MassHealth Accountable Care Organizations and Included Programs Overview

***September 2024**

Boston Medical Center
HEALTH SYSTEM

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

Introduction and Scope of Content

Introduction

WellSense Health Plan partnered with eight health care organizations to serve over 500,000 MassHealth patients in the 1115 waiver that went into place on 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
- 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 and Health Equity
- Pharmacy
- Care Management
- Behavioral Health
- Community Partners
- HRSN Services
- Primary Care Sub-capitation

MassHealth Accountable Care Organizations (ACOs) 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]

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

Overall, 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 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

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 (CCM, transitions of care, low acuity ED visits)
  - Supplemental payments for safety net providers

Current waiver:
Deepening payment reform & advancing health equity

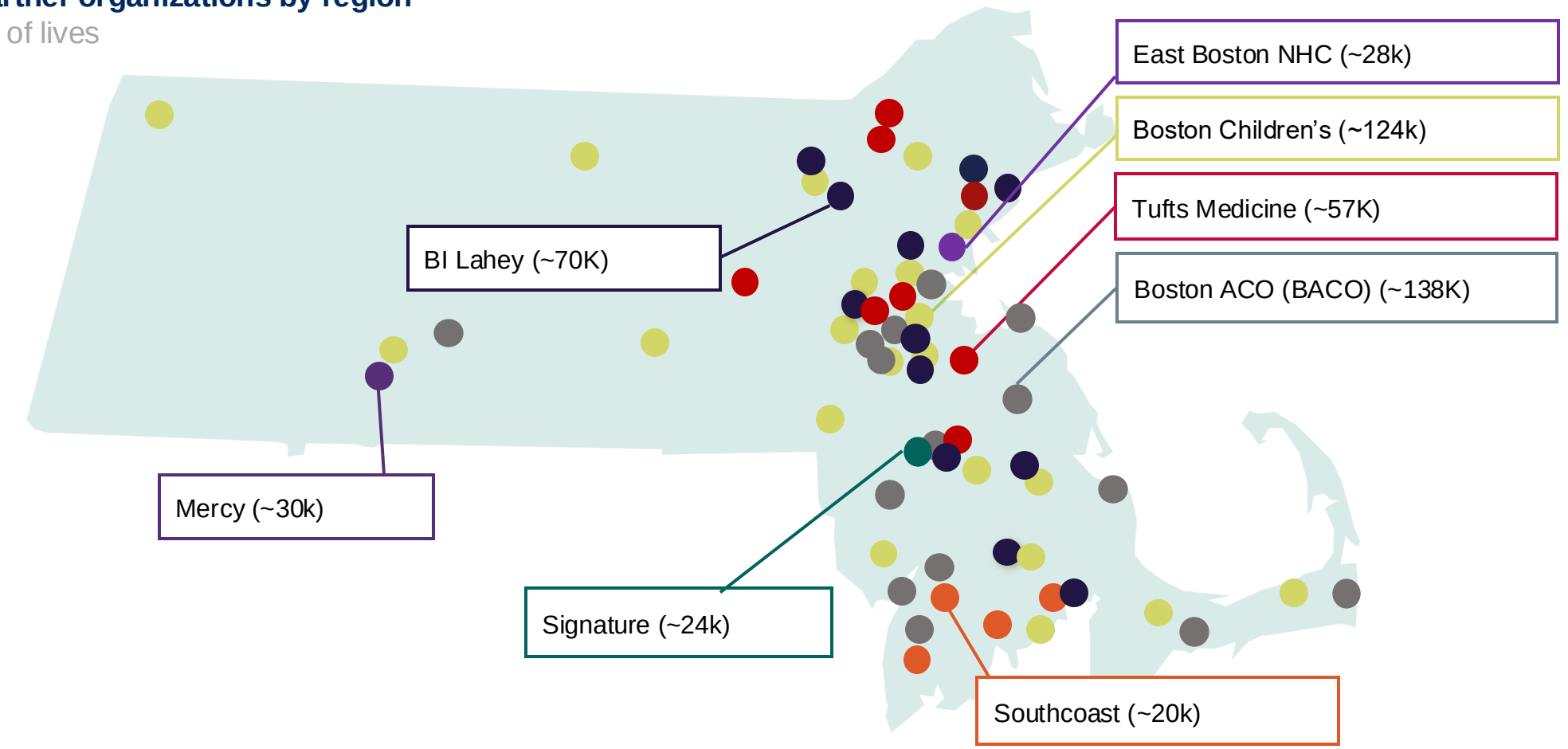
What's at stake?

- **Financial stability of safety net providers** – can MH reform how high-Medicaid hospitals are financed?
- **Future of payment reforms and accountable care**, including:
  - Next iteration of ACO/MCO programs
  - New 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 being required to meet certain benchmarks

WellSense ACO partners responsible for ~40% of MassHealth ACO lives statewide

ACO partner organizations by region

Number of lives



Note: The figures above reflect the ACO membership following member redetermination, which ran from April 2023 to June 2024. As context, 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). Following the end of the PHE, MassHealth redetermined members, resulting in a decrease in the number of members for each ACO.

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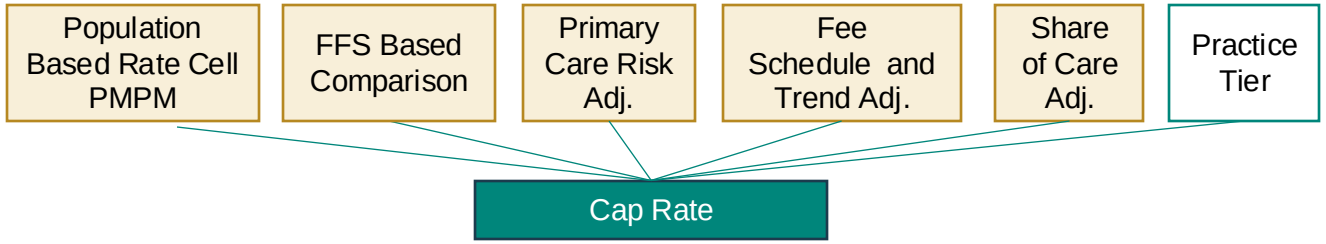
Why is attribution important for our ACO model?

WellSense member attribution

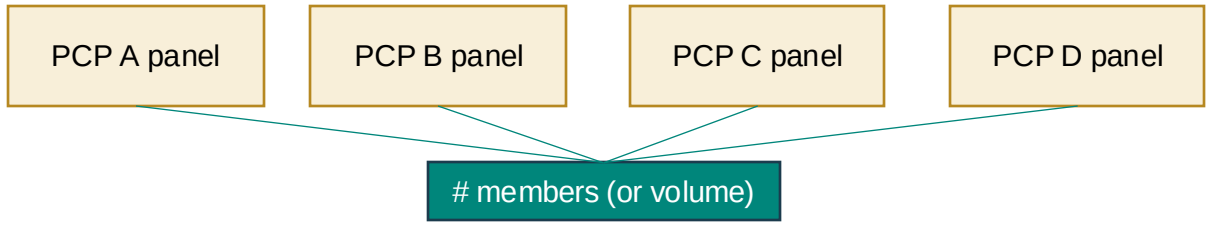
- **WellSense assigns members through one of three methods:**
  - **Member selection** of a PCP during MassHealth enrollment
  - **Auto-assignment** of new members if no PCP selected
  - Provider- or member-driven **change requests**
- **WellSense's auto-assignment algorithm uses a few criteria:**
 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

Why it matters for PC sub-cap

- MH calculates cap rates based on five factors, including four driven by panel characteristics (in yellow):



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



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

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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

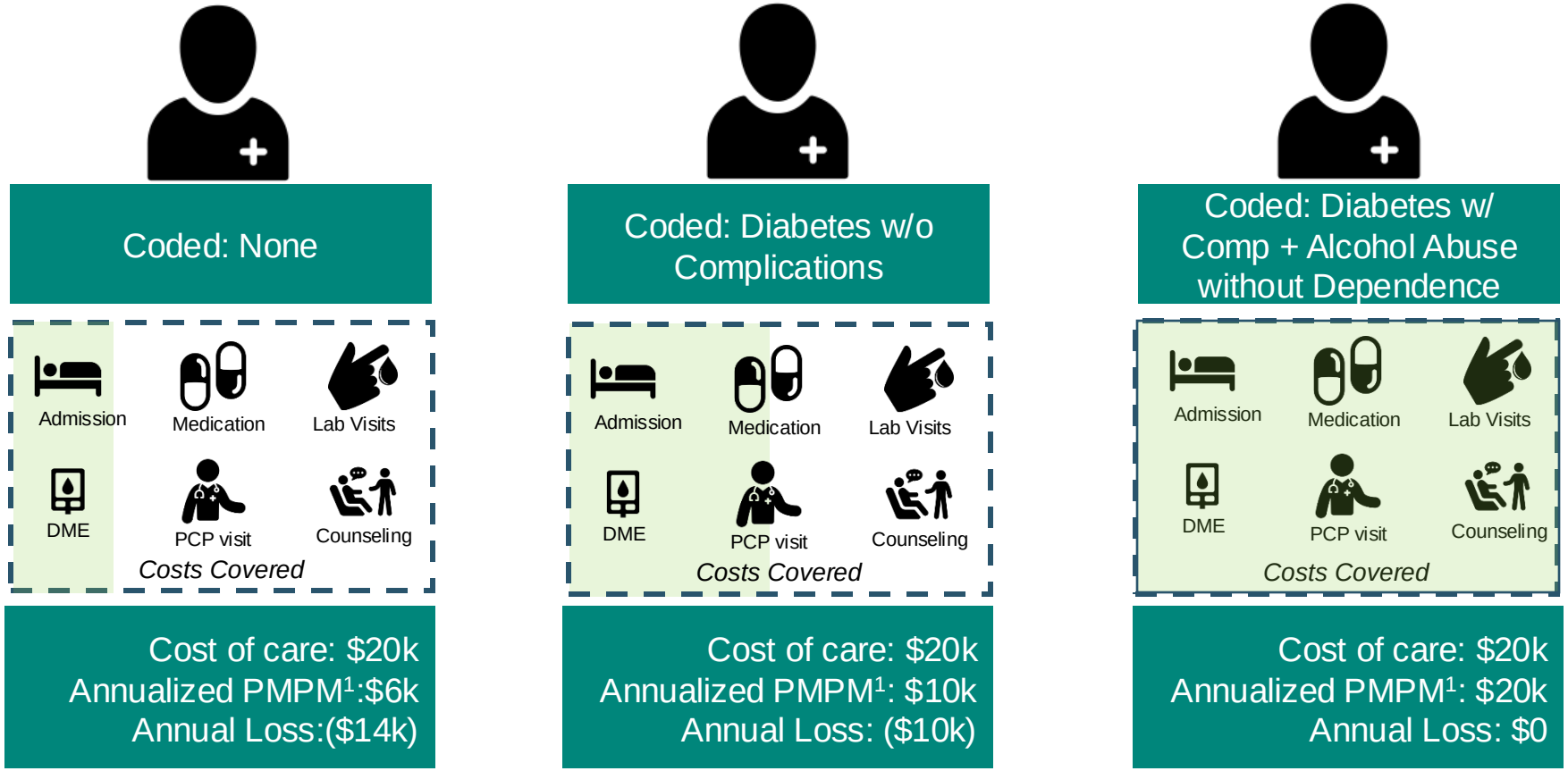
- A provider is paid for every unit of service provided. Focus on **episodic care and accurate billing of (on site) services** that are reimbursed by health insurers

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



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

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The MassHealth Quality Incentive program is an upside-only incentive payment based on the Quality Score

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 and Health Equity Score Calculation

- ACOs are scored in multiple **domains for each incentive:**
- Points are earned through:
  - **Achievement points** for performance between attainment and goal thresholds;
  - **Improvement points** for meeting the improvement target.
  - **Bonus points** (Health Equity only)
  - Achievement points are earned linearly while improvement points are all or nothing

The measure slate for the 2023-2027 waiver period is smaller than the previous slate with a near equal mix of hybrid and claims measures

Domain	Measure	Acronym	Steward	Data Source	P4P Transition Year
Preventive and Pediatric Care	Immunizations for Adolescents	IMA	NCQA	Hybrid	2024
	Childhood Immunization	CIS	NCQA	Hybrid	2024
	Screening for Depression and Follow Up Plan	DSF	CMS	Hybrid	2023
	Topical Fluoride for Children at Elevated Caries Risk	TFC	ADA DQA	Claims	2024
	Developmental Screening in the First 3 Years of Life	..	OHSU	Claims	2025
	Timeliness of Prenatal Care and Postpartum Care^	PPC	NCQA	Hybrid	2023
Care Coordination/Care for Acute and Chronic Conditions	Comprehensive Diabetes Care: A1c Poor Control	A1C	NCQA	Hybrid	2024
	Follow-up after ED visit for alcohol and other drug use or dependence	FUA	NCQA	Claims	2023
	Asthma Medication Ratio	AMR	NCQA	Claims	2024
	Follow-up after ED visit for Mental Illness (7 days)	FUM	NCQA	Claims	2023
	Follow-Up After Hospitalization for Mental Illness (7 days)	FUH	NCQA	Claims	2023
	Controlling High Blood Pressure	CBP	NCQA	Hybrid	2024
	Initiation and Engagement of Alcohol, or Other Drug Abuse or Dependence Treatment	IET	NCQA	Claims	2024
Member Experience	Overall Rating/Care Delivery	ORCD	AHRQ	Survey	2023
	Person Centered/Integrated Care	PCIC	AHRQ	Survey	2023

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Prenatal and postnatal visits (each weighted at 0.5) and initiation and engagement (each weighted at 0.5) are composite measures.
^Postpartum Care is a new measure
*Pedi Replacement Measure - Metabolic monitoring for children on antipsychotics replaces both Controlling High Blood Pressure and Comprehensive Diabetes Care: Poor a1c Control

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

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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

Domain:	*Subdomain:*	*Metric:*
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
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
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

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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.

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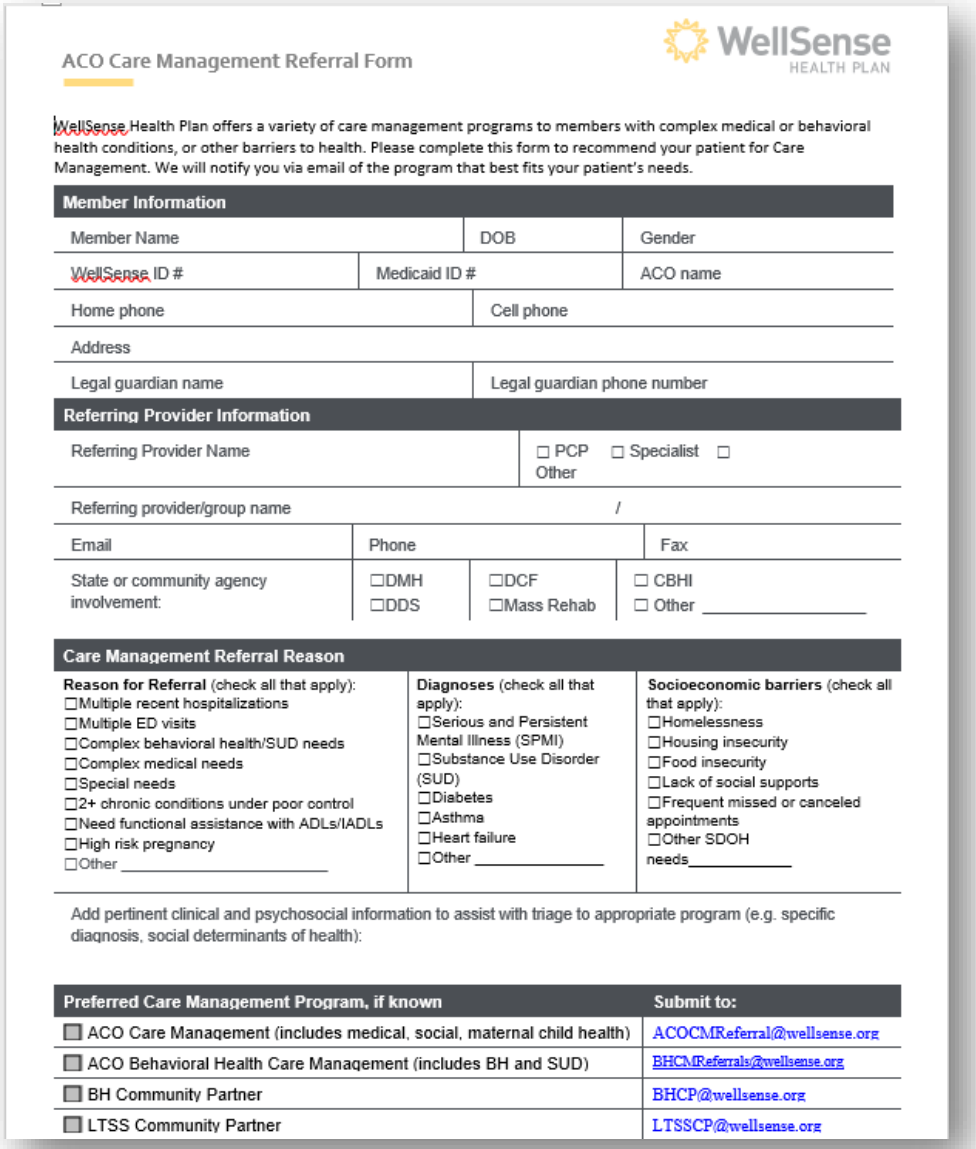
Care Management programs – *overview*

Program	Program goal
Complex Care Management (CCM)	– CCM team **embeds in primary care with the goal of establishing the highest risk 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 aged 18-64 with significant behavioral health needs**, including serious mental illness and addiction – **Serves moderate-to-high-risk population**
Long term services & supports Community Partners (LTSS CP)	– Provide longitudinal support in the community for **individuals aged 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. – **Serves moderate-to-high-risk population**
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 – **Serves low to moderate risk population**
Flex Services	– Provides health-related social supports for housing and nutrition in order to improve member health outcomes and reduce TCOC

How do I make a referral to care management?

- WellSense has a centralized referral form for all CM referrals.
- You can send your referral to ACOCMReferral@wellsense.org for triage OR you can send to the specific email address associated with a specific program
- If you have CCM staff on-site, follow your clinic workflow to refer the patient to care management or directly contact CCM team

Link to access the referral form:
WellSense ACO Care Management Referral Form



ACO Care Management Referral Form

WellSense HEALTH PLAN

WellSense Health Plan offers a variety of care management programs to members with complex medical or behavioral health conditions, or other barriers to health. Please complete this form to recommend your patient for Care Management. We will notify you via email of the program that best fits your patient's needs.

Member Information

Member Name	DOB	Gender
WellSense ID #	Medicaid ID #	ACO name
Home phone	Cell phone	
Address		
Legal guardian name	Legal guardian phone number	

Referring Provider Information

Referring Provider Name	☐ PCP ☐ Specialist ☐ Other		
Referring provider/group name	/		
Email	Phone		Fax
State or community agency involvement:	☐DMH ☐DDS	☐DCF ☐Mass Rehab	☐ CBHI ☐ Other _____

Care Management Referral Reason

Reason for Referral (check all that apply):	**Diagnoses** (check all that apply):	**Socioeconomic barriers** (check all that apply):
☐Multiple recent hospitalizations ☐Multiple ED visits ☐Complex behavioral health/SUD needs ☐Complex medical needs ☐Special needs ☐2+ chronic conditions under poor control ☐Need functional assistance with ADLs/IADLs ☐High risk pregnancy ☐Other _____	☐Serious and Persistent Mental Illness (SPMI) ☐Substance Use Disorder (SUD) ☐Diabetes ☐Asthma ☐Heart failure ☐Other _____	☐Homelessness ☐Housing insecurity ☐Food insecurity ☐Lack of social supports ☐Frequent missed or canceled appointments ☐Other SDOH needs_____

Add pertinent clinical and psychosocial information to assist with triage to appropriate program (e.g. specific diagnosis, social determinants of health):

Preferred Care Management Program, if known	**Submit to:**
☐ ACO Care Management (includes medical, social, maternal child health)	ACOCMReferral@wellsense.org
☐ ACO Behavioral Health Care Management (includes BH and SUD)	BHCMReferrals@wellsense.org
☐ BH Community Partner	BHCP@wellsense.org
☐ LTSS Community Partner	LTSSCP@wellsense.org

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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) until 12/1/2026**
  - 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

Future state:

As part of the overarching strategy to better integrate behavioral and medical healthcare, WellSense will **insource behavioral health operations in Massachusetts and New Hampshire effective 12/1/2026.**

Upon completing this transition, our plan is to maintain those services supporting our members' behavioral health currently offered through Carelon and offer additional programs and services. **Minimizing disruption to our members is our top priority.**

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Community Partners (CPs) are community-based organizations contracted with WellSense ACOs-MCO to provide care management and coordination to members with complex needs

Community Partners

BH CP
Behavioral Health

LTSS CP
Long-term services and supports

There are 12 BH CPs and 8 LTSS CPs geographically spread across the state. Patients are assigned to CPs according to their city or town of residence, their diagnosis(es), and the CPs that are contracted to provide supports to patients in that area and their BH/LTSS expertise.

The CP Program is 100% voluntary and patients/members are referred into the program either through using claims-based algorithms, or provider referrals.

1 Patient Outreach

- Encourages patients to participate in the program; minimum of three attempts, including at least one face to face

2 Assessment and care planning

- Comprehensive assessment including a Health-Related Social Needs screening; must be person-centered with goals identified and approved by the patient
- Care plan is shared with the patient's primary care team

3 Care management/ coordination

- Facilitates communication among patient and their care team; act as subject matter experts for BH/LTSS community services
- Helps patient coordinate services across state agencies, and specialty providers
- Connect patients to appropriate programs
- Assist with discharge planning, appointment access/follow-ups and a face-to-face interaction within three days post-discharge
- Assist enrolled patients with SDOH needs including referral to Flexible Services.

How can CPs help patients and ACOs?

Community Partners Provide:

Outreach to Patients

Encourages members to participate in the program; minimum of three attempts, including at least one face to face, expected

Care Management

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

Assessment & Care Planning

Comprehensive assessment; must be person-centered with goals identified and approved by the member

Transitions of Care

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

Care Team Coordination

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

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
- Leverage expertise of CPs into existing CM programming, i.e. CM, or CCM.
- Provider a clinic Point of Contact (POC) for CPs/Wellsense

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

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In January 2025, MassHealth will transition CSP services and Flexible Services into a new service category called HRSN Services

Changes in terminology:

- HRSN Services will encompass CSP-HI, CSP-JI, and CSP-TPP (these will be unchanged), as well as a set of housing and nutritional services that largely mirror the current Flexible Services program (FSP).
- Services formerly categorized as Flexible Services will be called "HRSN Supplemental Services".

Changes in programming:

- HRSN Supplemental Services for housing and nutrition, as well as Social Service Organization (SSO) partners, will vary by ACO.
- Please reach out to your ACO specific HRSN point of contact for guidance on how to submit a referral under the new HRSN program framework.

HRSN Housing Services	HRSN Nutrition Services
• **For members experiencing homelessness:** Transitional Goods • **For members at risk of homelessness:** HRSN Housing Navigation • **For members living in unhealthy, inaccessible, unsafe housing:** Healthy Homes	• **Primary Services:** Medically Tailored and Nutritionally Appropriate versions of (1) home-delivered meals, (2) food boxes, and (3) food prescriptions and vouchers. • **Secondary Services** (can only be provided in tandem with a Primary Service): Kitchen Supplies, Nutrition Education, Nutrition Counseling

ACOs partner with a variety of social service organizations (SSOs) for HRSN Services to provide nutrition and housing supports

- Social Service Organization (SSO) partners for HRSN Supplemental Services housing and nutrition supports vary by ACO.
- Types of Services or Health Needs-Based Criteria may differ between SSOs.

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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's **sub-cap medical premium for each primary care location** (PIDSL-Provider ID/Service Location) is based on:
  - Historical average PC Sub-Capitation experience (i.e., "Population-Based Rate Cell PMPM")
  - Predicted growth in primary care costs
  - How much primary care a TIN delivers
  - Member acuity differences

PC Cap tier funding

- In addition to medical premiums, primary care groups (at the PIDSL level) receive **additional funding by meeting the sub-cap tier requirements**. The tier funding is 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)
- Groups must attest to meeting Tier 1 to participate 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

What's included in the Capitation

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.

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

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. These will remain the same for 2025

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

TIER 1	TIER 2	TIER 3
• Traditional primary care • Referral to specialty care • Oral health screening and referral • BH and substance use disorder screening • BH referral with bi-directional communication, tracking, and monitoring • BH medication management • Health-Related Social Needs screening • Care coordination • Clinical Advice and Support Line • Postpartum depression screening • Use of Prescription Monitoring Program • 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**	• Brief intervention for BH conditions • Telehealth BH referral partner • E-consults available in at least three (3) specialties • After-hours or weekend session (4+ hrs) • Team-based staff role • Maintain consulting independent BH clinician • On-site staff with children, youth, and family-specific expertise (part or full time) **P** • Provide SNAP and WIC assistance **P** • LARC provision, at least one option **A** • Active Buprenorphine Availability **A** • Active AUD Treatment Availability **A**	• One of: clinical pharmacist visits; group visits; educational liaison for pedi pts • E-consults available in 5+ specialties • After-hours or weekend sessions (12+ hrs) • Three team-based staff roles • Maintain consulting BH clinician with prescribing capability • On-site staff with children, youth, family-specific expertise (FT) **P** • LARC provision, at least 1 option **P** • Active Buprenorphine Availability **P** • LARC provision, multiple options **A** • Next-business-day MOUD induction and F/U **A**

Note: Requirements as of September 2024

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