WellSense ACO Overview Provider Training

April 2023

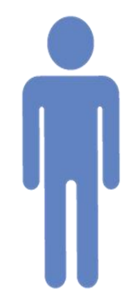
Agenda

- MassHealth ACO Program
- WellSense ACO Overview
- Continuity of Care
- Community Partners Program
- Flexible Services Program
- ACO Quality Improvement
- Primary Care Providers
- Provider Responsibilities
- Provider Claims and Administrative Appeals
- Member Appeals and Grievances
- Fraud, Waste and Abuse
- WellSense Provider Portal
- Helpful Information & Resources

MassHealth ACO Program

What is an Accountable Care Organization?

- Accountable Care Organizations (ACOs) are groups of doctors, hospitals, and other health care providers, that collectively manage the care of a group of patients.
- They are designed to help patients manage their illnesses and reduce health care costs by preventing unnecessary or duplicate tests and reducing preventable hospital admissions and emergency room visits.
- Shifts from the traditional fee-for-service system to an one that is financially accountable for cost, quality, and member experience.



Patient

ACCOUNTABLE CARE ORGANIZATION

Medical Professionals

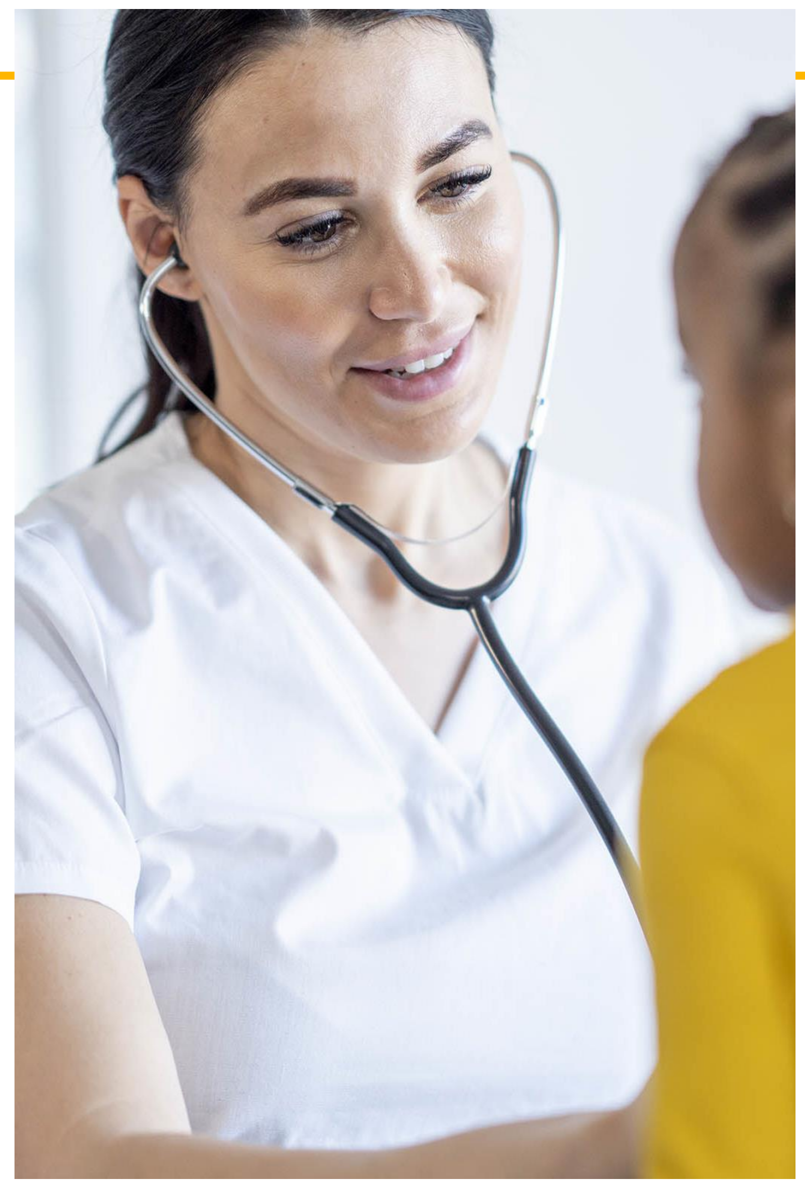
Providers

Payors

- Together, assume the **responsibility for a group of patients' health care**
- Receive a **fixed amount of money** per member per month
- Invest to **reduce unnecessary healthcare utilization**
- **Address social determinants** that drive health care costs

MassHealth ACO Program

- MassHealth ACO program was implemented in 2018 to shift from a traditional fee-for-service model of paying for the volume of health care services to paying for the value of health care services provided to members.
- The new waiver for the ACO program will go-live on 4/1/23.
- Focus for the next phase of the ACO program is to build upon and strengthen integrated, outcomes-based care for MassHealth members while working to close existing disparities in quality and access that will advance health equity throughout Massachusetts.
- ACO program upholds MassHealth's commitment to:
  - Hold providers accountable for quality, total costs and experience of care for their patients
  - Provide clinical and community-based support for members with significant behavioral and long-term health care needs, through ACO partnerships with community-based organizations called Community Partners
  - Support preventive care, including investing $115M per year for primary care delivery and behavioral health integration through a new value-based payment model for primary care
  - Address health-related social needs, such as housing and nutrition, through the innovative Flexible Services Program
  - Advance health equity, including new incentive programs through which ACOs and hospitals are eligible to earn more than $2B over five years for closing disparities in health care quality and access
  - Ensure that members who are at high risk receive comprehensive care coordination, such as expanded supports for high-risk pregnancy and postpartum care, as well as a new targeted case management benefit for children with complex medical needs



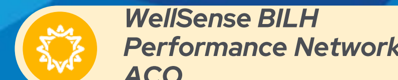
WellSense ACO Overview

WellSense Health Plan

WellSense Health Plan is a non-profit health plan that provides health insurance coverage to Massachusetts residents, including low-income, underserved, and disabled. We were established in 1997 by Boston Medical Center and have 25 years of experience delivering accessible care to complex populations.

In 2023, WellSense became the largest Medicaid health plan in the state, covering more than 500,000 MassHealth members in eight ACO partnerships across Massachusetts. We are supporting the care of nearly 40% of MassHealth ACO adult and child members.

WellSense ACO Partners

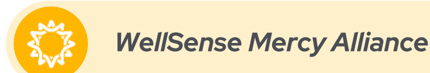

WellSense BILH Performance Network ACO

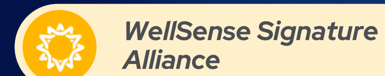
Boston Accountable Care Organization

WellSense Community Alliance

WellSense Boston Children's ACO

East Boston Neighborhood Health WellSense Alliance


WellSense Mercy Alliance


WellSense Signature Alliance

WellSense Southcoast Alliance

TuftsMedicine

WellSense Care Alliance

WellSense Clinical Vendors

Vendor Name	Services Managed	Website	Phone	Additional Info
Carelon Behavioral Health [formerly Beacon Health Options*]	Behavioral Health	Carelon Behavioral Health	1-877-957-5600	• Available 24/7 for members & providers • Prior authorization may be required for certain services
Northwood	Durable Medical Equipment Prosthetics & Orthotics (DMEPOS)	Northwood Inc.	1-866-802-6471	• Prior authorization is required for all DMEPOS dispensed & billed by a supplier
Express Scripts	Pharmacy	Express Scripts	1-877-417-1822	• Submit coverage review requests online via one o the ePA portals: Surescripts, CoverMyMeds or ExpresPAth • Can also submit request using General Medication Request Form
eviCore	High-End Radiology Genetic Testing Musculoskeletal Services	eviCore Healthcare	1-866-802-6471	• Prior authorization may be required for certain services
AxisPoint Health	Nurse Advice Line		1-800-973-6273	• Available 24/7 for members • Audio health library of recorded information, by topic, can be accessed through the advice line

**Effective 3/1, Beacon Health Options changed its name to Carelon Behavioral Health. This is a name change only; services, authorizations, operations, etc. will not be impacted.*

Key ACO Program Milestones

Notice of Procurement
ACOs can add/remove PCPs
Mar-Apr 2022

Bidders' Response Due
Summer 2022

Contracts Awarded
Fall 2022

Member Health Plan Mailings
Jan-Feb 2023

New ACO Waiver Go-Live

Member Enters New ACO & 90-Day Plan Selection Period Begins
April 1, 2023

Member Enters Fixed Enrollment Period
Members cannot make changes outside of their health plan at this point unless they meet an exception
July 1, 2023

ACO Member Enrollment, PCP Changes and ACO Changes

When possible, MassHealth strives to keep members with their primary care provider (PCP); therefore members are moved with their PCP to an ACO

- How a member's PCP is determined
  - Member's health plan and PCP is assigned at point of enrollment
    1. Members can select their health plan and PCP
    2. If member does not select a health plan and PCP within 14 days, a health plan is automatically assigned to the member
- How MassHealth moves members
  - PCPs are assigned at a site level and not an individual provider level
  - Members have the option to:
    1. Move with their PCP into a new ACO
    2. Stay with their current health plan and select a new PCP
    3. Select a new health plan and a new PCP
- How MassHealth messages ACO changes
  - Historically, MassHealth has given members a 60-day notice on ACO and PCP changes
    1. Members receive an ACO notice indicating the change and any call to action
       - MassHealth sent letters to WellSense members on 2/9/23 regarding ACO go-live on 4/1
    2. If members do not respond by 3/31/23, they will be automatically moved with their PCP into the new ACO
    3. Changes made during this time are prospective and will not take effect until 4/1/23

ACO Member Enrollment Packet

Messaging	Description
ACO Letter	• Member-specific letter that indicates a member's PCP and the ACO they will be moving to • Includes a call to action: members that do not respond will automatically follow their PCP • If a member does not wish to do so, they must contact MassHealth before 3/31/23 • Explains a member's 90-day Plan Selection Period and Fixed Enrollment Period

Enrollment Guide	• Members will receive the annual MassHealth Enrollment Guide to view their health plan choices
	  – Guide is available online at: EG-MH-Rev 0223 New.pdf (masshealthchoices.com)
	• Members are encouraged to review this guide and make any changes before 3/31/23
	• Health plan and PCP changes can be made:
	  – Online at MassHealthChoices.com
	  – By calling MassHealth Customer Service at 800-841-2900
	  – In-person with an Enrollment Assister
	  – Mailing or faxing an enrollment form

MASSHEALTH 2023

News About Your MassHealth Health Plan

COMMONWEALTH OF MASSACHUSETTS | Executive Office of Health and Human Services

[PARENT/GUARDIAN OF]
[MEMBER FIRST NAME] [MEMBER LAST NAME]
[STREET ADDRESS 1] [STREET ADDRESS 2]
[CITY], [STATE] [ZIPCODE]

Date: [DATE]
Member ID: [XXXXXXXXXX]

FPO QR CODE

Dear [Member Name],

Your Plan Selection Period this year begins on April 1, 2023 and ends on June 30, 2023. Now is a great time to see if your plan still meets your health care needs.

If you are happy with the plan you have now, <ACO_NAME_CUR>, you do not need to do anything.

If you want to learn about health plans or change your health plan, please read below.

Learn about new health plans

We have new MassHealth health plans starting on April 1, 2023. If you want to learn about new health plans, read about them in the Enrollment Guide we send to the head of your household. You can also find the Enrollment Guide online at MassHealthChoices.com.

Make sure the doctors you like are in your plan

You can find this information in any of these ways:

- Go to the plan's website: <ACO_URL>
- Call your current plan at <ACO_PHONE>
- Go to MassHealthChoices.com
- Read the Enrollment Guide

What to do if you change your plan and are getting medical care now

If you decide to change your plan, your new MassHealth health plan will coordinate your ongoing care. Your MassHealth benefits will stay the same.

MH-SA LTR 2: Plan Selection Period (01/23)

page 1 of 2

Key Dates for ACO Members

Plan Selection Period

The plan selection period is the annual, 90-day period for individuals enrolled in a managed care organization (MCO) or an ACO health plan. During this time, members can choose a health plan or switch their health plan for any reason.

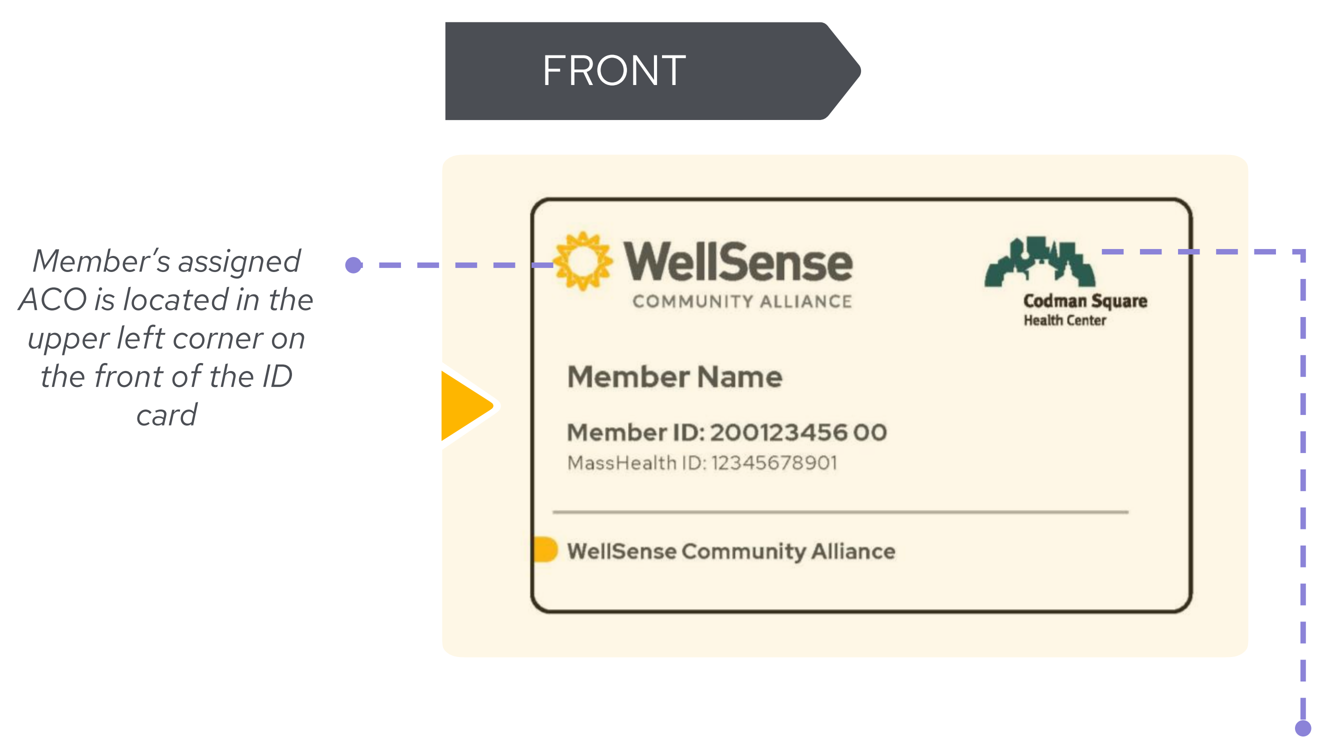
- Plan selection periods are member specific.
- It allows members to try out their new health plan and make adjustments as needed.
- For members moving into a new ACO on April 1, 2023, their Plan Selection Period will be:
  - April 1, 2023 –June 30, 2023

Fixed Enrollment Period

Members in an ACO or an MCO will have a fixed enrollment period when their plan selection period has ended. During the fixed enrollment period, members will not be able to change their health plan until the next plan selection period, except for certain reasons.

- Fixed enrollment periods are member specific
- Members can still make changes within their health plan, such as changing from one PCP to another, as along as they are in the same ACO
- Exceptions can be found at Fixed Enrollment Period | Mass.gov

ACO Member ID Card



BACK

Members wellsense.org/community

Member Services Department

English: (888) 566-0010 | **Español:** (888) 566-0012 | **TTY:** 711

Mental Health/Substance Use:

Beacon Health Strategies (888) 217-3501

Pharmacy: Express Scripts (888) 566-0010

Emergency Care: Go to the ER or call 911

Providers

Provider Services Department: (888) 566-0008

Behavioral Health: (866) 444-5155

Pharmacies: Express Scripts (877) 401-2069 **BIN:** 003858 **PCN:** MA **RxGRP:** MAHLTH

Member's PCP Site logo is located in the upper right corner on the front of the ID card

ACO Member IDs

ACO member IDs have number sequencing according to the ACO they are assigned to, as shown in the following table:

ACO	Prefix	ID Numbering Scheme
WellSense Community Alliance	20	20XXXXXX
WellSense Boston Children's ACO	71	71XXXXXX
WellSense BILH Performance Network ACO	70	70XXXXXX
East Boston Neighborhood Health WellSense Alliance	72	72XXXXXX
WellSense Mercy Alliance	30	30XXXXXX
WellSense Signature Alliance	40	40XXXXXX
WellSense Southcoast Alliance	50	50XXXXXX
WellSense Care Alliance	73	73XXXXXX

ACO Covered Services

- WellSense will authorize, arrange, coordinate and provide to members all medically necessary ACO-covered services in an amount, duration, and scope that is no less than the same services furnished to members under MassHealth fee-for-service.
- All medically necessary ACO-covered services include but are not limited to those that:
  - Prevent, diagnose and treat diseases, conditions or disorders that result in health impairments
  - Achieve age-appropriate growth and development
  - Attain, maintain or regain functional capacity
- WellSense will not arbitrarily deny or reduce the amount, duration or scope of a required ACO-covered service solely because of diagnosis, type of illness or condition of the member.
- Authorization will not be denied for an ACO-covered service demonstrated to be medically necessary by a healthcare professional who has the clinical expertise in treating the member's medical condition or performing the procedures, whether or not there is a service not covered by the ACO that might also meet the member's medical needs.
- WellSense may place appropriate limits on an ACO-covered service on the basis of medical necessity or for the purpose of utilization control provided that the furnished services can reasonably be expected to achieve their purpose.
- Members will not have an annual dollar limit, an aggregate lifetime dollar limit or a quantitative treatment limitation imposed on behavioral health services.

Services Not Covered by the ACO

- WellSense will coordinate the provision of all services not covered by the ACO and will inform members and providers of:
  - The availability of such services
  - How to access such services through MassHealth's prior authorization process, where applicable
- WellSense is not responsible for providing or coordinating any excluded services.
- Services obtained outside the United States and its territories will not be covered and payments will not be made to any entity or financial institution located outside the United States.

Continuity of Care

Continuity of Care: Medical [1/7]

- At the time new members join one of the WellSense ACO plans, they may be authorized for a limited time to continue to see an out-of-network (OON) provider
  - This could be a provider within or outside of the WellSense statewide network
  - This is referred to as continuity of care (CoC), and it applies, for example, to pregnant members or those needing continuing care for an existing chronic condition.
- CoC describes both state-mandated and WellSense-driven efforts to minimize disruption of plan changes on members' access to care, primarily related to utilization management (UM) and network participation.
- New members who were already receiving care from an OON provider when they join can continue to see the OON provider if the PCP or specialist is providing an active course of treatment for a chronic or acute medical condition.
  - During the initial transition for ACO go-live, WellSense will accept authorizations from legacy carriers.
  - Longer-term, providers will need to submit new authorizations to WellSense for continued OON access.
- The WellSense Care Management team will work to transition members to in-network providers when appropriate.

Continuity of Care: Medical [2/7]

- WellSense also allows special, additional consideration for certain members, including:
  - Pregnant members
  - Members with significant health care needs
  - Members with autism spectrum disorder (ASD)
  - Members undergoing treatment for substance use disorder (SUD)
  - Members who are receiving ongoing services, such those undergoing dialysis or who are hospitalized
  - Members who are in Department of Children & Families (DCF) care, affiliated with Department of Youth Services (DYS) or otherwise justice-involved
  - Members may need to have an existing authorization in place for all of the above situations

Continuity of Care: Medical [3/7]

- When it comes to ACO go-live, CoC can refer to:
  - Actions taken by MassHealth, managed care organizations (MCOs) and providers to ensure members' continued access to care.
  - The defined transition period (a minimum of 90 days for MassHealth) during which these actions are in effect.
- CoC affects several aspects of MCO operations, including UM/prior authorization (PA), referrals and OON coverage.
- As part of CoC at ACO go-live, WellSense will load and honor any active authorizations into our system and provide some flexibility for the first 90 days of the new waiver so that members can transition smoothly.
  - WellSense is working closely with our delegated vendors, including Carelon Behavioral Health (behavioral health), eviCore (high-end radiology, genetic testing, and musculoskeletal procedures) and Northwood (durable medical equipment, prosthetics and orthotics)
- On an ongoing basis (after the first 90 days of ACO go-live), WellSense has an OON policy that allows members to continue seeing OON providers when medically necessary, including to avoid interruptions in care.
  - New ACO members requiring OON care longer-term will require PA.

Continuity of Care: Medical 4/7

WellSense's full network of contracted specialists, facilities and ancillary services is available to ACO members.

WellSense requires PA on a limited range of services, including, but not limited to:

- Acute inpatient and outpatient hospital services
- CDRHs and nursing facilities
- Certain diagnostic services
- DME
- Home health
- Hospice
- Interventional pain procedures
- Genetic testing
- High-end radiology
- Non-24-hour diversionary services
- Outpatient rehab (PT, OT, ST)
- Prosthetics and orthotics

Continuity of Care: Medical [5/7]

- Other PA Information:
  - All OON services require PA, with some exceptions for emergency care and urgent care.
    - PCPs should direct members to other WellSense participating providers for needed medical and behavioral health care services unless the required services are unavailable through a WellSense participating provider.
    - Providers must seek PA from Carelon Behavioral Health for behavioral health services prior to referring members to non-participating providers.
- For MassHealth members, no PA is needed for family planning services, including family planning counseling, birth control advice, pregnancy tests and sterilization services. Follow-up health care can be provided from any WellSense or MassHealth contracted family planning services provider.
  - Infertility treatment is not a MassHealth covered service
- For patients who previously had WellSense and are transitioning to our ACO, WellSense will transfer the approved authorization to your patient's new ID.
  - A new request for this approved service does not have to be resubmitted.
  - If this is an ongoing service, a new PA request will need to be submitted for continued services before the expiration date.

Continuity of Care: Medical [6/7]

- Exceptions for Pregnant Members
  - An exception for OON care may be provided if one of the following applies:
    - The member is pregnant when they became a WellSense member, and they have an established relationship with a nonparticipating OB provider
    - The member's WellSense participating OB provider becomes nonparticipating while the member is pregnant
    - The member speaks a language not spoken by any in-network OB provider
  - WellSense must authorize all OON maternity care, including delivery at the facility where the OON OB is affiliated.

Continuity of Care: Medical [7/7]

WellSense's Action	Goal	Where WellSense Will Need Providers' Help
Broad messaging campaign for providers	Alert providers that requirements are changing and encourage them to review WellSense materials	Reinforce messaging with providers and encourage them to double-check PA/network
Transfer open authorizations from legacy MCO to WellSense and our delegated vendors	Ensure claims continue to pay correctly for previously approved services	WellSense team may have questions on open authorizations and may ask you to help us educate providers on which authorizations are carried over to avoid unnecessary effort
Provide some flexibility for authorization/OON denials in first 90 days of transition, per MassHealth guidelines for certain populations	Minimize disruption to providers while they adjust to new MCO requirements	WellSense will reach out to you if we see patterns of denials in order to avoid future disruption
Continue monitoring authorization denials after CoC period ends	Identify and fix problems early before they affect members' health	Keep an open line of communication; help us reinforce education with providers

Continuity of Care: Behavioral Health

- Behavioral health services for WellSense ACO members are managed by Carelon Behavioral Health* ("Carelon").

  *Effective 3/1, Beacon Health Options changed its name to Carelon Behavioral Health. This is a name change only; services, authorizations, operations, etc. will not be impacted.

- Carelon has a CoC policy for new ACO members that aligns with WellSense's policy and allows for a 90-day grace period.
- During the grace period, providers will either be working towards in-network status, or for those members seeing a provider that will not be coming in-network, Carelon will work with members to find an appropriate provider that is already in-network by the end of the 90-day period.
- Claims received during the 90-day grace period will pend to ensure we have OON providers loaded. Once the providers are loaded, the claims will be processed.

Continuity of Care: Pharmacy [1/2]

- **Formulary**
  - Effective April 1, MassHealth is fully unifying their Unified Pharmacy Product List (UPPL) across all health plans.
  - New members will be granted a transition period until June 1 that will allow existing prescriptions that may otherwise require PA to pay temporarily.
  - To find covered alternatives or which drugs require prior authorization, search the MassHealth drug list on the WellSense website at: Prescription Information | WellSense Health Plans | WellSense Health Plan.
  - Prior authorization is required to continue coverage of the existing prescriptions after June 1. Information on how to submit a prior authorization request is available at wellsense.org.
- **Retail Network**
  - Effective April 1, new members will have 90 days of continuity of coverage at their existing pharmacy, which includes Walgreens pharmacies.
  - By July 1, members must transition their prescriptions to a WellSense in-network pharmacy, which excludes Walgreens pharmacies.
  - To find out if a pharmacy is in the WellSense network, please search the Find a Pharmacy directory on the WellSense website at: Prescriptions I MassHealth | WellSense Health Plan.

Continuity of Care: Pharmacy [2/2]

- **Specialty Network**
  - Effective April 1, WellSense will have a new network of Specialty Pharmacies.
  - New members will have the option of a first specialty fill allowance at any in-network *retail* pharmacy for specialty drugs.
  - Upon the member's second fill, they will need to use an in-network *specialty* pharmacy.
  - The list of in-network Specialty Pharmacies is available on the WellSense website at: Pharmacy Programs I MassHealth | WellSense Health Plan.

Continuity of Care: Care Management

- ACO Partners will start notifying current care management (CM) members in March 2023 of CM transition.
- Complex care management (CCM) has provided new ACO Partners with a transition guide for ACO Partners whose CM services will end on March 31.
  - The guide highlights criteria to refer current CM members to WellSense CM programs or graduate eligible members out of CM.
  - List and/or volume of potential eligible members should be provided back to CCM ahead of April 1 go-live.

Community Partners Program

What is a Community Partner?

Community Partners (CPs) are community-based organizations awarded vendor contracts by MassHealth and contracted with ACOs to provide enhanced care coordination to MassHealth members with complex needs.

Behavioral Health Community Partner (BH CP)	Long Term Services and Supports Community Partner (LTSS CP)
Ages 21-64	Ages 3-64
Community-based agencies whose role is to care manage the complex medical, behavioral health and psycho-social issues for members with severe and persistent mental illness. They have experience providing services and supports members with serious mental illness and/or addiction.	Community-based entities partnering with ACOs, providers, and social services organizations and community resources to support members with complex LTSS needs. They have experience providing services and supports to patients with complex LTSS needs including brain injury or cognitive impairments, physical disabilities or intellectual/developmental disabilities
Predominant behavioral health need(s): serious mental illness (SMI), serious emotional disturbance, substance use disorder (SUD) and co-occurring SMI/SUD	Predominant LTSS needs: significant functional impairments, history of high and sustained LTSS utilization, or LTSS-related diagnoses

What's changing in the CP Program in the new waiver?

CP program current waiver	CP program in the 1115 waiver
Many CPs (9 LTSS, 18 BH), each contracted with multiple ACOs	Consolidation of CP network to help simplify and streamline relationships between CPs and ACOs
CPs contracted and paid directly by MassHealth; required to submit qualifying activity (QA) for payment	CPs contracted and paid directly by ACO; not required to submit QA, paid PMPM
BH CPs conduct comprehensive assessment and care planning; LTSS CPs only do care planning	Both BH and LTSS CP conduct comprehensive assessment and care planning
CP performance is variable—many ACO partners have complained about their CP partner performance	MassHealth has aligned care coordination and management activities across BH and LTSS CPs, reinforcing integration and quality goals

How can a CP help patients and how can ACOs partner with CPs?

Community Partners responsibilities to patients:

Outreach to Patients

To encourage members to participate in the program, expected a minimum of three attempts, including at least one face-to-face

Assessment & Care Planning

Comprehensive assessment expected, which must be person centered with goals identified and approved by the member

Care Team Coordination

Facilitate communication among members and act as subject matter experts for BH/LTSS community services

Care Management

Coordinate between members, state agencies, specialty providers; connect programs appropriate for members

Transitions of Care

Assist with discharge planning, appointment access/follow-ups and a face-to-face interaction within three days post-discharge

Connection to Social Services

Assist enrolled members with social determinants of health needs, including referral to flexible services

How to partner with CPs

- Generate referrals
- Warm handoffs
- PCP engagement with CP/patient
- Provide EMR access to CPs
- Site CM or CCM leverage community expertise of CP
- Provide a clinic POC for CPs/Wellsense

A point of contact (POC) acts as a liaison between each site's PCP and CP who has a relationship with the site's PCP and has access to member demographic data

Which members are appropriate to refer to CP services?

LTSS CPs

- Members with diagnosis codes, including, but not limited to: Alzheimer's disease and related disorders; or Senile Dementia, Autism Spectrum Disorders, Cerebral Palsy, Intellectual Disabilities and related conditions; mobility impairments; members that need help with ADLs/IADLs, Multiple Sclerosis and Transverse Myelitis, Muscular Dystrophy, Spina Bifida and other Congenital Anomalies of the Nervous System, Spinal Cord Injury, Traumatic Brain injury and Nonpsychotic Mental Disorders due to Brain Damage
- Members who need to be connected with these services, or have a history of utilizing these services: Personal Care Attendant (PCA), Therapy Services (PT/OT/Speech), Adult Day Health, Adult Foster Care (AFC), Group Adult Foster Care (GAFC), Durable Medical Equipment, Prosthetics, Orthotics (DMEPOS), Hospice, PERS, Oxygen & Respiratory Therapy Equipment, Assistive Devices, Early Intervention (intensive), Home Health Agency (HHA), Speech & Hearing Center, Extended Care Facility, Continuous Skilled Nursing, Nursing Facilities, ADL/IADL in-home supports outside the scope of traditional LTSS benefits [i.e. homemaking, personal care, home delivered meals, heavy chore, companion care, medical escort]

BP CPs

- Members with diagnosis codes, including, but not limited to: SUD, Schizophrenia, Bipolar Disorder, Psychosis, Depression, Adjustment Disorder/Reaction, Anxiety, PTSD
- Members who are utilizing the following healthcare services:

Both

- Members who need help with SDoH: Housing insecurity or homelessness, transportation, food assistance; insecurity, job training/education resources, access issues (housing, utilities, public transportation, medical care); assistance with applying to benefits

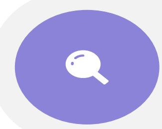
Resources Available

- **Process for making a referral:**
  - Send Care Management Referral Form to either BHCP@wellsense.org or LTSSCP@wellsense.org.
  - This form can be found on WellSense website at: Documents and Forms | Providers - Massachusetts | WellSense Health Plan.
  - It is helpful to include member demographics, MMIS # and member/treatment team contacts (if applicable).
  - For members who are inpatient and require immediate community support, it is helpful to have the social work and hospital contact info and reason for urgent referral to expedite.
  - All referrals confirmed by WellSense BH/LTSS CP team will show on MassHealth's Electronic Verification System (EVS).
- **Reporting on enrollment:**
  - All ACO groups receive a monthly roster of enrolled members as well as a status and outreach report.

- **Additional resources:**
  - MassHealth Community Partners (CP) Program: Information for Providers | Mass.gov
  - Provider PCDI resources | Mass.gov
- **Contacts:**
  - BH and LTSS CP questions and escalations: Kristen.Hackney@bmchp-wellsense.org
  - Member-specific inquiries and referrals: BHCP@wellsense.org or LTSSCP@wellsense.org

Flexible Services Program

What is the MassHealth Flexible Services Program?



The Flexible Services Program (FSP) provides health-related social supports for housing and nutrition with the goal of improving member health outcomes and reducing total cost of care (TCOC).

FSP Eligibility

- Actively enrolled in the ACO
- Meet at least one of the Health-Needs-Based Criteria: behavioral health need, complex physical health need, needing assistance with one or more documented activities of daily living or instrumental activities of daily living needs, repeat ED use or experiencing a high-risk pregnancy or complications associated with pregnancy
- Meet at least one of the Risk Factors: experiencing homelessness, at risk of homelessness, or risk for nutritional deficiency or imbalance due to food insecurity

FSP Supports

- Pre-Tenancy – Individual: assisting members with obtaining and completing housing applications
- Pre-Tenancy – Transitional Assistance Funds: supports one-time household set-up costs and move-in expenses incurred (e.g., first/last month's rent)
- Tenancy Sustaining: assisting members with communicating with landlords; obtaining adaptive skills needed to live independently in the community
- Home Modification: needed to ensure member's health and safety (e.g., installation of grab bars and hand showers, doorway modifications, or in-home environmental risk assessments
- Nutrition: includes goods, transportation and services that educate members about appropriate nutrition and help members access food needed to meet their nutritional needs.

FSP Health Needs-Based Criteria Detail

Behavioral Health Eligibility

The member is assessed to have a behavioral health need, such as a mental health or substance use disorder (e.g., depression, bipolar disorder), requiring improvement, stabilization or prevention of deterioration of functioning (including the ability to live independently without support).

Physical Health Eligibility

The member is assessed to have a complex physical health need, which is defined as one or more persistent, disabling or progressively life-threatening physical health condition (e.g., diabetes, hypertension) requiring improvement, stabilization or prevention of deterioration of functioning (including the ability to live independently without support).

High Risk Pregnancy

The member is pregnant & experiencing high-risk pregnancy or complications associated with pregnancy including:

- individuals 60 days postpartum
- their children up to one year of age
- their children born of the pregnancy up to one year of age

ACOs Partner with Variety of Social Service Organizations for FSP Nutrition and Housing Supports

- Social service organization (SSO) partners for FSP housing and nutrition supports vary by ACO.
- Types of services or health-needs-based criteria may differ between SSOs.
- Please reach out to your ACO-specific FSP point of contact (POC) for confirmation on SSOs accepting FSP referrals for your members.
  - This information is also available through the Flexible Services Program Directory posted online by MassHealth.

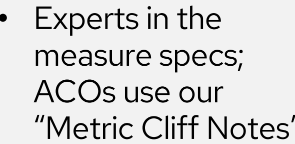
FSP Referral Workflow

- Please reach out to your ACO FSP POC for confirmation on how to submit a referral for FSP housing or nutrition supports. Referrals generally occur through either:
  - A web-based case management system for referral entry
  - Manual completion of a FSP Verification, Planning, and Referral (VPR) Form
- Upon referral submission, the ACO will review and approve the referral or follow up if any information is missing.
- SSOs will then conduct outreach to members in order to engage them and begin services (timelines vary).
- If you have any questions, please contact Paulina Lange [Paulina.Lange@bmc.org] or Jasper Frank [Jasper.Frank@bmc.org] at Boston Medical Center (BMC) Health System.

ACO Quality Improvement

BMC Health System Quality team provides a number of supports to assist in quality performance

Measure Expertise	Clinical Training	Performance Measurement	Data Analytics	Implementation Support	Program Administration
• Experts in the measure specs; ACOs use our "Metric Cliff Notes" • Coordinate metric-level Best Practice Summits throughout the year	Network-wide clinical training sessions (i.e., SMART therapy for asthma care, new guidelines in diabetes care, etc.)	Monthly metric-level performance dashboards with custom cuts for each ACO (e.g., by group or PCP)	Custom analytics to guide targeting of efforts across and within measures, such as gap lists, ADT feeds, clinical supporting data (such as MPR) and dashboards displaying trended performance, found on on Box.com	Where possible, partner on implementation and shared programming (e.g., Behavioral Health Team assists with depression remission and response follow-up; Clinical Pharmacy Team supports medication adherence outreach for asthma medication ratio)	Manage all MassHealth-related items: attend office hours, coordinate deliverables (e.g., chart abstractions, performance improvement projects), advocate for MassHealth program changes



In addition to measure performance, we partner with ACOs on other initiatives

Performance Improvement Plan (PIP)

- ACOs are responsible for implementing PIPs by identifying opportunity of improvement that are aligned with the performance measures of the contract and in accordance with guidance specific and approved by EOHHS as to improve the care and services provided to MassHealth members.
- Our team partners with ACOs to guide and support them during the entire PIP process, which includes identification of the improvement areas for the PIPs; implementing, testing and evaluating interventions for the PIPs; and reports submissions for the PIPs using the Submission Templates developed by EOHHS or its designee.

External Quality Review Organization (EQRO) Audits

- EQRO analysis and evaluate aggregated information on quality, timeliness and access to health care services that a managed care plan or it's contractors furnish Medicaid benefits.
- Our team leads EQRO activities coordinating closely with WellSense and our ACO partners. When possible, our team offers best practice coaching and guidance for ACOs on EQRO deliverables (e.g. PIPs).

Chart Abstractions

- Chart abstractions is one way ACOs can achieve compliance with MassHealth hybrid measures that are included in the MassHealth ACO Quality Payment Program measure slate.
- Our team partners with ACOs to utilize and complete the excel-based clinical data collection tool developed by MassHealth, which was developed to allow for inclusion of claims data, for the collection of clinical data elements necessary to make adherence determinations.

BMC Health System will collaborate with your ACO teams on specific strategies that apply to your ACO

Examples of past collaborations include, but aren't limited to the following:

Past Collaborations

1. Worked with pharmacy team to implement AMR best practices within BACO and Signature
2. Assisted Greater New Bedford CHC with DRR
3. Created an Arcadia report for Signature to help them identify kids at risk of missing rotavirus vaccine for CIS
4. Helped Southcoast plan out their CIS strategy reviewing 1:1 with them the tools they use for population health and suggesting best practices for a registry of CIS patients

Primary Care Providers

PCPs Participating in the ACO Program

- PCPs may only enroll in one ACO.
- Dual PCPs/specialists can provide specialty services to eligible members both within and outside of the ACO.
- PCPs act as the coordinator of all medical and behavioral care for their assigned members.
- Members are assigned to a PCP within their selected ACO and must utilize that PCP for all primary care services.
- PCPs will make best effort to direct members to specialists and other providers within the ACO or with whom there is an established relationship.
- Members may go to any contracted specialist or other provider within the WellSense network subject to the specialist/other provider obtaining a prior authorization for the service, if applicable.
- Participation of non-PCPs (specialists, ancillaries, facilities, etc.) is not limited by ACO participation.

Early and Periodic Screening, Diagnosis and Treatment Services

- PCPs are required to provide or arrange for the provision of early and periodic screening, diagnosis, and treatment (EPSDT) services.
- EPSDT services are available to all members under the age of 21.
- EPSDT services apply to MassHealth Standard and CommonHealth members.
- To ensure the health of members and to comply with contractual and legal requirements, PCPs must:
  - Screen all MassHealth Standard and CommonHealth members under the age of 21 in accordance with the EOHHS's EPSDT medical protocol and periodicity schedule. Provide or refer these members for all medically necessary care in accordance with EPSDT requirements.
- In addition, PCPs must offer to perform behavioral health (mental health and substance use disorder) and developmental screens to all members under the age of 21 as part of every EPSDT visit.
  - Visit the WellSense website at Provider Resources | Massachusetts | WellSense Health Plan for a list of available resources, such as the PCP Tool Kit and Tips for CBHI providers working with MCPAP. There is also a link to the MassHealth-approved screening tools.
- 130 CMR 450.140 through 450.150 can be referenced for more information about EPSDT services.

Preventative Pediatric Healthcare Screening and Diagnosis Services

- PCPs are required to provide or arrange for the provision of preventative pediatric healthcare screening and diagnosis (PPHSD) services.
- PPHSD services are available to all members under the age of 21.
- PPHSD services apply to MassHealth Family Assistance members.
- To ensure the health of members and to comply with contractual and legal requirements, PCPs must:
  - Screen all MassHealth Family Assistance members under the age of 21, in accordance with EOHHS's PPHSD medical protocol and periodicity schedule. Provide or refer these members for all medically necessary treatment services in accordance with PPHSD requirements.
- In addition, PCPs must offer to perform behavioral health (mental health and substance use disorder) and developmental screens to all members under the age of 21 as part of every PPHSD visit.
  - Visit the WellSense website at Provider Resources | Massachusetts | WellSense Health Plan for a list of available resources, such as the PCP Tool Kit and Tips for CBHI providers working with MCPAP. There is also a link to the MassHealth-approved screening tools.
- 130 CMR 450.140 through 450.150 can be referenced for more information about PPHSD services.

MassHealth Recommended Trainings for PCPs

- PCPs are encouraged to review the training resources that are available on the WellSense Provider Portal and also via Massachusetts Health Quality Partners (MHQP) website [http://www.mhqp.org/] to learn more about the following:
  - Issues concerning adults and regular care they should be receiving
  - Issues of adolescence
  - Issues concerning women
  - Issues concerning persons with disabilities
  - Issues concerning other special populations, including individuals experiencing homelessness, high-risk pregnant individuals and children in the care or custody of Department of Children & Families (DCF) and Department of Youth Services (DYS)

Monthly PCP Rosters

- To ensure accurate primary care sub-capitation (PC sub-cap) payments, WellSense will be sending monthly PCP rosters to each ACO Partner to distribute to their participating groups/sites.
- The rosters will be generated at the group/site level and will include the following demographic information for verification:

Provider Name	Tax ID Number
NPI	Tax ID Name
Primary Address	Specialty
Primary Phone Number	Panel Status
Group Name	Provider Directory Status

- Providers are strongly encouraged to review the rosters and submit any changes/updates to WellSense as soon as possible to avoid impact to your PC sub-cap payments due to incorrect provider data.
- Changes/updates should be submitted to WellSense using the Provider Change and Termination Form located on our website at Documents and Forms | Providers - Massachusetts | WellSense Health Plan
- Please contact your WellSense Provider Relations Consultant if you have any questions.

Verifying PCPs and PCP Changes

- Verifying PCPs:
  - It is important to check PCP assignment at every visit.
  - If a provider has multiple affiliations, you must verify that the member is assigned to the affiliation where services are being provided.
  - To verify member assignment on date of service, use the WellSense Provider Portal or call the WellSense Provider Hotline at 800-900-1451.
- PCP Changes:
  - MassHealth ACO members may request a change in their PCP at anytime.
    - PCP changes outside of the member's selection period can only be done within the member's assigned ACO.
  - Change Requests:
    - Should be submitted electronically via the WellSense Provider Portal or faxed to the WellSense Member Enrollment Department at 617-897-0838.
    - PCP Selection Forms must be received before or on the date of service to avoid claim denials.

Member Transfer Policy

- Member Transfer Policy:
  - PCPs must provide a 60-day notice to a member before the effective date of a member termination.
  - A completed Member PCP Transfer Request Form with appropriate documentation to help support the reason for the request to transfer the member can be submitted via the WellSense Provider Portal or a fax to the WellSense Member Enrollment Department at 617-897-0838.
  - WellSense will initiate member outreach to reassign the member.
  - A transition plan will be arranged to ensure there is no interruption in care for the member.

Involuntary Member Transfer or Plan Disenrollment Policy

- WellSense is expected to make all reasonable efforts to support and furnish services to all members, including members who exhibit disruptive behavior, which may impair the provider's ability to furnish services to that member or other members.
- In an extremely limited number of circumstances, the involuntary disenrollment of a member from a PCP panel, specialty/ancillary services or WellSense may be considered.
- The WellSense Involuntary Member Transfer or Plan Disenrollment Policy describes the processes and EOHHS requirements that must be considered in the event of an ACO member's involuntary disenrollment from a PCP panel, specialty/ancillary services or WellSense.
  - The policy is available on the WellSense website at: Involuntary-Member-Transfer-or-Plan-Disenrollment-Policy-04.03.20.pdf.

Provider Responsibilities

Wait Time Policy

Appointment Type	Primary Care	Specialty Care
Urgent Care	48 hours	48 hours
Non-Urgent Symptomatic Care	10 calendar days	30 calendar days
Non-Symptomatic Care	45 calendar days	60 calendar days

Requirements for Hospitals

- Hospitals are required to:
  - Notify WellSense of emergency care and observation services rendered to members
  - Notify the member's PCP within one business day of the member's presentation at the emergency room; notification may include a secure electronic notification of the visit
  - Notify WellSense of newborn births
  - Coordinate with WellSense's hospital care coordinators on concurrent review and discharge planning activities for medical and surgical services
  - Adhere to clinical authorization policies

Documentation of Health-Related Social Needs

- Members will receive a health-related social needs (HRSN) screening upon enrollment with WellSense and annually thereafter.
- Providers should include applicable ICD-10 Z codes (categories Z55-65 and Z75) on any claims submitted for a member related to the encounter where a HRSN is identified.
  - Z codes should be used as supplemental diagnosis codes and not as the admitting or primary diagnosis codes on claims.
- Refer to the ICD-10-CM Official Guidelines for Coding and Reporting for the list of available Z codes as well as guidance on when and how to report HRSN.
  - Guidelines are located on:
    1. Centers for Medicare and Medicaid Services (CMS) website at https://www.cms.gov/Medicare/Coding/ICD10
    2. Centers for Disease Control and Prevention (CDC) website at https://www.cdc.gov/nchs/icd/index.htm

MassHealth Enrollment Requirement

- Changes in federal law set forth in 42 CFR § 438.602 require all managed care entities (MCEs) network providers, including WellSense Health Plan providers, to enroll with MassHealth.
  - This means all WellSense network providers must have two provider contracts in place:
    1. A network provider contract with WellSense Health Plan
    2. A provider contract with MassHealth
- MassHealth has developed the MassHealth Nonbilling Managed Care Entity (MCE) Network-only Provider Contract for MCE network providers who do not already have a provider contract with MassHealth.
  - This specific MassHealth provider contract does not require the WellSense network providers to render services to MassHealth fee-for-service members.
  - Visit MCE Nonbilling Network Only Contract | Mass.gov to complete the contract for this requirement.
- Please contact your dedicated WellSense Provider Relations Consultant if you have any questions or you can send an email inquiry to our WellSense Provider Engagement team at Provider.Info@bmchp-wellsense.org.

Provider Demographic Changes

- It is critical to notify WellSense of provider demographic changes in a timely fashion.
- WellSense is required to keep provider information updated and ensure the provider directory displays the most accurate information.
- Providers are expected to notify WellSense of any changes/updates as they occur and on a regular basis.
- Demographic changes that you should notify WellSense about include:

Payment information (Payments will be delayed or interrupted if incorrect)	**Telephone number**
Tax Identification Number (TIN) or entity affiliation (W-9 Form required for change)	Fax number
Group name or affiliation	Termination or expiration
National Provider Identifier (NPI)	Panel Status
Mailing address	

- Please submit changes/updates to WellSense within 60 days of the effective date using the following method:
  - Emailing a completed Provider Change and Termination Form to Provider.ProcessingCenter@bmchp.wellsense.org (include a W-9 Form for TIN and remittance changes)
  - Form is available on the WellSense website at Documents and Forms | Providers - Massachusetts | WellSense Health Plan

Provider and Staff Contact Information

- To ensure you receive important updates and notices from WellSense, please be sure to keep your contact information up to date with us.
- Please reach out to your WellSense Provider Relations Consultant to inform us of staff changes in your office.
- You can also send an email to: Provider.Info@bmchp-wellsense.org to request a General Contact Form so that WellSense can update your contacts as needed.

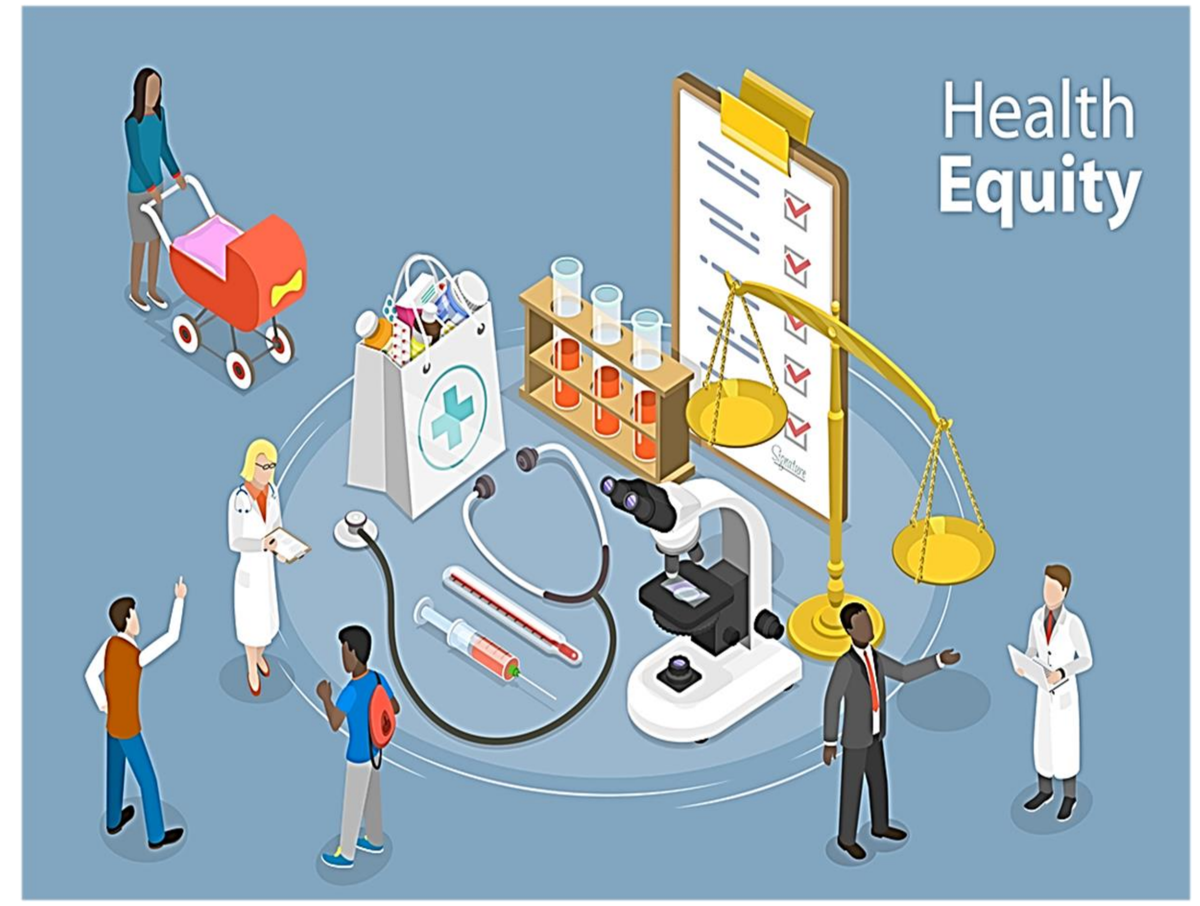
Cultural Competency

- WellSense encourages and expects providers to:
  - Be aware of cultural differences and the potential impact of those cultural differences
  - Acquire cultural knowledge and skills to understand the needs of the populations they serve
  - Ask questions relevant to how the family and culture values might influence the patient's health care perceptions and needs
  - Listen to the patient's opinion in considering treatment options
  - Assist patients (such as those with disabilities) in maximizing both their involvement in their care as well as their independence and functioning

Additional information is available on the WellSense website at
Training and Support | Providers - Massachusetts | WellSense Health Plan

Health Equity [1/2]

- WellSense expects providers to:
  - Provide care with consideration for the member's race/ethnicity, disability, sexual orientation, gender identity and language
  - Make reasonable attempts to collect member self-reported data regarding race, ethnicity, language, disability, sexual orientation, gender identity and other social risk factors
  - Ensure that all member-facing staff through operations, delivery of services, or other patient-facing roles (e.g., security officers or receptionists) receive trainings periodically related to the advancement of health equity aligned to the topics listed on the following slide.



Health Equity [2/2]

1. An overview of the organization's health equity strategy, including populations prioritized for intervention
2. The role(s) trainees can play to promote and achieve health equity
3. The importance of and best practices related to:
   - Collecting self-reported social risk factor data, such as race, ethnicity, language, disability, sexual orientation and gender identity
   - Addressing inequities experienced by enrollees with social risk factors, including but not limited to race, ethnicity, language, disability, sexual orientation and gender identity
   - Adherence to CLAS standards
   - The role of trauma-informed practices for marginalized individuals
   - Identifying and mitigating the impact of implicit biases on delivery of high quality, equitable health care
   - Anti-racism, including topics but not limited to the role of structural and institutional racism in health care
   - A description of how health equity training content reinforces the organization's mission, values, and priorities and how trainees have applied or are expected to apply the training to their work

Additional information is available on the WellSense website at
Training and Support | Providers - Massachusetts | WellSense Health Plan

Provider Marketing Limitations

- Prohibition on Promoting WellSense:
  - Providers should not encourage members to enroll with WellSense or to either not enroll with or disenroll from another MCO.
  - If a provider is concerned that their communication with members may be interpreted as promoting WellSense, please consult your WellSense Provider Relations Consultant.
- Use of State-Approved Materials Exception:
  - Providers may post marketing materials that have been approved by MassHealth in their offices.
- For more information, please visit the "Marketing to Members Guidelines" section on the WellSense website at Training and Support | Providers - Massachusetts | WellSense Health Plan

Provider Claims and Administrative Appeals

Provider Claims Overview [1/2]

- Claims Filing Limit:
  - 150 days (COB and other party liability rules apply)
- To expedite payments, WellSense strongly encourages providers to submit claims electronically and only submit paper claims when necessary.
- Electronic Claims:
  - Providers can submit claims directly to WellSense through our Provider Portal or via a third party.
  - Providers can register with Trizetto Payer Solutions or use one of the following clearinghouses:
    - Gateway EDI
    - New England Healthcare EDI Network (NEHEN)
- Paper claims can be submitted via U.S. mail by filling out the Professional Paper Claim Form (CMS-1500) or Institutional Paper Claim Form [UB-04/CMS-1450] and sending it to the following mailing address.
- Paper Claims Mailing Address:

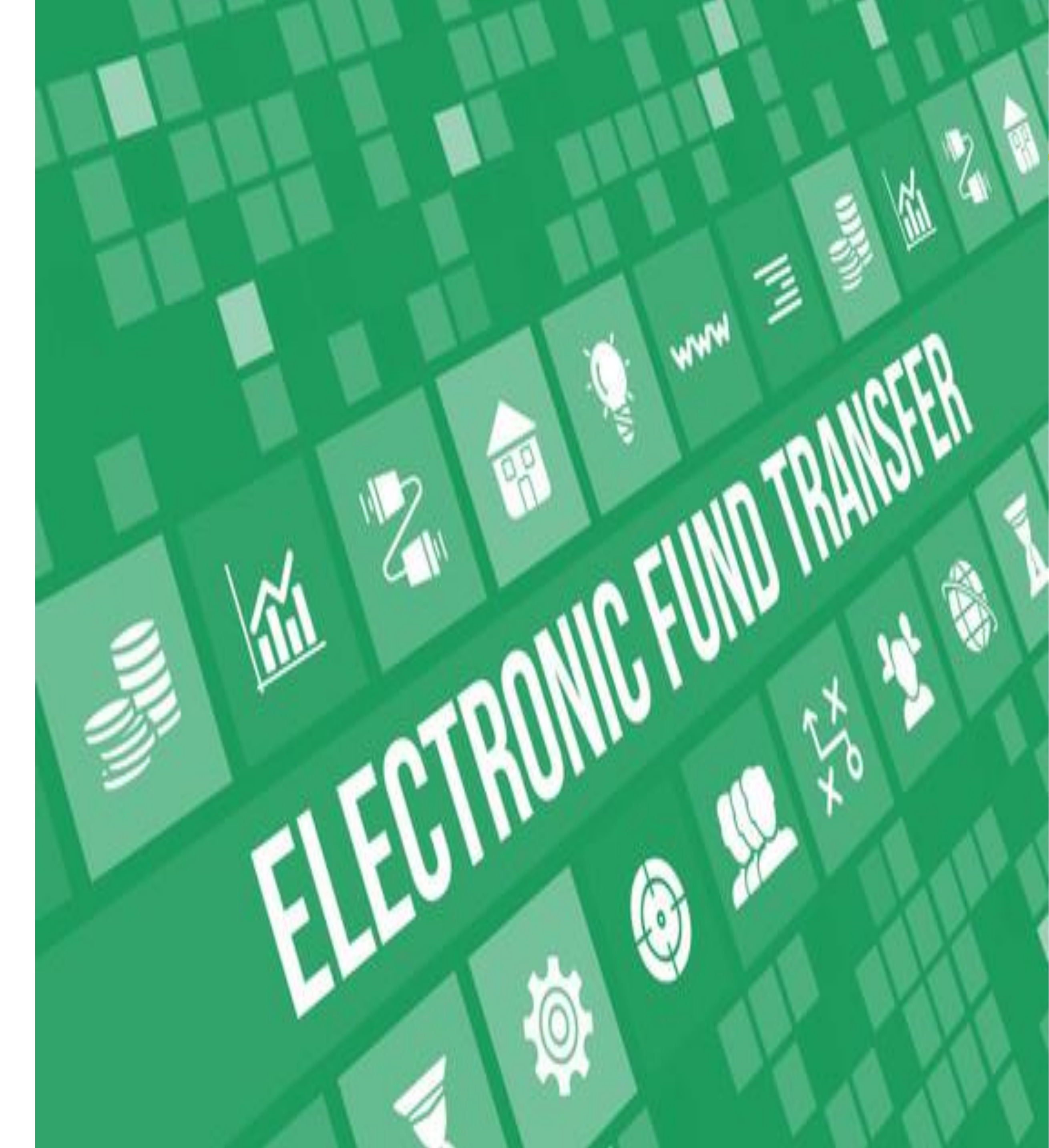
WellSense Health Plan
P.O. Box 55282
Boston, MA 02205-5282

Provider Claims Overview [2/2]

- To find more information about submitting claims to WellSense, please visit our website at Submit Claims | Providers - Massachusetts | WellSense Health Plan
- There is helpful information and resources about the following:
  - Submitting claims
  - Corrected claims
  - Overpayments and returned checks
  - Request for claim review
  - Submitting provider administrative claims appeals
  - Documents and forms
  - Training guides for provider portal
- For questions or assistance, please contact your dedicated WellSense Provider Relations Consultant or call our Provider Service Department at 888-566-0008.

Electronic Funds Transfer (EFT)

- EFT permits a direct deposit of your WellSense claim reimbursements into the bank account that you designate.
- In addition to being a convenient and efficient option for receiving payments, EFT offers the following advantages:
  - Prompt payment (no waiting for checks to clear)
  - Improved cash flow
  - No lost checks or postal delays
  - Administrative savings
  - Reduced paperwork
  - Secure payment environment
- For more information about how to enroll in EFT or for assistance, please contact your dedicated WellSense Provider Relations Consultant or call the Provider Service Department at 888-566-0008.



Provider Administrative Claims Appeals [1/3]

- Providers may request that WellSense review a claim that has already been processed and denied for an administrative reason.
- We offer one level of internal administrative review to providers.
- The Provider Administrative Claims Appeals Process may be used to request a review of a denied claim for one of the following reasons:
  - Claims timely filing limit
  - Level of compensation/reimbursement
  - No prior authorization/inpatient notification
  - Member eligibility issues
  - Non-covered/unlisted codes
  - Coordination of benefits/third party liability/other party liability
  - Duplicate claims appeals
- All required information and documentation that a provider would like to have considered for their administrative claims appeal must be submitted at the time the appeal is filed.
  - If an appeal is submitted without all required information, WellSense will dismiss the appeal and providers will be notified in writing.

Provider Administrative Claims Appeals [2/3]

  - Once a decision has been made, additional information will not be accepted by WellSense.
  - Decisions are made within 30 calendar days from the date the appeal is received by WellSense.
- Provider Administrative Claims Appeals Timeframes:
  - Appeals must be filed within 150 calendar days from the original denial date and no later than 300 calendar days from the date of service.
    - An administrative claim appeal filed after this timeframe will be denied.
  - Retrospective adjustments (beyond the maximum 300 calendar days) will be denied or considered at WellSense's discretion.
- Administrative claims appeals can be filed by:
  - Submitting a request via the WellSense Provider Portal
    - For instructions on how to file an appeal using the portal, refer to the "Request for Claim Review" section on our website at Submit Claims | Providers - Massachusetts | WellSense Health Plan
  - Downloading, submitting, and mailing the Request for Claim Review Form located on the WellSense website at Documents and Forms | Providers - Massachusetts | WellSense Health Plan
    - Forms should be sent to the following mailing address:

WellSense Health Plan
Attn: Provider Administrative Claims Appeals
P.O. Box 55282
Boston, MA 02205-5282

Provider Administrative Claims Appeals [3/3]

- For questions about Provider Administrative Claims Appeals, call the WellSense Provider Service Department at 888-566-0008.
- For additional guidance on administrative claims appeals, please refer to our Provider Administrative Claims Appeals Policy – Number: O.5.019 located on our website at Policies | Providers - Massachusetts | WellSense Health Plan.
- For more information on filing an administrative claims appeal, please reference the "Billing & Reimbursement" section of our Provider Manual located on our website at Provider Manual | Providers - Massachusetts | WellSense Health Plan.

Member Appeals and Grievances

Member Appeals and Grievances [1/6]

- WellSense strives to promptly resolve member appeals and grievances and has implemented an efficient process to manage them.
- Difference between member and provider appeals:
  - Provider Administrative Claims Appeals
    - A formal process for providers to request review of their claims that have been processed and denied for an administrative reason as listed in the previous slides.
  - Member Appeals
    - A formal process for members or their authorized representatives, which includes providers, to request review of denied services that have not yet occurred.
    - When a prior authorization or inpatient stay is denied in advance of the member receiving the services, a WellSense denial letter is issued to the member and requesting/servicing provider(s). The denial letter includes member appeal rights.
    - Also includes WellSense applicable benefit reviews for excluded services/member reimbursements pertaining to out-of-pocket member liability. These are typically filed by members themselves.
- Member appeals must be submitted to WellSense within 60 calendar days of the date of the notice of an adverse action.
- A member or authorized representative, which includes a provider acting on behalf of the member, may request three types of member appeals.

Member Appeals and Grievances [2/6]

- Types of Member Appeals:
  - Standard Internal Appeal
    - Resolved within 30 calendar days, unless extended.
    - A signed Authorized Representative Form is required from the member for a provider or any other authorized representative to file the appeal on the member's behalf.
    - The appeal is dismissed if this form is not received within 30 calendar days.
  - Expedited Internal Appeal
    - Resolved within 72 hours, unless extended.
    - For WellSense's records, a provider must formally assert that a member's health and/or life is in serious jeopardy awaiting the standard internal appeal timeframe.
    - If this is the case, a signed Authorized Representative Form from the member is not required for a provider to file the appeal on the member's behalf.
  - External EOHHS Hearing
    - May be utilized only after the internal appeals process has been exhausted.
    - These appeals must be filed within 120 calendar days of the date of WellSense's Internal Appeal Denial Letter.
- Information on the Member Appeals Process is included in all initial denial letters sent to members and requesting/servicing providers.
  - The appeals process is included after the denial or partial approval rationale.

Member Appeals and Grievances [3/6]

- The detailed information in the letter from WellSense includes, but is not limited to:
  - Timeframes for filing appeal
  - Methods and contact information for filing appeal
  - Timeframes for processing appeal
  - Rights of the member throughout the appeal process
  - Information on authorized representatives
  - An informative member appeals insert
  - An Authorized Representative Form

- It is essential that providers/office staff review the denial or partial approval letter in its entirety to ensure any member appeals for prospective services are sent to the appropriate department at WellSense.
  - This will allow us to process the appeal as quickly as possible.
- Provider tips for an effective and efficient member appeals process:
  - Review the initial denial/partial approval rationale. The rationale for the decision will inform the provider which part(s) of the clinical criteria a member did not meet to qualify for coverage of the service, supply, medication or inpatient stay.
  - If clinical information/documentation exists to prove the member meets the clinical coverage criteria but was not sent initially, be sure to include that information with the appeal request.

Member Appeals and Grievances [4/6]

- Provider tips for an effective and efficient member appeals process:
  - Include a written narrative supporting the appeal on the member's behalf, including documentation of new/additional information being sent; the reason(s) the member should be covered for the service, supply, medication, or inpatient stay; and any other information pertinent to the request.
- The provider tips listed above will reduce the number of follow-up phone calls required, based upon provider availability, and allow for faster processing of the member appeal.
- A hearing through the Massachusetts EOHHS is an independent review by an EOHHS Hearing Officer (attorney) of a WellSense internal appeal adverse action.
  - A member may be eligible for an external hearing appeal only after they have exhausted WellSense's internal appeals process.
  - The external hearing appeal must be filed within 120 calendar days of the date on WellSense's Internal Member Appeal Adverse Action Notice.
  - The member or their authorized representative, including providers filing on the member's behalf, must be present for the EOHHS hearing.
  - Representative(s) from WellSense also participate in the hearing.

Member Appeals and Grievances [5/6]

- Member Grievances
  - Process where members or their authorized representative, including providers filing on a member's behalf, express dissatisfaction about the services they receive from WellSense and/or providers.
- Types of member grievances include, but are not limited to:
  - Plan processes
  - Plan staff
  - Provider attitude/service
  - Provider staff attitude/service
  - Quality of care
  - Quality of practitioner office site
  - Billing/financial issues
  - Access and availability
- Providers may assist members or their authorized representatives in bringing forth grievances.

Member Appeals and Grievances [6/6]

- Member grievances may be filed with WellSense:
  - Verbally by calling the Member Services Department at 1-888-566-0010
  - Via fax to the Member Appeals and Grievances Department at 617-897-0805
  - In writing to the following mailing address:

Member Appeals & Grievances Department
529 Main Street, Suite 500
Charlestown, MA 02129

- If a member or their authorized representative files a grievance against a facility, provider and/or provider staff, the provider is expected to work with WellSense by reviewing the expression of dissatisfaction and responding in a timely fashion to WellSense's requests for administrative and/or clinical information.
  - This information is crucial to WellSense's timely review and response to the member.

Fraud, Waste and Abuse

What is Fraud, Waste and Abuse (FWA)?

Fraud

- Intentionally making, or attempting to make, a false claim, representation or promise in an effort to receive payment or property to which one is not entitled.
- It can also be a concealment or omission of a material fact.

Waste

- Poor or inefficient practices occurring without intent to deceive that result in the provision of unnecessary health care services and subsequent expenditures.

Abuse

- Any activity that unjustly allows the perpetrator to obtain money or health care services to which he or she is not entitled, but for which there is not the intent to deceive that is necessary for fraud to have occurred.

Common FWA Situations to Avoid

- Billing for services not rendered
- Billing for a non-covered service as a covered service
- Billing for medically unnecessary services
- Misrepresenting dates of service, locations of service and/or provider of service
- Billing services performed by one professional under another professional's Provider ID
- Waiving of deductibles and/or copayments
- Incorrect reporting of diagnoses, modifiers or procedures
- Overutilization of services
- False or unnecessary issuance of prescription drugs
- Up-coding services by billing for services at a higher complexity than services actually provided
- Billing for services included in a panel, global reimbursement or capitation arrangement (unbundling)
- Paying or receiving "kickbacks" in exchange for referring business
- Charging members out-of-pocket for covered services
- Cutting and pasting electronic medical records (cloning)
- Double billing for services
- Billing for a provider whose license has lapsed, is no longer in practice, is deceased or is an ineligible Medicaid provider

Suspected Member Fraud: What Should be Reported

Insurance card sharing

Ineligible members:

- Financial or geographical

Identity theft:

- Look for complaints of member's claiming they did not have a service with you or that their ID was stolen
- Photo ID does not match individual seen in your office

Prescription fraud:

- Allegations of forged prescriptions
- Doctor shopping
- Theft of prescription pads/paper

Reporting FWA

- Under federal and state regulations, a provider or member who commits FWA may be subject to fines and/or imprisonment.
- FWA does not need to be proven or investigated, but needs to be reported if suspected.
  - You must report any provider, member or pharmacy who is suspected of committing FWA.
- You can file a report anonymously via the WellSense Compliance Hotline.
  - The Compliance Hotline is administered by Global Compliance.
  - You do not have to give your name to file a report.
  - If you desire follow-up, leave detailed information.
- To report an incident:
  - Call the Compliance Hotline at 1-888-411-4959
  - Email WellSense Special Investigations Unit at: FraudAbuse@bmchp-wellsense.org
  - Mail a written report to:

WellSense Health Plan
Special Investigations Unit
Schrafft's City Center, Suite 500
Charlestown, MA 02129

WellSense Provider Portal

Provider Portal – My HealthNet

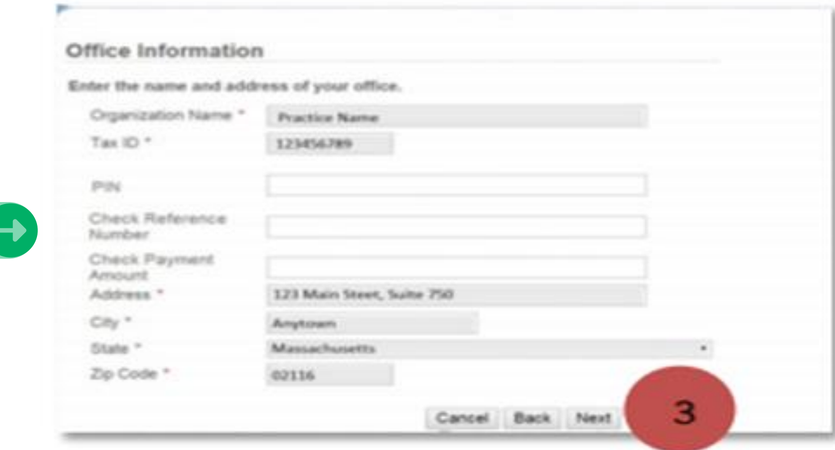
- Please visit our improved provider portal, My HealthNet.
  - Based on provider feedback, we have enhanced features to help make your job easier.
- My HealthNet can be accessed from the WellSense website at HealthTrio connect - HBoston Medical Center HealthNet Plan.
- The portal is your one stop place to:
  - Submit and check status of prior authorizations (can upload supporting documentation)
  - Check member eligibility
  - Submit claims
  - Check claims status
  - Submit claims appeals and corrected claims
  - Request PCP changes
  - Report member demographic changes (phone and address changes)

Provider Portal Registration

- For providers who do not have an existing HealthTrio Connect account:
  - On the home page of the provider portal, under PLEASE SIGN IN, click on “Provider Registration.”
  - On the User Information page, complete all fields and click the Next button.
  - On the Office Information page, complete requested information and click the Next button.
  - On the Registration Summary page, verify your information and click the Finish button.
  - Once registration is complete, everyone who has been registered by the Office Administrator in your Provider office will be listed.
- If you do not have account access, please contact your designated office administrator.

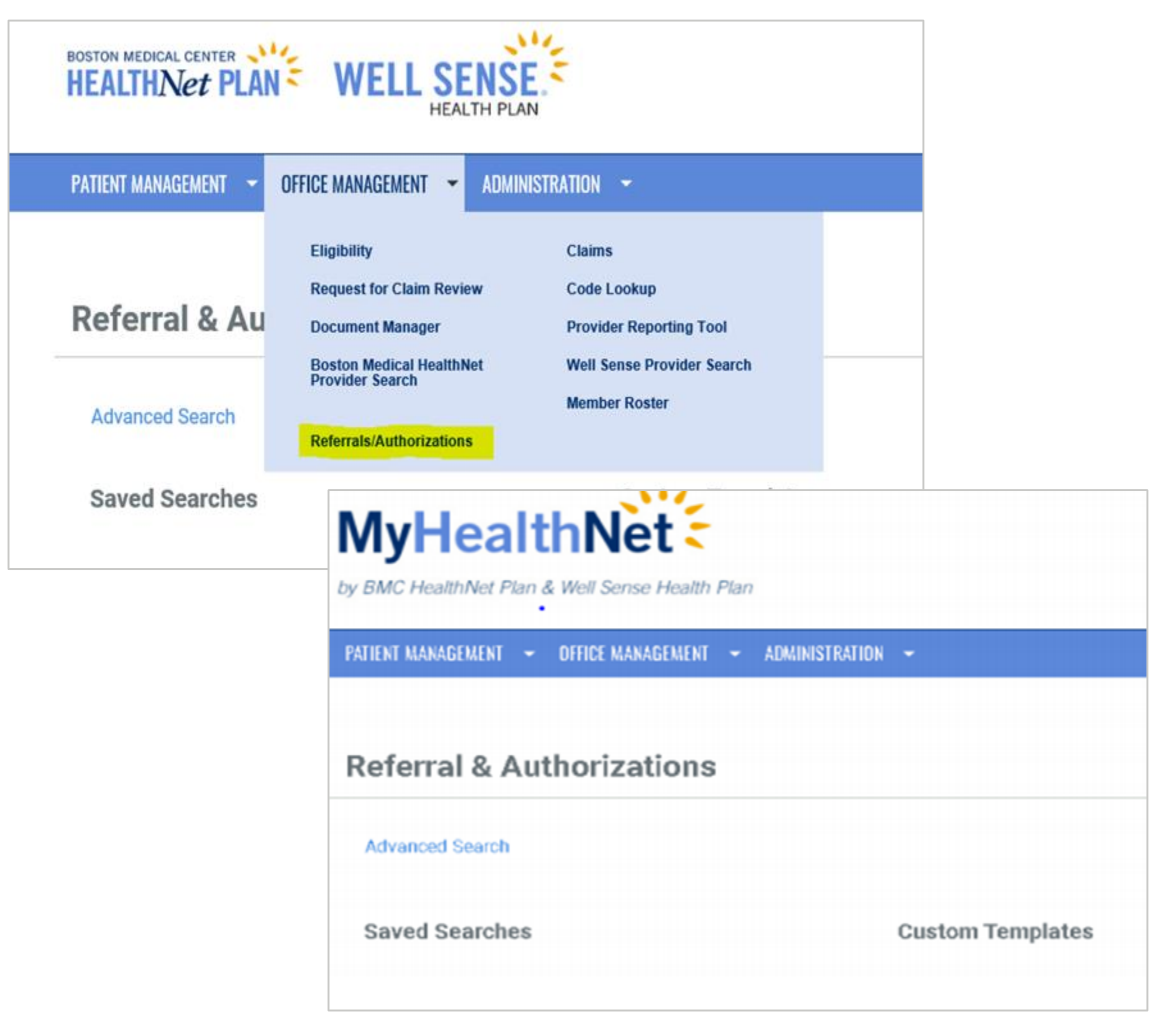
Fill in fields

Fill in fields



Submitting Prior Authorizations via Provider Portal

- WellSense strongly encourages providers to submit prior authorizations (PAs) via the provider portal.
- Submitting PAs via the portal offers the following benefits:
  - Streamlined process for WellSense and provider
  - Reduces paper, time and resources, resulting in higher efficiency
  - Ability to check the status of PA requests online at your convenience
  - Offers more security to protect PHI
- Online submission of PA requests will be mandated in the near future.



Provider Portal Resources

- The WellSense Provider Relations team can train you on how to use My HealthNet, so that you can take full advantage of its many features!
  - Please contact the team if training is needed in your office or if you need secure access.
- Additional provider portal resources are available on the WellSense website at Training and Support | Providers - Massachusetts | WellSense Health Plan.
  - Click on the "Provider Portal Training" drop-down
  - Training Guides available for download include:
    - Provider Portal – Claims Submission
    - Member Eligibility & Basic Use Overview
    - Office Management
    - Prior Authorization
    - Registration
    - Claims Update

Helpful Information and Resources

WellSense Provider Engagement Team Support

- The WellSense Provider Engagement team offers training and education for providers and their staff through onsite visits, online/virtual events or phone calls for the following:
  - New or Refresher Provider Orientations
  - New or Refresher Provider Portal Training
  - CPT-HCPCS Look-Up Tool Training
  - Re-education
  - Review of Polices and Procedures
  - General Health Plan Questions
  - Participation Status Inquiries
  - Requests to Join WellSense
  - Requests for Materials
- Contact your Provider Relations Consultant by vising the WellSense website at Service Area Listing-PR Territories All Regions (wellsense.org)
- Email the Provider Engagement team at provider.info2@wellsense.org
- Call the Provider Service Department at 888-566-0008

WellSense Provider Resources and Tools

- WellSense Provider Website:
  - Provider Resources | Massachusetts | WellSense Health Plan
- WellSense Provider Portal (My HealthNet):
  - HealthTrio connect - HBoston Medical Center HealthNet Plan
- WellSense Provider Quick Reference Guide:
  - Provider-Quick-Reference-and-Contact-Information-Guide.pdf (hubspotusercontent-na1.net)
- WellSense Provider Manual:
  - Provider Manual | Providers - Massachusetts | WellSense Health Plan
- WellSense Document and Forms:
  - Documents and Forms | Providers - Massachusetts | WellSense Health Plan
- WellSense Provider Policies:
  - Policies | Providers - Massachusetts | WellSense Health Plan
- WellSense Prior Authorizations:
  - Prior Authorizations | Providers - Massachusetts | WellSense Health Plan

THANK YOU