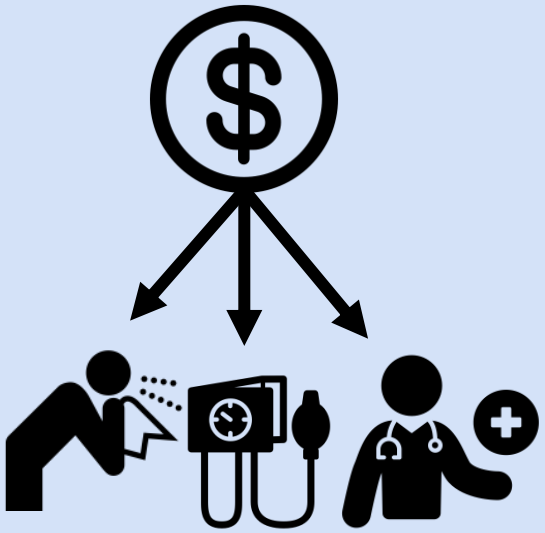
Agenda

- **PC cap overview**
- WS payment timing and reports
- Claims suppression logic
- Suggested next steps
- How to update data with WS
- Appendix

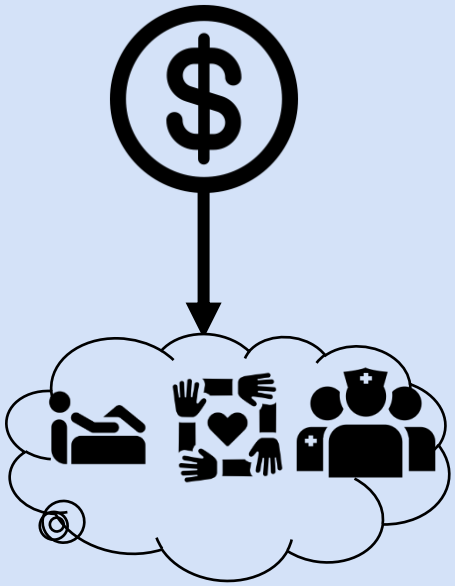
MassHealth hopes to invest more in primary care through the next ACO waiver Primary Care Sub-capitation program

- Primary Care Sub-Capitation is a **fixed amount of money (or capitation)** paid to the primary care practices for each month for each patient who is enrolled with that practice for primary care. This is moving away from a fee for service payment model.
- Primary care groups are rewarded more funding who prove to provide enhanced primary care services such as (IBH, care coordination, after hours and weekend, video telemedicine, LARC placements, etc.) aka tiers
- This is an opportunity to truly **innovate the way we are reimbursed and ultimately deliver care to patients**, where partnered care team members who may not currently bill now are funded

Fee-for-Service



Capitation



What are the main components of our work on the PC cap program?

PID/SLs and PCEs

- PID/SLs are a provider identifier used to MassHealth, intended to correspond to the site of care delivery
- PCEs (primary care entities) are synonymous with TINs (Tax ID Numbers)
- Program payment is structured around PID/SLs and PCEs; claim suppression is tied to PCE

Tiers

- Tiers are intended to reflect the type of integrated primary care / level of services offered at a given primary care site. Each site has a Tier. Initial attestations submitted to MH in 2022
- Payment is tied to tiers – higher tiers mean higher payments

Tier payments PMPM	Pediatric	Adult
Tier 1	~$5 – ~$7	~$4 – ~$6
Tier 2	~$7 – ~$9	~$6 – ~$8
Tier 3	~$13 – ~$15	~$10 – ~$12

Financials

- There are two components of PC cap payment: the base monthly cap (based on member characteristics, historical claims, etc.), and the tier payment (based on the tier attestations)
- The PC cap itself is intended to replace all claims associated with primary care provision and tier requirements. These claims will be “zero paid” by WellSense, in lieu of the cap payment itself

WellSense operations

- Reconfiguring WellSense systems to pay the PC cap in an accurate and timely fashion to all providers

Advocacy

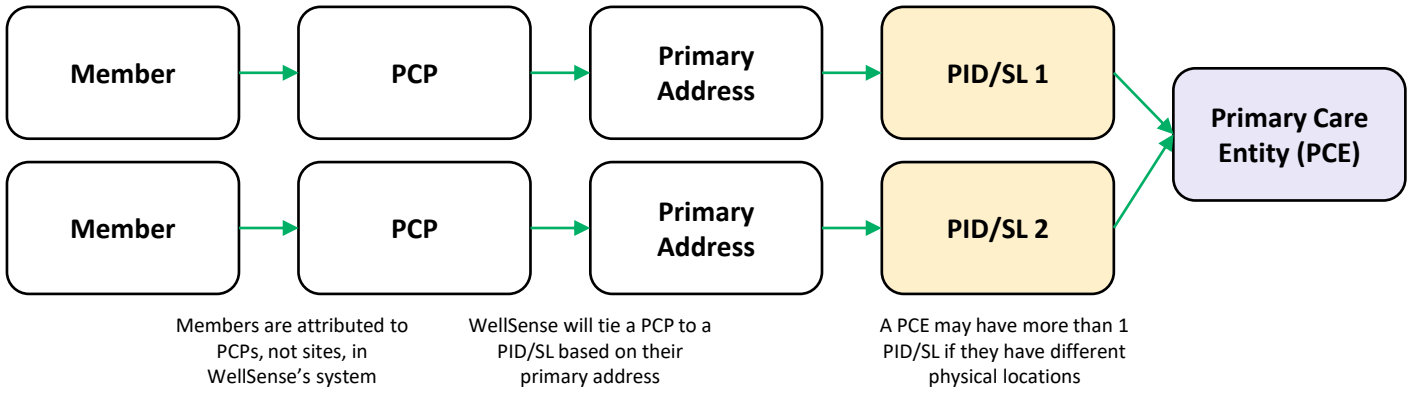
- Ongoing dialogue with MassHealth (via written material submission, formal Bidders Conferences) focused on major issues with program design and suggestions for improvement

PID/SLs 101

- **Definition:** A PID/SL is the "provider ID and service location."
  - MassHealth-specific construct used to identify providers
  - MassHealth defines as a "a single practice location identifier, which generally aligns with the consistent location a member visits to receive care" – intention is that it corresponds to a single site of care delivery / address
  - Any provider serving MassHealth members (in FFS and/or an ACO) MUST have a PID/SL
  - There are PID/SLs for all providers – primary care, ED, urgent care, specialty clinics, school-based clinics, etc. – but *only the primary care PID/SLs participate in the PC cap program*
- **Creation and updates:**
  - MassHealth is the only entity who can assign a PID/SL
  - MassHealth uses a vendor called Maximus to maintain their PID/SL database
  - Providers can update all types of PID/SLs (add, drop, combine, split, change, etc.) in Maximus using the "Coversheet" process, details in appendix
- **PID/SLs and member attribution:**
  - MassHealth attributes members to PID/SLs, not to PCPs
  - In the WellSense system, members are assigned to PCPs, which are then assigned to PID/SLs
  - PID/SLs are then assigned to a Primary Care Entity, which is a TIN
- **Importance of PID/SL clean up:**
  - Rates are calculated at the TIN level. To get the right rate for the TIN, it is important that members are assigned to the right PID/SL, and PID/SLs are assigned to the right TIN – *details follow*

Financials: How practices are paid (PCEs)

The primary care cap will be paid at the Primary Care Entity (PCE) level. MassHealth has defined the PCE as the Tax ID (TIN)



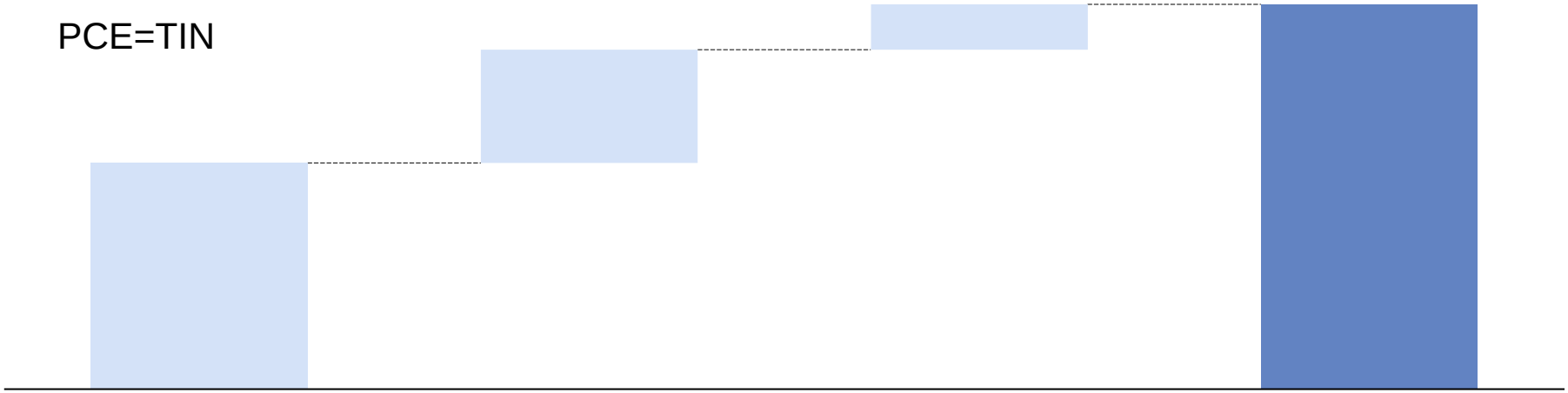
How does payment flow from MassHealth to WellSense ACOs to practices?

- **MassHealth pays WellSense PC cap funds as part of overall ACO capitation payment**. ACOs will submit data on payments to MassHealth that includes detail on the PCE and PID/SL level payments, and reconciliation will occur "at least annually" to ensure each ACO as a whole paid out the full subcap amount to all PCEs, and ensure that the ACO paid each PCE at least 90% of their funded amount
- **WellSense pays PCEs/TINs the sub-cap amount using existing payment infrastructure.** WellSense "zero pays" any primary care claim lines that are within the PC cap code set (non-primary care claims and non-included claim lines are paid FFS). Payment occurs prospectively monthly
- **PCEs/TINs are responsible to allocate funds across PID/SLs** based on risk adjustment (using PCAL model) and Tier. *We're assessing the feasibility of this - what would paying PIDSLs look like for you?*

Financials: Capitation rate calculation
Details in appendix

Timing for PC subcap rates: MH released rates on 11/14 assuming all PCEs are tier 1; will release an update in Q1 2023 using updated tier attestations.

The overall PCE PMPM (for each PCE) is built up from several components – *illustrative only, scale may not be reflective*



Base rate	Prospective adjustments	Tier payment	Total PCE PMPM
PCE's **historical experience** in FY 2021 (June 2020-June 2021) for RY 2023 (rather than market rates) ▪ Includes all claims for members attributed to the PCE/TIN ▪ Excludes service codes not in PC cap, ineligible provider types and specialties	**Prospective adjustments** to historical primary care spend to mirror future payment. This includes: price normalization, trend, program changes (utilization and service mix) ▪ Details not yet provided on specific methodology	**Weighted average of the tiers of PID/SLs** that comprise the PCE. E.g., for a PCE with 2 PID/SLs: (% members in PCE at PID/SL 1 * Tier rate of PID/SL 1) + (% of members in PCE at PID/SL 2 * Tier rate of PID/SL 2) = Total Tier PMPM	Multiplied by the member months attributed to the PCE = Total monthly payment to the PCE

Major changes since last announcement: using historical rates vs. market, and making adjustments to account for utilization changes (particularly important since base year is during COVID)

Base rates and tier payments will be tied to member's rating categories

Plan	TIN	PC Provider Type	RC	MMs	Blended PMPM	Tier Add-on PMPM	Final Rate
WS-X	123456	PCP	RC I & IX Adult	34,449	$12.48	$4.00	$16.48
WS-X	123456	PCP	RC I Child	25,471	$24.23	$5.00	$29.23
WS-X	123456	PCP	RC II & X Adult	2,962	$20.36	$4.00	$24.36
WS-X	123456	PCP	RC II Child	682	$20.60	$5.00	$25.60
WS-X	123456	PCP	All RCs	63,565	$17.64	$4.41	$22.05

- For each TIN, MH has developed a base rate (the blended PMPM – a blend of the site's historical experience and market rate) for every RC.
- Each RC then receives a tier add-on payment ($4 for adult rating categories and $5 for pediatric rating categories are the tier 1 placeholder numbers). We anticipate that the tier payments will change when MH issues updated guidance in Q1 2023. MH will be calculating a blended tier rate for each TIN at the start of the program year.
- Summing the base rate and tier add-ons gives the final rate for each rating category
- Taking a weighted average (weighted by member months) provides the overall final primary care sub-cap rate for each TIN.

Financials: What's included the cap (non-hospital licensed FQHCs only)

The logic below determines whether **an incoming claim falls under Primary Care Sub-capitation (i.e. should it be zero-paid?).**

Topic	Sequence	Description
Member Attribution	**1**	Is the member enrolled for the full date of service on the claim? If yes, continue
	2	Is the billing provider on the claim the Member's assigned PIDSL or affiliated with the Member's assigned PIDSL? If yes, continue
Specialist Logic	**3**	Does the practitioner performing the service have a sub-capitation "included" specialty? If yes, continue.
	4	Does the practitioner performing the service have a sub-capitation "excluded" specialty? If no, continue.
Sub-capitation code list	**5**	Is the procedure code on the sub-capitation list? If yes, continue.
	6	This is a sub-capitation claim line, zero-pay. Label the claim line sub-capitation.

Sample "included" specialties: Nurse Practitioner, Internal Medicine, Pediatrics, Family Practice/Medicine, Geriatric Medicine, and Physician Assistant, Adolescent Medicine

Sample "excluded" specialties: Anesthesiology, Dermatology, Nuclear Medicine, Psychiatry, Psychiatry (Child), Radiology (Diagnostic), Radiology (Therapeutic), Surgery (Cardiothoracic), Surgery (Colon and Rectal), Surgery (General), Surgery (Neurological), Surgery (Orthopedic), Surgery (Plastic and Reconstructive), Surgery (Vascular), Surgery (Other), Physical Therapy

A full list of included and excluded specialties is in the appendix.

All specialties on the included and excluded list or subject to change.

Specialties will be pulled from information currently in WS' internal system, which was populated during credentialing and can be updated on an ad hoc basis.

Note: *Specialist Logic does not apply to FQHCs.*

Non hospital-licensed FQHCs have different logic (specialty step is skipped).

FQHC – overview of differences

FQHCs

- **PC cap payments vs PPS rates**: The state has not clarified base rate/tier payments plan to align with PPS rates. WellSense will monitor this that PPS is met in the program
- **FQHCs Base Rate:** have a unique calculation developed into the base rate
- **Tier designation**: *FQHCs shall participate in the Primary Care Sub-Capitation Program with a Tier Designation of Tier 3; provided however that a FQHC may participate with a Tier Designation of Tier 1 or Tier 2 with written approval from EOHHS*; we have a question out to the state to ask for clarify if FQHCs automatically meet Tier 3 given this language
- **PC Cap payment**: must be at 100% in monthly payments to set base + tier rate: *For each FQHC that is a Network PCP, make a monthly payment in an amount that is no less than 100% of the amount indicated for such PCP in Appendix S.*
- **Specialty logic:** MH specialty logic for determining capitation does not apply to FQHCs.

Hospital Licensed Health Centers

- **PC cap payments vs PPS rates**: Health centers under hospital licensure are not held to the PPS rates determined by the state
- **FQHCs Base Rate**: These health centers will be considered a hospital based physician practice, not an FQHC, when factoring in the base rate calculation
- **Tier designation** : this is TBD if health centers under a hospital license also have these rules apply, *pending state response*
- **PC Cap payment**: this is TBD if health centers under a hospital license also have these rules apply, *pending state response*

Federally-Qualified Health Center (FQHC) – an entity that has been determined by the Centers for Medicare and Medicaid Services (CMS) to satisfy the criteria set forth in 42 USC 1396d(1)(2)(B).

FQHCs – What's included the cap (professional claims only)

Overview / key points

- FQHC: will include all claims into sub cap not just PCPs
- Hospital license CHCs: this logic likely doesn't apply, but awaiting further clarification on the state

Step	Description
1	Is the Member enrolled in PCACO for the full date of service on the claim? If yes, continue.
2	Is the PCE identified by information on the claim the Member's assigned PID/SL or affiliated with the Member's assigned PID/SL? If yes, continue.
3-4	Do not apply to CHCs; see below
5	Is the procedure code on the sub-capitation list? If yes, continue.
6	This is a sub-capitation claim, zero-pay.

Important notes from MassHealth

- For CHC claims, MassHealth does not receive information on the *individual practitioner* that rendered the service. Therefore, specialty information will not be used to help determine whether a claim from a CHC is a sub-capitation claim
- Because of this, CHC prospective rates may incorporate more claims (and therefore be correspondingly higher) than for other provider types

Agenda

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- **WS payment timing and reports**
- Claims suppression logic
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PC Sub-Cap Payment Timing

1st of the month

Membership snapshot for monthly capitation payment

2nd Tuesday of the month

Capitation payment provided to ACOs with payment summary and cap payment detail reporting

Payment and reports will include any retroactive adjustments for members who may have termed or joined in prior month(s)

Quarterly

For FQHCs: EOHHS will provide quarterly PPS reconciliation and wrap payments (if applicable)

As Usual

WellSense will pay FFS claims that do not meet the PC sub-cap logic.

Allowed amounts will be included on the 835s (sent weekly) for all claims – including those that are zero paid through the PC sub-cap.

Groups will receive their first PC sub-cap payment on April 11th

WellSense will send three reports along with capitated payments, providing additional detail on these payments

Report	Overall Summary	Cap Payment Detail	PIDSL Reference
Purpose	Payment by PCE, FFSE reconciliation	Member attribution and associated payment	PIDSL-level payment guidance
Detail	This report will show the following information for every TIN in each ACO: • Date range • Check # • Current month paid • Adjustments • Net payment • Cumulative net payment • # of members • # of member months • List of associated PIDSLs with member months, total paid (current month) and aggregate PMPM	This report will show the following information for every TIN in each ACO: • Member name • Member ID • DOB • Rating category • PCP name • Assigned PIDSL • RC rate • Month • # of member-months (in month) • Cap paid for member	This report will show the following information for every PIDSL in each TIN within each ACO: • Tier • TIN • Health-status adjustment (PCAL) score • Member attribution by rating category

- Financial reporting related to the primary care sub-capitation payments will also be incorporated into quarterly ACO-level financial statements
- For your ACO: WS will also conduct an annual reconciliation at the TIN level to ensure total capitation payment (incl. tier $s) are no less than 110% FFS equivalent on MH fee schedule for zero-paid claims

Sample Overall Summary

ACO group name:	ACO A
Date range:	4/1/2023 - 4/30/2023
TIN:	12-3456789
Check #:	XXX
PAYMENT SUMMARY	
PC Subcap Rate Payments:	$ 2,245.02
Tier Payments:	$ 558.00
Adjustments:	$ -
Net payment:	$ 2,803.02
# members:	100
# member-months:	100

- WellSense recommends using this report in order to get a high level picture of monthly sub-cap payments to each TIN, the member months those payments are derived from, and the breakdown of those payments across base medical and tier payments (in addition to any applied adjustments). The sum of these payments can be compared with FFSE (by pulling a report of suppressed payments based on “24” remit code – more to follow).

Sample Cap Payment Detail

ACO group name:	ACO A
Date range:	4/1/2023 - 4/30/2023
TIN:	12-3456780
Check #	XXX

Member name	Member ID	DOB	RC	PCP name	PCP PIDSL	RC rate	Tier Payment	Month	# member-months in month	Cap paid for member
Jane Doe	XXXXXX1	X/X/XXXX	RC I & IX Adult	Dr. Jane Doe	XXXXX90	$ 20.60	$ 5.33	April	1	$ 25.93
John Doe	XXXXXX2	X/X/XXXX	RC I & IX Adult	Dr. John Doe	XXXXX90	$ 20.60	$ 5.33	April	1	$ 25.93
Jane Doe	XXXXXX3	X/X/XXXX	RC I & IX Adult	Dr. Jane Doe	XXXXX90	$ 20.60	$ 5.33	April	1	$ 25.93
John Doe	XXXXXX4	X/X/XXXX	RC I & IX Adult	Dr. John Doe	XXXXX90	$ 20.60	$ 5.33	April	1	$ 25.93
Jane Doe	XXXXXX5	X/X/XXXX	RC I & IX Adult	Dr. Jane Doe	XXXXX91	$ 20.60	$ 5.33	April	1	$ 25.93
John Doe	XXXXXX6	X/X/XXXX	RC I & IX Adult	Dr. John Doe	XXXXX92	$ 20.60	$ 5.33	April	1	$ 25.93

- WellSense recommends using this monthly report in order to get a more detailed picture of the members that the capitated payment is being made for, and their attribution by PCP and PIDSL.
- WellSense also plans to use this report to detail any retroactive changes to capitation payments (i.e. if a member's eligibility status changes retroactively for a prior month).

Sample PIDSL Reference

ACO group name:	ACO A
Date range:	4/1/2023 - 4/30/2023
TIN:	12-3456789

		Member Months					Cap Rate									
PCP PIDSL	**TIN**	**RC I & IX Adult**	**RC I Child**	**RC II & X Adult**	**RC II Child**	**Total**	**RC I & IX Adult**	**RC I Child**	**RC II & X Adult**	**RC II Child**	**Pre Risk-Adj Cap Pmt**	**Normalized PCAL**	**Risk-Adj Cap Pmt**	**Tier**	**Tier Pmt**	**Total Pmt**
XXXXX90	123456789	4	0	0	0	4	$20.60	$18.84	$38.26	$18.31	$82.39	1.7105	$140.93	2	$23.05	$163.98
XXXXX91	123456789	1	0	0	0	1	$20.60	$18.84	$38.26	$18.31	$20.60	0.6652	$13.70	2	$5.76	$19.46
XXXXX92	123456789	1	0	0	0	1	$20.60	$18.84	$38.26	$18.31	$20.60	0.9408	$19.38	1	$3.84	$23.22
XXXXX93	123456789	1	0	0	0	1	$20.60	$18.84	$38.26	$18.31	$20.60	2.0906	$43.06	1	$3.84	$46.90
XXXXX94	123456789	6	0	0	0	6	$20.60	$18.84	$38.26	$18.31	$123.59	0.7127	$88.08	2	$34.57	$122.65
XXXXX95	123456789	18	3	0	0	21	$20.60	$18.84	$38.26	$18.31	$427.29	0.7792	$332.95	2	$123.89	$456.84
XXXXX96	123456789	0	1	0	0	1	$20.60	$18.84	$38.26	$18.31	$18.84	1.3399	$25.25	2	$6.72	$31.97
XXXXX97	123456789	0	13	0	0	13	$20.60	$18.84	$38.26	$18.31	$244.98	2.6987	$661.14	2	$87.40	$748.53
XXXXX98	123456789	0	7	13	0	20	$20.60	$18.84	$38.26	$18.31	$629.29	0.5702	$358.79	1	$83.56	$442.35
XXXXX99	123456789	31	0	0	1	32	$20.60	$18.84	$38.26	$18.31	$656.84	0.8552	$561.74	2	$185.36	$747.10
TOTAL		**62**	**24**	**13**	**1**	**100**					**$2,245.01**	**1.00**	**$2,245.01**		**$558.00**	**$2,803.01**

- WellSense is planning to provide this report on a quarterly basis in order to support ACOs that are tying PIDSL-level payment to health status of the members attributed to each PIDSL. WellSense is still in conversation with MassHealth regarding the meaning of tendering payment to an individual PIDSL.
- Please note that we anticipate more detail in the final version of this report, specifically the raw PCAL scores and Tier payment adjustments (tier payments will be adjusted as needed if members shift between PIDSLs with different tiers and create a mismatch between the MassHealth mandated rates and the actual distributions of members across PIDSLs).

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Financials: What's included the cap (N/A for non-hospital licensed FQHCs)

MassHealth's logic below determines whether **an incoming claim falls under Primary Care Sub-capitation (i.e. should it be zero-paid?).**

Topic	Sequence	Description
Member Attribution	**1**	Is the member enrolled for the full date of service on the claim? If yes, continue
	2	Is the billing provider on the claim the Member's assigned PIDSL or affiliated with the Member's assigned PIDSL? If yes, continue
Specialist Logic	**3**	Does the practitioner performing the service have a sub-capitation "included" specialty? If yes, continue.
	4	Does the practitioner performing the service have a sub-capitation "excluded" specialty? If no, continue.
Sub-capitation code list	**5**	Is the procedure code on the sub-capitation list? If yes, continue.
	6	This is a sub-capitation claim line, zero-pay. Label the claim line sub-capitation.

Sample "included" specialties: Nurse Practitioner, Internal Medicine, Pediatrics, Family Practice/Medicine, Geriatric Medicine, and Physician Assistant, Adolescent Medicine

Sample "excluded" specialties: Anesthesiology, Dermatology, Nuclear Medicine, Psychiatry, Psychiatry (Child), Radiology (Diagnostic), Radiology (Therapeutic), Surgery (Cardiothoracic), Surgery (Colon and Rectal), Surgery (General), Surgery (Neurological), Surgery (Orthopedic), Surgery (Plastic and Reconstructive), Surgery (Vascular), Surgery (Other), Physical Therapy

A full list of included and excluded specialties is in the appendix.

All specialties on the included and excluded list or subject to change.

Specialties will be pulled from information currently in WS' internal system, which was populated during credentialing and can be updated on an ad hoc basis.

Note: *Specialist Logic does not apply to FQHCs.*

Non hospital-licensed FQHCs have different logic (specialty step is skipped).

Claims processing detail (N/A for non-hospital licensed FQHCs)

The logic below determines whether **an incoming claim falls under Primary Care Sub-capitation (i.e. should it be zero-paid?).**

Topic	Step	Description	WellSense Implementation of MassHealth Logic
Member Attribution	1	Is the member enrolled for the full date of service on the claim? If yes, continue	WellSense will check whether the TIN on the claim matches the TIN that the member's PCP is associated with. In WellSense's data warehouse, each provider has a separate record for each TIN that they bill under. Members will be attributed to the appropriate record, and this is the record that we will use in order to check TIN and member attribution.
	2	Is the billing provider on the claim the Member's assigned PIDSL or affiliated with the Member's assigned PIDSL? If yes, continue	
Specialist Logic	3	Does the practitioner performing the service have a sub-capitation "included" specialty? If yes, continue.	WellSense is requesting an exception to use its own specialty information for this check. On facility claims, WS will use the attending provider. On professional claims, WS will use servicing provider. This logic will not be applied to non-hospital licensed FQHC claims.
	4	Does the practitioner performing the service have a sub-capitation "excluded" specialty? If no, continue.	
Sub-capitation code list	5	Is the procedure code on the sub-capitation list? If yes, continue.	
	6	This is a sub-capitation claim line, zero-pay. Label the claim line sub-capitation.	WellSense will be returning suppressed claims with the remit code "24" in order to assist partners in identifying FFS claims that have been zero-paid under the sub-capitation program.

FAQs related to claims suppression in specific scenarios are included in the Appendix

Non hospital-licensed FQHCs have different logic (specialty step is skipped).

WellSense is working to provide partners with the information they need in order to build their own reconciliation reports

Topic	Step	Description	Information Needed and Provided for Partner Reconciliation
Member Attribution	1	Is the member enrolled for the full date of service on the claim? If yes, continue	Information about participating TINs is in the revised Attachment C which we have finalized together. Provider rosters reflect the association between TIN and provider. For new ACOs, this information is being covered in the course of credentialing and onboarding for your providers.
	2	Is the billing provider on the claim the Member's assigned PIDSL or affiliated with the Member's assigned PIDSL? If yes, continue	
Specialist Logic	3	Does the practitioner performing the service have a sub-capitation "included" specialty? If yes, continue.	For new ACOs, we encourage you to apply the MH specialty logic to your own providers. Non-hospital licensed FQHCs can build a reconciliation report without specialty information, as specialist logic does not apply.
	4	Does the practitioner performing the service have a sub-capitation "excluded" specialty? If no, continue.	
Sub-capitation code list	5	Is the procedure code on the sub-capitation list? If yes, continue.	MassHealth has previously shared the list of capitated codes as part of the procurement process. Follow-up with your WellSense contact if you require a copy.
	6	This is a sub-capitation claim line, zero-pay. Label the claim line sub-capitation.	WellSense will be returning suppressed claims with the remit code "24" in order to assist partners in identifying FFS claims that have been zero-paid under the sub-capitation program.

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Suggested next steps for partners

Next Steps

1 **Attribution**	▪ Work with WS to ensure that provider rosters are correct and complete. ▪ Work with WS to ensure that members are attributed to the correct PCP.
2 **Finance**	▪ Align financial systems with capitation including funds flow, budgeting, rate analysis, and reconciliation.
3 **Tier readiness**	▪ Focus on readiness for July 1. ▪ Strategize for enhancing tier payments.
4 **Governance and priority-setting**	▪ Establish systems of oversight/support to focus on performance in primary care setting and drive towards, engagement, quality, and TCOC goals.

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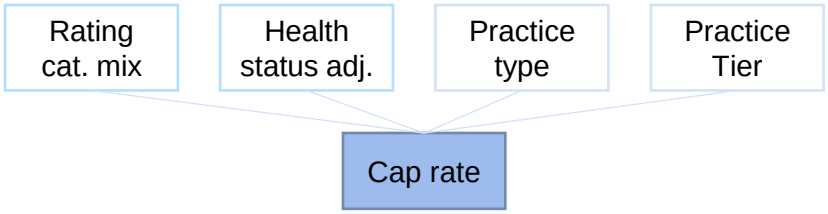
Reminder: How WellSense attributes members, and why it matters now more than ever

WellSense member attribution

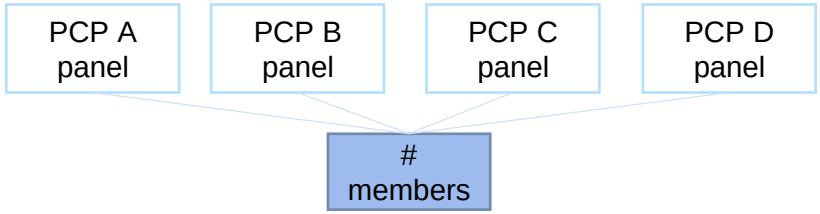
- WellSense assigns members through one of three methods:
  - **Member selection** of a PCP during MassHealth enrollment
  - **Auto-assignment** of new members if no PCP selected
  - Provider- or member-driven **change requests**
- WellSense's auto-assignment algorithm uses a few criteria:
  - **Ages and genders** accepted
  - Provider **location**
  - Provider **panel status**

Why it matters for PC sub-cap

- MH calculates cap rates based on four factors, including two driven by panel characteristics:



- WellSense then calculates the number of members per site by totaling the number of members per PCP



Member attribution affects both cap rates and cap volume. Attribution can be updated in the HealthTrio portal. For large, bulk changes, please work with your Provider Relations contact.

WellSense's existing roster review process is an important component of correct PCP attribution; the PR team has also recently shared reconciliation reports

WellSense will have a regular process to update provider data

1. WellSense Provider Data team pulls provider rosters by site two times per year
2. WellSense Provider Relations team distributes rosters to designated site contacts
3. Site contacts review rosters in detail, noting any changes or errors (e.g. new location, closed panel)
4. Site contacts return corrected rosters to WellSense Provider Relations team
5. WellSense Provider Relations team works with Provider Data team to update provider records in WellSense systems

The process allows ACOs to ensure better PCP attribution

Field	Why it matters
Provider Name	Allows sites to ensure that providers are active
Location	Geographic proximity for auto-assigned members
Specialty	Whether provider is PCP
Acceptance of new members	Ensures members are only assigned to PCP w/ capacity
Languages	Improves linguistic competency and access

Please work with your ACO Pop Health Ops Lead in order to ensure correct provider roster data. Existing partners will receive rosters to review; new partners are reviewing this information as part of the onboarding process.

The WS Provider Relations team asks providers for biannual updates on most fields relevant to the PCP assignment algorithm

Category	Information Collection and Validation	Department
Name	Self-reported	Provider Relations
Gender	Self-reported	Provider Relations
Office Location	Self-reported	Provider Relations
Specialty	Self-reported and validated	Provider Relations
Hospital Affiliations	Self-reported and validated	Credentialing
Board Certification	Verified by Credentialing team	Credentialing
Acceptance of new member	Self-reported	Provider Relations
Languages	Self-reported	Provider Relations
Physical Accessibility	Self-reported	Provider Relations
Group Names	Self-reported and validated	Provider Relations
Facility Name	Self-reported and validated	Provider Relations
Facility Location and Phone Number	Self-reported and validated	Provider Relations
Facility Accreditation	Self-reported and validated	Credentialing
Hospital Quality Data	Verified by Credentialing team	Credentialing

A note on termed providers and closed panels

Situation	Notice required	Why it matters
Provider is leaving an ACO	60 days	• Allows us to enter term date ahead of time, which prevents auto-assignment algorithm from assigning new members to departing PCP • MassHealth requires that members receive advance notice of PCP change
Provider's panel is closing	60 days	• Allows WellSense to update our data to prevent additional members from being auto-assigned
Members must be reassigned to another PCP	60 days	• MassHealth requires that members receive advance notice of PCP change • Gives WellSense sufficient time to work with ACO to appropriately re-assign members to new PCPs

Proper notice prevents attribution problems and reduces abrasion for both members and providers

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- PC cap overview
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Financials: Overview of capitation rate development (prior to tier payment)

Base Rate

- Base rate is set based on historical claims and encounters experience from FY 2021 (July 2020 – June 2021) for each member attributed to a PID/SL
- *How is this different than a market rate?*
  - Because the rate is based on the provider's specific historical data, it better reflects patient acuity and actual cost

Prospective Rate Adjustment

- Adjustments are applied to account for expected future payments. These adjustments include:
  - Price normalization: accounts for changes in the fee schedule between the base period contract period
  - Trend: accounts for changes in utilization and service mix (i.e., COVID, redetermination, etc.)
  - Program Changes: Accounts for changes in the covered population, covered service and/or payment methodology

PCE Rate

- A weighted average of the rates is developed to determine the PCE's capitation amount. Rates will be provided based on the following categories: 1) RC II Adult and RC X 2) RC I Child 3) RC I Adult and RC IX 4) RC II Child
- *How are cost differences between combined rate cells being addressed?*
  - Because rates are developed using historical experience they already account for differences in acuity (i.e., a provider that sees more RCX patients will have higher historical claims than a provider with RC II patients)

Financials: How are PCEs advised to distribute funds to PID/SLs?

- The amount PCEs pay to PID/SLs should vary by two factors:
  1. **PID/SLs Tier** – PID/SLs will be paid differently according to their tier designation in Attachment C
  2. **PID/SL Health Status** – accounts for differences in risk status amongst PID/SLs; a PCAL score will be calculated for each PID/SL that accounts for their patient acuity

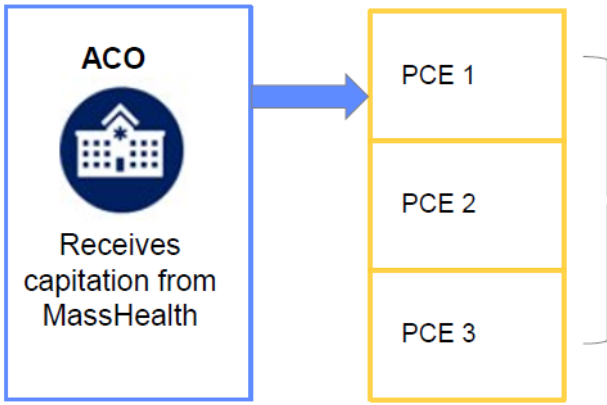
- **What is PCAL?**
  - PCAL stands for Primary Care Activity Levels and is a risk adjustment model developed in 2012 to risk adjust primary care spend
  - PCAL infers primary care need based on both primary care spend and some non-primary care spend in the dependent variable

NOTE: The Health Status Adjustment is only considered for payment distribution, it will no be considered for rate development for RY2023.

Financials – Illustrative ACO monthly payment flow from MassHealth

Illustrative ACO monthly payment flow

April 2023 illustration



PCE 1

PCE 2

PCE 3

		PCE 1	PCE 2	PCE 3	Total Amount
A	Member months	15	10	5	
B	PCE rate (PMPM)	$45	$50	$55	
C =A*B	Expected Payment	$675	$500	$275	$1,450
D	Actual Payment	$700	$450	$300	$1,450
E=D/C	*Funding percent*	*104%*	*90%*	*109%*	*100%*

PCE funding is **allocated to PID/SLs** and must be based on tier and member health status

ACOs will **report PCE payments to MassHealth on a monthly basis**, including detail on PID/SL-level payments, member months, and rating category. MassHealth will perform reconciliation at least annually

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Financials: Examples of claim suppression logic (N/A for non-hospital licensed FQHCs, 1/3)

Situation	Payment outcome	Additional detail
Provider is dually certified in internal medicine and non-excluded specialty. They practice as a PCP with patients attributed to them	Payment is suppressed for all claims for attributed members with a capitated code.	WellSense will be running specialist logic against its own data.
Provider is dually certified in internal medicine and non-excluded specialty. They do not practice as PCP.	Payment is suppressed for all claims for attributed members with a capitated code.	Payment is still suppressed in this situation because the member attribution check happens at the PCE/TIN level, and the provider is included by the specialist logic.
Provider at a PCP site bills under a TIN not associated with the MassHealth ACO PC cap program	Provider will be paid FFS for the claim (assuming that the site is in-network otherwise).	
Member has a primary care visit at a provider whose PID/SL is NOT associated with the same TIN as the PID/SL they're attributed to	Provider will be paid FFS for the claim (assuming that the site is in-network otherwise).	In the WellSense system, the check will be whether the provider record that the member is attributed to is associated with the billing TIN or not.

Financials: Examples of claim suppression logic (N/A for non-hospital licensed FQHCs, 2/3)

Situation	Payment outcome	Additional detail
Provider carries panels at multiple PCE/TINs, all of which participate with the MH ACO program.	Claims will be suppressed for this provider at each TIN that they carry a panel under. If the TIN is participating, but not as a primary care site, the claim will be paid FFS.	Members will be attributed to PIDSLs, and so there is no issue here either with payment or claims suppression (i.e. appropriate claims for members that are visiting the PIDSL/PCE they are assigned to will be suppressed, payment will be the number of members multiplied by the applicable rate). In the WS system, attribution will be to an individual provider record, which is only associated with a single TIN (i.e. each provider has a separate record for each TIN they bill under).
Provider carries panels at multiple PIDSLs within one PCE/TIN.	Claims will be suppressed for this provider at the single TIN/PCE that they practice at.	Partners will need to select a primary address (which will tie to PIDSL) for each physician, because the member – PIDSL relationship runs through physician, and each physician can only have one primary address within a given PCE/TIN. This will not impact claim suppression, but WS will tie member attribution (and hence, payment) to a single PIDSL (which will roll-up to PCE).
Provider is covering for another provider, but practices under a different TIN.	Claims processing logic will not take covering into account, and so the claim will be suppressed if the covering physician bills under the same TIN as the patient is attributed to. It will be paid FFS otherwise.	

Financials: Examples of claim suppression logic (N/A for non-hospital licensed FQHCs, 3/3)

Situation	Payment outcome	Additional detail
A member goes to see their PCP at an outpatient on-campus hospital which bills place of service 22. Two claims come in – one for the professional component, and one for the facility component, under two different TINs.	The professional component is included under the cap and is zero-paid. The facility claim will be paid fee-for-service since the TIN does not match the TIN of the member's PCP	
Primary care claim is billed by an APP.	Claims from APPs will be included in the cap if they are billing under the same TIN that the member is attributed to (and the other capitation criteria are satisfied). Otherwise, it will be paid FFS.	CRNAs and psychiatric NPs will be excluded from the cap.
Member gets an urgent care visit with a physician who is a PCP.	As long as the physician has an included specialty (e.g., internal medicine or family medicine), the codes billed are on the list of PC cap codes, and the provider bills under the same TIN as the patient is attributed to, this code would be zero-paid.	

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Included Specialties

Acute Care Nurse Practitioner	Internal Medicine
Adolescent Medicine	Neonatal Nurse Practitioner
Adult Nurse Practitioner	Nurse Practitioner
Certified Nurse Midwife	Osteopathic Manipulative Medicine
Family Medicine	Pediatric Nurse Practitioner
Family Nurse Practitioner	Pediatrics
Family Practice with OMT	Physician Assistant
General Practice	Preventive Medicine
Geriatric Medicine	Public Health & General Preventive Medicine
Gerontological Nurse Practitioner	Women's Health Care Nurse Practitioner

Excluded Specialties

Anesthesiology	Pain Medicine
Brain Injury Medicine	Pediatric Anesthesiology Sleep Medicine
Child and Adolescent Neurology	Pediatric Dermatology
Child and Adolescent Psychiatry	Pediatric Neurology
Colon and Rectal Surgery	Pediatric Radiology
Complex General Surgical Oncology	Pediatric Surgery
Congenital Cardiac Surgery	Physical Medicine and Rehabilitation
Dermatology	Plastic and Reconstructive Surgery
Diagnostic Radiology	Plastic Surgery
Female Pelvic Med Recon Surg	Plastic Surgery Within the Head and Neck
Forensic Psychiatry	Podiatric Surgery
Geriatric Psychiatry	Psychiatry
Neurodevelopmental Disabilities	Radiation Oncology
Neurological Surgery	Radiologic Physics
Neurology	Sleep Medicine
Neuromuscular Medicine	Spinal Cord Injury Medicine
Neurophysiology	Surgery
Neuroradiology	Surgery of the Hand
Nuclear Medicine	Surgery, Obstetrics-Gynecology
Nuclear Radiology	Thoracic Surgery
Nurse Anesthetist	Vascular and Interventional Radiology
Oral and Maxillo-Facial Surgery	Vascular Surgery
Orthopedic Surgery	

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CPT Codes included in MassHealth sub-cap (1/5)

CPT Code	Definition
T1015	Clinic visit/encounter, all-inclusive
90460	Immunization administration through 18 years of age via any route of administration, with counseling by physician or other qualified health care professional; first or only component of each vaccine or toxoid administered
90461	Immunization administration through 18 years of age via any route of administration, with counseling by physician or other qualified health care professional; each additional vaccine or toxoid component administered (List separately in addition to code for primary procedure)
90471	Immunization administration (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); 1 vaccine (single or combination vaccine/toxoid)
90472	Immunization administration (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); each additional vaccine (single or combination vaccine/toxoid) (List separately in addition to code for primary procedure)
90473	Immunization administration by intranasal or oral route; 1 vaccine (single or combination vaccine/toxoid)
90474	Immunization administration by intranasal or oral route; each additional vaccine (single or combination vaccine/toxoid) (List separately in addition to code for primary procedure)
90882	Environmental intervention for medical management purposes on a psychiatric patient's behalf with agencies, employers, or institutions
90887	Interpretation or explanation of results of psychiatric, other medical examinations and procedures, or other accumulated data to family or other responsible persons, or advising them how to assist patient
96160	Administration of patient-focused health risk assessment instrument (e.g., health hazard appraisal) with scoring and documentation, per standardized instrument
96161	Administration of caregiver-focused health risk assessment instrument (e.g., depression inventory) for the benefit of the patient, with scoring and documentation, per standardized instrument
98966	Telephone assessment and management service provided by a qualified nonphysician health care professional to an established patient, parent, or guardian not originating from a related assessment and management service provided within the previous 7 days nor leading to an assessment and management service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion
98967	Telephone assessment and management service provided by a qualified nonphysician health care professional to an established patient, parent, or guardian not originating from a related assessment and management service provided within the previous 7 days nor leading to an assessment and management service or procedure within the next 24 hours or soonest available appointment; 11-20 minutes of medical discussion
98968	Telephone assessment and management service provided by a qualified nonphysician health care professional to an established patient, parent, or guardian not originating from a related assessment and management service provided within the previous 7 days nor leading to an assessment and management service or procedure within the next 24 hours or soonest available appointment; 21-30 minutes of medical discussion
99050	Services provided in the office at times other than regularly scheduled office hours, or days when the office is normally closed (e.g., holidays, Saturday or Sunday), in addition to basic service
99051	Service(s) provided in the office during regularly scheduled evening, weekend, or holiday office hours, in addition to basic service
99173	SCREENING TEST VISUAL ACUITY QUANTITATIVE BILAT
99202	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and straightforward medical decision making, when using time for code selection, 15-29 minutes of total time is spent on the date or the encounter.
99203	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and straightforward medical decision making, when using time for code selection, 30-44 minutes of total time spent on the date of the encounter.
99204	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and straightforward medical decision making, when using time for code selection, 45-59 minutes of total time spent on the date of the encounter
99205	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and straightforward medical decision making, when using time for code selection, 60-74 minutes of total time spent on the date of the encounter.

CPT Codes included in MassHealth sub-cap (2/5)

CPT Code	Definition
99211	Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician or other qualified health care professional. Usually, the presenting problem(s) are minimal.
99212	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making, when using time for code selection, 10-19 minutes of total time spent on the date of the encounter
99213	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making, when using time for code selection, 20-29 minutes of total time spent on the date of the encounter.
99214	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making, when using time for code selection, 30-39 minutes of total time spent on the date of the encounter.
99215	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making, when using time for code selection, 40-54 minutes of total time spent on the date of the encounter.
99241	Office consultation for a new or established patient, which requires these 3 key components: A problem focused history; A problem focused examination; and Straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self-limited or minor. Typically, 15 minutes are spent face-to-face with the patient and/or family.
99242	Office consultation for a new or established patient, which requires these 3 key components: An expanded problem focused history; An expanded problem focused examination; and Straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low severity. Typically, 30 minutes are spent face-to-face with the patient and/or family.
99243	Office consultation for a new or established patient, which requires these 3 key components: A detailed history; A detailed examination; and Medical decision making of low complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate severity. Typically, 40 minutes are spent face-to-face with the patient and/or family.
99244	Office consultation for a new or established patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 60 minutes are spent face-to-face with the patient and/or family
99245	Office consultation for a new or established patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 80 minutes are spent face-to-face with the patient and/or family
99354	Prolonged evaluation and management or psychotherapy service(s) (beyond the typical service time of the primary procedure) in the office or other outpatient setting requiring direct patient contact beyond the usual service; first hour (List separately in addition to code for office or other outpatient Evaluation and Management or psychotherapy service)
99355	Prolonged evaluation and management or psychotherapy service(s) (beyond the typical service time of the primary procedure) in the office or other outpatient setting requiring direct patient contact beyond the usual service; each additional 30 minutes (List separately in addition to code for prolonged service)
99358	Prolonged evaluation and management service before and/or after direct patient care; first hour
99359	Prolonged evaluation and management service before and/or after direct patient care; each additional 30 minutes (List separately in addition to code for prolonged service)
99366	Medical team conference with interdisciplinary team of health care professionals, face-to-face with patient and/or family, 30 minutes or more, participation by nonphysician qualified health care professional
99367	Medical team conference with interdisciplinary team of health care professionals, patient and/or family not present, 30 minutes or more; participation by physician
99368	Medical team conference with interdisciplinary team of health care professionals, patient and/or family not present, 30 minutes or more; participation by nonphysician qualified health care professional

CPT Codes included in MassHealth sub-cap (3/5)

CPT Code	Definition
99381	Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient; infant (age younger than 1 year)
99382	Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient; early childhood (age 1 through 4 years)
99383	Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient; late childhood (age 5 through 11 years)
99384	Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient; adolescent (age 12 through 17 years)
99385	Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient; 18-39 years
99386	Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient; 40-64 years
99387	Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient; 65 years and older
99391	Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, established patient; infant (age younger than 1 year)
99392	Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, established patient; early childhood (age 1 through 4 years)
99393	Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, established patient; late childhood (age 5 through 11 years)
99394	Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, established patient; adolescent (age 12 through 17 years)
99395	Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, established patient; 18-39 years
99396	Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, established patient; 40-64 years
99397	Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, established patient; 65 years and older
99401	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 15 minutes
99402	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 30 minutes
99403	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 45 minutes
99404	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 60 minutes
99406	Smoking and tobacco use cessation counseling visit; intermediate, greater than 3 minutes up to 10 minutes
99407	Smoking and tobacco use cessation counseling visit; intensive, greater than 10 minutes
99408	Alcohol and/or substance (other than tobacco) abuse structured screening (e.g., AUDIT, DAST), and brief intervention (SBI) services; 15 to 30 minutes
99409	Alcohol and/or substance (other than tobacco) abuse structured screening (e.g., AUDIT, DAST), and brief intervention (SBI) services; greater than 30 minutes
99411	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to individuals in a group setting (separate procedure); approximately 30 minutes
99412	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to individuals in a group setting (separate procedure); approximately 60 minutes
99417	Prolonged office or other outpatient evaluation and management service(s) beyond the minimum required time of the primary procedure which has been selected using total time, requiring total time with or without direct patient contact beyond the usual service, on the date of the primary service, each 15 minutes of total time (List separately in addition to codes 99205, 99215 for office or other outpatient Evaluation and Management services)

CPT Codes included in MassHealth sub-cap (4/5)

CPT Code	Definition
99421	Online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 5-10 minutes
99423	Online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 21 or more minutes
99441	Telephone evaluation and management service by a physician or other qualified health care professional who may report evaluation and management services provided to an established patient, parent, or guardian not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion
99442	Telephone evaluation and management service by a physician or other qualified health care professional who may report evaluation and management services provided to an established patient, parent, or guardian not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 11-20 minutes of medical discussion
99443	Telephone evaluation and management service by a physician or other qualified health care professional who may report evaluation and management services provided to an established patient, parent, or guardian not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 21-30 minutes of medical discussion
99484	Care management services for behavioral health conditions, at least 20 minutes of clinical staff time, directed by a physician or other qualified health care professional, per calendar month, with the following required elements: initial assessment or follow-up monitoring, including the use of applicable validated rating scales; behavioral health care planning in relation to behavioral/psychiatric health problems, including revision for patients who are not progressing or whose status changes; facilitating and coordinating treatment such as psychotherapy, pharmacotherapy, counseling and/or psychiatric consultation; and continuity of care with a designated member of the care team.
99492	Initial psychiatric collaborative care management, first 70 minutes in the first calendar month of behavioral health care manager activities, in consultation with a psychiatric consultant, and directed by the treating physician or other qualified health care professional, with the following required elements: outreach to and engagement in treatment of a patient directed by the treating physician or other qualified health care professional; initial assessment of the patient, including administration of validated rating scales, with the development of an individualized treatment plan; review by the psychiatric consultant with modifications of the plan if recommended; entering patient in a registry and tracking patient follow-up and progress using the registry, with appropriate documentation, and participation in weekly caseload consultation with the psychiatric consultant; and provision of brief interventions using evidence-based techniques such as behavioral activation, motivational interviewing, and other focused treatment strategies.
99493	Subsequent psychiatric collaborative care management, first 60 minutes in a subsequent month of behavioral health care manager activities, in consultation with a psychiatric consultant, and directed by the treating physician or other qualified health care professional, with the following required elements: tracking patient follow-up and progress using the registry, with appropriate documentation; participation in weekly caseload consultation with the psychiatric consultant; ongoing collaboration with and coordination of the patient's mental health care with the treating physician or other qualified health care professional and any other treating mental health providers; additional review of progress and recommendations for changes in treatment, as indicated, including medications, based on recommendations provided by the psychiatric consultant; provision of brief interventions using evidence-based techniques such as behavioral activation, motivational interviewing, and other focused treatment strategies; monitoring of patient outcomes using validated rating scales; and relapse prevention planning with patients as they achieve remission of symptoms and/or other treatment goals and are prepared for discharge from active treatment
99494	Initial or subsequent psychiatric collaborative care management, each additional 30 minutes in a calendar month of behavioral health care manager activities, in consultation with a psychiatric consultant, and directed by the treating physician or other qualified health care professional (List separately in addition to code for primary procedure)
99495	Transitional Care Management Services with the following required elements: Communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge Medical decision making of at least moderate complexity during the service period Face-to-face visit, within 14 calendar days of discharge
99496	Transitional Care Management Services with the following required elements: Communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge Medical decision making of high complexity during the service period Face-to-face visit, within 7 calendar days of discharge

CPT Codes included in MassHealth sub-cap (5/5)

CPT Code	Definition
G0009	ADMINISTRATION OF PNEUMOCCOCCAL VACCINE
G0396	ALCOHOL &/SUBSTANCE ABUSE ASSESSMENT 15-30 MIN
G0397	ALCOHOL &/SUBSTANCE ABUSE ASSESSMENT >30 MIN
G0442	ANNUAL ALCOHOL MISUSE SCREENING 15 MINUTES
G0443	BRIEF FACE-FACE BEHAV CNSL ALCOHL MISUSE 15 MIN
G0444	Annual depression screening
G0463	Hospital outpatient clinic visit for assessment and management of a patient
G0511	Rural health clinic or federally qualified health center (RHC or FQHC) only, general care management, 20 minutes or more of clinical staff time for chronic care management services or behavioral health integration services directed by an RHC or FQHC practitioner (physician, NP, PA, or CNM), per calendar month (Behavioral health integration; applies to all MassHealth community health centers)
G0512	Rural health clinic or federally qualified health center (RHC or FQHC) only, psychiatric collaborative care model (psychiatric COCM), 60 minutes or more of clinical staff time for psychiatric COCM services directed by an RHC or FQHC practitioner (physician, NP, PA, or CNM) and including services furnished by a behavioral health care manager and consultation with a psychiatric consultant, per calendar month (applies to all MassHealth community health centers)

Agenda

- PC cap overview
- WS payment timing and reports
- Claims suppression logic
- Suggested next steps
- How to update data with WS
- **Appendix**
  - Additional financial information
  - Claims suppression FAQs
  - Included and Excluded Specialties
  - Included codes
  - **Tier requirements**
  - PID/SL “Coversheet” process

Overview of primary care sub-capitation tier requirements

Overview

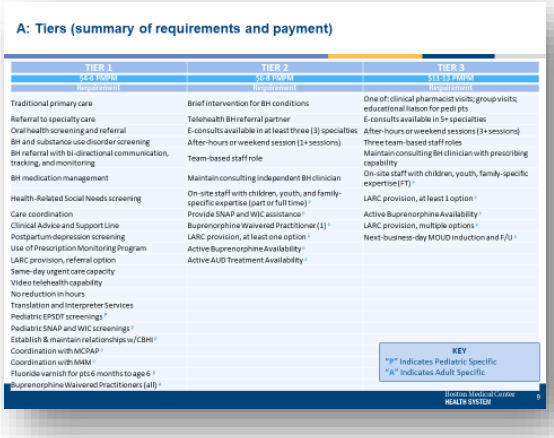
- MassHealth defined a set of 45 total PC Sub-Cap requirements and divided those into three tiers.
- Each PID/SL needs to attest to a Tier based on the requirements that can be achieved by July 1, 2023.
- Some tier requirements can be met centrally (e.g., after-hours access).
- A PID/SL must meet all Tier 1 requirements by July 1st in order to participate in the ACO program
- The Primary Care Entity will be paid a PMPM amount reflecting the tier designations of each of its PID/SL's.
- PID/SL tier attestations will be locked in yearly; we will have one chance this fall to update tiers before the start of the waiver.

Audit

- Mass Health will audit up to 25% of PID/SLs annually. The audit will mostly involve document review. There will be a 6-9 month period to remediate any issues.
- There will be a 30-day notice to practice of an audit occurring. Practices are expected to meet tier requirements by July 1st.
- MassHealth has not released guidance on documentation requirements that would satisfy the audit.

Next Steps

- Work is underway to create resources, best practices, audit document preparations, etc. for groups to feel knowledgeable and comfortable meeting their tiers by July 1 (e.g. Weekly Provider Collaboration Series)
- Provider Collaboration Series recordings and materials are posted to Box.Com and/or Moveit
- To support programmatic goals and advancing your practice capabilities, we will support you longer-term in advancing your Tier level.
- We are awaiting further clarification from MassHealth on several requirements and are optimistic that we will be able to more openly communicate now that the procurement was awarded.
- Example questions open: Are CHCs automatically Tier 3, or do they need to meet all Tier 3 requirements? Does each PID/SL need to meet the LARC, BUP, and OUD requirements, or can these be met centrally?


A: Tiers (summary of requirements and payment)

TIER 1	TIER 2	TIER 3
$4.6 PMPM	$6.8 PMPM	$11.13 PMPM
Requirement	Requirement	Requirement
Traditional primary care	Brief intervention for BH conditions	One of: clinical pharmacist visits; group visits; educational liaison for pedi pts
Referral to specialty care	Telehealth BH referral partner	E-consults available in 5+ specialties
Oral health screening and referral	E-consults available in at least three (3) specialties	After-hours or weekend sessions (3+sessions)
BH and substance use disorder screening	After-hours or weekend session (1+ sessions)	Three team-based staff roles
BH referral with bi-directional communication, tracking, and monitoring	Team-based staff role	Maintain consulting BH clinician with prescribing capability
BH medication management	Maintain consulting independent BH clinician	On-site staff with children, youth, family-specific expertise (FT)
Health-Related Social Needs screening	On-site staff with children, youth, and family-specific expertise (part or full time)	LARC provision, at least 1 option
Care coordination	Provide SNAP and WIC assistance	Active Buprenorphine Availability
Clinical Advice and Support Line	Buprenorphine Waivered Practitioner (1)	LARC provision, multiple options
Postpartum depression screening	LARC provision, at least one option	Next-business-day MOUD induction and F/U
Use of Prescription Monitoring Program	Active Buprenorphine Availability	
LARC provision, referral option	Active AUD Treatment Availability	
Same-day urgent care capacity		
Video telehealth capability		
No reduction in hours		
Translation and Interpreter Services		
Pediatric EPSDT screenings		
Pediatric SNAP and WIC screenings		
Establish & maintain relationships w/CBHI		
Coordination with MCPAP		
Coordination with M4M		
Fluoride varnish for pts 6 months to age 6		
Buprenorphine Waivered Practitioners (all)		

KEY
"P" Indicates Pediatric Specific
"A" Indicates Adult Specific

Boston Medical Center HEALTH SYSTEM

PID/SL: Provider ID / Service Location
Additional details on tier requirements and the audit notice and timing can be found in the appendix.

Tiers (summary of requirements and payment)

TIER 1	TIER 2	TIER 3
$4-6 PMPM	$6-8 PMPM	$11-13 PMPM
Requirement	Requirement	Requirement
Traditional primary care	Brief intervention for BH conditions	One of: clinical pharmacist visits; group visits; educational liaison for pedi pts
Referral to specialty care	Telehealth BH referral partner	E-consults available in 5+ specialties
Oral health screening and referral	E-consults available in at least three (3) specialties	After-hours or weekend sessions (3+ sessions)
BH and substance use disorder screening	After-hours or weekend session (1+ sessions)	Three team-based staff roles
BH referral with bi-directional communication, tracking, and monitoring	Team-based staff role	Maintain consulting BH clinician with prescribing capability
BH medication management	Maintain consulting independent BH clinician	On-site staff with children, youth, family-specific expertise (FT) P
Health-Related Social Needs screening	On-site staff with children, youth, and family-specific expertise (part or full time) P	LARC provision, at least 1 option P
Care coordination	Provide SNAP and WIC assistance P	Active Buprenorphine Availability P
Clinical Advice and Support Line	Buprenorphine Waivered Practitioner (1) P	LARC provision, multiple options A
Postpartum depression screening	LARC provision, at least one option A	Next-business-day MOUD induction and F/U A
Use of Prescription Monitoring Program	Active Buprenorphine Availability A	
LARC provision, referral option	Active AUD Treatment Availability A	
Same-day urgent care capacity		
Video telehealth capability		
No reduction in hours		
Translation and Interpreter Services		
Pediatric EPSDT screenings P		
Pediatric SNAP and WIC screenings P		
Establish & maintain relationships w/CBHI P		
Coordination with MCPAP P		
Coordination with M4M P		
Fluoride varnish for pts 6 months to age 6 P		
Buprenorphine Waivered Practitioners (all) A		

KEY
"**P**" Indicates Pediatric Specific
"**A**" Indicates Adult Specific

Primary Care Sub-capitation Requirements – Tier 1 (1/9)

Tier	Requirement Type	Title of Requirement	Full Requirement Description
1	Care Delivery	Traditional primary care	Provide accessible, comprehensive, longitudinal, person-centered, and coordinated primary care services including evaluation and management of common health issues, disease prevention, and wellness promotion. While practices may offer some traditional primary care virtually via telehealth, Enrollees must be able to access this requirement on-site.
1	Care Delivery	Referral to specialty care	Be able to guide and coordinate referrals and request evaluation of a patient by clinicians outside of the primary care practice for specific concerns. Such referrals shall include the primary care practice's ability to communicate with and receive communications from the specialty practice, with the primary care practice continuing to serve as a central home of health care services for the patient. This includes sub-specialty medical, oral health , mental health, and substance use disorder referrals.
1	Care Delivery	Oral health screening and referral	Conduct an annual (every 12 months) structured oral health screening for attributed patients. For example, a clinic tool may use the National Health and Nutrition Examination Survey Oral Health Questionnaire (https://wwwn.cdc.gov/nchs/data/nhanes/2015-2016/questionnaires/OHQ_I.pdf). An on-site dental exam for attributed patients shall meet this requirement. An assessment screening shall clearly define what constitutes a positive screening result versus a negative result and shall assess if the patient currently has access to an oral health provider or a regular and reliable source for oral health needs. Additionally, retain and provide to patients (and/or their parents/caregivers) a list of local and reasonably-accessible oral health providers who are within the MassHealth network for their particular patients (MassHealth providers are available at: https://provider.masshealth-dental.net/MH_Find_a_Provider#/home). This information shall be updated at least annually for any openings/closings or additions/removals of MassHealth coverage of these providers. Such a list shall be provided to patients with a positive oral health screen and those without an oral health provider. Such a list may be adapted from materials provided by MassHealth of practices and providers currently enrolled in the program. While practices may offer some oral health screenings and referrals virtually via telehealth, Enrollees must be able to access this requirement on-site.
1	Care Delivery	BH and substance use disorder screening	Conduct an annual and universal practice-based screening of attributed patients >21 years of age. Such a screen shall at minimum assess for depression, tobacco use, unhealthy alcohol use, other substance use, and preexisting mental health disorders using an age-appropriate, evidence-based, standardized screening tool. When any screening is positive, the practice shall respond with appropriate interventions and/or referrals. See below under this Section 1, subsection C for screening expectations for any attributed patients younger than 21 years of age per the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) protocol and schedule. While practices may offer some BH and substance use screening virtually via telehealth, Enrollees must be able to access this requirement on-site.
1	Care Delivery	BH referral with bi-directional communication, tracking, and monitoring	Retain and provide to patients a list of local and reasonably-accessible BH providers who are within the MassHealth network, including those that offer therapy and counseling services, BH medication management, and intensive outpatient or day treatment programs. The list of local BH providers shall be providers with whom the practice can conduct bi-directional communication about the patient. This can include electronic health record, phone, fax, or other modalities. This communication can be asynchronous, but it shall allow for both the primary care practice and the BH practice to communicate back and forth with each other. The practice shall also regularly assess if such partners continue to have bandwidth to see its patients within reasonable turnaround times. In addition, track referrals made through the practice and problem-solve for patients who are unable to engage in a referral visit.
1	Care Delivery	BH medication management	Prescribe, refill, and adjust medications for the treatment of common BH issues amenable to treatment in the primary care setting, including but not limited to major depressive disorder, generalized anxiety disorder, and attention deficit-hyperactivity disorder. Such services can occur independently or providers may receive assistance from available resources such as the Massachusetts Child Psychiatry Access Program (MCPAP), a clinical pharmacist, psychiatrist, psychiatric clinical nurse specialist, etc. While practices may offer some BH medication management virtually via telehealth, Enrollees must be able to access this requirement on-site.

Primary Care Sub-capitation Requirements – Tier 1 (2/9)

Tier	Requirement Type	Title of Requirement	Full Requirement Description
1	Care Delivery	Health-Related Social Needs (HRSN) screening	Conduct universal practice- or ACO-based screening of attributed patients for HRSN using a standardized, evidence-based tool, and shall have the ability to provide a regularly-updated inventory of relevant community-based resources to those with positive screens. Pediatric screening questions shall be reviewed by the ACO's designated Pediatric Expert. HRSN screening may be met exclusively via a central or virtual resource, including being provided by the ACO.
1	Care Delivery	Care coordination	Participate in formalized practice-driven and/or ACO-driven care coordination that identifies patients at risk due to medical, BH, HRSN, psychosocial and/or other needs and deploys risk-stratified interventions and approaches to addressing patients' needs. Such approaches can include but are not limited to communication and information-sharing between care team patients and specialists or ancillary services, identification and rectification of gaps in preventive care or chronic disease management, assisting patients with transitions of care, pre-visit planning, post-hospitalization coordination, and assistance with patient self-management of chronic disease. Such approaches can also include connecting patients to community-based services, state agencies (e.g., Massachusetts Department of Children and Families [DCF], Massachusetts Department of Developmental Services [DDS], Massachusetts Department of Mental Health [DMH], Massachusetts Department of Public Health [DPH], Massachusetts Department of Transitional Assistance [DTA], Massachusetts Department of Youth Services [DYS]), federal programs (e.g., Supplemental Nutrition Assistance Program [SNAP], Special Supplemental Nutrition Assistance Program for Women, Infants, and Children [WIC]), other ACO programs such as the ACO Care Management, Community Partners and Flexible Services programs, and other supports and care management resources. These services may be provided by practice-based personnel directly, or by ACO- or system-level resources and care pathways that coordinate with the primary care practice . Such interventions shall be standardized and consistent workstreams for the practice and align with the greater ACO's strategies around physical health, BH, HRSN, and other care coordination. For more information on ACO expectations around care coordination, please refer to Section 2.6 of the Contract. Care coordination may be met exclusively via a central or virtual resource, including being provided by the ACO.
1	Care Delivery	Clinical Advice and Support Line	Ensure patients are made aware of the availability of after-hours telephonic advice, either through the ACO's Clinical Advice and Support Line, or a resource provider by the practice. Clinical advice and support line services may be met exclusively via a central or virtual resource, including being provided by the ACO.
1	Care Delivery	Postpartum depression screening	If caring for infants in the first year of life or for postpartum individuals who are within 12 months of delivery, screen for postpartum depression using an evidence-based and validated tool, such as the Edinburgh Postnatal Depression Scale (EPDS). For individuals who have a positive screen for postpartum depression, the practice shall be able to provide referral, or follow-up, and/or care coordination for the patient. Care coordination models shall be evidence-based (examples of such models include PRISM - Program In Support of Moms and ROSE - Reach Out Stay Strong Essentials for mothers of newborns). While practices may offer some postpartum depression screenings virtually via telehealth, Enrollees must be able to access this requirement on-site.
1	Care Delivery	Use of Prescription Monitoring Program	All prescribing personnel at the practice site shall have access to and regularly use the Massachusetts Prescription Awareness Tool (Mass PAT) in accordance with Commonwealth of Massachusetts General Law: https://malegislature.gov/Laws/GeneralLaws/PartI/TitleXV/Chapter94C/Section24A.
1	Care Delivery	LARC provision, referral option	Have the ability to discuss options for LARC (e.g., intrauterine device or subdermal implant) with relevant patients and refer patients seeking such options to known in-network providers who can place these for the patient. Providers may also, rather than referring patients, provide and place these directly for patients within the primary care practice.

Primary Care Sub-capitation Requirements – Tier 1 (3/9)

Tier	Requirement Type	Title of Requirement	Full Requirement Description
1	Structure and Staffing	Same-day urgent care capacity	Make available time slots each day for urgent care needs for its patient population. While practices may offer some urgent care capacity virtually via telehealth, Enrollees must be able to access this requirement on-site.
1	Structure and Staffing	Video telehealth capability	Have the ability to conduct visits with practice staff using a synchronous audio-video telehealth modality in lieu of an in-person patient encounter.
1	Structure and Staffing	No reduction in hours	Relative to regular practice hours prior to engagement in the sub-capitation program, offer the same or increased number of total regular on-site operating hours and clinical sessions in which patients have been historically seen.
1	Structure and Staffing	Access to Translation and Interpreter Services	Provide interpreter services for attributed patients, in accordance with applicable state and federal laws, including options to accommodate preferred languages and the needs of enrollees who are deaf or hard of hearing. Such services shall be noted to be available in a patient's or their caregiver's preferred language and should come without additional cost to the patient.
1	Pediatric Population	Pediatric EPSDT screenings	Administer, at a minimum, BH, developmental, social, and other screenings and assessments as required under EPSDT. While practices may offer some EPSDT screenings virtually via telehealth, Enrollees must be able to access this requirement on-site.
1	Pediatric Population	Pediatric SNAP and WIC screenings	Screen for SNAP and WIC eligibility, in accordance with Provider Manual Appendix W, if applicable: Practices shall also complete the medical referral form for WIC eligible patients. Patients and families deemed eligible for these programs should be referred to further resources in order to apply for and engage these programs. While practices may offer some SNAP and WIC screenings virtually via telehealth, Enrollees must be able to access this requirement on-site.
1	Pediatric Population	Establish and maintain relationships with local Children's Behavioral Health Initiative (CBHI)	The practice shall identify its staff member(s) responsible for 1) communicating with and reporting to CBHI program in a closed-loop manner, and 2) maintaining a roster of children attributed to the practice who are receiving CBHI services.
1	Pediatric Population	Coordination with MCPAP	Enroll with MCPAP at https://www.mcpap.com/. The practice shall consult with and use the services of MCPAP to augment the BH expertise provided within the practice as a means to maintain the management of youth with mild to moderate BH conditions in primary care. Alternatively, the practice can satisfy this requirement by accessing equivalent resources available within their own health system – such as consultation with child and adolescent psychiatrists working in the clinic or a neighboring site or via consultation from an asynchronous resource such as an e-consult. Use of such an alternative resource, however, does not exempt the practice from enrolling with MCPAP.

Primary Care Sub-capitation Requirements – Tier 1 (4/9)

Tier	Requirement Type	Title of Requirement	Full Requirement Description
1	Pediatric Population	Coordination with Massachusetts Child Psychiatry Access Program for Moms (M4M)	If providing obstetrical services, enroll in the M4M program at https://www.mcpapformoms.org/. The practice shall consult with M4M to augment the BH expertise provided within the practice as a means to maintain the management of perinatal patients with mild to moderate BH conditions in primary care. Alternatively, the practice can satisfy this requirement by accessing equivalent resources available within their own health system – such as consultation with a psychiatrist or appropriately trained Ob/Gyn of suitable expertise working in the clinic or a neighboring site, or via consultation from an asynchronous resource such as an e-consult. Use of such an alternative resource however does not exempt the practice from enrolling with the M4M program. While practices may offer some coordination with MCPAP for Moms virtually via telehealth, Enrollees must be able to access this requirement on-site.
1	Pediatric Population	Fluoride varnish for patients ages 6 months up to age 6	Assess the need for fluoride varnish at all preventive visits from six (6) months to six (6) years old, and, once teeth are present, must provide application of fluoride varnish on-site in the primary care office at least twice per year for all children, starting when the first tooth erupts and until the patient has another reliable source of dental care (https://publications.aap.org/pediatrics/article/146/6/e2020034637/33536/Fluoride-Use-in-Caries-Prevention-in-the-Primary). For those pediatric patients who do not have a dental home, the practice must share a list of MassHealth dental providers with the parent/caregiver as noted above. If there is a co-located dental office or evidence that the dental office has already provided this service, such may substitute in this requirement for the relevant patients who have access to or have accessed these resources. Enrollees must be able to access this fluoride varnish on-site.
1	Adult Population	Buprenorphine Waivered Practitioner Requirement	All individual Primary Care Providers must have the capability and credentialing to prescribe buprenorphine. This requirement can be met by prescribers either submitting the Substance Abuse and Mental Health Services Administration (SAMHSA) notice of intent (NOI) without additional training requirements, or via having a buprenorphine waiver. More information can be found here (https://www.samhsa.gov/medication-assisted-treatment/become-buprenorphine-waivered-practitioner). The individual providers need not be actively prescribing buprenorphine to meet this requirement.

Primary Care Sub-capitation Requirements – Tier 2 (5/9)

Tier	Requirement Type	Title of Requirement	Full Requirement Description
2	Care Delivery	Brief intervention for BH conditions	Provide brief interventions for patients with identified BH needs, as appropriate, such as Screening, Brief Intervention, and Referral to Treatment (SBIRT), brief Cognitive Behavioral Therapy (CBT), or an equivalent model. These may be provided by a front-line clinical provider or by an integrated member of the clinical team, such as a licensed independent clinical social worker (LICSW). While practices may offer some BH interventions for BH conditions virtually via telehealth, Enrollees must be able to access this requirement on-site.
2	Care Delivery	Telehealth-capable BH referral partner	Include at least one BH provider who is capable of providing services via a synchronous audio-video telehealth modality among its local and reasonably-accessible list of BH providers who are within the MassHealth network.
2	Structure and Staffing	E-consults available in at least three (3) specialties	Be capable of asynchronous, consultative, provider-to-provider communications within a shared Electronic Health Record (EHR) or web-based platform between primary care and specialist providers over a secure electronic medium that involves sharing of patient-specific information and discussing clarification or guidance regarding targeted clinical care. E-consults shall be available to clinical staff within the practice to discuss with specialists in at least three distinct and non-redundant American Board of Medical Specialties (ABMS)-recognized specialties. For example, offering e-consults to multiple specialties with board certification under the pathways of Internal Medicine, such as cardiology, endocrinology, and nephrology meets this requirement. On the other hand, multiple specialties with certification under a shared subspecialty would be considered redundant; for example, seeking to count e-consults in general cardiology, clinical cardiac electrophysiology, and interventional cardiology as three distinct specialties would not meet this requirement.
2	Structure and Staffing	After-hours or weekend session (at least 1)	Offer at least four hours for in-person or telehealth visits, with the practice's own providers or with providers from another of the Contractor's Network PCPs (ACPP) or Participating PCPs (PCACO) as further specified below, at least once per week within any of the following periods (Monday through Friday: Outside the hours of 8:00 a.m.-5:00 p.m. Saturday or Sunday: During any period) These session(s) may be covered by the practice's own providers or with providers from another of the Contractor's Network PCPs (ACPP) or Participating PCPs (PCACO) such that one practice may cover the weekend or after-hours sessions for a maximum of two other practices. If the practice utilizes another practice for this coverage, EOHHS encourages the Contractor to utilize practices that are located in close geographic proximity to the practice. In addition, any providers staffing such sessions (including those at another practice site) must have access to the practice's EHR and must document the visit within the practice's EHR. Sessions cannot be those offered by a third-party or a group unaffiliated with the primary care practice as described above, unable to access the practice's EHR, or unaffiliated with the practice's patient population. The required after-hours or weekend session shall provide behavioral health referral with bi-directional communication, tracking, and monitoring. Providers staffing after-hours or weekend sessions shall communicate any visits during those sessions to the Enrollee's primary care provider. The Contractor or the practice shall communicate to Enrollees where to access after-hours or weekend sessions.
2	Structure and Staffing	Team-based staff role	Maintain at least one (1) team-based staff role dedicated to the specific primary care site. This role may be met virtually but must be on-site at least monthly. If this role is offered virtually, the practice must have multimedia available for Enrollees to engage with the role from the practice. This role shall consist of any of the following or similar roles: o Community health worker (CHW) o Peer (Certified Peer Specialist, Recovery Coach, Family Partner, Family Navigator) o Social worker (licensed clinical social worker [LCSW], LICSW) or other master's-prepared clinician such as a Master of Social Work (MSW) o Nurse case manager Such team-based role shall: o Be available and doing work on behalf of the specific practice site for at least three or more equivalent 4-hour sessions (i.e., >0.3 FTE) per week, o Conduct activities such as but not limited to team-based huddles, activities on behalf of patients at the site, or patient-facing activities. o Participate in team activities such as team huddles, i.e., standing team meetings for the purpose of pre-visit planning, population health management, process improvement, etc.

Primary Care Sub-capitation Requirements – Tier 2 (6/9)

Tier	Requirement Type	Title of Requirement	Full Requirement Description
2	Structure and Staffing	Maintain a consulting independent BH clinician	Maintain a dedicated and accessible consulting BH clinician available to assist the practice with cases of moderate complexity. This role shall be a licensed BH provider, such as a psychiatrist, psychologist, psychiatric clinical nurse practitioner, LICSW, licensed mental health counselor (LMHC), or licensed marriage and family therapist (LMFT). This requirement may be fulfilled via a single role fulfilling both this requirement and the team-based staff role requirement above . o This resource shall be available to assist the practice with cases of moderate BH complexity on a regular basis and assist with co-management of referred cases that can otherwise remain anchored in the primary care setting. Where feasible, this resource shall also be available for team-based huddles and warm-handoffs to support patient care . o This resource may be virtually available to the practice and can utilize asynchronous means of communication inclusive of e-consult but shall be able to respond to queries within two business days.
2	Pediatric Population	On-site staff with children, youth, and family-specific expertise (part or full time)	Identify at least one non-clinical team member with demonstrable experience addressing the BH and HRSN of children, youth, and families in a health care setting and/or possessing specialized training, degree, licensing, or certification in such work. This role may be met virtually but shall be on-site at least monthly. This role shall be responsible for communicating with and being the site's primary and reliable point of contact to the CBHI program, Family Resource Centers (FRCs), and schools/early childhood settings.
2	Pediatric Population	Provide SNAP and WIC assistance	Provide patients and their families who are eligible for SNAP and WIC application assistance through the practice in order to assist patients and their families to apply for and engage those programs. While practices may offer some assistance virtually, Enrollees must be able to access this requirement on-site.
2	Pediatric Population	Buprenorphine Waivered Practitioner Requirement	At least one (1) individual Primary Care Provider at the practice must have the capability and credentialing to prescribe buprenorphine. This requirement can be met by prescribers either submitting the Substance Abuse and Mental Health Services Administration (SAMHSA) notice of intent (NOI) without additional training requirements, or via having a buprenorphine waiver. More information can be found here. The individual Primary Care provider with the capability and credentialing to prescribe buprenorphine need not be actively prescribing buprenorphine to meet this requirement. Providers may leverage the partnership and guidance of MCPAP for guidance on prescribing buprenorphine: www.mcpap.com.
2	Adult Population	LARC provision, at least one option	Have the on-site ability to place at least one (1) type of long-acting reversible contraceptive (e.g., intrauterine device or subdermal implant). This service shall be available on-site during normal business hours at least one session every other week (i.e., twice monthly). This activity may occur either in the primary care office or from a co-located provider at the same practice site. Enrollees must be able to access this requirement on-site.
2	Adult Population	Active Buprenorphine Availability	Have at least one (1) individual provider actively prescribing buprenorphine for management of opioid use disorder to patients with opioid use disorder as clinically indicated. Actively prescribing means that a provider is either currently prescribing buprenorphine for Enrollees at the practice, or is willing and able to if and when any Enrollee is in need of this service, without having to refer the Enrollee to another location. This provider shall be dedicated and available to patients in the practice on-site or virtually on at least a weekly basis. Providing referrals to SUD care or maintaining agreements with other providers or practices that require the Enrollee to present at a different location does not meet this requirement.
2	Adult Population	Active Alcohol Use Disorder (AUD) Treatment Availability	At least one provider actively prescribing or willing and able to prescribe relevant medications for management of alcohol use disorder (e.g., Disulfiram, Acamprosate, Naltrexone, etc.). This requirement may be met virtually. However, providers must be capable of asynchronous, consultative, provider-to-provider communications within a shared Electronic Health Record (EHR) or web-based platform between primary care and specialist providers over a secure electronic medium that involves sharing of patient-specific information and discussing clarification or guidance regarding targeted clinical care.

Primary Care Sub-capitation Requirements – Tier 3 (7/9)

Tier	Requirement Type	Title of Requirement	Full Requirement Description
3	Care Delivery	Fulfill one of the following: clinical pharmacist visits OR group visits OR designated educational liaison for pediatric patients	The practice shall fulfill at least one of the following three requirements: 1) Clinical pharmacist visits: offer its patients the ability to conduct office-based or virtual appointments with a licensed clinical pharmacist focused on medication management and teaching. This role may conduct its activities virtually. The clinical pharmacist shall be dedicated to the practice for a minimum of three (3) or more equivalent 4-hour sessions per week (i.e., >0.3 FTE) OR 2) Group visits: offer its patients the ability to participate in office-based or virtual appointments at which services are provided to multiple patients for a shared condition and peer support is elicited (e.g., mental health, substance use disorder, antenatal care, etc.). These visits may be conducted virtually. Group visits shall be offered by staff that are dedicated to the practice for a minimum of three (3) or more equivalent 4-hour sessions per week (i.e., >0.3 FTE) OR 3) Designated Educational Liaison for pediatric patients: For practices serving pediatric patients, have dedicated staff member that serves as an office-based or virtual resource for families navigating the intersection of the medical and educational systems. This role may conduct its activities virtually. The Educational Liaison shall have knowledge of education and special education systems, including early education settings, and shall create relationships with local schools and early education settings. The Educational Liaison shall provide support to patients with medical, developmental, and/or BH needs and shall be available to provide input to the educational team at schools as needed and shall be dedicated to the practice for a minimum of three (3) or more equivalent 4-hour sessions per week (i.e., >0.3 FTE).
3	Structure and Staffing	E-consults available in at least five (5) specialties	Be capable of asynchronous, consultative, provider-to-provider communications within a shared EHR or web-based platform between primary care and specialist providers over a secure electronic medium that involves sharing of patient-specific information and discussing clarification or guidance regarding targeted clinical care. E-consults shall be available to clinical staff within the primary care practice to discuss with specialists in at least five (5) distinct and non-redundant ABMS-recognized specialties. For example, offering e-consults to multiple specialties with board certification under Internal Medicine, such as cardiology, endocrinology, and nephrology meets this requirement. On the other hand, multiple specialties with certification under a shared subspecialty would be considered redundant; for example, general cardiology, clinical cardiac electrophysiology, and interventional cardiology would not meet this requirement.
3	Structure and Staffing	After-hours or weekend sessions (at least 3)	Offer at least 12 hours for in-person or telehealth visits with the practice's own providers or with providers from another of the Contractor's Network PCPs (ACPP) or Participating PCPs (PCACO) as further specified below, falling within any of the following periods (Monday through Friday: Outside the hours of 8:00 a.m.-5:00 p.m. Saturday or Sunday: During any period of at least four hours) These session(s) may be covered by the practice's own providers or with providers from another of the Contractor's Network PCPs (ACPP) or Participating PCPs (PCACO) such that one practice site may cover the weekend or after-hours sessions for a maximum of two other practices. If the practice utilizes another practice site for this coverage, EOHHS encourages the Contractor to utilize practice sites that are located in close geographic proximity to the practice. In addition, any providers staffing such sessions (including those at another practice site) must have access to the practice's EHR and must document the visit within the practice's EHR. Sessions cannot be those offered by a third-party or a group unaffiliated with the primary care practice as described above, unable to access the practice's EHR, or unaffiliated with the practice's patient population. At least 4 hours shall be in-person. At least 4 hours must fall on a weekend day. Providers staffing after-hours or weekend sessions shall communicate any visits during those sessions to the Enrollee's primary care provider. The Contractor or the practice shall communicate to Enrollees where to access after-hours or weekend sessions.

Primary Care Sub-capitation Requirements – Tier 3 (8/9)

Tier	Requirement Type	Title of Requirement	Full Requirement Description
3	Structure and Staffing	Three team-based staff roles	Maintain at least three (3) team-based staff roles dedicated to the specific primary care site. These roles may be met virtually but must be on-site at least monthly. If these roles are offered virtually, the practice must have multimedia available for Enrollees to engage with the role from the practice site. These roles shall consist of the following: o At least one (1) staff role shall be a licensed BH clinician (e.g., psychologist, LICSW, LCSW) o At least one (1) staff role shall be a peer, family navigator, CHW, or similar. o The other staff role(s) may be one of the following, or similar: - Peer (Certified Peer Specialist, Recovery Coach, Family Partner, Family Navigator) - Social worker (LCSW, LICSW) or other master's-prepared clinician such as a Master of Social Work (MSW) - Nurse case manager Such team-based roles shall: o Be available and doing work on behalf of the specific practice site for a minimum of three (3) or more equivalent 4-hour sessions per week (i.e., >0.3 FTE) individually, and at minimum collectively 1.0 FTE per the practice. o Conduct activities such as but not limited to team-based huddles, activities on behalf of patients at the site, or patient-facing activities. o Collectively, ensure at least one (1) FTE meeting these staff roles is available and dedicated to the practice at each of the 10 usual business hour sessions (Monday through Friday, mornings and afternoons) to respond in real-time to practice needs. o All participate in regular team activities such as team huddles (i.e., standing team meetings for the purpose of pre-visit planning), population health management, and/or process improvement
3	Structure and Staffing	Maintain a consulting BH clinician with prescribing capability	Maintain a consulting BH clinician with prescribing capability: maintain a dedicated and accessible consulting BH clinician on-site or virtually with prescribing capability available to assist the practice with cases of moderate and rising complexity. Such BH clinician shall: o Have familiarity with titration of BH medications (e.g., psychiatrist or psychiatric clinical nurse practitioner). o Be regularly available for activities including but not limited to making appointments on behalf of the practice in the same week, participating in case management activities, answering practice queries within two (2) business days, and assisting with co-management of referred cases
3	Pediatric Population	Full-time, on-site staff with children, youth, and family-specific expertise	Identify at least one non-clinical team member with experience addressing BH and HRSN of children, youth, and families in a health care setting and/or with specialized degree, license, training, or certification in such work. Such staff shall be available during normal business hours (Monday through Friday, mornings and afternoons), and shall be responsible for communicating with and being the site's primary and reliable point of contact to the CBHI program, FRCs, and schools/early childhood education settings. This role may be met virtually but shall be on-site at least monthly.
3	Pediatric Population	LARC provision, at least one (1) option	Have the ability on-site to insert at least one type of LARC (e.g., intrauterine device or subdermal implant). This service shall be available on-site during normal business hours at least one session every other week (i.e., twice monthly). Enrollees must be able to access this requirement on-site.

Primary Care Sub-capitation Requirements – Tier 3 (9/9)

Tier	Requirement Type	Title of Requirement	Full Requirement Description
3	Pediatric Population	Active Buprenorphine Availability	Must have at least one (1) provider actively prescribing buprenorphine for management of opioid use disorder to patients with opioid use disorder, as clinically indicated. Actively prescribing means that a provider is either currently prescribing buprenorphine for enrollees at the practice, or is willing and able to if and when any Enrollee is in need of this service without having to refer the Enrollee to another location. This provider shall be available to patients in the practice on at least a weekly basis. Providing referrals to SUD care or maintaining agreements with other providers or practices at a different location does not meet this requirement. Providers may leverage the partnership and guidance of MCPAP for guidance on prescribing buprenorphine: www.mcpap.com. This requirement may be met virtually. However, providers must be capable of asynchronous, consultative, provider-to-provider communications within a shared Electronic Health Record (EHR) or web-based platform between primary care and specialist providers over a secure electronic medium that involves sharing of patient-specific information and discussing clarification or guidance regarding targeted clinical care.
3	Adult Population	LARC provision, multiple options	Have the ability on-site to insert multiple forms of LARC (e.g., intrauterine device and subdermal implant). This service shall be available on-site during normal business hours at least one (1) session per week. Enrollees must be able to access this requirement on-site.
3	Adult Population	Capability for next-business-day Medication for Opioid Use Disorder (MOUD) induction and follow-up	Must have an evidence-based written protocol (such as SAMHSA's guidance found here) and the capability to provide in-office or virtual induction (as permitted by federal law, including but not limited to the Ryan Haight Act) of buprenorphine and opioid withdrawal management within one business day of diagnosis of opioid use disorder or treatment of withdrawal or relapse. The MOUD induction requirement may be met virtually, including by third party entities. However, the practice must fulfill Tier 2 requirements set forth above regarding maintenance prescribing at the practice. Providers must be capable of asynchronous, consultative, provider-to-provider communications within a shared Electronic Health Record (EHR) or web-based platform between primary care and specialist providers over a secure electronic medium that involves sharing of patient-specific information and discussing clarification or guidance regarding targeted clinical care.

Agenda

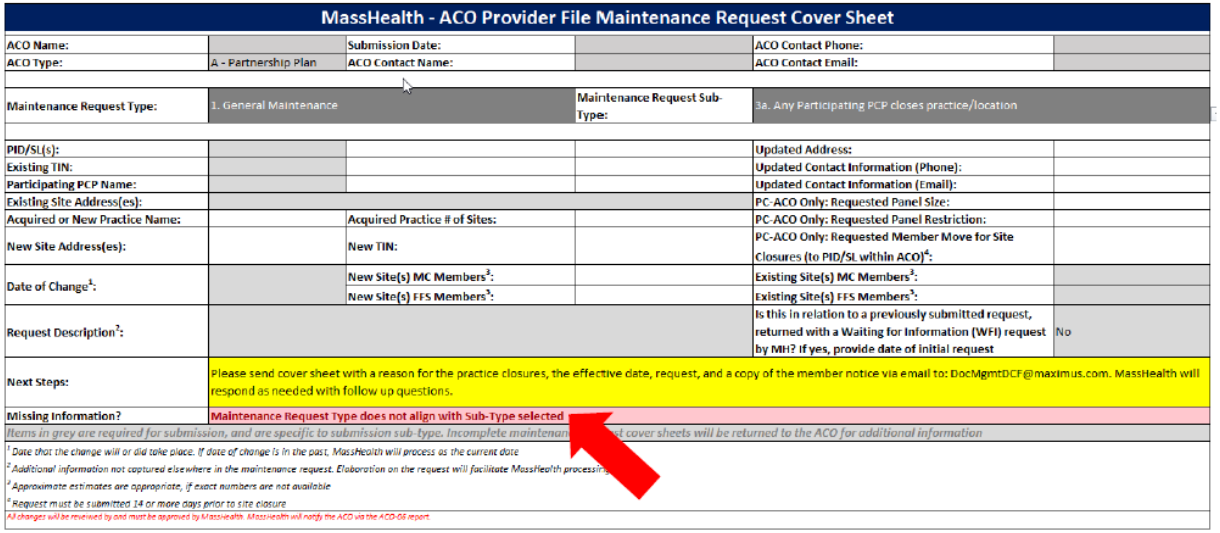
- PC cap overview
- WS payment timing and reports
- Claims suppression logic
- Suggested next steps
- How to update data with WS
- **Appendix**
  - Additional financial information
  - Claims suppression FAQs
  - Included and Excluded Specialties
  - Included codes
  - Tier requirements
  - **PID/SL “Coversheet” process**

“Ongoing Provider Maintenance Coversheet” process: how providers update PID/SLs with MassHealth (1/2)

Providers can make the following updates to PID/SLs in Maximus using the Coversheet process

1. General Maintenance	a. Any Participating PCP has updated contact information
	b. Any Participating PCP wants to update certain legal entity information
2. Open New PID/SL	a. Any Participating PCP opens a new site location
	b. Any Participating PCP **purchases** a provider entity and folds prior site locations under the Participating PCP’s TIN
	c. Any Participating PCP **merges with** a provider entity and a new TIN is generated with new site location(s) that are not in existing ACO network
3. Closures	a. Any Participating PCP closes
4. Site Movement	a. Participating PCP (individual or group practice) moves office location (15 miles or less)
	b. A Participating PCP (CHC, HLHC, or OPD) moves office location (15 miles or less)
	c. Participating PCP (individual or group practice) moves office location (more than 15 miles)
	d. A Participating PCP (CHC, HLHC, or OPD) moves office location (more than 15 miles)
5. Linkages	a. Participating PCP enrolled in MassHealth Fee-For-Service (FFS) wants to link an individual practitioner that is **new to MassHealth and wants to be a FFS provider**
	b. Participating PCP enrolled in MassHealth Fee-For-Service wants to link an individual practitioner that is **an existing FFS provider**
	c. Participating PCP enrolled in MassHealth Fee-For-Service wants to end linkage with an individual FFS practitioner

“Ongoing Provider Maintenance Coversheet” process: how providers update PID/SLs with MassHealth (2/2)



MassHealth - ACO Provider File Maintenance Request Cover Sheet

ACO Name:		Submission Date:		ACO Contact Phone:	
ACO Type:	A - Partnership Plan	ACO Contact Name:		ACO Contact Email:	
Maintenance Request Type:	1. General Maintenance		Maintenance Request Sub-Type:	3a. Any Participating PCP closes practice/location	
PID/SL(s):				Updated Address:	
Existing TIN:				Updated Contact Information (Phone):	
Participating PCP Name:				Updated Contact Information (Email):	
Existing Site Address(es):				PC-ACO Only: Requested Panel Size:	
Acquired or New Practice Name:		Acquired Practice # of Sites:		PC-ACO Only: Requested Panel Restriction:	
New Site Address(es):		New TIN:		PC-ACO Only: Requested Member Move for Site Closures (to PID/SL within ACO)[4]:	
Date of Change[1]:		New Site(s) MC Members[3]:		Existing Site(s) MC Members[3]:	
		New Site(s) FFS Members[3]:		Existing Site(s) FFS Members[3]:	
Request Description[2]:				Is this in relation to a previously submitted request, returned with a Waiting for Information (WFI) request by MH? If yes, provide date of initial request	No
Next Steps:	Please send cover sheet with a reason for the practice closures, the effective date, request, and a copy of the member notice via email to: DocMgmtDCF@maximus.com. MassHealth will respond as needed with follow up questions.				
Missing Information?	Maintenance Request Type does not align with Sub-Type selected				

Items in grey are required for submission, and are specific to submission sub-type. Incomplete maintenance request cover sheets will be returned to the ACO for additional information

[1] *Date that the change will or did take place. If date of change is in the past, MassHealth will process as the current date*

[2] *Additional information not captured elsewhere in the maintenance request. Elaboration on the request will facilitate MassHealth processing*

[3] *Approximate estimates are appropriate, if exact numbers are not available*

[4] *Request must be submitted 14 or more days prior to site closure*

All changes will be reviewed by and must be approved by MassHealth. MassHealth will notify the ACO via the ACO-06 report.

Overall notes

- Template screenshot above; excel template for Coversheet available from WellSense upon request and Box link forthcoming
- Providers email Coversheet to Maximus at DocMgmtDCF@Maximus.com
- “Batch” changes are not currently allowed – each record change requires its own coversheet to be submitted
- Providers find out if coversheet changes have been processed via the weekly “ACO-6” report of changes in the past week that Maximus generates weekly
- Only if there are any problems/questions will Maximus will reach out to the point of contact on the coversheet

Steps for filling out excel (from MassHealth)

- User will complete administrative fields: ACO Name, ACO Contact Name, ACO Contact Phone, Submission Date, ACO Contact Email, and ACO Type
- User will select Maintenance Request Type from dropdown menu
- User will select Maintenance Request Subtypefrom dropdown menu
- User will complete all required fields shaded in grey following the dropdown selections (driven by Maintenance Request Subtype selection)
- User will follow Next Steps outlined based on their dropdown selections

Audit Process and Details

MH will provide a ~30 day notice prior to auditing a practice. The notification will request specific documents and information. MH did not commit to sharing audit details before this 30 day window. MH anticipates auditing a maximum of 25% of practices annually and that audits will begin summer/fall 2023

Practices will be notified of results within 3 months.

If there is not a timely remediation during the PIP period, MH will work with the ACOs to put in place a performance mediation plan (2-3 months)

6 - 9 months

The audit itself will be a remote desk audit (e.g., resumes, staff list, copy of screening tools from EMR, workflows), with on-site follow-up as needed. Audit will largely focus on tier requirements that are new, unique to the sub-cap program. MH will be looking to see whether requirements are met at time of audit and does not anticipate needing to look at past information. If there is a temporary reason while a requirement is not being met (e.g. staffing gap), MH will look at past records and ongoing attempts to meet the requirement.

If practices do not meet the criteria that they've attested to, ACOs will work with them on a performance improvement plan to meet requirements within a reasonable time frame (2-3 months). MH expects most issues can be addressed by work between the ACO and practice.

If issues are not resolved during the PRP period, MH will work with ACOs to put a corrective action plan into place (2-3 months). If the CAP is not successful, capitation rates will be modified (MH did not clarify whether modification would be retroactive).