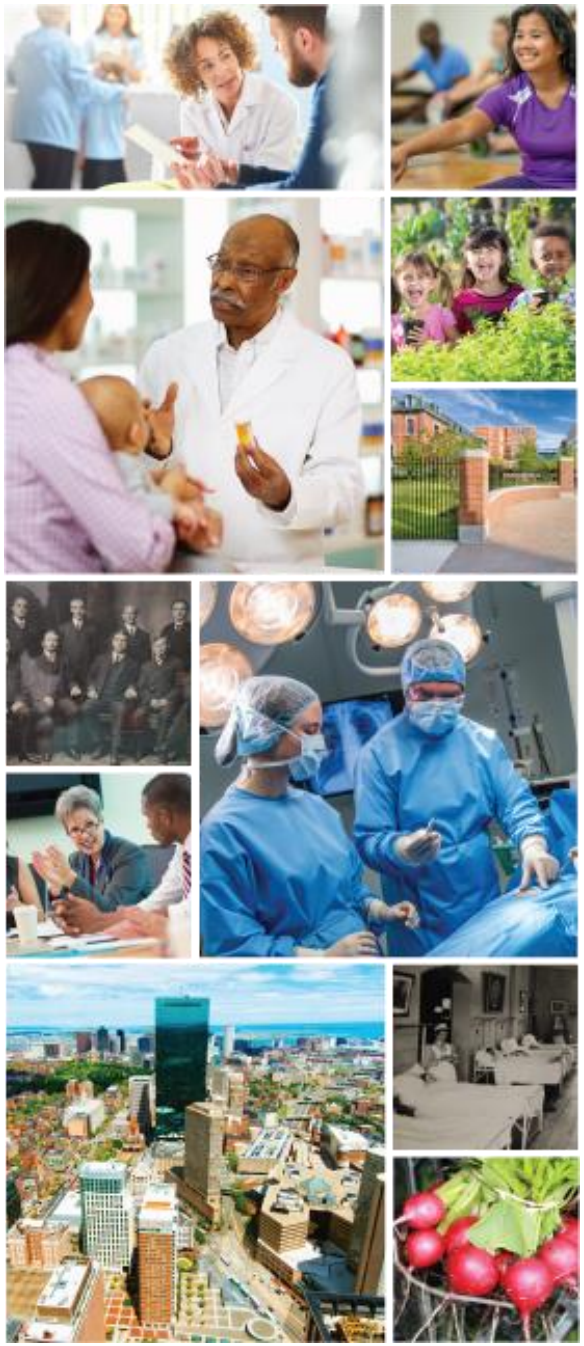


Boston Medical Center
HEALTH SYSTEM

MassHealth Primary Care Sub-Capitation Provider Collaboration Series

Primary Care SubCap – Payment Logic

This is a living document and will be updated and maintained as we develop further understanding of the requirements. Please reach out to your ACO Operations Lead if you have questions.

Goals for today

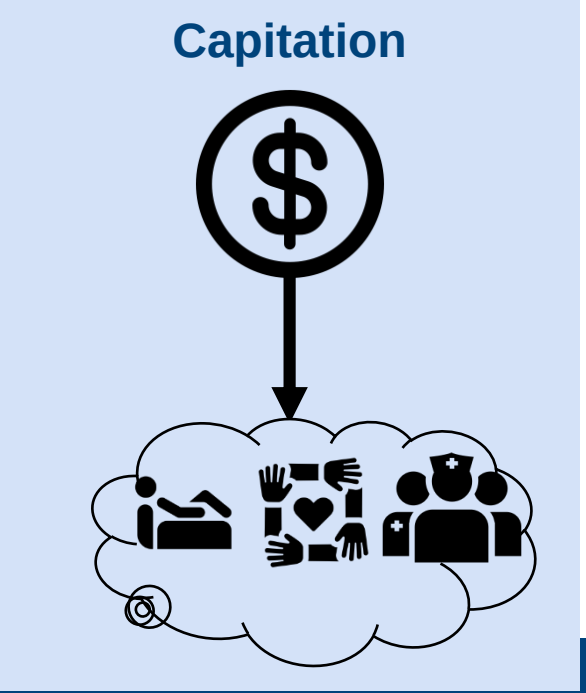
- Review the basics of primary care sub-capitation
- Briefly review **primary care sub-capitation program payment reporting tools, and claims suppression logic**
- Discuss steps that your ACO can take to:
  - Reconcile payment against FFSE and audit suppressed claims
  - Ensure clean data with WellSense
- Additional resources available at: https://www.wellsense.org/providers/ma/sub-capitation

Agenda

- **PC cap overview**
- WS payment reports
- Claims suppression logic
- 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



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 were submitted as part of the RFR
- 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*

Overview of primary care sub-capitation tier requirements

Overview

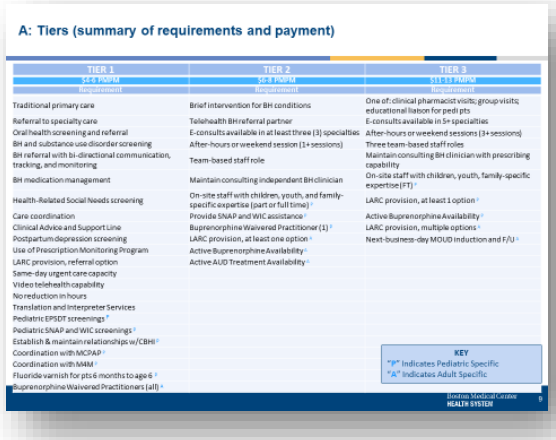
- MassHealth defined a set of 45 total PC Sub-Cap requirements and divided those into three tiers.
- Each PID/SL needs to attest to a Tier based on the requirements that can be achieved by July 1, 2023.
- Some tier requirements can be met centrally (e.g., after-hours access).
- A PID/SL must meet all 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.


A: Tiers (summary of requirements and payment)

TIER 1	TIER 2	TIER 3
$0.45 PMPM	$0.8 PMPM	$1.15 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)		

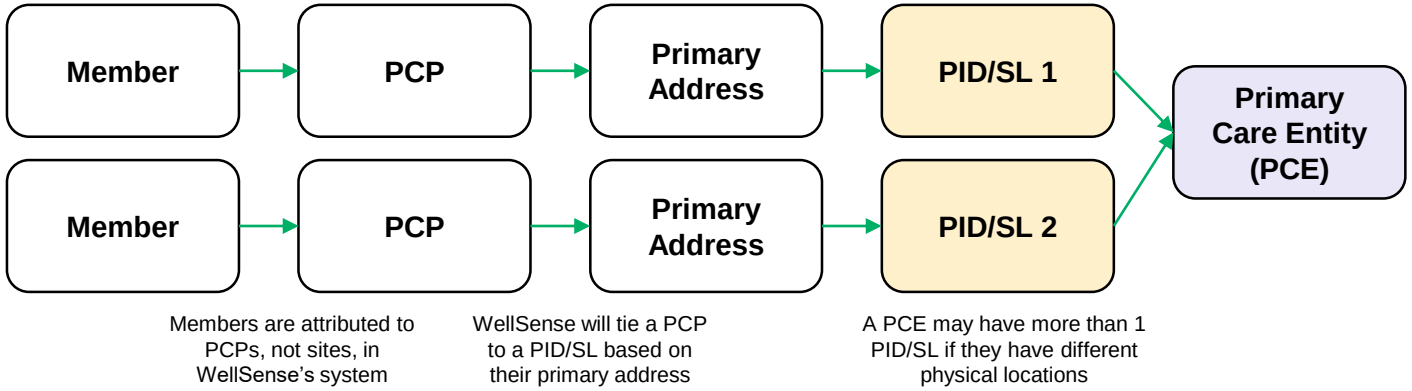
KEY
"P" Indicates Pediatric Specific
"A" Indicates Adult Specific

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.

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)



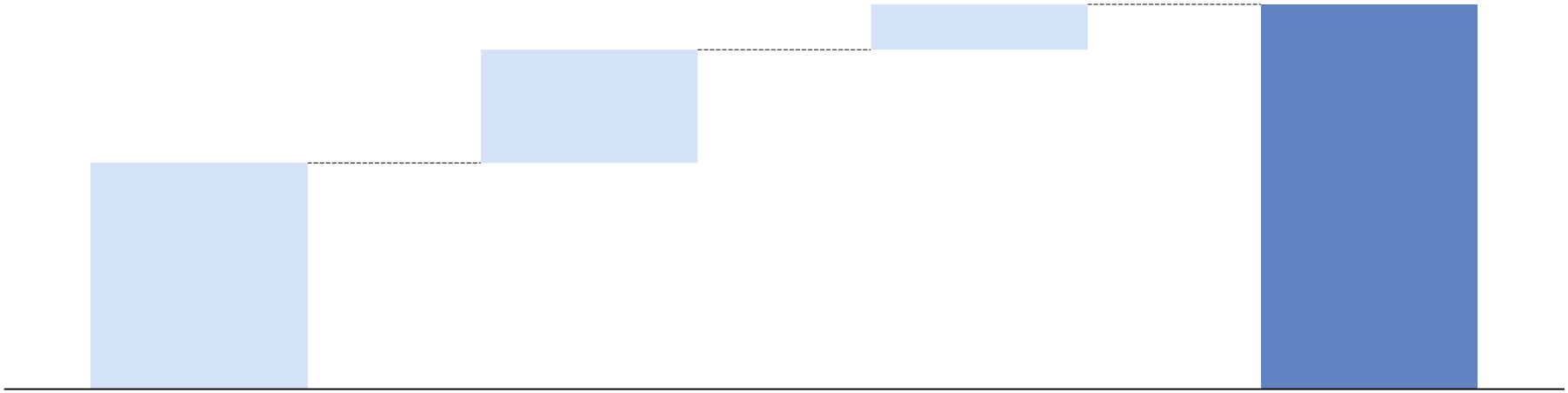
How does payment flow from MassHealth to WellSense ACOs to practices?

- **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.

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 (complete s

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

- PC cap overview
- **WS payment reports**
- Claims suppression logic
- How to update data with WS
- Appendix

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

Report	Overall Summary	Cap Payment Detail
Purpose	Payment by PCE, FFSE reconciliation	Member attribution and associated payment
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

- Financial reporting related to the primary care sub-capitation payments will also be incorporated into quarterly financial statements.

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).

PC Subcap 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 subcap logic.

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

PCEs will receive their first PC subcap payment on April 11th

Agenda

- PC cap overview
- WS payment reports
- **Claims suppression logic**
- How to update data with WS
- Appendix

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. For existing partners, provider rosters reflect the association between TIN and provider. For new partners, 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 existing partners, WellSense is planning to circulate a provider roster with a field that indicates whether a provider's claims will be zero-paid under specialty logic or not. For new partners, 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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- PC cap overview
- WS payment reports
- Claims suppression logic
- **How to update data with WS**
  - PID/SL “Coversheet” process
- Appendix

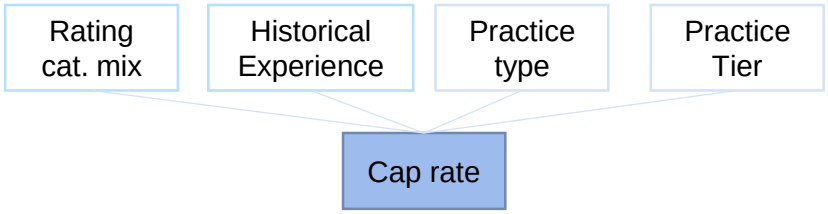
Reminder: How WellSense attributes members, and why it matters now more than ever

WellSense member attribution

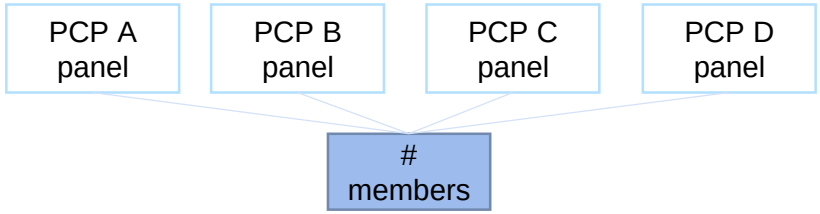
- WellSense assigns members through one of three methods:
  - **Member selection** of a PCP during MassHealth enrollment
  - **Auto-assignment** of new members if no PCP selected
  - Provider- or member-driven **change requests**
- WellSense's auto-assignment algorithm uses a few criteria:
  - **Ages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

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 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 PR 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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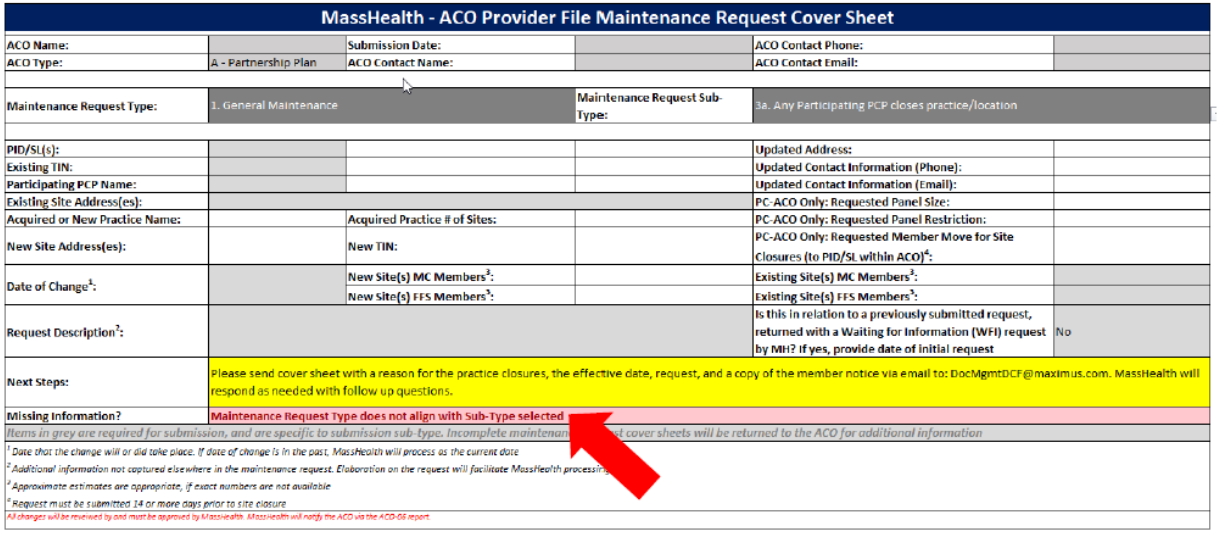
- PC cap overview
- WS payment reports
- Claims suppression logic
- **How to update data with WS**
  - **PID/SL “Coversheet” process**
- Appendix

“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 allrequired 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

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  - Included codes
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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
Orthopaedic 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 reports
- Claims suppression logic
- How to update data with WS
- **Appendix**
  - Claims suppression FAQs
  - Included and Excluded Specialties
  - Included codes
  - **Additional financial information**

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

ACO

Receives capitation from MassHealth

- 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