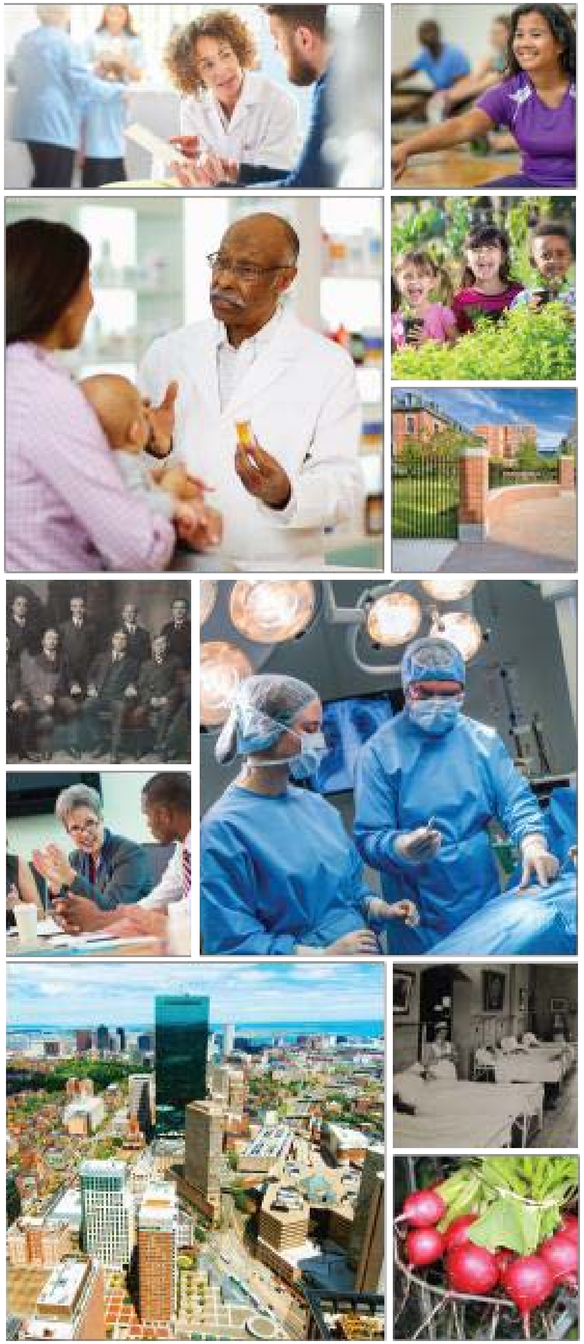

Boston Medical Center
HEALTH SYSTEM

MassHealth Accountable Care Organizations and Included Programs Overview

*April 2023

*Note, updates to the MH 1115 waiver may have been implemented since the development and recording of this material

Introduction and Scope of Content

Introduction

WellSense Health Plan has partnered with eight health care organizations to serve over 500,000 MassHealth patients in the 1115 waiver, effective 4/1/2023. In partnership with providers and government, WellSense has formed Accountable Care Organizations to share responsibility for patient outcomes and managing overall cost of care for MassHealth patients.

After viewing this presentation, the audience will be able to:

- Understand the definition, goals, and priorities of an accountable care organization (ACO)
- Understand MassHealth rationale and logic for attributing patients to ACOs and process for redetermining patient eligibility in MassHealth beginning 4/1/2023
- Understand the foundation of the MassHealth ACO financial model, leveraging risk adjustment, and capitation based on tier of services provided in a primary care setting
- Understand quality and health equity incentives based on performance
- Understand pharmacy resources available to provider organizations, through their ACO
- Understand high-level programs and services that contribute to the holistic care of MassHealth patients including care management, behavioral health services, flexible services, and community partner programs

Agenda

- **ACO Overview**
- Attribution and continued enrollment with MH
- Finance and Risk Adjustment
- Quality
- Health Equity
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MassHealth Accountable Care Organizations were founded to improve patient outcomes and manage costs

An Accountable Care Organization (ACO) is.... An organization of practitioners, health plans, and government that **agrees to be accountable for overall care of its patients**. ACOs are responsible for **improving patient outcomes and managing costs**. It is designed to help patients manage illnesses and reduce health care costs by preventing unnecessary or duplicate tests, reducing preventable admissions to the hospital and emergency room visits.

The state's goals in creating the MassHealth ACO were...

1. To improve patient experience by engaging members (e.g. transitions of care and improved coordination between providers)
2. To strengthen patient-PCP relationships
3. To encourage ACOs to develop clinically integrated partnerships including coordinated care teams and networks
4. To increase and integrate Behavioral Health and Long Term Care Service

1 in 4 Massachusetts residents are covered by MassHealth and over half of MassHealth members are in an ACO[1]

[1] Commonwealth Medicine UMass Chan Medical School, "MassHealth: The Basics"

MassHealth offers a wide array of services to enrollees to improve health outcomes

- Children, persons with disabilities, and people with low incomes make up a large portion of the ACO
- MassHealth coverage offers an added layer of services to meet the complex needs of our patient population

TYPICAL COMMERCIAL INSURANCE COVERAGE

- Hospital services
- Physician services
- Well child visits
- Ancillary services (lab tests, radiology, etc.)
- Prescription drugs
- Mental health/substance use disorder treatment
- Vision, hearing, medical equipment

+

ADDITIONAL BENEFITS

- Long-term services and supports (community- and facility-based)[1]
- Diversionary behavioral health services (to avert hospitalization)
- Enhanced mental health/substance use disorder treatment [2]
- Dental services
- Transportation to medical appointments[1]

= MassHealth

Source: Commonwealth Medicine UMass Chan Medical School, "MassHealth: The Basics"

[1] LTSS and transportation to medical appointments are available to most but not all MassHealth members.

[2] See Massachusetts Division of Insurance, The Catalogue of Carrier Coverage of Inpatient, Outpatient and Community Behavioral Health Services (November 10, 2017), Excel sheet available at https://www.mass.gov/info-details/health-care-access-bureau.

The approved 1115 MassHealth waiver will shape patient care, financial health, and priorities for ACOs for the next five years.

Historical waiver:
Accountable care transformation

2017 – 2022

Central themes in the historical waiver…

- **Leading-edge (in US) payment reform** in which:
  - Payors and providers vertically integrate
  - Providers assume material upside and downside risk
  - Creation of community partner organizations to facilitate BH and LTSS care
- Investment funding to **support accountable care infrastructure and safety net hospitals**
  - Analytic and population health capabilities
  - Outpatient quality infrastructure
  - Medical management programs (e.g., CCM, transitions of care, low acuity ED visits)
  - Supplemental payments for safety net providers

Current Waiver
Deepening payment reform and advancing health equity

2022 – 2027

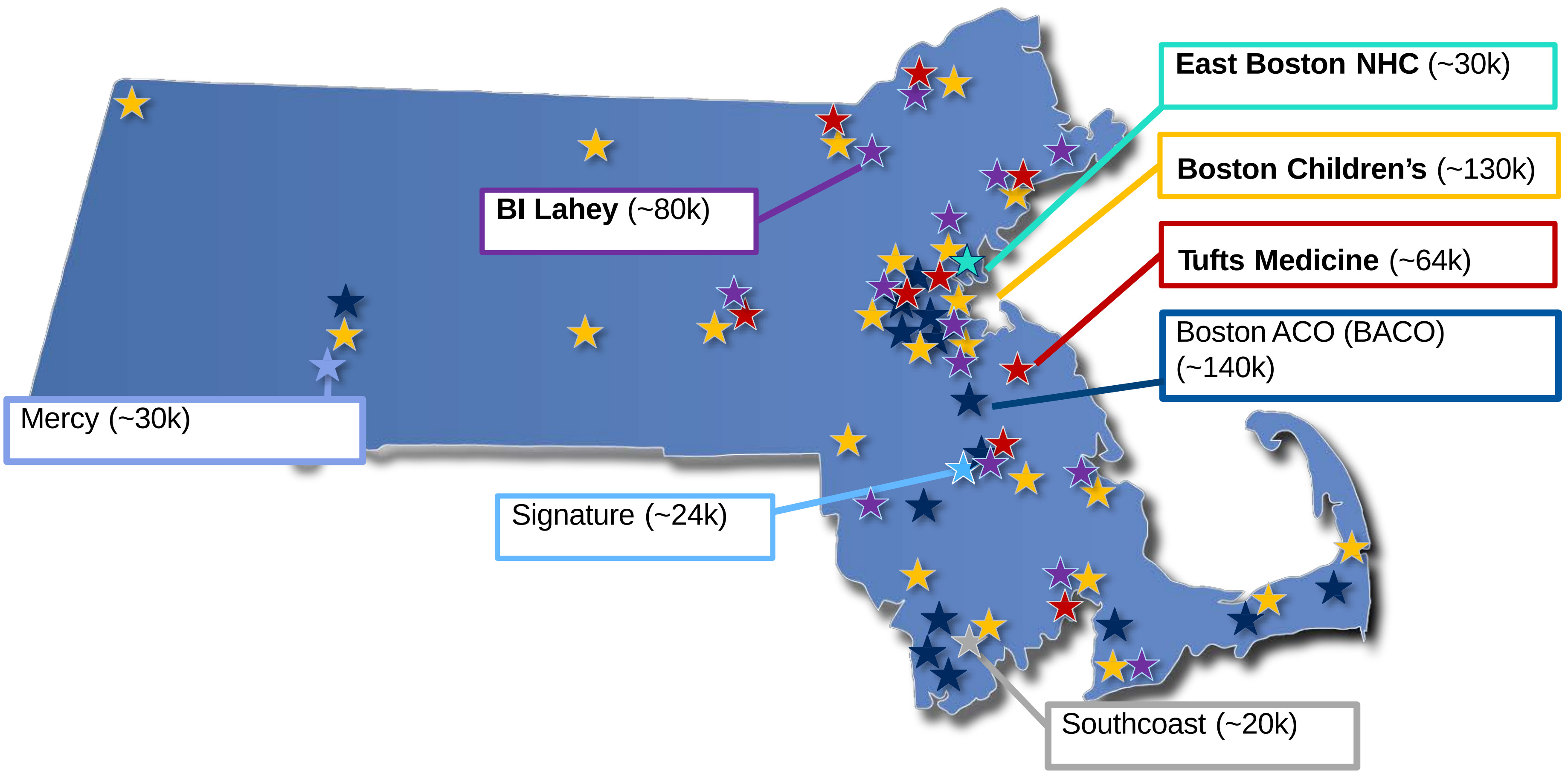
What's at stake…

- **Financial stability of safety net providers—**can MH reform how high-Medicaid hospitals are financed?
- **Future of payment reform and accountable care**, including…
  - Next iteration of ACO/MCO programs
  - Next iteration of care coordination/CP
  - Primary care capitation
- **A more equitable and effective Medicaid program for our community**, including…
  - A significant investment in health equity, with health systems required to meet certain benchmarks

WellSense will be responsible for ~40% of MassHealth ACO lives statewide

ACO partner organizations by region

Number of lives



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Why is attribution important for our ACO model?

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:

Rating cat. mix | Historical Experience | Practice type | Practice Tier

→ Cap rate

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

PCP A panel | PCP B panel | PCP C panel | PCP D panel

→ # members

Member attribution affects both cap rates and cap volume. Attribution can be updated in the MyHealthNet portal.

MassHealth Member Redeterminations launched April 1st 2023

Overview of Member Determinations

- MassHealth member determinations were paused during the COVID-19 pandemic based on federal coverage requirements that prevented members' Medicaid coverage from ending during the COVID-19 Public Health Emergency (PHE).
- As outlined in the 2023 Consolidated Appropriations Act, these continuous coverage requirements ended on April 1, 2023.
- MassHealth redeterminations that began on April 1st of 2023 will take place on a rolling basis over 12 months.
- MassHealth engaged in outreach to notify and educate members on how to renew their coverage between February through June of 2023.

Resources for Providers

- MassHealth is in close coordination with WellSense, providing continuous updates and resources to support providers, health plans, and community partners.
- Resources to facilitate the renewal process can be found by visiting www.mass.gov/masshealth-eligibility-redeterminations
- WellSense is ready for redeterminations and will support providers through:
  - Robust outreach to members (cascade of texts, calls, e-mails)
  - Provider playbooks and trainings (e.g., renewal process overview, workflows, how to schedule MassHealth appointments, FAQs, etc.)
  - Providing lists of members possibly at-risk for losing their coverage as they are received from MassHealth
  - Web-based resources for providers at https://www.wellsense.org/providers/ma/masshealth-redetermination-providers

*This information was updated on 3/27/23.

Agenda

MassHealth developed the Accountable Care Organization (ACO) finance model to support value based care over fee for service

Services Identified

Annually, MassHealth determines a **list of services** that will be **included in Total Cost of Care (TCOC) budget**, and which services are carved out or excluded from the ACO budget. (e.g. high cost medications)

Capitation Budgeted

MassHealth then determines Market TCOC benchmark, factors in ACO specific adjustments to then determine ACO TCOC benchmark

Surplus/ Deficit

If an ACO over-performs (spends below ACO TCOC benchmark), the ACO is in a surplus. If an ACO underperforms (spends above the TCOC benchmark) the ACO is in a deficit.

Added Incentives

In addition, there are other incentive payments MassHealth provides to ACOs to encourage participation in the program

What is Risk Adjustment?

Risk adjustment is a methodology that allows plans/providers to be paid for the **predicted cost** of managing a populations' overall health, rather than for individual units of service

FFS model

- A provider is paid for every unit of service provided. Focus on **episodic care and accurate billing of (on site) services** that are reimbursed by health insurers

Risk adjustment model

- MassHealth/CMS knows how complex patients are based on the diagnosis codes submitted on claims/encounters. Diagnoses need to be documented every year.
- Focus remains on **understanding/documenting patients' social and medical complexity**
- Within the MassHealth model, conditions like **neighborhood stress, serious mental illness, and homelessness** are factors in the risk adjustment methodology

To ensure we are paid appropriately for the complex care we provide patients, we must document and diagnose patient's conditions in full

Mr. Smith has Diabetes with Complications and Alcohol Abuse Without Dependence and various care needs to support these throughout this year. He had 2 inpatient admissions, 4 PCP visits, counseling for his alcohol use, 4 lab visits and DME/medication scripts during 2021. Depending on how Mr. Smith is coded, not all of the annual cost to treat him will be covered with the state's payments

Coded: None

Admission
Medication
Lab Visits
DME
PCP visit
Counseling

Costs Covered

Cost of care: $20k
Annualized PMPM[1]:$6k
Annual Loss:($14k)

Coded: Diabetes w/o Complications

Admission
Medication
Lab Visits
DME
PCP visit
Counseling

Costs Covered

Cost of care: $20k
Annualized PMPM[1]: $10k
Annual Loss: ($10k)

Coded: Diabetes w/ Comp + Alcohol Abuse without Dependence

Cost of care: $20k
Annualized PMPM[1]: $20k
Annual Loss: $0

[1]Dollar figures are illustrative and do not reflect the exact amount received for the conditions represented

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The 2023 MassHealth Quality program is an upside-only incentive payment with a smaller measure slate than prior years

Incentive Payment

- ACOs will receive a **Quality Incentive Payment based on the Quality Score and valued at 0.75% of the capitation rate.** This is a bonus incentive only structure; hospitals who meet safety net criteria will have 20% of safety net dollars tied to this performance score

Quality Score Calculation

- ACOs are scored in **three domains**: preventative and pediatric care, care coordination/care for chronic and acute conditions, and member experience. Points are earned through:
- Up to **10 achievement points** for performance between attainment and goal thresholds;
- **5 improvement points** for meeting the improvement target. **Improvement Points** will be reset in the new waiver and used for calculating the Quality Score **beginning PY2**

[1] Measure crosswalk with measure descriptions can be found in the appendix

The new measure slate consists of 17 measures; year 1 has a limited measures slate that includes 8 measures

Data Source	Measure	Steward
Hybrid	Immunizations for Adolescents	NCQA
	Childhood Immunization	NCQA
	Screening for Depression and Follow Up Plan	CMS
	Controlling High Blood Pressure	NCQA
	Comprehensive Diabetes Care: A1c Poor Control	NCQA
	Timeliness of Prenatal Care	NCQA
	Postpartum Care Visit	NCQA
Claims/Hybrid	Developmental Screening in the First 3 Years of Life	OHSU
Claims	Topical Fluoride for Children at Elevated Caries Risk	ADA DQA
	Asthma Medication Ratio	NCQA
	Initiation and Engagement of Alcohol, or Other Drug Abuse or Dependence Treatment	
	Follow-up after ED visit for alcohol and other drug use or dependence	NCQA
	Follow-up after ED visit for Mental Illness (7 days)	NCQA
	Follow-Up After Hospitalization for Mental Illness (7 days)	NCQA
Patient Experience Survey	Overall Rating/Care Delivery	AHRQ
	Person Centered/Integrated Care	AHRQ

*Measure benchmarks are not defined in the model contract.
Count of 17 measures includes separating prenatal and postnatal visits and initiation and engagement measures

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WellSense and ACOs will work together to meet health equity-related requirements and succeed in the Health Equity Incentive program

	Requirement
Health Equity Committee	▪ Health Equity Committee formed with diverse representation (e.g. members, providers, administrators) and is responsible for overseeing the ACO's health equity strategy, monitoring progress towards addressing inequities, developing equity reporting, etc.
Population & Community Health Needs Assessment	▪ Complete a population and community needs assessment that provides a description of the ACO's Enrollee population and community, population and community needs, and existing resources (updated annually)
Health Equity Strategic Plan and Reporting	▪ Health Equity Committee will create, monitor, and update as needed a five-year Health Equity Strategic Plan that includes input from multiple stakeholders and describes plans to partner with affiliated hospitals, approaches for building an equity culture, equity-oriented policy review, etc.
Health Equity, Anti-Racism, Implicit Bias, and Related Trainings	▪ The ACO will ensure that all member-facing staff and network providers periodically receive meaningful trainings to advance health equity
Health Equity Incentive	▪ The ACO will participate in the ACO Health Equity Incentive Arrangement and identify Health Equity Partner Hospitals to EOHHS ▪ Incentive determined by the health equity score calculated based on performance in three domains: 1) Demographic and HRSN Data; 2) Equitable Access and Quality; 3) Capacity and Collaboration *More on following slide*

1. NCQA = National Committee on Quality Assurance. Accreditation will be through the health plan / MCO, not the provider.

Framework for the ACO Health Equity Incentive

	Subdomain	Metric
Domain 1: Demographic and HRSN Data	Demographic Data Collection	Race, ethnicity, language, disability, sexual orientation, and gender identity (RELDSOGI) data completeness
	Health Related Social Needs Screening	Screening for Social Drivers of Health (CMS measure) - Meaningful improvement on rates of health-related social needs screenings from the baseline period by the end of year 5
Domain 2: Equitable Access and Quality	Equity Reporting	Stratified performance reporting on a subset of quality metrics specified by Executive Office of Health and Human Services (EOHHS)
	Equity Improvement	Equity Performance Improvement Projects (PIPs)
	Access	Access to language services
		Disability competencies
		Disability accommodation needs met
	Disparities Reduction	Targeted quality performance to reduce disparities on clinical quality incentive measures (not applicable in Performance Year 1)
Domain 3: Capacity and Collaboration	Capacity	Member Experience: CG-CAHPS survey with supplemental items on cultural competence from Agency for Healthcare Research and Quality (AHRQ)
		Achievement of National Committee for Quality Assurance (NCQA) Health Equity Accreditation

Agenda

We have a dedicated pharmacy division to help focus on pharmacy cost reduction and support ACO pharmacy specific programs

Medical Expense Initiatives

- **Academic Detailing:** Identifying opportunities to prescribe lower cost, clinically appropriate, medications within our Mass Health formulary.
- **90 Day supply:** Encouraging patients to switch medications to a 90 day supply, bring financial benefits in cost savings with our pharmacy benefits manager
- **Mail Order Pharmacy:** Similarly, mail order pharmacy in alignment with 90 day supply ordering brings greater med adherence, patient convenience and cost savings

ACO/WellSense Program Initiatives

- **Pharmacy Benefits Manager:** Express Scripts (ESI) - WellSense's third-party administrator of prescription drugs, primarily responsible for processing and paying drug claims. They typically negotiate discounts and rebates with drug manufacturers, contract with pharmacies and ensure meeting formulary
- **MassHealth Formulary**: WellSense is required to adhere to MassHealth formulary and prior authorization criteria.
- **Asthma Medication Ratio:** pharmacy resources supporting the ACO quality performance in AMR

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Care Management programs – *overview*

Increasing program intensity

	Program goal
Complex Care Management (CCM)	– CCM team embeds in primary care with the goal of establishing patients (particularly those with complex needs) with ambulatory care, and community based supports to achieve patient-identified goals, improve health related outcomes, and reduce avoidable hospital utilization
Behavioral Health Community Partners (BH CP)	– Provide longitudinal support in the community for individuals ages 18-64 with significant behavioral health needs, including serious mental illness and addiction
Long term services and supports Community Partners (LTSS CP)	– Provide longitudinal support in the community for individuals age 3-64 with complex LTSS needs, such as children and adults with physical and developmental disabilities and brain injuries AND individuals with general health-related social needs.
Behavioral Health Care Management	– Provides enhanced care coordination, including transition of care, to high risk members with SPMI and baseline care coordination to non-high risk members with behavioral health or SUD needs. Services are provided telephonically and priority is given to members not already engaged in CCM or CP unless additional BH support is needed.
WellSense Central CM	– Addresses urgent, escalated, and inbound CM needs from patients, providers, and MassHealth; outreaches to members based on health assessment completion and identified needs for care management; manages high risk maternal and child health cases; provides baseline care coordination; helps connect members to longer-term CM supports where necessary
Flex Services	– Provides health-related social supports for housing and nutrition in order to improve member health outcomes and reduce TCOC

Agenda

BMCHS/WellSense, in partnership with Carelon (formerly Beacon), supports partners' BH performance from strategy to operations

- **Behavioral Health Network**: A uniform, broad behavioral health network for ACOs administered by **Carelon (formerly Beacon Health Options)**
  - —Covering the full spectrum of BH care (incl. outpatient, day programs, diversionary, inpatient and acute)
  - —Carelon conducts contracting, credentialing, prior authorizations, claims processing
  - —Carelon requires prior authorization for some higher-level BH services, but **does not require referrals** for any services (Note: We have worked with Carelon to lessen authorization requirements over time, improving member and provider experience)
- **Behavioral Health Data**: Visibility into members' BH condition prevalence, utilization across the levels of BH care, and quality metric performance
- **Care Management**: Services provided to members with BH conditions alongside existing efforts in your practices (e.g., integrated or collaborative care in primary care), including:
  - —WellSense/Carelon telephonic BH care management, incl. post-inpatient support for transitions of care
  - —BH Community Partner program
  - —Interdisciplinary complex care management for highest-risk members with co-morbid medical and behavioral health needs

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What is a Community Partner (CP)?

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

There are two types of CPs:

Behavioral Health Community Partner (BH CP)	**Long Term Services & 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), such as: SMI, Serious emotional disturbance (SED), Substance use disorder (SUD) Co-occurring SMI/SUD	Predominant LTSS needs, such as: Significant functional impairments and history of high and sustained LTSS utilization, or LTSS related diagnoses

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 min of **3 attempts, including at least one face-to-face**

Assessment & Care Planning

Comprehensive Assessment expected which must be person-centered with member-identified and approve goals.

Care Team Coordination

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

Care Management

Coordinate between member's, 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 3 days post-discharge

Connection to Social Services

Assist enrolled members with SDOH needs including referral to Flexible Services

How to partner with CPs

Recommendations for ACO Groups

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

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What is the MassHealth Flexible Services Program (FSP)?

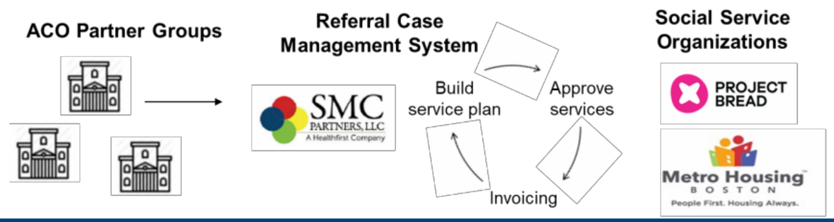
Flexible Services program is MassHealth funded to provider health-related social supports with the goal of improving member health outcomes and reducing TCOC

FSP Eligibility

- **Actively enrolled in the ACO and include one of each of the following two criteria**
- **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, repeat ED use, or experiencing a high-risk pregnancy/complications with pregnancy
- **Meet at least one of the Risk Factors:** experiencing homelessness, at risk of homelessness, or risk for nutritional deficiency

FSP Supports

- **Pre-tenancy:** assisting members with obtaining and completing housing applications**;**
- **Transitional assistance funds** to support one-time household set up costs and first/last month's rent
- **Tenancy Sustaining:** assisting members with communicating with landlords; obtaining adaptive skills needed to live independently in the community
- **Home Modifications:** needed to ensure member's health and safety (e.g., installation of grab bars)
- **Nutrition**: includes goods, transportation, and services that educate members about appropriate nutrition and help members access food needed to meet their nutritional needs.



ACOs partner with a variety of social service organizations (SSOs) 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 for confirmation on SSOs accepting FSP referrals for your members and how to submit a referral. This information is also available through the Flexible Services Program Directory posted online by MassHealth.

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In the waiver period that began April 2023, MassHealth implemented a sub-capitation program for all primary care practices

Medical premiums or base rate

- MassHealth developed the **sub-cap medical premium for each primary care location** (PIDSL-Provider ID/Service Location) based on:
  - —Historical performance (during 2021) across rating categories and practice type
  - —A panel-specific health status adjustment

PC Cap tier funding

- In addition to medical premiums, primary care groups (at the PIDSL level) received **additional funding by meeting the sub-cap tier requirements**. The tier funding was intended to be an incremental investment in primary care.
- There are requirements, by tier, related to care delivery, structure and staffing, and population specific requirements (see following slide)
  - — Requirements did not need to be met until **July 1, 2023**
- Groups must attest to meeting tier 1 to be in the program

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

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 can be found here.

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* specialty credentialing must align with certification and licensure recognized by BORIM.

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

The higher the tier a practice or PIDSL achieves, the more funding available to that practice/PIDSL*

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

KEY
- ✓ Existing capacity or light lift
- ● Moderate lift
- ▲ More challenging to achieve

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

Online Resources Available through WellSense

Topic	Resource	Link
Essential Go-Live Training Materials	Go-Live FAQ	Provider Resources – 2023 ACO Launch Guidance
	Continuity of Care	WellSense-Providers – Massachusetts – Continuity of Care
	Training materials (including recorded Provider Portal trainings)	WellSense-Providers – Massachusetts – Training and Support
Primary Care Sub-capitation	WellSense overview and payment logic	WellSense-Providers - Massachusetts - Primary Care Sub-capitation
Provider Portal/ Health Trio	Provider Portal	HealthTrio connect - Boston Medical Center HealthNet Plan
Prior Auth Tools	Forms and resources	Documents and Forms | Providers - Massachusetts | WellSense Health Plan
	Matrix (Service type, vendor, contact info):	MA Prior Auth Matrix (wellsense.org)
	CPT lookup (medical only)	WellSense MA CPT.pdf
	HCPCS lookup (medical only)	WellSense MA HCPCS.pdf
	Pharmacy	Prescription Information | WellSense Health Plans | WellSense Health Plan