Boston Medical Center
HEALTH SYSTEM

MASSHEALTH ACO PRIMARY CARE SUB-CAPITATION IMPLEMENTATION MANUAL

February 2024

This document was developed by BMCHS/WS and is intended to share best practices, supports and/or services to assist with meeting primary care sub-capitation tier requirements.

Executive Summary

The primary care sub-capitation manual is intended to be used as a tool for understanding and implementing tier requirements. All content in this manual is based on BMCHS/WS best understanding at the time of publication. The manual will be updated on a regular basis to be sure we are providing the most current and accurate information.

Per MassHealth, tier requirements must be met at the Provider ID and Service Location (PID/SL) level. All PIDSLs participating in an ACO must meet at least tier 1 requirements. Some requirements may be accessible to enrollees on-site if the enrollee so chooses, without leaving the practice building. Some requirements may be met exclusively via a central or virtual resource, including being provided by the ACO. Please refer to each requirement for specific details on the location and method permitted.

Any questions on the MH ACO primary care sub-capitation program, including questions on tier requirements, should be directed to your BMCHS/WS ACO Lead.

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Summary of Tier Requirements

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1	All	Structure and Staffing	Access to Translation and Interpreter Services
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1	Ped	Pediatric Population	Establish and maintain relationships with local Children's Behavioral Health Initiative (CBHI)
1	Ped	Pediatric Population	Coordination with MCPAP
1	Ped	Pediatric Population	Coordination with Massachusetts Child Psychiatry Access Program for Moms (M4M)
1	Ped	Pediatric Population	Fluoride varnish for patients ages 6 months up to age 6
2	All	Care Delivery	Brief intervention for BH conditions
2	All	Care Delivery	Telehealth-capable BH referral partner
2	All	Structure and Staffing	E-consults available in at least three (3) specialties
2	All	Structure and Staffing	After-hours or weekend session (at least 1)
2	All	Structure and Staffing	Team-based staff role
2	All	Structure and Staffing	Maintain a consulting independent BH clinician
2	Ped	Pediatric Population	Staff with children, youth, and family-specific expertise
2	Ped	Pediatric Population	Provide SNAP and WIC assistance
2	Adult	Adult Population	LARC provision, at least one option
2	Adult	Adult Population	Active buprenorphine availability
2	Adult	Adult Population	Active alcohol use disorder (AUD) treatment availability
3	All	Care Delivery	Fulfill one of the following: clinical pharmacist visits OR group visits OR designated educational liaison for pediatric patients
3	All	Structure and Staffing	E-consults available in at least five (5) specialties
3	All	Structure and Staffing	After-hours or weekend sessions (at least 4)
3	All	Structure and Staffing	Three team-based staff roles
3	All	Structure and Staffing	Maintain a consulting BH clinician with prescribing capability
3	Ped	Pediatric Population	Full-time staff with children, youth, and family-specific expertise
3	Ped	Pediatric Population	LARC provision, at least one (1) option
3	Ped	Pediatric Population	Active Buprenorphine Availability
3	Adult	Adult Population	LARC provision, multiple options
3	Adult	Adult Population	Capability for next-business-day Medication for Opioid Use Disorder (MOUD) induction and follow-up

Tier 1 Practice Requirements

Traditional Primary Care

Tier 1

Description: Provide accessible, comprehensive, longitudinal, person-centered, and coordinated primary care services including evaluation and management of common health issues, disease prevention, and wellness promotion. While practices may offer some traditional primary care virtually via telehealth, Enrollees must be able to access this requirement on-site.

Requirement Note: Practices within the network already provide the primary care services to meet this requirement. Many practices will have this information documented on their website or in regulatory materials that document services provided.

NCQA PCMH Alignment: Practices who are recognized by the National Committee for Quality Assurance (NCQA) as Patient Centered Medical Homes (PCMH) may find alignment with the following PCMH standards:

- **Knowing and Managing Your Patients**: The practice captures and analyzes information about the patients and community it serves and uses the information to deliver evidence-based care that supports population needs and provision of culturally and linguistically appropriate services
- **Patient-Centered Access and Continuity**: The PCMH model expects continuity of care. Patients/families/caregivers have 24/7 access to clinical advice and appropriate care facilitated by their designated clinician/care team and supported by access to their medical record. The practice considers the needs and preferences of the patient population when establishing and updating standards for access.

Referral to specialty care

Tier 1

Description: Be able to guide and coordinate referrals and request evaluation of a patient by clinicians outside of the primary care practice for specific concerns. Such referrals shall include the primary care practice's ability to communicate with and receive communications from the specialty practice, with the primary care practice continuing to serve as a central home of health care services for the patient. This includes sub-specialty medical, oral health, mental health, and substance use disorder referrals.

Requirement Notes: Primary care practices traditionally refer patients to specialty care based on clinical findings. Practices also traditionally have workflows in place for receiving clinical notes back from the specialist as needed. This may be via fax, EHR connection, etc.

Operational Considerations: Consider documenting a workflow or process flow to illustrate how a provider or care team member places a referral and what pathways the specialist note is returned to the practice.

NCQA PCMH Alignment: Practices who are recognized by the National Committee for Quality Assurance (NCQA) as Patient Centered Medical Homes (PCMH) may find alignment with the following PCMH standards

- **Care Coordination and Care Transitions**: The practice systematically tracks tests, referrals and care transitions to achieve high quality care coordination, lower costs, improve patient safety and ensure effective communication with specialists and other providers in the medical neighborhood

Oral health screening and referral

Tier 1

Description: Conduct an annual (every 12 months) structured oral health screening for attributed patients. For example, a clinic tool may use the National Health and Nutrition Examination Survey Oral Health Questionnaire. An on-site dental exam for attributed patients shall meet this requirement. An assessment screening shall clearly define what constitutes a positive screening result versus a negative result and shall assess if the patient currently has access to an oral health provider or a regular and reliable source for oral health needs. Additionally, retain and provide to patients (and/or their parents/caregivers) a list of local and reasonably-accessible oral health providers who are within the MassHealth network for their particular patients. This information shall be updated at least annually for any openings/closings or additions/removals of MassHealth coverage of these providers. Such a list shall be provided to patients with a positive oral health screen and those without an oral health provider. Such a list may be adapted from materials provided by MassHealth of practices and providers currently enrolled in the program. While practices may offer some oral health screenings and referrals virtually via telehealth, Enrollees must be able to access this requirement on-site.

Implementation Recommendations

Option 1: In-person

- Screening question(s) asked by MA during rooming process
- Responses input into EHR and shared with PCP
- PCP discusses with patient if findings are positive
- Standardized handout or AVS dot phrase provided to patient at visit close

Option 2: Remote

- Patient completes screening question(s) within patient portal as part of pre-visit intake
- Standardized handout or AVS dot phrase provided to patient at visit close (and accessible within patient portal)

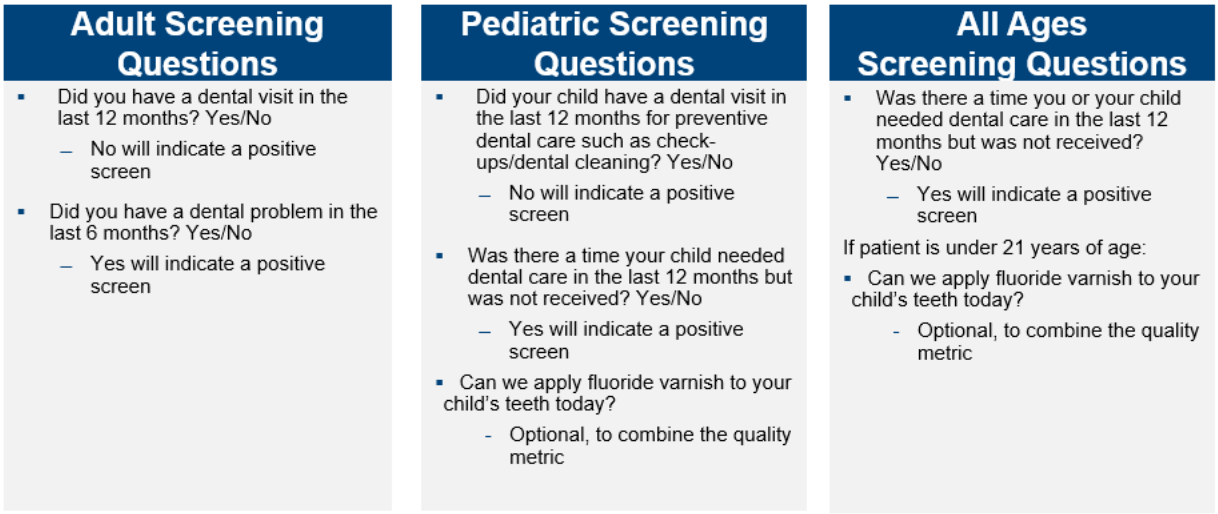
Operational Considerations

- Health equity: Are screening questions translated into multiple languages, or is real-time interpretation use for patients who speak a language other than English?
- Timing: Determine where in the clinic visit to screen. Determine if screening can be incorporated in the fluoride varnish workflow for pediatric patients.
- Staffing: Decide which member of the care team can deliver the screening and document the referral.

Examples of Oral Health Screener

- No mandated screening tool as per MassHealth
- Screening can be done using 1-2 questions
- It can be a template included in a visit note, a separate questionnaire, or a scanned paper.

- Screening and referral can be offered virtually via telehealth/patient portal, enrollees must be able to access this requirement on-site



MassHealth Coverage

- MassHealth covers most dental treatment including exams and cleanings, fillings, and even dentures. It does not pay for implants.
- Patients can also get care from a dental school. They may have lower prices for treatments MassHealth doesn't cover. They also accept MassHealth.
- Boston Medical Center has a dental clinic just for pulling teeth. They do not make appointments - one must call the same day to have a visit.

NCQA PCMH Alignment: Practices who are recognized by the National Committee for Quality Assurance (NCQA) as Patient Centered Medical Homes (PCMH) may find alignment with the following PCMH standards

- **Knowing and Managing Your Patients:** Oral Health Assessment and Services, Assesses oral health needs and provides necessary services during the care visit based on evidence-based guidelines or coordinates with oral health partners.

Resources and Supports

Member Resources:

- MassHealth: Dental Provider Finder
- All **three dental schools** in Massachusetts:
  - Boston University School of Dental Medicine, 635 Albany Street, (617) 358-8300
  - Harvard School of Dental Medicine, 188 Longwood Avenue, (617) 432-1434
  - Tufts School of Dental Medicine, 1 Kneeland Street, (617) 636-6828
  - Boston Medical Center, Yawkey Ambulatory Care Center, 850 Harrison Avenue, 6th Floor, Boston, MA 02118, (617) 414-2243
- DentaQuest: Members can have remote care coordination assistance https://www.masshealth-dental.net/MassHealth/media/Docs/MassHealth-ORM.pdf

Provider Resources:

- American Academy of Pediatrics – Oral Health Practice Tools
- North Carolina Oral Health – Into the Mouths of Babes Toolkit

BH and substance use disorder screening

Tier 1

Description: Conduct an annual and universal practice-based screening of attributed patients ≥21 years of age. Such a screen shall at minimum assess for depression, tobacco use, unhealthy alcohol use, other substance use, and preexisting mental health disorders using an age-appropriate, evidence-based, standardized screening tool. When any screening is positive, the practice shall respond with appropriate interventions and/or referrals.

See below under this Section 1, subsection C for screening expectations for any attributed patients younger than 21 years of age per the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) protocol and schedule.

While practices may offer some BH and substance use screening virtually via telehealth, Enrollees must be able to access this requirement on-site.

Implementation Recommendations

Option 1: To meet requirements

- Utilize the following screening tools:
- For depression: PHQ-2 (2 questions), followed by PHQ-9 (9 questions) if positive as defined either
    - "Yes" to either PHQ-2 question
    - Total PHQ-2 score ≥ 2 or ≥ 3
- For tobacco use, unhealthy alcohol use, and other substance use: NIDA Quick Screen (4 questions)
    - Any answer other than "No" indicates risk
- For preexisting mental health disorders: Ask "Do you have any preexisting mental health or substance use disorder diagnoses?"

Option 2: Alternative and additional tools

- For depression: Screen all patients with PHQ-9
- For alcohol and substance use screening or as follow-up to positive NIDA Quick Screen:
    - Alcohol: AUDIT (10 questions)
    - Other substances: DAST-10 (10 questions)
- Other:
    - For suicidality (e.g., if PHQ-9 Question 9 ≥ 1): C-SSRS (The Columbia Protocol) (up to 6 questions)
    - For anxiety: GAD-2 (2 questions), followed by GAD-7 (7 questions) if positive as defined either Total GAD-2 score ≥ 2 or ≥ 3

Considerations

- Timing: Decide when the course of a visit the patient will be screened for BH and SUD (for example: in the waiting room, during rooming, or during the PCP encounter)
    - Note: an on-site screening must be offered
- Staffing: Decide who will perform the screening (for example: by patient as a pen & paper or electronic self-assessment, by medical assistant, by nurse, or by PCP)

- Documentation: Decide where the screening will be documented within the EMR and by whom
- Eligibility: Decide how the practice will track which patients for whom screening has been completed and which patients are due for screening

NCQA PCMH Alignment: Practices who are recognized by the National Committee for Quality Assurance (NCQA) as Patient Centered Medical Homes (PCMH) may find alignment with the following PCMH standards

- **Knowing and Managing Your Patients**: Depression Screening, Conducts depression screenings for adults and adolescents using a standardized tool.
- **Knowing and Managing Your Patients**: Behavioral Health Screenings: Conducts behavioral health screenings and/or assessments using a standardized tool. (Implement two or more.) A. Anxiety. B. Alcohol use disorder. C. Substance use disorder. D. Pediatric behavioral health screening. E. Post-traumatic stress disorder. F. Attention deficit/hyperactivity disorder. G. Postpartum depression.

Resources and Supports

- **NIDA Quick Screen**
- **PHQ-2 and PHQ-9**
- **C-SSRS (The Columbia Protocol)**
- **GAD-2 and GAD-7**
- **AUDIT-10**
- **DAST-10**

BH referral with bi-directional communication, tracking, and monitoring

Tier 1

Description: BH referral with bi-directional communication, tracking, and monitoring: retain and provide to patients a list of local and reasonably-accessible BH providers who are within the MassHealth network, including those that offer therapy and counseling services, BH medication management, and intensive outpatient or day treatment programs. The list of local BH providers shall be providers with whom the practice can conduct bi-directional communication about the patient. This can include electronic health record, phone, fax, or other modalities. This communication can be asynchronous, but it shall allow for both the primary care practice and the BH practice to communicate back and forth with each other. The practice shall also regularly assess if such partners continue to have bandwidth to see its patients within reasonable turnaround times.

In addition, track referrals made through the practice and problem-solve for patients who are unable to engage in a referral visit.

Implementation Recommendations

- Referral list: Maintain document to "provide to patients" with local BH providers of (a) psychotherapy, (b) psychopharmacology, and (c) intensive outpatient or partial hospitalization programs
- BMCHS/WS created a list for practices to use with their patients. The list is accessible on the BMCHS/Wellsense Masshealth ACO Resource Hub ,team will provide example of document list that sites may use for this purpose
    - If a practice is developing their own list, the list should include:
        - Phone and/or fax info
        - Referral bandwidth (optional): Sites may add an indicator to referral list of whether provider is accepting new referrals. Community Behavioral Health Centers (CBHCs) across the state are all required to accept new referrals throughout the year.
- Bi-directional communication: Ensure practice has a method of obtaining consent for release of information (ROI) to/from other providers ("with whom the practice can conduct bi-directional communication")
- Tracking and monitoring: As a routine practice in care, check with patients after referral whether they made contact w/ provider (e.g., at PCP follow-up visit)

The following activities are **not** required

- Proactive patient tracking and monitoring: Team member performing outreach to patients referred on whether they made contact with provider (e.g., after 1 month)
- Proactive BH provider bi-directional communication: For BH providers with whom patients are shared, recurring contact regarding cases and referral bandwidth
- EMR connectivity with BH providers

Considerations

- Bi-directional communication follows similar principles to any clinical collaboration with any specialty providers (e.g., consent for release of information, HIPAA)
- Areas of flexibility: When/how often to engage in bi-directional communication, when/how often to track referrals, and when/how often to update information about referral bandwidth (“regularly“)
- Note: Most BH providers continue to offer telehealth capability today

NCQA PCMH Alignment: Practices who are recognized by the National Committee for Quality Assurance (NCQA) as Patient Centered Medical Homes (PCMH) may find alignment with the following PCMH standards

- **Care Coordination and Care Transitions**: Behavioral Health Referral Expectations, Works with behavioral healthcare providers to whom the practice frequently refers to set expectations for information sharing and patient care.
- **Care Coordination and Care Transitions**: Behavioral Health Integration, Integrates behavioral healthcare providers into the care delivery system of the practice site.

Resources and Supports

- BMCHS PHS team will distribute BH network directory tool for ACOs/sites to use, this can be located on the BMCHS/Wellsense Masshealth ACO Resource Hub
- All members and providers have access to MABHA and Beacon Provider Network directories (public sites)

BH medication management

Tier 1

Description: Prescribe, refill, and adjust medications for the treatment of common BH issues amenable to treatment in the primary care setting, including but not limited to major depressive disorder, generalized anxiety disorder, and attention deficit-hyperactivity disorder. Such services can occur independently or providers may receive assistance from available resources such as the Massachusetts Child Psychiatry Access Program (MCPAP), a clinical pharmacist, psychiatrist, psychiatric clinical nurse specialist, etc. While practices may offer some BH medication management virtually via telehealth, Enrollees must be able to access this requirement on-site.

Implementation Recommendations

- **On-site BH prescribing ("Prescribe, refill, and adjust"):** On-site provider team should include prescribers comfortable with prescribing for Major Depressive Disorder (MDD), Generalized Anxiety Disorder (GAD), and Attention Deficit Hyperactivity Disorder (ADHD)

Optional: Additional specialty BH support (not required)

- **Consultant assistance:** On-site prescribers may consult with MCPAP and MCPAP For Moms, if relevant (See also **Coordination with MCPAP** and **Coordination with M4M** Tier 1 requirements.)
- **Consulting BH prescriber:** Some sites may have on-site, hybrid, or virtual specialty BH prescribers supporting BH prescribing, however, some on-site availability of BH medication management is required. (See also **Maintain consulting BH clinician with prescribing capability** Tier 3 requirement.)

Considerations

- Medication management for ADHD does not necessarily require the use of controlled substances; bupropion, atomoxetine, clonidine, and guanfacine have evidence for use in ADHD.

Resources and Supports

- BMCHS/WS provider education resources on MDD available on Box.com
- BMCHS Integration Steps: Integrated behavioral health trainings, including medication for depression and SUD
- Harvard Review of Psychiatry: ADHD in Primary Care

Health-Related Social Needs (HRSN) screening

Tier 1

Description: Conduct universal practice- or ACO-based screening of attributed patients for HRSN using a standardized, evidence-based tool, and shall have the ability to provide a regularly-updated inventory of relevant community-based resources to those with positive screens. Pediatric screening questions shall be reviewed by the ACO's designated Pediatric Expert. HRSN screening may be met exclusively via a central or virtual resource, including being provided by the ACO.

Implementation Recommendations

- Implement an evidence based tool to implement at your practice. Some examples include THRIVE and PRAPARE.
- Both of these tools have been verified by pediatric experts at the ACO.
- Develop a bank of resources for each domain in the event a patient screens positive or refer to an existing bank such as Find Help (formerly Aunt Bertha).

Operational Considerations

- Tool: Select a tool that best fits your population and practice. You may consider choosing a tool that is pre-built in your EHR if it eases virtual administration, or may choose to print the tool for completion by patients.
- Staffing: Decide who will perform each screening and at which point during the clinic visit (e.g. the member may respond via a patient portal prior to the visit, in the waiting room, or the MA may assess during rooming)
- Documentation: Screening can happen on paper, virtually via a patient portal, by phone, or on paper. Determine which method of screening works best for your practice and patient population.
- Health Equity: Ensure screeners are available in the language spoken by members or ask for translation services assistance.
- Referral Resources:
    - Decide how the practice will track which patients for whom screening has been completed and which patients are due for screening.
    - Identify whether resource will exist as a 'letter' or 'resource template' in the EHR, through utilization of Find Help, or if members will be referred to a clinic resource such as a Resource Navigator for support.

NCQA PCMH Alignment: Practices who are recognized by the National Committee for Quality Assurance (NCQA) as Patient Centered Medical Homes (PCMH) may find alignment with the following PCMH standards

- **Knowing and Managing Your Patients:** Social Determinants of Health, Understands social determinants of health for patients, monitors at the population level and implements care interventions based on these data.
- **Knowing and Managing Your Patients:** Community Resource Needs, Uses information on the population served by the practice to prioritize needed community resources

- **Knowing and Managing Your Patients:** Community Resource List, Routinely maintains a current community resource list based on the needs identified in KM 21
- **Knowing and Managing Your Patients:** Community Resource Assessment, Assesses the usefulness of identified community support resources.

Resources and Supports

- PRAPARE screening tool
- BMCHS THRIVE
- Find Help (formerly Aunt Bertha)
- Joint Commission screening tool reference

Care Coordination

Tier 1

Description: Participate in formalized practice-driven and/or ACO-driven care coordination that identifies patients at risk due to medical, BH, HRSN, psychosocial and/or other needs and deploys risk-stratified interventions and approaches to addressing patients' needs.

Such approaches can include but are not limited to communication and information-sharing between care team patients and specialists or ancillary services, identification and rectification of gaps in preventive care or chronic disease management, assisting patients with transitions of care, pre-visit planning, post-hospitalization coordination, and assistance with patient self-management of chronic disease. Such approaches can also include connecting patients to community-based services, state agencies (e.g., Massachusetts Department of Children and Families [DCF], Massachusetts Department of Developmental Services [DDS], Massachusetts Department of Mental Health [DMH], Massachusetts Department of Public Health [DPH], Massachusetts Department of Transitional Assistance [DTA], Massachusetts Department of Youth Services [DYS]), federal programs (e.g., Supplemental Nutrition Assistance Program [SNAP], Special Supplemental Nutrition Assistance Program for Women, Infants, and Children [WIC]), other ACO programs such as the ACO Care Management, Community Partners and Flexible Services programs, and other supports and care management resources.

These services may be provided by practice-based personnel directly, or by ACO- or system-level resources and care pathways that coordinate with the primary care practice. Such interventions shall be standardized and consistent work streams for the practice and align with the greater ACO's strategies around physical health, BH, HRSN, and other care coordination.

Document your process for referring to WellSense programs (eg., email to acocmreferral@wellsense.org). Note that this referral process connects patients with a range of WellSense programs including Complex Care Management (CCM)*, Community Partners (CPs), Behavioral Health Care Management, and, **for patients not meeting criteria for these programs, telephonic** care coordination/**care management**. If practices have additional internal care management programs, they can include processes for these referrals as well.

For more information on ACO expectations around care coordination, please refer to Section 2.6 of the Contract. Care coordination may be met exclusively via a central or virtual resource, including being provided by the ACO.

Requirement Notes

The Tier 1 Care Coordination requirement is met through an array of WellSense-coordinated care management offerings, including Complex Care Management (CCM), Community Partners (CPs), Behavioral Health Care Management, and short-term care coordination for urgent needs. All of these programs include communication and information-sharing between patients and specialists or ancillary services, identification and rectification of gaps in preventive care or chronic disease management, assisting patients with transitions of care, assistance with patient self-management of chronic disease, and connecting patients to community-based services / state agencies. There are multiple ways that patients may be enrolled in these programs: provider referral, patient self-referral, or algorithmic identification. To demonstrate that this requirement is met:

- For ACOs with WellSense-run CCM: practices should document their internal workflows for provider referrals to the central WellSense care management, which can be completed by emailing ACOCMReferral@wellsense.org or by warm handoff to a CCM (or in some cases CP) team embedded at a practice site.

- For ACOs with delegated CCM: practices should document their internal workflows for referral to their own CCM team, as well as their workflows for provider referrals to the central WellSense care management team and CPs, which can be completed by emailing ACOCMReferral@wellsense.org

NCQA PCMH Alignment: Practices who are recognized by the National Committee for Quality Assurance (NCQA) as Patient Centered Medical Homes (PCMH) may find alignment with the following PCMH standards

- **Care Management and Support:** The practice identifies patient needs at the individual and population levels to effectively plan, manage and coordinate patient care in partnership with patients/families/caregivers. Emphasis is placed on supporting patients at highest risk
- **Care Coordination and Care Transitions:** The practice systematically tracks tests, referrals and care transitions to achieve high quality care coordination, lower costs, improve patient safety and ensure effective communication with specialists and other providers in the medical neighborhood

Clinical Advice and Support Line

Tier 1

Description: Ensure patients are made aware of the availability of after-hours telephonic advice, either through the ACO's Clinical Advice and Support Line, or a resource provider by the practice. Clinical advice and support line services may be met exclusively via a central or virtual resource, including being provided by the ACO.

Requirement Notes

WellSense provides a nurse advice line that is available 24 hours per day, 7 days per week. More information on this service can be found On the WellSense website under Members (here).

- The phone number for the WellSense 24/7 nurse advice line is 1-800-973-6273.

Operational Considerations: WellSense provides a welcome packet to new members that includes information regarding how to access the nurse advice line.

NCQA PCMH Alignment: Practices who are recognized by the National Committee for Quality Assurance (NCQA) as Patient Centered Medical Homes (PCMH) may find alignment with the following PCMH standards

- **Patient-Centered Access and Continuity:** Timely Clinical Advice by Telephone, Provides timely clinical advice by telephone

Postpartum Depression Screening

Tier 1

Description: If caring for infants in the first year of life **or** for postpartum individuals who are within 12 months of delivery, screen for postpartum depression using an evidence-based and validated tool, such as the Edinburgh Postnatal Depression Scale (EPDS).

For individuals who have a positive screen for postpartum depression, the practice shall be able to provide referral, or follow-up, and/or care coordination for the patient. Care coordination models shall be evidence-based (examples of such models include PRISM - Program In Support of Moms and ROSE - Reach Out Stay Strong Essentials for mothers of newborns). While practices may offer some postpartum depression screenings virtually via telehealth, Enrollees must be able to access this requirement on-site.

Implementation Recommendations

Option 1: To meet requirements

- Adult and Pedi practices screen postpartum individuals within 12 months of delivery using the following screening tools:
    - PHQ-2 (2 questions), followed by PHQ-9 (9 questions) if positive as defined either
        - "Yes" to either PHQ-2 question
        - Total PHQ-2 score ≥ 2 or ≥ 3
- As per the MassHealth All Provider Bulletin 348: For members aged six months and younger, providers must continue Maternal and Caregiver Depression Screening by administering and scoring the Edinburgh Postnatal Depression Scale (EPDS) with the member's caregiver during a well-child visit or as needed for non-routine visits. Providers may use either the EPDS, or the Survey of Well-being of Young Children (SWYC). SWYC forms for infants six months and younger also include a modified version of the EPDS. Providers must continue submitting claims for maternal-caregiver depression screenings with service code 96110, with either U1 (no need identified), or U2 (need identified), and UD modifiers to indicate the administration and scoring of the EPDS. Providers must also continue to administer Maternal and Caregiver Depression Screening in accordance with MassHealth All Provider Bulletin 301.
- Screening should be performed a minimum of one time within 12 months of delivery; the American College of Obstetricians and Gynecologists (ACOG) recommends screening for depression at least once in the perinatal period (ACOG, 2018)

Option 2: Alternative and additional tools

- PHQ-9 (9 questions)
- EPDS (Edinburgh Postnatal Depression Scale) (10 questions)
- For suicidality (e.g., if PHQ-9 Question 9 ≥ 1 or EPDS Question 10 ≥ 1): C-SSRS (The Columbia Protocol) (up to 6 questions)

Considerations

- Note: Routine population-wide depression screening will capture most postpartum individuals annually
- Timing: Decide when the course of a visit the patient will be screened for BH and SUD (for example: in the waiting room, during rooming, or during the PCP encounter) Note: an on-site screening must be offered
- Staffing: Decide who will perform the screening (for example: by patient as a pen & paper or electronic self-assessment, by medical assistant, by nurse, or by PCP)
- Documentation: Decide where the screening will be documented within the EMR and by whom
- Eligibility: Decide how the practice will identify patients eligible for screening (within 12 months of delivery or infants ≤ 1 year old) and track that screening has been completed
    - EMR build: Consider EMR alert for postpartum status or ≤ 1 year old to perform depression screening
    - Provider education to screen for new caregiver status

NCQA PCMH Alignment: Practices who are recognized by the National Committee for Quality Assurance (NCQA) as Patient Centered Medical Homes (PCMH) may find alignment with the following PCMH standards

- **Knowing and Managing Your Patients:** Behavioral Health Screenings, Conducts behavioral health screenings and/or assessments using a standardized tool. (Implement two or more.) A. Anxiety. B. Alcohol use disorder. C. Substance use disorder. D. Pediatric behavioral health screening. E. Post-traumatic stress disorder. F. Attention deficit/hyperactivity disorder. G. Postpartum Depression
- **Knowing and Managing Your Patients:** Clinical Decision Support, Implements clinical decision support following evidence-based guidelines for care of (Practice must demonstrate at least four criteria): A. A mental health condition. B. A substance use disorder. C. A chronic medical condition. D. An acute condition. E. A condition related to unhealthy behaviors. F. Well-child or adult care. G. Overuse/appropriateness issues.
- **Care Coordination and Care Transitions:** Behavioral Health Referral Expectations, Works with behavioral healthcare providers to whom the practice frequently refers to set expectations for information sharing and patient care.

Resources and Supports

- PHQ-2 and PHQ-9
- EPDS
- C-SSRS (The Columbia Protocol)
- Evidence for the use of PHQ-2 postpartum: Gjerdingen 2009, Chae 2012
- MCPAP for Moms recommendations

Use of Prescription Monitoring Program

Tier 1

Description: All prescribing personnel at the practice site shall have access to and regularly use the Massachusetts Prescription Awareness Tool (Mass PAT) in accordance with Commonwealth of Massachusetts General Law: https://malegislature.gov/Laws/GeneralLaws/PartI/TitleXV/Chapter94C/Section24A.

Implementation Recommendations

Recommendations to Meet Minimum Requirement

- Prescriber "access" to MassPAT: Ensure all prescribers are registered for MassPAT
    - MassPAT registration takes 5-10 minutes online, must be performed by the prescriber, and requires the following information:
        - Professional email address
        - DEA Number
        - Professional License Number
        - Controlled Substance ID (MCSR Number)
- "Regular use": Ensure the regular use of MassPAT, including via electronic/EMR reminders
    - Alternative: Ensure practice has a policy around the use of MassPAT when prescribing controlled substances

Additional Support Options

- Prescriber access to MassPAT: For EMRs that offer it, offer EMR integration of MassPAT (removes steps of opening and signing into MassPAT for provider)

Operational Considerations

- Prescribers should be already registered for MassPAT
- E-prescribing software should ask prescribers to use MassPAT before the prescription of controlled substances
- "Delegated" RNs can check MassPAT on behalf of providers
- Develop controlled substance best practices for your clinic that include checking MassPAT before prescribing controlled substances

NCQA PCMH Alignment: Practices who are recognized by the National Committee for Quality Assurance (NCQA) as Patient Centered Medical Homes (PCMH) may find alignment with the following PCMH standards

- **Knowing and Managing Your Patients**: Controlled Substance Database Review, Reviews a controlled substance database when prescribing relevant medications
- **Knowing and Managing Your Patients**: Prescription Claims Data, Systematically obtains prescription claims data in order to assess and address medication adherence

Resources and Supports

- Registration for MassPAT

LARC provision, referral option

Tier 1

Description: Referral Option: Have the **ability to discuss options for LARC** (e.g., intrauterine device or subdermal implant) with relevant patients and **refer patients** seeking such options to known in-network providers who can place these for the patient. Providers may also, rather than referring patients, provide and place these directly for patients within the primary care practice.

Operational Considerations

- Groups are likely already meeting this requirement as part of daily primary care operations
- Check-in on capacity for patient-centered contraception counseling
- Consider the education materials available to patients and ensure they include LARC
- Verify referral options for patients interested in LARC placement

Resources and Supports

- Even if not required, we encourage all providers to do a baseline training such as the ACOG's LARC Video Series, to build comfort and skills
- Review ACOG guidance on Patient-Centered Contraceptive Counseling
- Review ACOG guidance on Counseling Adolescents About Contraception
- Reproductive Access has patient facing materials on LARC and all forms of contraception in multiple languages (English, Spanish, Chinese, Vietnamese, Hindi)

Same-day Urgent Care Capacity

Tier 1

Description: Make available time slots each day for urgent care needs for its patient population. While practices may offer some urgent care capacity virtually via telehealth, Enrollees must be able to access this requirement on-site.

Requirement Notes

Practices should have same day appointment access available, which are available for patients who call and require to be seen in person or via telehealth on the same day.

Provider Training/Credentialing: Not applicable

Operational Considerations

A practice may choose to implement this in several ways. Examples are provided below.

- Hold slots on an on-site provider schedule: The practice may hold slots on a provider schedule that can only be scheduled on the same day. These slots may be opened up to any patient if not filled so they don't go unused.
- Hold slots on a telehealth provider schedule: The practice may utilize a similar workflow as noted above for holding slots, but do so on a telehealth provider schedule. This can be helpful if the patient is triaged and determined not to need an in-person visit. If the practice chooses this option, the practice must also make sure there is availability for the patient to be seen on site if needed.

NCQA PCMH Alignment: Practices who are recognized by the National Committee for Quality Assurance (NCQA) as Patient Centered Medical Homes (PCMH) may find alignment with the following PCMH standards

- **Patient-Centered Access and Continuity:** Same-Day Appointments, Provides same-day appointments for routine and urgent care to meet identified patient needs.

Video telehealth capability

Tier 1

Description: Have the ability to conduct visits with practice staff using a synchronous audio-video telehealth modality in lieu of an in-person patient encounter.

NCQA PCMH Alignment: Practices who are recognized by the National Committee for Quality Assurance (NCQA) as Patient Centered Medical Homes (PCMH) may find alignment with the following PCMH standards

- **Patient-Centered Access and Continuity:** Alternative Appointments, Provides scheduled routine or urgent appointments by telephone or other technology-supported mechanisms
- **Patient-Centered Access and Continuity:** Two-Way Electronic Communication, Has a secure electronic system for two-way communication to provide timely clinical advice

No reduction in hours

Tier 1

Description: Relative to regular practice hours prior to engagement in the sub capitation program, offer the same or increased number of total regular on site operating hours and clinical sessions in which patients have been historically seen.

Audit Documentation Considerations

- Option 1: Consider leveraging screenshots from your practice's website demonstrating practice hours
- Option 2: As applicable to your practice, potential to leverage HRSA forms which document practice hours
- Option 3: If your practice has marketing materials containing practice hours, you could leverage those, as well

Additionally - consider documenting practice hours before 4/1/2023 and after 4/1/2023 to demonstrate participation in the ACO program has not changed your practices hours

- *Tier 1 No Reduction in Hours: Relative to regular practice hours prior to engagement in the sub capitation program,* ***offer the same or increased number of total regular on site operating hours and clinical sessions in which patients have been historically seen.***

NCQA PCMH Alignment: Practices who are recognized by the National Committee for Quality Assurance (NCQA) as Patient Centered Medical Homes (PCMH) may find alignment with the following PCMH standards

- **Patient-Centered Access and Continuity:** Access Needs and Preferences, Assesses the access needs and preferences of the patient population

Access to Translation and Interpreter Services

Tier 1

Description: Provide interpreter services for attributed patients, in accordance with applicable state and federal laws, including options to accommodate preferred languages and the needs of enrollees who are deaf or hard of hearing. Such services shall be noted to be available in a patient's or their caregiver's preferred language and should come without additional cost to the patient.

Requirement Notes

- All members in the WellSense network have access to interpreters through Community Interpreter Services (Community Interpreters | Trained Professional Interpreters & Translators (communityinterpreterservices.org)). When a practice within the WellSense network contacts CTI, the services will be free of charge as long as the patient is a WellSense member.
- WellSense requires all providers to be culturally competent in delivery care to members as defined in section 4.16 of the WellSense provider manual. To provide competent care means "having the capacity to function effectively as an individual and an organization within the context of the cultural beliefs, behaviors, and needs presented by consumers and their communities, as defined in the National Standards for Cultural and Linguistically Appropriate Services in Health Care."

Operational Considerations

Practice should make sure that any process or workflow documentation within the practice identifies CTI as a resource for WellSense members.

The National CLAS Standards are intended to advance health equity, improve quality, and help eliminate health care disparities. With regards to communications and language assistance, the CLAS standards require:

- Offer language assistance to individuals who have limited English proficiency and/or other communication needs, at no cost to them, to facilitate timely access to all health care and services.
- Inform all individuals of the availability of language assistance services clearly and in their preferred language, verbally and in writing.
- Ensure the competence of individuals providing language assistance, recognizing that the use of untrained individuals and/or minors as interpreters should be avoided.
- Provide easy-to-understand print and multimedia materials and signage in the languages commonly used by the populations in the service area

NCQA PCMH Alignment: Practices who are recognized by the National Committee for Quality Assurance (NCQA) as Patient Centered Medical Homes (PCMH) may find alignment with the following PCMH standards

- **Knowing and Managing Your Patients:** Language, Assesses the language needs of its population

Pediatric EPSDT screenings

Tier 1

Description: Administer, at a minimum, BH, developmental, social, and other screenings and assessments as required under EPSDT. While practices may offer some EPSDT screenings virtually via telehealth, Enrollees must be able to access this requirement on-site.

*Please note that EPSDT requirements are **required for any MassHealth members 21 years of age or younger, regardless of the practice type**.*

Implementation Recommendations

- Utilize the MassHealth Provider Manual to identify all relevant screening topics and expected timelines and tools for administration.
- Pediatric preventative healthcare visits should occur at a minimum of: newborn, 3-5 days and monthly at 1, 2, 4, 6, 9, 12, 15, 18, 24, and 30 months, then yearly from three to 21 years.
- Those visits should include:
    - History (e.g. family history, immunization history, etc.)
    - Measurements (e.g. length, weight, height, etc.)
    - Sensory (vision, hearing)
    - Developmental / Behavioral Health (e.g. autism spectrum, psychosocial, tobacco, etc.)
    - Physical exam
    - Procedures (e.g. newborn blood, newborn bilirubin, lead exposure, etc.)
    - Oral health
    - Anticipatory guidance

Operational Considerations

- Scheduling: Determine if any schedule template changes need to be made to ensure ample time is allotted for the visit.
- Population Health: Identify workflows to keep members/caregivers engaged in care (e.g. check out process to schedule next appointment, outreach process to identify members that are missing upcoming appointments)
- Staffing: Decide who will perform each screening and at which point during the clinic visit (e.g. the MA may take measurements, the member/caregiver may complete a health history form in the waiting area)
- Documentation: Consider EHR documentation templates that include all of the required ESPDT screenings.
- Eligibility: Decide how the practice will track which patients for whom screening has been completed and which patients are due for screening

NCQA PCMH Alignment: Practices who are recognized by the National Committee for Quality Assurance (NCQA) as Patient Centered Medical Homes (PCMH) may find alignment with the following PCMH standards

- **Knowing and Managing Your Patients:** Comprehensive Health Assessment, Comprehensive health assessment includes (all items required): A. Medical history of patient and family. B. Mental health/substance use history of patient and family. C. Family/social/cultural characteristics. D. Communication needs. E. Behaviors affecting health. F. Social functioning. G. Social determinants of health. H. Developmental screening using a standardized tool. (NA for practices with no pediatric population under 30 months of age.) I. Advance care planning. (NA for pediatric practices)

Resources and Supports

- EPSDT protocol & schedule: Appendix W of the MassHealth Provider Manual

Pediatric SNAP and WIC screenings

Tier 1

Description: Screen for SNAP and WIC eligibility, in accordance with Provider Manual Appendix W, if applicable: Practices shall also complete the medical referral form for WIC eligible patients. Patients and families deemed eligible for these programs should be referred to further resources in order to apply for and engage these programs. While practices may offer some SNAP and WIC screenings virtually via telehealth, Enrollees must be able to access this requirement on-site.

Implementation Recommendations

Women, Infants & Children (WIC) is a nutrition program that provides healthy foods, nutrition education, breastfeeding support, and referrals to healthcare and other services, free of charge, to Massachusetts families who qualify.

Supplemental Nutrition Assistance Program (SNAP) provides nutrition benefits to supplement the food budget of needy families so they can purchase healthy food and move towards self-sufficiency

- Screening for SNAP and WIC is included in the ESPDT requirements in MassHealth Provider Manual Appendix W:
  > *"Make every effort to inform a potentially eligible member or the parent or guardian about the Women, Infants, and Children (WIC) nutrition program. A referral to WIC should be made using the WIC Medical Referral Form (MRF) from the Massachusetts WIC Program. In addition, the member, parent, or guardian may also be referred to the Supplemental Nutrition Assistance Program (SNAP), which is administered by the Department of Transitional Assistance"*
- Recommend using one of the following options for screening:
  - Ask "Do you have or are you interested in SNAP or WIC?" (yes / no)
  - Utilize HRSN screening food domain to identify if a patient is eligible for SNAP or WIC.
- Add referral forms to the EHR to ease the burden to the provider and member of manually completing the data.

Operational Considerations

- Virtual offering: Determine if your practice will choose to offer screening virtually. This is not a requirement, but is an option and should be considered if virtual pediatric preventative visits are offered.
- On-site offering: Identify a workflow for screening within the practice (e.g. HRSN screening question for food insecurity).
- Staffing: Decide who will perform the screening and at what point during the clinic visit that screening will occur.
- Documentation:
  - Determine how a positive screening will be flagged for a referral to SNAP and/or WIC.
  - Consider adding a template of referral resources to the EHR, which may be in the form of a letter, after visit summary, or other means used by your EHR to share patient education materials.

- Consider adding the medical referral forms to the EHR to ease the burden of completion. These forms may be automatically populated with relevant data from the EHR.

Resources and Supports

- Massachusetts SNAP Office
- Massachusetts WIC Medical Referral Forms
- Appendix W of the MassHealth Provider Manual

Establish and maintain relationships with local Children's Behavioral Health Initiative (CBHI)

Tier 1

Description: The practice shall identify its staff member(s) responsible for 1) communicating with and reporting to CBHI program in a closed-loop manner, and 2) maintaining a roster of children attributed to the practice who are receiving CBHI services.

Summary of CBHI Services

- CBHI provides multidisciplinary BH services to children with MassHealth with an array of complex behavioral health needs, and are provided through a statewide network of home & community-based service provider agencies
- There are 6 key CBHI Services:
    - Intensive Care Coordination (ICC): Care coordination for youth under age 21 with serious emotional disturbance
    - Family Support & Training (FST): Provides parent/caregiver education, support, and training in in member's home
    - Mobile Crisis Intervention (MCI): Therapeutic response to youth in behavioral health crisis, available 24/7, will meet patients in the community
    - In-home behavioral services (IHBS): Includes in-home behavioral health management therapy and behavior management monitoring services from specially trained therapist
    - Therapeutic mentoring (TM): Helps youth with behavioral health needs improve their functioning with coaching and skill building
    - In-home therapy (IHT): In-home assessment, risk management, and therapy services provided by maser's level clinician for child in crisis or requiring acute level of care
- CBHI providers may provide any subset of the 6 CBHI services. Many agencies provide more than 1, but not necessarily all 6, CBHI services.
    - MCI services are provided by 28 CBHCs (Community Behavioral Health Centers) across the state; MCI can be accessed by patients and providers alike via the state-wide Behavioral Health Help Line (BHHL), 833-773-2445
    - 32 CSAs (Community Service Agencies) offer Intensive Care Coordination across the state; these CSAs often provide multiple other CBHI services

Implementation Recommendations

- Find CBHI providers: https://www.mabhaccess.com/Search.aspx and helplinema.org
    - BMCHS PHS team will distribute BH network tool for ACOs/sites to use
- Practices identify local agencies and other providers of CBHI services and key contacts at each organization.
- "Communicating with and reporting to CBHI": Since there is no central CBHI organization, this should entail (a) placing referrals and (b) coordinating care and sharing clinical information with CBHI providers as needed
    - Ensure CBHI referrals are documented in patients' plans; follow up as needed
    - Ensure practice has a method of obtaining consent for release of information (ROI) to/from other providers

- Maintain “a roster” of children referred for CBHI services, with identified key parties (contact your ACO operations lead for example BMCHS/WS template roster)
- BMCHS/WS are providing a **monthly list of service authorizations for CBHI services** that can be filtered to the PIDSL level. This is a way to identify members who have recently engaged with CBHI services via claims.
    - This is an excel file that will be updated monthly and **shared via Box/Moveit.**
    - See Tip Sheet located on Box.

Operational Considerations

- Note: For Tier 2 and 3 sites, CBHI liaison(s) should be the same staff used to meet Tier 2/3 requirement for staff with children, youth, and family-specific expertise – which entails CBHI liaising.
- Non-clinician staff member may fulfill this requirement, but may also be performed by a clinician with dedicated non-clinical/administrative responsibilities
- Practices can leverage centralized staff via telehealth – but must be on-site monthly.

Resources and Supports

- BH network tool: ACO Quick Reference Guide
- CBHI brochure: https://www.mass.gov/service-details/cbhi-brochures-and-companion-guide
- Find CBHI providers: https://www.mabhaccess.com/Search.aspx and helplinema.org

Coordination with MCPAP

Tier 1

Description: Enroll with MCPAP at https://www.mcpap.com/. The practice shall consult with and use the services of MCPAP to augment the BH expertise provided within the practice as a means to maintain the management of youth with mild to moderate BH conditions in primary care. Alternatively, the practice can satisfy this requirement by accessing equivalent resources available within their own health system – such as consultation with child and adolescent psychiatrists working in the clinic or a neighboring site or via consultation from an asynchronous resource such as an e-consult. Use of such an alternative resource, however, does not exempt the practice from enrolling with MCPAP.

Summary of Service

- Real-time provider-to-provider consultation on treating children with behavioral health and/or substance use disorder needs
- Virtual counseling for pediatric patients with SUD by an LICSW specializing in pediatric SUD

MCPAP Phone Numbers for Provider Consultations

- Western & Central MA: 844-926-2727
- Eastern MA – Boston South : 844-636-2727
- Eastern MA – Boston North: 855-627-2763

Implementation Recommendations

- All pediatricians must enroll in MCPAP via one of two methods:
    - Complete one spreadsheet enrollment form for all ACO providers enrolling in MCPAP and/or M4M using template/instructions provided by BMCHS/WS located on the **BMCHS/Wellsense Masshealth ACO Resource Hub** and send to: mcpap@beaconhealthoptions.com.
        - Note: This spreadsheet may be used to enroll providers across any practice or any collection of practices (not for ACOs only)
    - OR, complete the online enrollment form for each individual provider at www.mcpap.com/Provider/EnrollInMcPAP.aspx
- ACOs can enroll all providers if simpler to complete provider enrollment forms; there are no consequences to enrolling multiple times if unsure if a provider is enrolled
- Submitting enrollment forms is quick lift that can be completed by central admin staff
- Provide guidance to care teams on how to access these services (up to providers if/when to “consult with and use” service)
- Providers can still call MCPAP for patient consultations – even if not enrolled

NCQA PCMH Alignment: Practices who are recognized by the National Committee for Quality Assurance (NCQA) as Patient Centered Medical Homes (PCMH) may find alignment with the following PCMH standards

- **Care Coordination and Care Transitions:** Behavioral Health Integration, Integrates behavioral healthcare providers into the care delivery system of the practice site.
- **Care Coordination and Care Transitions:** Co-Management Arrangements, Documents co-management arrangements in the patient's medical record.

Coordination with Massachusetts Child Psychiatry Access Program for Moms (M4M)

Tier 1

Description: If providing obstetrical services, enroll in the M4M program at https://www.mcpapformoms.org/. The practice shall consult with M4M to augment the BH expertise provided within the practice as a means to maintain the management of perinatal patients with mild to moderate BH conditions in primary care. Alternatively, the practice can satisfy this requirement by accessing equivalent resources available within their own health system – such as consultation with a psychiatrist or appropriately trained Ob/Gyn of suitable expertise working in the clinic or a neighboring site, or via consultation from an asynchronous resource such as an e-consult. Use of such an alternative resource however does not exempt the practice from enrolling with the M4M program. While practices may offer some coordination with MCPAP for Moms virtually via telehealth, Enrollees must be able to access this requirement on-site.

Summary of Service

- Real-time provider-to-provider consultation (including OB, adult and peds PCPs, and psychiatrists) treating postpartum patients with behavioral health and/or substances use disorder needs

M4M Phone Number for Provider Consultations 855-Mom-MCPAP (855-666-6272)

Implementation Recommendations

- All PCPs providing obstetric services (e.g., Family Medicine) enroll in M4M via one of two methods:
    - Complete one spreadsheet enrollment form for all ACO providers enrolling in MCPAP and/or M4M using template/instructions provided by BMCHS/WS located on the **BMCHS/Wellsense Masshealth ACO Resource Hub** and send to: mcpap@beaconhealthoptions.com.
        - Note: This spreadsheet may be used to enroll providers across any practice or any collection of practices (not for ACOs only)
    - OR, complete the online enrollment form for each individual provider at www.mcpapformoms.org/Providers/EnrollInMCPAPMOM.aspx#
    - Note: all adult, peds, OBGYN practices are *eligible* to enroll in M4M (but not required)
- Submitting enrollment forms is quick lift that can be completed by central admin staff
- Provide guidance to care teams on how to access these services (up to providers if/when to “consult with and use” service)
- Providers can still call M4M for patient consultations – even if not enrolled

NCQA PCMH Alignment: Practices who are recognized by the National Committee for Quality Assurance (NCQA) as Patient Centered Medical Homes (PCMH) may find alignment with the following PCMH standards

- **Care Coordination and Care Transitions:** Behavioral Health Integration, Integrates behavioral healthcare providers into the care delivery system of the practice site.
- **Care Coordination and Care Transitions**: Co-Management Arrangements, Documents co-management arrangements in the patient's medical record.

Fluoride varnish for patients ages 6 months up to age 6

Tier 1

Description: Assess the need for fluoride varnish at all preventive visits from six (6) months to six (6) years old, and once teeth are present, must provide application of fluoride varnish on-site in the primary care office **at least twice per year** for all children, starting when the first tooth erupts and until the patient has another reliable source of dental care.

For those pediatric patients who do not have a dental home, the practice must share a list of MassHealth dental providers with the parent/caregiver as noted below.

(https://publications.aap.org/pediatrics/article/146/6/e2020034637/33536/Fluoride-Use-in-Caries-Prevention-in-the-Primary)

If there is a co-located dental office or evidence that the dental office has already provided this service, such may substitute in this requirement for the relevant patients who have access to or have accessed these resources. Enrollees must be able to access this fluoride varnish on-site.

Implementation Recommendations

a. Identify a fluoride varnish workgroup focused on designing and implementing workflows, monitoring progress, and reporting performance to stakeholders. We recommend designating an oral health champion within your practice.

A Fluoride Varnish Workgroup can include members from the listed departments:

Oral Health Champion	• Will ensure everyone is on board for successful implementation of the fluoride varnish workflows in the clinic • Could be a member of any of the departments listed below
Operations	• Establish workflows for fluoride varnish application • Order fluoride varnish through your local distributor: – **0.25 ml** unidose for children under 6 – **0.4 ml** unidose for children 6 and older
Clinical	• Designate personnel responsible for fluoride varnish application • Ensure training opportunities for personnel designated to do the application
IT	• Add "Fluoride Varnish Progress Note" to EHR • Add Billing Codes to the EHR – Well Child Visit – Bill using **CPT service code 99188*** AND **ICD-10 code Z00.129**: **"Routine Child Health Check"** – Any other visit – Bill using **CPT service code 99188*** AND **ICD-10 code Z41.8**: **"Need for Prophylactic Fluoride Administration"**
Quality	• Track the performance for the quality measure

b. Select an appropriate training for the care team:

i. Who applies fluoride varnish and when during the visit?

List of Eligible Personnel Who Can Apply Fluoride Varnish

- Physician
- Independent Certified Nurse Practitioner
- Clinical Nurse Specialists
- Registered Nurse

- Licensed Practical Nurses
- Physician Assistants
- Medical Assistants
- Community Health Workers (CHW) under the supervision of physician and employed by the submitting physician or group practice*

  *For claims submitted by physician, the CHW must be under the supervision of the physician. For claims submitted by group practice, the CHW must be under the supervision of a MH enrolled physician who is a member of the group practice

ii. What is the best training delivery method?

Office-based training

- **From the First Tooth**
  - Hands on training on fluoride varnish application and assistance with office flow and billing provided in collaboration with MassHealth Dental program
  - Uses the Smiles for Life curriculum
  - One CME credit available on completion of training
  - Average time to complete training – 2-3 hours
- **To schedule training**, contact Jenna Blanchette, DentaQuest Outreach Coordinator/MassHealth Dental Program. Jenna.Blanchette@dentaquest.com or 617-886-1797

On-Line Training

- **The Smiles for Life, a National Oral Health Program**
  - Online course (Course 6 on the right hand side of the home page)
  - No official application is necessary
  - One CME credit is available upon completion through American Academy of Family Physicians (AAFP) upon completion http://www.smilesforlifeoralhealth.org
  - Average time to complete training – 1-2 hours

On-Line Resources

- UMass Medical School's Fluoride Varnish Training for MA Pediatric Providers (this program is managed by DentaQuest and includes in-office and remote support for practices)
- Smiles for Life Oral Health Varnish Module and Implementation Manual
- North Carolina's "Into the Mouths of Babes" toolkit
- SUNY Albany's "Applying Fluoride Varnish in the Medical Setting for Medical Providers"

Contact your Ops Lead if interested in scheduling an on-site training for fluoride varnish application

Order Fluoride Varnish Supplies

- Order fluoride varnish through your local distributor:
  - **0.25 ml** unidose for children under 6
  - **0.4 ml** unidose for children 6 and older

Create a portable Fluoride Varnish Basket

- Patient Handouts
- Fluoride Varnish
- Progress Notes
- Gloves
- Gauze

Schedule a meeting with clinic staff

- Explain fluoride varnish program
- Explain how using fluoride varnish will be beneficial to a child's oral health
- Explain the ease of doing a fluoride varnish application
- Fluoride Varnish is a MassHealth reimbursable service
- Identify training methods and provide opportunities for staff to be properly trained

Advertise

- Advertise in your waiting room, office newsletters, and website about fluoride varnish service
- Create a list of local dentists that accept MassHealth (Call 1-800-207-5019 or visit www.masshealth-dental.net for a list)

c. Develop practice workflows for your organization considering specifically:
   i. Who will be responsible for ordering fluoride and appropriate supplies?
   ii. Who will be responsible for stocking fluoride and supplies and where?
   iii. How will the team document in the EHR?
   iv. Identify any EHR changes needed for documentation and billing purposes.

Establishing a workflow, incorporating progress notes and billing codes into the EHR will greatly support the successful implementation of fluoride varnish services into your practice

- MA reviews risk assessment and gets materials ready
- Designated team member (MA, LPN, RN, MD, PA, NP) provides varnish at visit close
- Positioning for varnish application:
  - Lap-to-lap for children <5 yr
  - Facing child for older patient
- Provider or RN reviews handouts with patient and provides prevention advice
- Add "Fluoride Varnish Progress Note" to your EHR
- Add Billing Codes to your EHR
  - Well Child Visit – Bill using **CPT service code 99188*** AND **ICD-10 code Z00.129**: **"Routine Child Health Check"**
  - Any other visit – Bill using **CPT service code 99188*** AND **ICD-10 code Z41.8**: **"Need for Prophylactic Fluoride Administration"**
  - Varnish application is billable for all children aged 6 months to 21 years
  - **Reimbursement** is currently **$26** and **can be billed four times a year**
  - Varnish application at a dentist's office is billed and administered separately and does not affect eligibility for varnish application during a medical visit either clinically or administratively

A few operational considerations and resources will be useful for a successful implementation strategy

- **American Academy of Pediatric Dentistry** recommends that physicians refer patients to the dentist six months after the first tooth erupts and no later than 12 months of age
- **Integration** of oral health screening
- Technician comfort with fluoride varnish application (in-office screening)
- **Standardized EHR template/note** to ensure documentation and billing and recurrence.
- Evidence-based Clinical Recommendations suggest that topical fluoride is dose-dependent and should be applied to children with a **frequency of every three to six months** based on risk for dental caries**.

d. Track workflow implementation and performance progress

Monitoring implementation and reporting performance to stakeholder is key to success

- Do a few test cases to assess:
  - Flow
  - Billing
  - Patient Satisfaction
  - Staff Satisfaction
- Conduct an audit:
  - Oral Screen
  - Fluoride Varnish Application

Template 1

Name of patient _____ DOB _____ MRN _____

Procedure Documentation

□ Child was positioned for varnish application. Teeth were dried. Varnish was applied.

Post-Procedure Documentation

□ Fluoride varnish handout provided

□ Caries prevention handout reviewed/provided or risk prevention discussed

_____ _____

Name, Title, and Signature of Varnish Provider Date/Time

_____ _____

Name and Signature of Supervising Physician Date/Time

□ I have reviewed risk assessment and have overseen application of fluoride varnish.

Sample of patient stamp:

Dental visit in last 6 months	Yes/No
Fluoride Rx given	Yes/No
Fluoride varnish applied	Yes/No
Oral Hygiene instruction	Yes/No
Dental referral done	Yes/No

Template 2

Name of patient _____ DOB _____ MRN _____

Oral Examination

□ Caries (including white or brown spots) or enamel defects present

□ Plaque present on teeth

Procedure Documentation

□ Child was positioned for varnish application. Teeth were dried. Varnish was applied.

Post-Procedure Documentation

□ Fluoride varnish handout provided

□ Caries prevention handout reviewed/provided or risk prevention discussed

_____ _____

Name, Title, and Signature of Varnish Provider Date/Time

_____ _____

Name and Signature of Supervising Physician Date/Time

□ I have reviewed risk assessment and have overseen application of fluoride varnish.

Sample of patient stamp:

Caries or defects	Yes/No
Dental visit in last 6 months	Yes/No
Systemic Fluoride assessed	Yes/No
Fluoride Rx given	Yes/No
Fluoride varnish applied	Yes/No
Oral Hygiene instruction	Yes/No
Dental referral done	Yes/No

On-Line Resources:

- MassHealth: Dental Provider Finder
- DentaQuest
- UMass Medical School's Fluoride Varnish Training for MA Pediatric Providers (this program is managed by DentaQuest and includes in-office and remote support for practices)
- Smiles for Life Oral Health Varnish Module and Implementation Manual
- North Carolina's "Into the Mouths of Babes" toolkit
- SUNY Albany's "Applying Fluoride Varnish in the Medical Setting for Medical Providers"
- Fluoride Varnish Training Manual for Massachusetts Health Care Professionals Resource Hub
- DentaQuest Referral Resources Resource Hub
- Forsyth Forsyth
- Provider Resources
    - American Academy of Pediatrics – Oral Health Practice Tools https://www.aap.org/en/patient-care/oral-health/oral-health-practice-tools/
        - American Academy of Pediatrics – FAQ Fluoride https://www.healthychildren.org/English/healthy-living/oral-health/Pages/FAQ-Fluoride-and-Children.aspx
        - Smiles for Life – Fluoride Varnish toolkit https://www.smilesforlifeoralhealth.org/resources/practice-tools-and-resources/state-specific-fluoride-varnish-information/

- New York State - Fluoride Varnish Training Materials https://www.health.ny.gov/prevention/dental/child_oral_health_fluoride_varnish_for_hcp.htm
- North Carolina Oral Health – Into the Mouths of Babes Toolkit https://www.dph.ncdhhs.gov/oralhealth/partners/IMB-toolkit.htm

Handouts/Posters That Can Be Used For Waiting Room Area

- Fluoride: Cavity Fighter (English)
  - https://eclkc.ohs.acf.hhs.gov/sites/default/files/pdf/cavity-fighter.pdf
- Fluoride: Cavity Fighter (Spanish)
  - https://eclkc.ohs.acf.hhs.gov/sites/default/files/pdf/cavity-fighter-esp.pdf
- Drinking water with fluoride (English)
  - https://eclkc.ohs.acf.hhs.gov/sites/default/files/pdf/drinking-fluoride.pdf
- Drinking water with fluoride (Spanish)
  - https://eclkc.ohs.acf.hhs.gov/sites/default/files/pdf/drinking-fluoride-esp.pdf
- Teaching Them to Brush (English)
  - https://eclkc.ohs.acf.hhs.gov/sites/default/files/pdf/teaching.pdf
- Teaching Them to Brush (Spanish)
  - https://eclkc.ohs.acf.hhs.gov/sites/default/files/pdf/teaching-esp.pdf

Fluoride Varnish Vendors – Most medical vendors sell individually-packaged fluoride varnish packets or trays. You do not need to purchase directly from a dental provider

- Henry Schein
- McKesson

WDSF - Fluoride Varnish Suppliers 201

Tier 2 Practice Requirements

Brief intervention for BH conditions

Tier 2

Description: Provide brief interventions for patients with identified BH needs, as appropriate, such as Screening, Brief Intervention, and Referral to Treatment (SBIRT), brief Cognitive Behavioral Therapy (CBT), or an equivalent model. These may be provided by a front-line clinical provider or by an integrated member of the clinical team, such as a licensed independent clinical social worker (LICSW). While practices may offer some BH interventions for BH conditions virtually via telehealth, Enrollees must be able to access this requirement on-site.

Implementation Recommendations

Option 1: For Sites with on-site BH clinicians

- BH clinician: Ensure on-site (may be hybrid on-site/telehealth) BH clinician (e.g., social worker, mental health counselor, or psychologist) utilizes brief interventions, such as CBT or SBIRT
- See also Consulting Independent BH Clinician Tier 2 requirement

Option 2: For Sites without on-site BH clinicians

- Offer training to primary care staff including clinicians (e.g., RN/NP/PA/MD) and non-clinicians (e.g. Recovery Coaches, Community Health Workers)
- in SBIRT and/or CBT for one-time, brief (~5 min) counseling following screening for MHSUD
- Not required for sites with clinical staff already skilled in intervention(s)

Operational Considerations

- Site of care: Provider must be a clinician with some on-site availability; ensure at least 1 such provider is identified for the site, with clearly identified intervention(s) (e.g., CBT, SBIRT, or other)
- Areas of flexibility:
    - Time: SBIRT may be performed in as short as 5 minutes in a single visit; a single CBT skill may be similarly brief; sites have discretion regarding how much time to spend on these services
    - Intervention fidelity: MassHealth does not provide specific guidance on intervention fidelity or clinician training to perform interventions; sites have discretion regarding how intervention is performed
    - Patient eligibility: MassHealth does not provide specific guidance on which patients should get a brief intervention; sites have discretion regarding which patients and how often to offer these services
- Option 2 workflow: Ensure staff with BH training have appropriate workflow to (a) identify and meet with screened patients in timely manner, (b) have sufficient time to perform intervention, (c) document patient interaction as needed

NCQA PCMH Alignment: Practices who are recognized by the National Committee for Quality Assurance (NCQA) as Patient Centered Medical Homes (PCMH) may find alignment with the following PCMH standards

- **Care Coordination and Care Transitions:** Behavioral Health Integration, Integrates behavioral healthcare providers into the care delivery system of the practice site.

Resources and Supports

- BMCHS/WS offers local SBIRT training and technical assistance through MASBIRT TTA
- Centralized BMCHS/WS provider education may be offered pending ACO partner interest
- SBIRT guide (MASBIRT), SBIRT guide (Anthem)

Telehealth-capable BH referral partner

Tier 2

Description: Include at least one (1) BH provider who is capable of providing services via a synchronous audio-video telehealth modality among its local and reasonably-accessible list of BH providers who are within the MassHealth network.

Implementation Recommendations

- Telehealth-capability: Ensure referral list indicates whether provider offers telehealth, or have list of telehealth BH providers ("at least one")
- **Note**: CBHCs (Community Behavioral Health Centers) are required to offer telehealth capability. There are 28 CBHCs across the state, all accepting MassHealth ACO members.
- **Additional note**: Most BH providers continue to offer telehealth capability today, including those listed on the directories in the "resources and supports" section

NCQA PCMH Alignment: Practices who are recognized by the National Committee for Quality Assurance (NCQA) as Patient Centered Medical Homes (PCMH) may find alignment with the following PCMH standards

- **Care Coordination and Care Transitions:** Behavioral Health Integration, Integrates behavioral healthcare providers into the care delivery system of the practice site.
- **Patient-Centered Access and Continuity:** Two-Way Electronic Communication, Has a secure electronic system for two-way communication to provide timely clinical advice

Resources and Supports

- BMCHS PHS team will distribute BH network directory tool for ACOs/sites to use, this can be located on the BMCHS/Wellsense Masshealth ACO Resource Hub
- For additional telehealth-capable providers: All members and providers have access to Beacon Provider Network directories (public sites)

E-consults available in at least three (3) specialties

Tier 2

Description: Be capable of asynchronous, consultative, provider-to-provider communications within a shared Electronic Health Record (EHR) or web-based platform between primary care and specialist providers over a secure electronic medium that involves sharing of patient-specific information and discussing clarification or guidance regarding targeted clinical care. E-consults shall be available to clinical staff within the practice to discuss with specialists in at least three distinct and non-redundant American Board of Medical Specialties (ABMS)-recognized specialties. For example, offering e-consults to multiple specialties with board certification under the pathways of Internal Medicine, such as cardiology, endocrinology, and nephrology meets this requirement. On the other hand, multiple specialties with certification under a shared subspecialty would be considered redundant; for example, seeking to count e-consults in general cardiology, clinical cardiac electrophysiology, and interventional cardiology as three distinct specialties would not meet this requirement.

Implementation Recommendations

Option 1:

Utilize current specialty network: Build e-consult infrastructure among current network multispecialty practices and/or local hospital and local subspecialty.

- Treating physician and subspecialist will likely be within the same EMR or view only access to review details of a patient's record
- Treating physician and subspecialists likely already have a relationship and referral pathways
- This may take away volume/revenue to specialists, what is the subspecialist's incentive to partner in an E-Consult program?
- May require internal resources and management to stand up as well as require IT lift

Option 2:

Hire a 3rd party vendor: Contract with E-Consult service that meets state requirement and local service level requirements

- It will satisfy the Tier 2/3 requirements relatively easily for a practice
- Cost potentially higher compared to insourcing
- Interface is a challenges where treating physician will need a portal separate from practices EMR so patient info will need to be entered with more detail vs sharing patients chart and history
- Need to ensure quality of care of vendor

After-hours or weekend session (at least 4 hours)

Tier 2

Description: Offer at least four hours for in-person or telehealth visits, with the practice's own providers or with providers from another of the Contractor's Network PCPs (ACPP) or Participating PCPs (PCACO) as further specified below, at least once per week within any of the following periods (Monday through Friday: Outside the hours of 8:00 a.m.-5:00 p.m. Saturday or Sunday: During any period) These session(s) may be covered by the practice's own providers or with providers from another of the Contractor's Network PCPs (ACPP) or Participating PCPs (PCACO) such that one practice may cover the weekend or after-hours sessions for a maximum of two other practices. If the practice utilizes another practice for this coverage, EOHHS encourages the Contractor to utilize practices that are located in close geographic proximity to the practice. In addition, any providers staffing such sessions (including those at another practice site) must have access to the practice's EHR and must document the visit within the practice's EHR. Sessions cannot be those offered by a third-party or a group unaffiliated with the primary care practice as described above, unable to access the practice's EHR, or unaffiliated with the practice's patient population. The required after-hours or weekend session shall provide behavioral health referral with bi-directional communication, tracking, and monitoring. Providers staffing after-hours or weekend sessions shall communicate any visits during those sessions to the Enrollee's primary care provider. The Contractor or the practice shall communicate to Enrollees where to access after-hours or weekend sessions.

Key Considerations

- **Offering Behavioral Health Referrals and Tracking**: The required after-hours or weekend session shall provide behavioral health referral with bi-directional communication, tracking, and monitoring.
- **Communication to Patients**: The practice must communicate to (MassHealth) patients where to access after-hours sessions.
- **Consider Leveraging Advanced Practice Providers (APP):** Practices may leverage APPs to meet this requirement
- **Benefits of Telehealth**: Offering telehealth vs. in-person after-hours care may be less burdensome given telehealth does not require the same support services (e.g. Medical Assistants, front-desk staff, etc.) in-person care requires.

Cross-Coverage Options

- **PIDSLs Unable to Meet Requirement**: Collaborate with your ACO Ops Leads to determine if you might be able to cover this requirement leveraging other sites within your ACO
- **Considerations if Leveraging Cross-Coverage**: the practice covering your ACO must (1) have EMR access and document within the EMR (2) cover a maximum or two other practices

Implementation Recommendations: Three sample schedules to meet the Tier 2 After Hours Requirement (4 hours) are exemplified below:

Example 1 – Telehealth Only

Mon	Tue	Wed	Thu	Fri	Sat	Sun
Telehealth Session 1 7am - 8am		*Telehealth Session 2 5pm - 6pm*		*Telehealth Session 3 5pm - 7pm*		

Example 2 – Telehealth and In-Person

Mon	Tue	Wed	Thu	Fri	Sat	Sun
Telehealth Session 1 7am - 8am		*In-Person Session 1 5pm - 7pm*		*Telehealth Session 2 7am – 8am*		

Example 3 – In-Person Only

Mon	Tue	Wed	Thu	Fri	Sat	Sun
			In-Person Session 1 5pm - 7pm		*In-Person Session 2 12pm - 2pm*	

Team-based staff role

Tier 2

Description: Team-based staff role: maintain at least one (1) team-based staff role dedicated to the specific primary care site. This role may be met virtually but must be on-site at least monthly. If this role is offered virtually, the practice must have multimedia available for Enrollees to engage with the role from the practice. This role shall consist of any of the following or similar roles:

- •Community health worker (CHW)
- •Peer (Certified Peer Specialist, Recovery Coach, Family Partner, Family Navigator)
- •Social worker (licensed clinical social worker [LCSW], LICSW) or other master's-prepared clinician such as a Master of Social Work (MSW)
- •Nurse case manager

Such team-based role shall:

- •Be available and doing work on behalf of the specific practice site for at least three or more equivalent 4-hour sessions (i.e., >0.3 FTE) per week,
- •Conduct activities such as but not limited to team-based huddles, activities on behalf of patients at the site, or patient-facing activities.
- •Participate in team activities such as team huddles, i.e., standing team meetings for the purpose of pre-visit planning, population health management, process improvement, etc.

Implementation Recommendations

Option 1: In-person Staff Rotations

- Ensure staff role is available on-site to a specific PIDSL for a minimum of 3, 4-hour sessions per week
  - Ex: 1 team-based staff role could meet staffing requirement for up to 3 separate PIDSL sites (see back-up slide for example)
- Note: A BH clinician can be used to meet both team-based staff requirement and Tier 2 "Consulting Independent BH Clinician" requirement

Option 2: Dedicated Virtual Availability

- Ensure staff role is available virtually to each specific PIDSL for a minimum of 3, 4-hour sessions per week
  - Ex: 1 remote team-based role could meet staffing requirement for up to 3 separate PIDSL sites (see next slide for example)
- Remote staff must be available on-site at each PIDSL site they cover **at least once per month**
  - Staffing at least one shift per week in-person at a unique PIDSL would meet this requirement

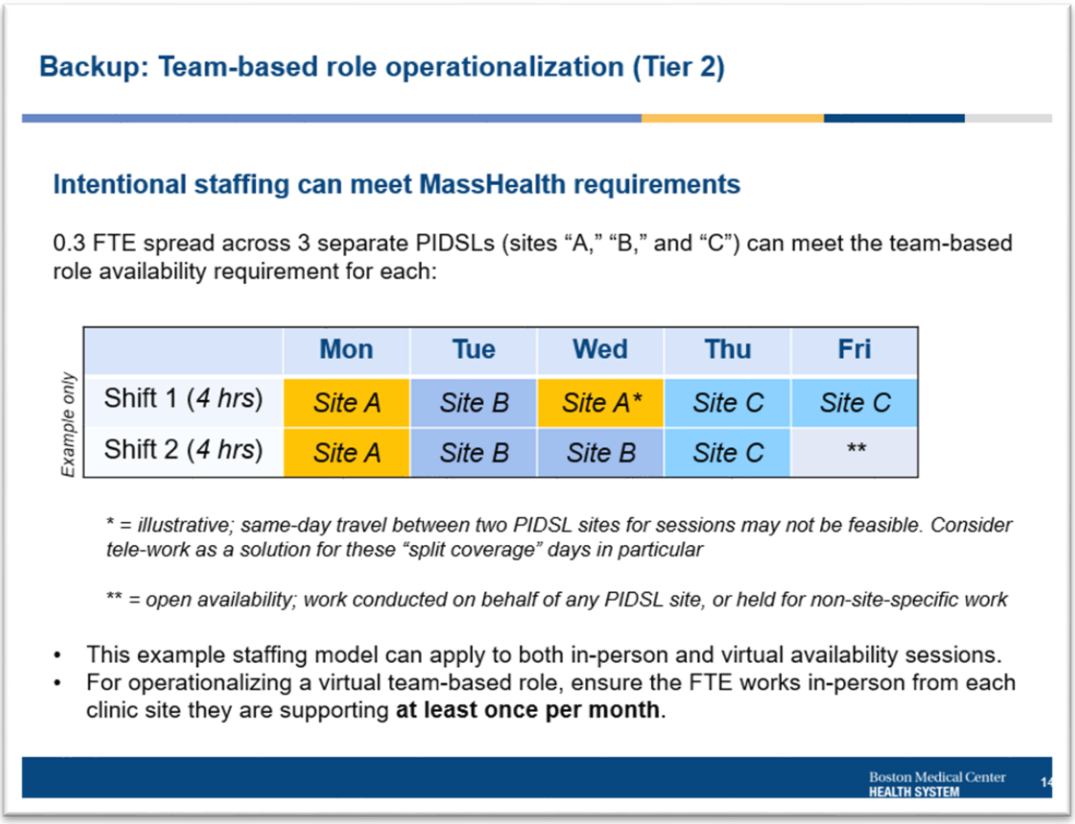
Operational Considerations

- For all implementation options: shift staffing for these roles should align with regular team huddles/care planning meetings at each PIDSL site
- We recommend scheduled shifts remain at consistent days/times as much as possible for reliable patient access and schedule management for team-based personnel
- We encourage sites to use existing roles/staff to meet these requirements where possible
- Sites should consider how meeting these team-based roles can best support their organizational priorities, including: care management, Flexible Services program referrals, HRSN screenings, quality performance, etc

NCQA PCMH Alignment: Practices who are recognized by the National Committee for Quality Assurance (NCQA) as Patient Centered Medical Homes (PCMH) may find alignment with the following PCMH standards

- **Team-Based Care and Practice Organization:** Structure and Staff Responsibilities, Defines the practice's organizational structure and staff responsibilities / skills to support key practice functions

Resources and Supports



Backup: Team-based role operationalization (Tier 2)

Intentional staffing can meet MassHealth requirements

0.3 FTE spread across 3 separate PIDSLs (sites "A," "B," and "C") can meet the team-based role availability requirement for each:

Example only

	Mon	Tue	Wed	Thu	Fri
Shift 1 (*4 hrs*)	*Site A*	*Site B*	*Site A**	*Site C*	*Site C*
Shift 2 (*4 hrs*)	*Site A*	*Site B*	*Site B*	*Site C*	**

** = illustrative; same-day travel between two PIDSL sites for sessions may not be feasible. Consider tele-work as a solution for these "split coverage" days in particular*

*** = open availability; work conducted on behalf of any PIDSL site, or held for non-site-specific work*

- This example staffing model can apply to both in-person and virtual availability sessions.
- For operationalizing a virtual team-based role, ensure the FTE works in-person from each clinic site they are supporting **at least once per month**.

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Maintain a consulting independent BH clinician

Tier 2

Description: Maintain a consulting independent BH clinician: maintain a dedicated and accessible consulting BH clinician available to assist the practice with cases of moderate complexity. This role shall be a licensed BH provider, such as a psychiatrist, psychologist, psychiatric clinical nurse practitioner, LICSW, licensed mental health counselor (LMHC), or licensed marriage and family therapist (LMFT). This requirement may be fulfilled via a single role fulfilling both this requirement and the team-based staff role requirement above. This resource shall be available to assist the practice with cases of moderate BH complexity on a regular basis and assist with co-management of referred cases that can otherwise remain anchored in the primary care setting. Where feasible, this resource shall also be available for team-based huddles and warm-handoffs to support patient care. This resource may be virtually available to the practice and can utilize asynchronous means of communication inclusive of e-consult but shall be able to respond to queries within two (2) business days.

Implementation Recommendations

- Consulting BH clinician: Independently licensed BH clinician (LICSW, LMHC, LMFT, psychologist, or psychiatric prescriber) with or without prescribing capability available for patient visits
- Note: This individual can also meet the “Team-based staff roles” requirements (Tier 2 and Tier 3)

Operational Considerations

- Fully virtual is acceptable: On-site or hybrid is not required
- BH clinician availability: To meet the two business day response requirement, the BH clinician will need to be available for response on at least 3 days within a typical 5-day work week
- Areas of flexibility: Team-based huddles and warm handoffs “where feasible”

NCQA PCMH Alignment: Practices who are recognized by the National Committee for Quality Assurance (NCQA) as Patient Centered Medical Homes (PCMH) may find alignment with the following PCMH standards

- **Team-Based Care and Practice Organization:** Behavioral Health Care Manager, Has at least one care manager qualified to identify and coordinate behavioral health needs.
- **Care Coordination and Care Transitions:** Behavioral Health Integration, Integrates behavioral healthcare providers into the care delivery system of the practice site

Staff with children, youth, and family-specific expertise (part-time or full-time)

Tier 2

Description: Identify at least one non clinical team member with demonstrable experience addressing the BH and HRSN of children, youth, and families in a health care setting and/or possessing specialized training, degree, licensing, or certification in such work. This role may be met virtually but shall be on site at least monthly. This role shall be responsible for communicating with and being the site's primary and reliable point of contact to the CBHI program, Family Resource Centers (FRCs), and schools/early childhood settings.

Requirement Notes

MassHealth did not indicate any specific training or credentialing needs for this staff member.

Operational Considerations

Assign these responsibilities to a staff role that has experience working with children, youth, and families. This may be a pediatric Medical Assistant, RN, CHW, Patient Navigator, etc. We recommend updating the job description for this role to include the sub-capitation requirement as noted above. Sample Job Description available upon request.

NCQA PCMH Alignment: Practices who are recognized by the National Committee for Quality Assurance (NCQA) as Patient Centered Medical Homes (PCMH) may find alignment with the following PCMH standards

- **Team-Based Care and Practice Organization:** Behavioral Health Care Manager, Has at least one care manager qualified to identify and coordinate behavioral health needs.
- **Knowing and Managing Your Patients:** School/Intervention Agency Engagement, Engages with schools or intervention agencies in the community

Provide SNAP and WIC assistance

Tier 2

Description: Provide patients and their families who are eligible for SNAP and WIC application assistance through the practice in order to assist patients and their families to apply for and engage those programs. While practices may offer some assistance virtually, Enrollees must be able to access this requirement on-site

Implementation Recommendations

- The staff member assuming the role of helping members apply for SNAP and WIC should receive training and familiarize themselves with the details of each program:
    - Eligibility
    - Application process and materials needed for each (e.g. income, expenses, DOB, SSN)
    - Contact information for SNAP/WIC
- Practices should decide if they will implement the process online with the member or they may consider printing the application for the member to fill out and the staff member may complete later.

Operational Considerations

- Virtual offering: Determine if your practice will choose to offer assistance virtually. This is not a requirement, but is an option and should be considered if virtual pediatric preventative visits are offered.
- On-site offering: Identify a workflow for assistance within the practice (e.g. refer patient to staff member/role who is on-site).
- Staffing: Decide who will assist with application and eligibility and at what point during the clinic visit that assistance will occur (e.g. will the staff member/role need a template/schedule to book appointments). Examples of roles include: Patient Navigator, Community Health Worker, Care Coordinator.
- Documentation: Determine if the visit for application assistance will be documented in the EHR. If so, consider adding a documentation template.

NCQA PCMH Alignment: Practices who are recognized by the National Committee for Quality Assurance (NCQA) as Patient Centered Medical Homes (PCMH) may find alignment with the following PCMH standards

- **Knowing and Managing Your Patients:** Competency F, Connecting With Community Resources. The practice identifies/ considers and establishes connections to community resources to collaborate and direct patients to needed support

Resources and Supports

- Massachusetts SNAP Office
- Massachusetts WIC Medical Referral Forms
- Appendix W of the MassHealth Provider Manual

LARC provision, at least one option

Tier 2 Adult Population

Description: One Option: Have the **on-site ability to place at least one (1) type of long-acting reversible contraceptive** (e.g., intrauterine device or subdermal implant). This service shall be available on-site during normal business hours **at least one session every other week (i.e., twice monthly).** This activity may occur either in the primary care office or from a co-located provider at the same practice site. Enrollees must be able to access this requirement on-site.

Requirement Notes:

- The LARC offering is required to be at the individual PIDSL level. The requirement is not met if LARC services are located at another PIDSL site within the health system (unless there is a co-located OB/GYN in the same building performing the procedure). Please see "Provider Training/Credentialing" section below for options on increasing LARC capacity at a PIDSL site.
- Injections such as Depo-Provera do not count towards the LARC requirement.

Provider Training/Credentialing

Enabling providers to place LARCs is a two-fold process, including training and credentialing. There are two types of LARC that meet the requirements – IUDs and implant (Nexplanon). Providers should be trained and credentialed separately for IUDs and Nexplanon.

LARC Placement Training Resources

- IUD – the following is a non-exhaustive list of organizations offering training on IUD insertion and removal:
    - Upstream
    - National Clinical Training Center for Family Planning
    - Beyond the Pill
    - Brand-Specific:
        - Kyleena
        - Liletta
        - Mirena
        - ParaGard
        - Skyla – call 1-888-84-BAYER (1-888-842-2937)
- Nexplanon – Organon offers clinical training to MDs, DOs, NPs, PAs, and CNMs on the insertion and removal of Nexplanon implants

Credentialing

After training, providers typically must perform a certain number of insertions under the supervision of a provider who is already credentialed to insert/remove the LARC in question.

- Credentialing requirements differ by health system/health center. Please check with your group to determine specific requirements for your practice.

- Providers typically need to meet a minimum threshold of insertions/removals per year to retain credentialing.

Options for groups <u>with no</u> credentialed providers <u>AT PIDSL</u>:

Float Provider

1. Consider floating a LARC-credentialed provider from another PIDSL within your system to align with the following tier cadences during normal business hours:
    - **<u>Tier 2</u> – One session every other week (i.e., twice monthly)**
    - **<u>Tier 3</u> – At least one session per week**

Build Site Capacity

- Support providers to get trained on one or both LARC options so they can begin the process of getting credentialed
- Once providers have been trained, have them work with the floating LARC-credentialed provider. This will allow them to obtain the minimum number of insertions/removals to be credentialed.

Operational Considerations

The following list contains important considerations for tier 2 and 3 PIDSLs looking to operationalize a LARC clinic (FPNTC, 2020):

- **Stocking Devices and Supplies**
    - Stock at least one of each type of LARC (Nexplanon implant, copper IUD, hormonal IUD, etc.)
    - Prepare easy-to-access kits for insertion and removal, containing all necessary supplies to perform the procedure, in or near (ie IUD cart) the patient's room
    - Develop staff protocol for re-stocking all LARC options as well as insertion/removal kits
    - Develop procedures for sterilizing medical instruments used during the procedure

- **Patient Education and Informed Consent**
    - Ensure the clinic has patient education forms for both IUDs and implant
    - Ensure the clinic has informed consent forms for both IUDs and implant (insertion and removal)
    - Consider including patient education and informed consent forms in supply kits

- **Documentation Set-up and Protocol**
    - Revisit order sets in EMR to ensure providers are easily able to select LARC options appropriately
    - Review billing procedures for accurate coding for LARC services (NOTE: LARC insertion and removal procedures are NOT included in the sub cap and thus practices can still bill and get reimbursed for this procedure)

- **Ensure LARC Service Availability**

    - As PIDSL capacity allows, update policy to allow for same-day service offering and/or incorporate into existing appointment slots
- **Staff Training**
    - Train staff on any new procedures related to stocking, education/consent, documentation, and billing
    - Incorporate LARC workflow training into new hire onboarding

Resources and Supports

Clinical and Operational

The following are useful resources for standing up a LARC clinic in your practice. Please reach out to your Operations Lead if there are additional resource topics that would be helpful.

- ACOG LARC Video Series covers clinical topics related to the provision of LARC methods, including insertion, removal and counseling scenarios
- ACOG Quick Coding Guide for both IUDs and implants
- Family Planning National Training Center's Same-Visit Contraception: A Toolkit for Family Planning Providers is a comprehensive guide detailing how clinics can stand up same-visit provision of LARC
- Beyond the Pill from UCSF's Bixby Center for Global Reproductive Health offers clinic and provider tools, including protocol for insertion, talking points for front desk staff, and various checklists
- ACOG guidance on Patient-Centered Contraceptive Counseling
- ACOG guidance on Counseling Adolescents About Contraception

Patient Materials

The following sites have useful resources to share with patients (both print and online):

- ACOG's FAQ on IUDs and implants
- Reproductive Health Access Project
- Bedsider
- Planned Parenthood

Active Buprenorphine Availability

Tier 2 Adult Population

Description: At least one (1) individual provider actively prescribing buprenorphine for management of opioid use disorder to patients with opioid use disorder as clinically indicated. Actively prescribing means that a provider is either currently prescribing buprenorphine for Enrollees at the practice, or is willing and able to if and when any Enrollee is in need of this service, without having to refer the Enrollee to another location. This provider shall be dedicated and available to patients in the practice on-site or virtually on at least a weekly basis. Providing referrals to SUD care or maintaining agreements with other providers or practices that require the Enrollee to present at a different location does not meet this requirement.

Implementation Recommendations

Option 1: Site and ACO Champions

- Identify at least 1 provider at each PIDSL that is willing and able to prescribe buprenorphine
- Consider identifying a champion at practice and/or ACO level, depending on the need, who can mentor other PCPs and support prescribing comfort and capacity across the practice and/or ACO over time, eg:

Option 2: Telehealth

- The MOUD requirement (tiers 2 & 3) can be met fully via telehealth if you have an addiction treatment program in your ACO with prescribing providers that can meet with OUD patients via telehealth, and communicate with PCPs via an EMR or other secure electronic medium

Operational Considerations

- Many opportunities to innovate and combine models—e.g. having a telehealth MOUD provider support induction/stabilization, and practice-based PCPs continue treatment
- To provide buprenorphine treatment to more than a few patients, most practices find it valuable to have nurse care managers, pharmacists or other staff to support patient education, outreach and monitoring

Resources and Supports

- BMCHS Grayken Center offers training and technical assistance – eg OBAT “Nuts & Bolts” Training
- Expert Consultation: MCSTAP for adult cases and MCPAP for pediatric cases

Active Alcohol Use Disorder (AUD) Treatment Availability

Tier 2

Description: At least one provider actively prescribing or willing and able to prescribe relevant medications for management of alcohol use disorder (e.g., Disulfiram, Acamprosate, Naltrexone, etc.). This requirement may be met virtually. However, providers must be capable of asynchronous, consultative, provider-to-provider communications within a shared Electronic Health Record (EHR) or web-based platform between primary care and specialist providers over a secure electronic medium that involves sharing of patient-specific information and discussing clarification or guidance regarding targeted clinical care.

Implementation Options

Option 1: Site and ACO Champions

- Leverage any PIDSL and ACO-level champions identified for MOUD to support clinicians in using more medication for AUD
- Share clinical pearls on medication for AUD at provider meetings or newsletters; can use BMCHS/WS tip sheets and materials

Option 2: Telehealth

- The AUD treatment requirement can be met fully via telehealth
- If you have an addiction treatment program in your ACO with prescribing providers that can meet with AUD patients via telehealth, and that can communicate with PCPs via an EMR or other secure electronic medium, that will be sufficient to meet this requirement

Operational Considerations and Supports

- Many practices are likely to already have PCPs who would fulfill this requirement
- Consider identifying 1 SUD lead per practice to serve as both AUD treatment and OUD treatment lead

Resources and Supports

- Training on AUD Treatment with Dr Alyssa Peterkin and AUD tip sheets available on Box/MoveIt in Sub-cap resources folder
- MCSTAP expert consultation available 5 days/week: www.mcstap.com

Tier 3 Practice Requirements

Fulfill one of the following: clinical pharmacist visits OR group visits OR designated educational liaison for pediatric patients

Tier 3

Description: Fulfill one of the following:

1) Clinical pharmacist visits: offer its patients the ability to conduct office based or virtual appointments with a licensed clinical pharmacist focused on medication management and teaching. This role may conduct its activities virtually. The clinical pharmacist shall be dedicated to the practice for a minimum of three (3) or more equivalent 4 hour sessions per week (i.e., >0.3 FTE)

OR

2) Group visits: offer its patients the ability to participate in office based or virtual appointments at which services are provided to multiple patients for a shared condition and peer support is elicited (e.g., mental health, substance use disorder, antenatal care, etc.). These visits may be conducted virtually. Group visits shall be offered by staff that are dedicated to the practice for a minimum of three (3) or more equivalent 4 hour sessions per week (i.e., >0.3 FTE)

OR

3) Designated Educational Liaison for pediatric patients: For practices serving pediatric patients, have dedicated staff member that serves as an office based or virtual resource for families navigating the intersection of the medical and educational systems. This role may conduct its activities virtually. The Educational Liaison shall have knowledge of education and special education systems, including early education settings, and shall create relationships with local schools and early education settings. The Educational Liaison shall provide support to patients with medical, developmental, and/or BH needs and shall be available to provide input to the educational team at schools as needed and shall be dedicated to the practice for a minimum of three (3) or more equivalent 4 hour sessions per week (i.e., >0.3 FTE).

Operational Considerations

This requirement will be practice dependent. Each PIDSL should identify which visit types they are able to offer. Each PIDSL needs to select *only one* of the above visit types. All of the visit type choices can be offered virtually. An ACO may be able to identify methods in which they can provide the role/visit virtually on behalf of multiple practices.

E-consults available in at least five (5) specialties

Tier 3

Description: Be capable of asynchronous, consultative, provider-to-provider communications within a shared EHR or web-based platform between primary care and specialist providers over a secure electronic medium that involves sharing of patient-specific information and discussing clarification or guidance regarding targeted clinical care. E-consults shall be available to clinical staff within the primary care practice to discuss with specialists in at least five (5) distinct and non-redundant ABMS-recognized specialties. For example, offering e-consults to multiple specialties with board certification under Internal Medicine, such as cardiology, endocrinology, and nephrology meets this requirement. On the other hand, multiple specialties with certification under a shared subspecialty would be considered redundant; for example, general cardiology, clinical cardiac electrophysiology, and interventional cardiology would not meet this requirement.

Implementation Recommendations

Option 1: Utilize current specialty network: Build e-consult infrastructure among current network multispecialty practices and/or local hospital and local subspecialty.

- Treating physician and subspecialist will likely be within the same EMR or view only access to review details of a patient's record
- Treating physician and subspecialists likely already have a relationship and referral pathways
- This may take away volume/revenue to specialists, what is the subspecialist's incentive to partner in an E-Consult program?
- May require internal resources and management to stand up as well as require IT lift

Option 2: **Hire a 3rd party vendor**: Contract with E-Consult service that meets state requirement and local service level requirements

- It will satisfy the Tier 2/3 requirements relatively easily for a practice, ~1 month to stand up
- Cost potentially higher compared to insourcing
- Interface is a challenges where treating physician will need a portal separate from practices EMR so patient info will need to be entered with more detail vs sharing patients chart and history
- Need to ensure quality of care of vendor

After-hours or weekend sessions (at least 12 hours)

Tier 3

Description: Offer at least 12 hours for in-person or telehealth visits with the practice's own providers or with providers from another of the Contractor's Network PCPs (ACPP) or Participating PCPs (PCACO) as further specified below, falling within any of the following periods:

- Monday through Friday: Outside the hours of 8:00 a.m.-5:00 p.m.
- Saturday or Sunday: During any period of at least four hours

These session(s) may be covered by the practice's own providers or with providers from another of the Contractor's Network PCPs (ACPP) or Participating PCPs (PCACO) such that one practice site may cover the weekend or after-hours sessions for a maximum of two other practices. If the practice utilizes another practice site for this coverage, EOHHS encourages the Contractor to utilize practice sites that are located in close geographic proximity to the practice. In addition, any providers staffing such sessions (including those at another practice site) must have access to the practice's EHR and must document the visit within the practice's EHR. Sessions cannot be those offered by a third-party or a group unaffiliated with the primary care practice as described above, unable to access the practice's EHR, or unaffiliated with the practice's patient population. At least 4 hours shall be in-person. At least 4 hours must fall on a weekend day. Providers staffing after-hours or weekend sessions shall communicate any visits during those sessions to the Enrollee's primary care provider. The Contractor or the practice shall communicate to Enrollees where to access after-hours or weekend sessions.

Key Considerations

- **Offering Behavioral Health Referrals and Tracking**: The required after-hours or weekend session shall provide behavioral health referral with bi-directional communication, tracking, and monitoring.
- **For Tier 3**: At least 4 hours shall be in-person. At least 4 hours must fall on a weekend day
- **Communication to Patients**: The practice must communicate to patients where to access after-hours sessions.
- **Consider Leveraging Advanced Practice Providers (APP):** Practices may leverage APPs to meet this requirement
- **Benefits of Telehealth**: Offering telehealth vs. in-person after-hours care may be less burdensome given telehealth does not require the same support services (e.g. Medical Assistants, front-desk staff, etc.) in-person care requires.

Cross-Coverage Options

- **PIDSLs Unable to Meet Requirement**: Collaborate with your ACO Ops Leads to determine if you might be able to cover this requirement leveraging other sites within your ACO
- **Considerations if Leveraging Cross-Coverage**: the practice covering your ACO must (1) have EMR access and document within the EMR (2) cover a maximum or two other practices

Implementation Recommendations: Two sample schedules to meet the Tier 2 After Hours Requirement (12 hours) are exemplified below:

Example 1 – Telehealth and In-Person

- Please note that, in accordance to the Tier 3 Requirement, four hours are falling on a weekend day and at least four hours are in-person

Mon	Tue	Wed	Thu	Fri	Sat	Sun
Telehealth Session 1 7am - 8am		*In-Person Session 1 5pm - 8pm*	*Telehealth Session 2 5pm - 8pm*	*Telehealth Session 3 7am – 8am*		*In-Person Session 2 12pm – 4pm*

Example 2 – In-Person Only

- Please note that, in accordance to the Tier 3 Requirement, four hours are falling on a weekend day

Mon	Tue	Wed	Thu	Fri	Sat	Sun
	In-Person Session 1 5pm - 7pm		*In-Person Session 2 5pm - 8pm*	*In-Person Session 3 5pm - 8pm*	*In-Person Session 4 12pm - 4pm*	

Three team-based staff roles

Tier 3

Description: Three team-based staff roles: maintain at least three (3) team-based staff roles dedicated to the specific primary care site. These roles may be met virtually but must be on-site at least monthly. If these roles are offered virtually, the practice must have multimedia available for Enrollees to engage with the role from the practice site. These roles shall consist of the following:

- At least one (1) staff role shall be a licensed BH clinician (e.g., psychologist, LICSW, LCSW)
- At least one (1) staff role shall be a peer, family navigator, CHW, or similar.
- The other staff role(s) may be one of the following, or similar:
    - Peer (Certified Peer Specialist, Recovery Coach, Family Partner, Family Navigator)
    - Social worker (LCSW, LICSW) or other master's-prepared clinician such as a Master of Social Work (MSW)
    - Nurse case manager

Such team-based roles shall:

- Be available and doing work on behalf of the specific practice site for a minimum of three (3) or more equivalent 4-hour sessions per week (i.e., >0.3 FTE) individually, and at minimum collectively 1.0 FTE per the practice.
- Conduct activities such as but not limited to team-based huddles, activities on behalf of patients at the site, or patient-facing activities.
- Collectively, ensure at least one (1) FTE meeting these staff roles is available and dedicated to the practice at each of the 10 usual business hour sessions (Monday through Friday, mornings and afternoons) to respond in real-time to practice needs.
- All participate in regular team activities such as team huddles (i.e., standing team meetings for the purpose of pre-visit planning), population health management, and/or process improvement

Implementation Recommendations

Option 1: In-Person Staff Rotations

- Ensure staff roles are available on-site to each specific PIDSL for a minimum of 3, 4-hour sessions per week individually
    - Ex: 3 team-based staff roles could meet staffing requirement for up to 3 separate PIDSL sites (see next slide example)
- Note: A BH clinician can count towards both team-based staff requirement and Tier 2 "Consulting Independent BH Clinician" requirement

Option 2: Dedicated Virtual Availability

- Ensure staff role is available virtually to each specific PIDSL for a minimum of 3, 4-hour sessions per week
    - Ex: 3 remote team-based roles could meet staffing requirement for up to 3 separate PIDSL sites (see next slide example)
- Remote staff must be available on-site at each PIDSL site they cover **at least once per month**

- Staffing each role for at least one shift per week in-person at one of the PIDSL sites they cover would meet this requirement

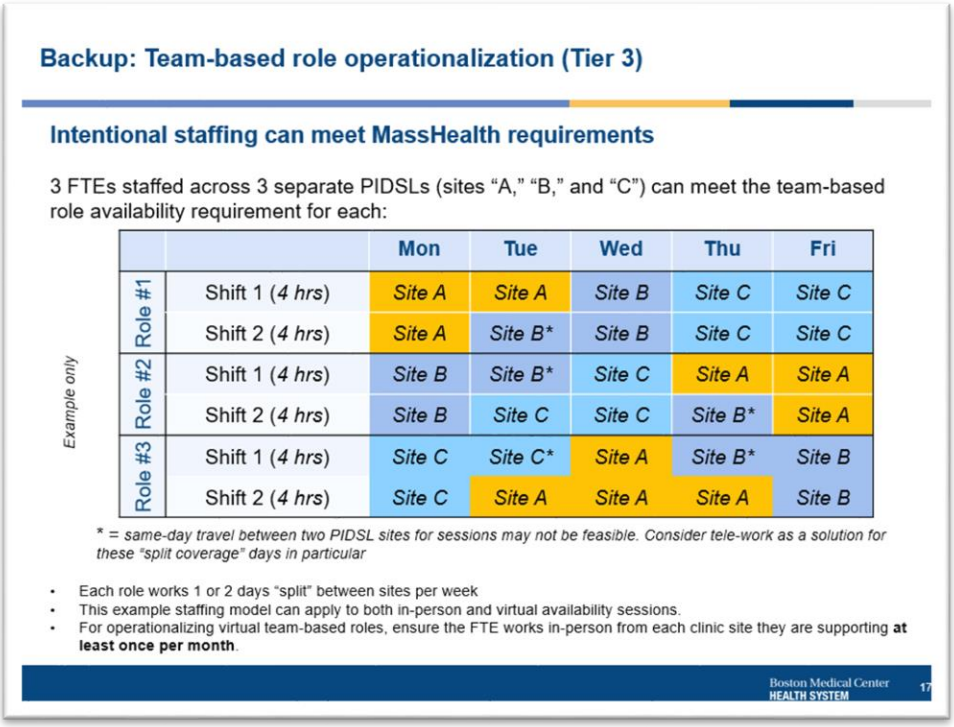
Operational Considerations

- Aligning with tier 2 strategy: shift staffing for these roles should align with regular team huddles/care planning meetings at each PIDSL site
- We recommend scheduled shifts remain at consistent days/times as much as possible for reliable patient access and schedule management for team-based personnel
- Team-based roles must also provide a **combined** support capacity of 1 FTE per week to each PIDSL site – unlike the tier 2 strategy, minimum staffing may not allow capacity for non-site-specific shifts
- Sites should consider how meeting these team-based roles can best support their organizational priorities, including: care management, Flexible Services program referrals, HRSN screenings, quality performance, etc.

NCQA PCMH Alignment: Practices who are recognized by the National Committee for Quality Assurance (NCQA) as Patient Centered Medical Homes (PCMH) may find alignment with the following PCMH standards:

- **Team-Based Care and Practice Organization:** Structure and Staff Responsibilities, Defines the practice's organizational structure and staff responsibilities / skills to support key practice functions

Resources and Supports



Backup: Team-based role operationalization (Tier 3)

Intentional staffing can meet MassHealth requirements

3 FTEs staffed across 3 separate PIDSLs (sites "A," "B," and "C") can meet the team-based role availability requirement for each:

		Mon	Tue	Wed	Thu	Fri
Role #1	Shift 1 (4 hrs)	Site A	Site A	Site B	Site C	Site C
	Shift 2 (4 hrs)	Site A	Site B*	Site B	Site C	Site C
Role #2	Shift 1 (4 hrs)	Site B	Site B*	Site C	Site A	Site A
	Shift 2 (4 hrs)	Site B	Site C	Site C	Site B*	Site A
Role #3	Shift 1 (4 hrs)	Site C	Site C*	Site A	Site B*	Site B
	Shift 2 (4 hrs)	Site C	Site A	Site A	Site A	Site B

Example only

* = same-day travel between two PIDSL sites for sessions may not be feasible. Consider tele-work as a solution for these "split coverage" days in particular

- Each role works 1 or 2 days "split" between sites per week
- This example staffing model can apply to both in-person and virtual availability sessions.
- For operationalizing virtual team-based roles, ensure the FTE works in-person from each clinic site they are supporting **at least once per month**.

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Maintain a consulting BH clinician with prescribing capability

Tier 3

Description: Maintain a consulting BH clinician with prescribing capability: maintain a dedicated and accessible consulting BH clinician on-site or virtually with prescribing capability available to assist the practice with cases of moderate and rising complexity. Such BH clinician shall: have familiarity with titration of BH medications (e.g., psychiatrist or psychiatric clinical nurse practitioner) and be regularly available for activities including but not limited to making appointments on behalf of the practice in the same week, participating in case management activities, answering practice queries within two (2) business days, and assisting with co-management of referred cases

Implementation Recommendations

- Consulting BH prescriber: BH clinician with prescribing capability available for patient visits, including same-week appointments. Can be a practice-specific provider or a cross-practice/ACO-wide provider that meets with patients in-person or via telehealth.
- Note: A Consulting BH prescriber will also meet the Tier 2 Consulting BH clinician requirement

Operational Considerations

- Fully virtual is acceptable and on-site or hybrid is not required.
- To meet the two business day response requirement, the BH clinician/prescriber will need to be available for response on at least 3 days within a typical 5-day work week
- Recommend "holding" subset of prescriber appointments until 1 week prior to date to create capacity for urgent appointments
- Sites have discretion how often/for which cases to offer same-week appointments
- We are currently seeking additional guidance on how this requirement should be met in pediatric practices given particularly limited children's psychiatry access.
- Note: Vendors that provide the Collaborative Care Model (CoCM) services will likely not meet Tier 3 Consulting BH prescriber requirements, as most CoCM prescribers do not provide direct patient care.

NCQA PCMH Alignment: Practices who are recognized by the National Committee for Quality Assurance (NCQA) as Patient Centered Medical Homes (PCMH) may find alignment with the following PCMH standards:

- **Team-Based Care and Practice Organization:** Behavioral Health Care Manager, Has at least one care manager qualified to identify and coordinate behavioral health needs.
- **Care Coordination and Care Transitions:** Behavioral Health Integration, Integrates behavioral healthcare providers into the care delivery system of the practice site

Full-time staff with children, youth, and family-specific expertise

Tier 3

Description: Provide accessible, comprehensive, longitudinal, person-centered, and coordinated primary care services including evaluation and management of common health issues, disease prevention, and wellness promotion. While practices may offer some traditional primary care virtually via telehealth, Enrollees must be able to access this requirement on-site.

Requirement Notes

MassHealth did not indicate any specific training or credentialing needs for providers.

Operational Considerations

Assign these responsibility to a staff role that has experience working with children, youth, and families. This may be a pediatric Medical Assistant, RN, CHW, Patient Navigator, etc. We recommend updating the job description for this role to include the sub-capitation requirement as noted above. Sample Job Description available upon request.

NCQA PCMH Alignment: Practices who are recognized by the National Committee for Quality Assurance (NCQA) as Patient Centered Medical Homes (PCMH) may find alignment with the following PCMH standards

- **Team-Based Care and Practice Organization:** Behavioral Health Care Manager, Has at least one care manager qualified to identify and coordinate behavioral health needs.
- **Knowing and Managing Your Patients:** School/Intervention Agency Engagement, Engages with schools or intervention agencies in the community

LARC provision, at least one (1) option

Tier 3 Pediatric Population

Description: One Option: Have the **ability on-site to insert at least one type of LARC** (e.g., intrauterine device or subdermal implant). This service shall be available on-site during normal business hours **at least one session every other week (i.e., twice monthly).** Enrollees must be able to access this requirement on-site.

Requirement Notes:

- The LARC offering is required to be at the individual PIDSL level. The requirement is not met if LARC services are located at another PIDSL site within the health system (unless there is a co-located OB/GYN in the same building performing the procedure). Please see "Provider Training/Credentialing" section below for options on increasing LARC capacity at a PIDSL site.
- Injections such as Depo-Provera do not count towards the LARC requirement.

Provider Training/Credentialing

Enabling providers to place LARCs is a two-fold process, including training and credentialing. There are two types of LARC that meet the requirements – IUDs and implant (Nexplanon). Providers should be trained and credentialed separately for IUDs and Nexplanon.

LARC Placement Training Resources

- IUD – the following is a non-exhaustive list of organizations offering training on IUD insertion and removal:
  - Upstream
  - National Clinical Training Center for Family Planning
  - Beyond the Pill
  - Brand-Specific:
    - Kyleena
    - Liletta
    - Mirena
    - ParaGard
    - Skyla – call 1-888-84-BAYER (1-888-842-2937)
- Nexplanon – Organon offers clinical training to MDs, DOs, NPs, PAs, and CNMs on the insertion and removal of Nexplanon implants

Credentialing

After training, providers typically must perform a certain number of insertions under the supervision of a provider who is already credentialed to insert/remove the LARC in question.

- Credentialing requirements differ by health system/health center. Please check with your group to determine specific requirements for your practice.
- Providers typically need to meet a minimum threshold of insertions/removals per year to retain credentialing.

Options for groups with no credentialed providers AT PIDSL:

Float Provider

- Consider floating a LARC-credentialed provider from another PIDSL within your system to align with the following tier cadences during normal business hours:
    - **Tier 2 – One session every other week (i.e., twice monthly)**
    - **Tier 3 – At least one session per week**

Build Site Capacity

- Support providers to get trained on one or both LARC options so they can begin the process of getting credentialed
- Once providers have been trained, have them work with the floating LARC-credentialed provider. This will allow them to obtain the minimum number of insertions/removals to be credentialed.

Operational Considerations

The following list contains important considerations for tier 2 and 3 PIDSLs looking to operationalize a LARC clinic (FPNTC, 2020):

- **Stocking Devices and Supplies**
    - Stock at least one of each type of LARC (Nexplanon implant, copper IUD, hormonal IUD, etc.)
    - Prepare easy-to-access kits for insertion and removal, containing all necessary supplies to perform the procedure, in or near (ie IUD cart) the patient's room
    - Develop staff protocol for re-stocking all LARC options as well as insertion/removal kits
- **Patient Education and Informed Consent**
    - Ensure the clinic has patient education forms for both IUDs and implant
    - Ensure the clinic has informed consent forms for both IUDs and implant (insertion and removal)
    - Consider including patient education and informed consent forms in supply kits
- **Documentation Set-up and Protocol**
    - Revisit order sets in EMR to ensure providers are easily able to select LARC options appropriately
    - Review billing procedures for accurate coding for LARC services
- **Ensure LARC Service Availability**
    - As PIDSL capacity allows, update policy to allow for same-day service offering and/or incorporate into existing appointment slots
- **Staff Training**
    - Train staff on any new procedures related to stocking, education/consent, documentation, and billing
    - Incorporate LARC workflow training into new hire onboarding

Resources and Supports

Clinical and Operational

The following are useful resources for standing up a LARC clinic in your practice. Please reach out to your Operations Lead if there are additional resource topics that would be helpful.

- ACOG LARC Video Series covers clinical topics related to the provision of LARC methods, including insertion, removal and counseling scenarios
- ACOG Quick Coding Guide for both IUDs and implants
- Family Planning National Training Center's Same-Visit Contraception: A Toolkit for Family Planning Providers is a comprehensive guide detailing how clinics can stand up same-visit provision of LARC
- Beyond the Pill from UCSF's Bixby Center for Global Reproductive Health offers clinic and provider tools, including protocol for insertion, talking points for front desk staff, and various checklists
- ACOG guidance on Patient-Centered Contraceptive Counseling
- ACOG guidance on Counseling Adolescents About Contraception

Patient Materials

The following sites have useful resources to share with patients (both print and online):

- ACOG's FAQ on IUDs and implants
- Reproductive Health Access Project
- Bedsider
- Planned Parenthood

Active Buprenorphine Availability

Tier 3 Pediatric Population

Description: At least one (1) provider actively prescribing buprenorphine for management of opioid use disorder to patients with opioid use disorder, as clinically indicated. Actively prescribing means that a provider is either currently prescribing buprenorphine for enrollees at the practice, or is willing and able to if and when any Enrollee is in need of this service without having to refer the Enrollee to another location. This provider shall be available to patients in the practice on at least a weekly basis. Providing referrals to SUD care or maintaining agreements with other providers or practices at a different location does not meet this requirement. Providers may leverage the partnership and guidance of MCPAP for guidance on prescribing buprenorphine: www.mcpap.com. This requirement may be met virtually. However, providers must be capable of asynchronous, consultative, provider-to-provider communications within a shared Electronic Health Record (EHR) or web-based platform between primary care and specialist providers over a secure electronic medium that involves sharing of patient-specific information and discussing clarification or guidance regarding targeted clinical care.

Implementation Recommendations

Option 1: Site and ACO Champions

- Identify at least 1 provider at each PIDSL that is willing and able to prescribe buprenorphine
  Consider identifying a champion at practice and/or ACO level, depending on the need, who can mentor other PCPs and support prescribing comfort and capacity across the practice and/or ACO over time.

Option 2: Telehealth

- The MOUD requirement (tiers 2 & 3) can be met fully via telehealth if you have an addiction treatment program in your ACO with prescribing providers that can meet with OUD patients via telehealth, and communicate with PCPs via an EMR or other secure electronic medium

Operational Considerations

- Many opportunities to innovate and combine models—e.g. having a telehealth MOUD provider support induction/stabilization, and practice-based PCPs continue tx
- To provide buprenorphine treatment to more than a few patients, most practices find it valuable to have nurse care managers, pharmacists or other staff to support patient education, outreach and monitoring

Resources and Supports

Supports that are live now:

- BMCHS Grayken Center offers training and technical assistance – eg OBAT “Nuts & Bolts” Training
- Expert Consultation: MCSTAP for adult cases and MCPAP for pediatric cases

LARC provision, multiple options

Tier 3 Adult Population

Description: Multiple Options: Have the **ability on-site to insert multiple forms of LARC** (e.g., intrauterine device and subdermal implant). This service shall be available on-site during normal business hours **at least one (1) session per week**. Enrollees must be able to access this requirement on-site.

Requirement Notes:

- The LARC offering is required to be at the individual PIDSL level. The requirement is not met if LARC services are located at another PIDSL site within the health system (unless there is a co-located OB/GYN in the same building performing the procedure). Please see "Provider Training/Credentialing" section below for options on increasing LARC capacity at a PIDSL site.
- Injections such as Depo-Provera do not count towards the LARC requirement.

Provider Training/Credentialing

Enabling providers to place LARCs is a two-fold process, including training and credentialing. There are two types of LARC that meet the requirements – IUDs and implant (Nexplanon). Providers should be trained and credentialed separately for IUDs and Nexplanon.

LARC Placement Training Resources

- IUD – the following is a non-exhaustive list of organizations offering training on IUD insertion and removal:
  - Upstream
  - National Clinical Training Center for Family Planning
  - Beyond the Pill
  - Brand-Specific:
    - Kyleena
    - Liletta
    - Mirena
    - ParaGard
    - Skyla – call 1-888-84-BAYER (1-888-842-2937)
- Nexplanon – Organon offers clinical training to MDs, DOs, NPs, PAs, and CNMs on the insertion and removal of Nexplanon implants

Credentialing

After training, providers typically must perform a certain number of insertions under the supervision of a provider who is already credentialed to insert/remove the LARC in question.

- Credentialing requirements differ by health system/health center. Please check with your group to determine specific requirements for your practice.
- Providers typically need to meet a minimum threshold of insertions/removals per year to retain credentialing.

Options for groups with no credentialed providers AT PIDSL:
Float Provider

- Consider floating a LARC-credentialed provider from another PIDSL within your system to align with the following tier cadences during normal business hours:
    - **Tier 2 – One session every other week (i.e., twice monthly)**
    - **Tier 3 – At least one session per week**

Build Site Capacity

- Support providers to get trained on one or both LARC options so they can begin the process of getting credentialed
- Once providers have been trained, have them work with the floating LARC-credentialed provider. This will allow them to obtain the minimum number of insertions/removals to be credentialed.

Operational Considerations

The following list contains important considerations for tier 2 and 3 PIDSLs looking to operationalize a LARC clinic (FPNTC, 2020):

- **Stocking Devices and Supplies**
    - Stock at least one of each type of LARC (Nexplanon implant, copper IUD, hormonal IUD, etc.)
    - Prepare easy-to-access kits for insertion and removal, containing all necessary supplies to perform the procedure, in or near (ie IUD cart) the patient's room
    - Develop staff protocol for re-stocking all LARC options as well as insertion/removal kits
- **Patient Education and Informed Consent**
    - Ensure the clinic has patient education forms for both IUDs and implant
    - Ensure the clinic has informed consent forms for both IUDs and implant (insertion and removal)
    - Consider including patient education and informed consent forms in supply kits
- **Documentation Set-up and Protocol**
    - Revisit order sets in EMR to ensure providers are easily able to select LARC options appropriately
    - Review billing procedures for accurate coding for LARC services
- **Ensure LARC Service Availability**
    - As PIDSL capacity allows, update policy to allow for same-day service offering and/or incorporate into existing appointment slots
- **Staff Training**
    - Train staff on any new procedures related to stocking, education/consent, documentation, and billing
    - Incorporate LARC workflow training into new hire onboarding

Resources and Supports

Clinical and Operational

The following are useful resources for standing up a LARC clinic in your practice. Please reach out to your Operations Lead if there are additional resource topics that would be helpful.

- ACOG LARC Video Series covers clinical topics related to the provision of LARC methods, including insertion, removal and counseling scenarios
- ACOG Quick Coding Guide for both IUDs and implants

- Family Planning National Training Center's Same-Visit Contraception: A Toolkit for Family Planning Providers is a comprehensive guide detailing how clinics can stand up same-visit provision of LARC
- Beyond the Pill from UCSF's Bixby Center for Global Reproductive Health offers clinic and provider tools, including protocol for insertion, talking points for front desk staff, and various checklists
- ACOG guidance on Patient-Centered Contraceptive Counseling
- ACOG guidance on Counseling Adolescents About Contraception

Patient Materials

The following sites have useful resources to share with patients (both print and online):

- ACOG's FAQ on IUDs and implants
- Reproductive Health Access Project
- Bedsider
- Planned Parenthood

Capability for next-business-day Medication for Opioid Use Disorder (MOUD) induction and follow-up

Tier 3

Description: Must have an evidence based written protocol (such as SAMHSA's guidance found here) and the capability to provide in office or virtual induction (as permitted by federal law, including but not limited to the Ryan Haight Act) of buprenorphine and opioid withdrawal management within one business day of diagnosis of opioid use disorder or treatment of withdrawal or relapse. The MOUD induction requirement may be met virtually, including by third party entities. However, the practice must fulfill Tier 2 requirements set forth above regarding maintenance prescribing at the practice. Providers must be capable of asynchronous, consultative, provider to provider communications within a shared Electronic Health Record (EHR) or web based platform between primary care and specialist providers over a secure electronic medium that involves sharing of patient specific information and discussing clarification or guidance regarding targeted clinical care.

Implementation Options

Option 1: Site and ACO Champions

- Identify at least 1 provider at each PIDSL comfortable with supporting next-day MOUD induction
- Site identifies a process whereby if PCP diagnoses a patient with OUD interested in buprenorphine:
- PCP prescribes bup, or
- Patient meets (in-person or virtually) with site MOUD lead, or
- Patient meets (in-person or virtually) with ACO-level provider

Option 2: Telehealth

- The same/next day buprenorphine start requirement can be met fully via telehealth if you have an addiction treatment program in your ACO with prescribing providers that can meet with OUD patients within one business day via telehealth, and that can communicate with PCPs via an EMR or other secure electronic medium.

Operational Considerations

- Sites may *choose* to make a "warm" referral of patients to a co-located or nearby MOUD treatment by provider champion/specialist if clinically relevant, but must have the *capability* to meet this requirement on-site or virtually with no physical travel required for patients
- Requirements allow MOUD to be met on following Monday for a Friday diagnosis; we encourage sites to consider workflows to support patients so there is no treatment gap over weekends

Resources and Supports

- Grayken Technical Assistance program

Appendix

Full Requirements Table

Tier	Category	Title of Requirement	Full Requirement Description
1	**Care Delivery**	**Traditional primary care**	Provide accessible, comprehensive, longitudinal, person-centered, and coordinated primary care services including evaluation and management of common health issues, disease prevention, and wellness promotion. While practices may offer some traditional primary care virtually via telehealth, Enrollees must be able to access this requirement on-site.
1	**Care Delivery**	**Referral to specialty care**	Be able to guide and coordinate referrals and request evaluation of a patient by clinicians outside of the primary care practice for specific concerns. Such referrals shall include the primary care practice's ability to communicate with and receive communications from the specialty practice, with the primary care practice continuing to serve as a central home of health care services for the patient. This includes sub-specialty medical, oral health , mental health, and substance use disorder referrals.
1	**Care Delivery**	**Oral health screening and referral**	Conduct an annual (every 12 months) structured oral health screening for attributed patients. For example, a clinic tool may use the National Health and Nutrition Examination Survey Oral Health Questionnaire (https://wwwn.cdc.gov/nchs/data/nhanes/2015-2016/questionnaires/OHQ_I.pdf). An on-site dental exam for attributed patients shall meet this requirement. An assessment screening shall clearly define what constitutes a positive screening result versus a negative result and shall assess if the patient currently has access to an oral health provider or a regular and reliable source for oral health needs. Additionally, retain and provide to patients (and/or their parents/caregivers) a list of local and reasonably-accessible oral health providers who are within the MassHealth network for their particular patients (MassHealth providers are available at: https://provider.masshealth-dental.net/MH_Find_a_Provider#/home). This information shall be updated at least annually for any openings/closings or additions/removals of MassHealth coverage of these providers. Such a list shall be provided to patients with a positive oral health screen and those without an oral health provider. Such a list may be adapted from materials provided by MassHealth of practices and providers currently enrolled in the program. While practices may offer some oral health screenings and referrals virtually via telehealth, Enrollees must be able to access this requirement on-site.
1	**Care Delivery**	**BH and substance use disorder screening**	Conduct an annual and universal practice-based screening of attributed patients >21 years of age. Such a screen shall at minimum assess for depression, tobacco use, unhealthy alcohol use, other substance use, and preexisting mental health disorders using an age-appropriate, evidence-based, standardized screening tool. When any screening is positive, the practice shall respond with appropriate interventions and/or referrals. See below under this Section 1, subsection C for screening expectations for any attributed patients younger than 21 years of age per the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) protocol and schedule. While practices may offer some BH and substance use screening virtually via telehealth, Enrollees must be able to access this requirement on-site.

1	**Care Delivery**	**BH referral with bi-directional communication, tracking, and monitoring**	Retain and provide to patients a list of local and reasonably-accessible BH providers who are within the MassHealth network, including those that offer therapy and counseling services, BH medication management, and intensive outpatient or day treatment programs. The list of local BH providers shall be providers with whom the practice can conduct bi-directional communication about the patient. This can include electronic health record, phone, fax, or other modalities. This communication can be asynchronous, but it shall allow for both the primary care practice and the BH practice to communicate back and forth with each other. The practice shall also regularly assess if such partners continue to have bandwidth to see its patients within reasonable turnaround times. In addition, track referrals made through the practice and problem-solve for patients who are unable to engage in a referral visit.
1	**Care Delivery**	**BH medication management**	Prescribe, refill, and adjust medications for the treatment of common BH issues amenable to treatment in the primary care setting, including but not limited to major depressive disorder, generalized anxiety disorder, and attention deficit-hyperactivity disorder. Such services can occur independently or providers may receive assistance from available resources such as the Massachusetts Child Psychiatry Access Program (MCPAP), a clinical pharmacist, psychiatrist, psychiatric clinical nurse specialist, etc. While practices may offer some BH medication management virtually via telehealth, Enrollees must be able to access this requirement on-site.
1	**Care Delivery**	**Health-Related Social Needs (HRSN) screening**	Conduct universal practice- or ACO-based screening of attributed patients for HRSN using a standardized, evidence-based tool, and shall have the ability to provide a regularly-updated inventory of relevant community-based resources to those with positive screens. Pediatric screening questions shall be reviewed by the ACO's designated Pediatric Expert. HRSN screening may be met exclusively via a central or virtual resource, including being provided by the ACO.
1	**Care Delivery**	**Care coordination**	Participate in formalized practice-driven and/or ACO-driven care coordination that identifies patients at risk due to medical, BH, HRSN, psychosocial and/or other needs and deploys risk-stratified interventions and approaches to addressing patients' needs. Such approaches can include but are not limited to communication and information-sharing between care team patients and specialists or ancillary services, identification and rectification of gaps in preventive care or chronic disease management, assisting patients with transitions of care, pre-visit planning, post-hospitalization coordination, and assistance with patient self-management of chronic disease. Such approaches can also include connecting patients to community-based services, state agencies (e.g., Massachusetts Department of Children and Families [DCF], Massachusetts Department of Developmental Services [DDS], Massachusetts Department of Mental Health [DMH], Massachusetts Department of Public Health [DPH], Massachusetts Department of Transitional Assistance [DTA], Massachusetts Department of Youth Services [DYS]), federal programs (e.g., Supplemental Nutrition Assistance Program [SNAP], Special Supplemental Nutrition Assistance Program for Women, Infants, and Children [WIC]), other ACO programs such as the ACO Care Management, Community Partners and Flexible Services programs, and other supports and care management resources. These services may be provided by practice-based personnel directly, or by ACO- or system-level resources and care pathways that coordinate with the primary care practice . Such interventions shall be standardized and consistent workstreams for the practice and align with the greater ACO's strategies around physical health, BH, HRSN, and other care coordination. Document your process for referring to WellSense programs (eg., email to acocmreferral@wellsense.org). Note that this referral process connects patients with a range of WellSense programs including Complex Care Management (CCM)*, Community Partners (CPs), Behavioral Health Care Management, and, **for patients not meeting criteria for these programs, telephonic** care coordination/**care management**. If practices have additional internal care management programs, they can include processes for these referrals as well. For more information on ACO expectations around care coordination, please refer to Section 2.6 of the Contract. Care coordination may be met exclusively via a central or virtual resource, including being provided by the ACO.

1	**Care Delivery**	**Clinical Advice and Support Line**	Ensure patients are made aware of the availability of after-hours telephonic advice, either through the ACO's Clinical Advice and Support Line, or a resource provider by the practice. Clinical advice and support line services may be met exclusively via a central or virtual resource, including being provided by the ACO.
1	**Care Delivery**	**Postpartum depression screening**	If caring for infants in the first year of life or for postpartum individuals who are within 12 months of delivery, screen for postpartum depression using an evidence-based and validated tool, such as the Edinburgh Postnatal Depression Scale (EPDS). For individuals who have a positive screen for postpartum depression, the practice shall be able to provide referral, or follow-up, and/or care coordination for the patient. Care coordination models shall be evidence-based (examples of such models include PRISM - Program In Support of Moms and ROSE - Reach Out Stay Strong Essentials for mothers of newborns). While practices may offer some postpartum depression screenings virtually via telehealth, Enrollees must be able to access this requirement on-site.
1	**Care Delivery**	**Use of Prescription Monitoring Program**	All prescribing personnel at the practice site shall have access to and regularly use the Massachusetts Prescription Awareness Tool (Mass PAT) in accordance with Commonwealth of Massachusetts General Law: https://malegislature.gov/Laws/GeneralLaws/PartI/TitleXV/Chapter94C/Section24A.
1	**Care Delivery**	**LARC provision, referral option**	Have the ability to discuss options for LARC (e.g., intrauterine device or subdermal implant) with relevant patients and refer patients seeking such options to known in-network providers who can place these for the patient. Providers may also, rather than referring patients, provide and place these directly for patients within the primary care practice.
1	**Structure and Staffing**	**Same-day urgent care capacity**	Make available time slots each day for urgent care needs for its patient population. While practices may offer some urgent care capacity virtually via telehealth, Enrollees must be able to access this requirement on-site.
1	**Structure and Staffing**	**Video telehealth capability**	Have the ability to conduct visits with practice staff using a synchronous audio-video telehealth modality in lieu of an in-person patient encounter.
1	**Structure and Staffing**	**No reduction in hours**	Relative to regular practice hours prior to engagement in the sub-capitation program, offer the same or increased number of total regular on-site operating hours and clinical sessions in which patients have been historically seen.
1	**Structure and Staffing**	**Access to Translation and Interpreter Services**	Provide interpreter services for attributed patients, in accordance with applicable state and federal laws, including options to accommodate preferred languages and the needs of enrollees who are deaf or hard of hearing. Such services shall be noted to be available in a patient's or their caregiver's preferred language and should come without additional cost to the patient.
1	**Pediatric Population**	**Pediatric EPSDT screenings**	Administer, at a minimum, BH, developmental, social, and other screenings and assessments as required under EPSDT. While practices may offer some EPSDT screenings virtually via telehealth, Enrollees must be able to access this requirement on-site.
1	**Pediatric Population**	**Pediatric SNAP and WIC screenings**	Screen for SNAP and WIC eligibility, in accordance with Provider Manual Appendix W, if applicable: Practices shall also complete the medical referral form for WIC eligible patients. Patients and families deemed eligible for these programs should be referred to further resources in order to apply for and engage these programs. While practices may offer some SNAP and WIC screenings virtually via telehealth, Enrollees must be able to access this requirement on-site.
1	**Pediatric Population**	**Establish and maintain relationships with local Children's Behavioral Health Initiative (CBHI)**	The practice shall identify its staff member(s) responsible for 1) communicating with and reporting to CBHI program in a closed-loop manner, and 2) maintaining a roster of children attributed to the practice who are receiving CBHI services.

1	**Pediatric Population**	**Coordination with MCPAP**	Enroll with MCPAP at https://www.mcpap.com/. The practice shall consult with and use the services of MCPAP to augment the BH expertise provided within the practice as a means to maintain the management of youth with mild to moderate BH conditions in primary care. Alternatively, the practice can satisfy this requirement by accessing equivalent resources available within their own health system – such as consultation with child and adolescent psychiatrists working in the clinic or a neighboring site or via consultation from an asynchronous resource such as an e-consult. Use of such an alternative resource, however, does not exempt the practice from enrolling with MCPAP
1	**Pediatric Population**	**Coordination with Massachusetts Child Psychiatry Access Program for Moms (M4M)**	If providing obstetrical services, enroll in the M4M program at https://www.mcpapformoms.org/. The practice shall consult with M4M to augment the BH expertise provided within the practice as a means to maintain the management of perinatal patients with mild to moderate BH conditions in primary care. Alternatively, the practice can satisfy this requirement by accessing equivalent resources available within their own health system – such as consultation with a psychiatrist or appropriately trained Ob/Gyn of suitable expertise working in the clinic or a neighboring site, or via consultation from an asynchronous resource such as an e-consult. Use of such an alternative resource however does not exempt the practice from enrolling with the M4M program. While practices may offer some coordination with MCPAP for Moms virtually via telehealth, Enrollees must be able to access this requirement on-site.
1	**Pediatric Population**	**Fluoride varnish for patients ages 6 months up to age 6**	Asesses the need for fluoride varnish at all preventive visits from six (6) months to six (6) years old, and, once teeth are present, must provide application of fluoride varnish on site in the primary care office at least twice per year for all children, starting when the first tooth erupts and until the patient has another reliable source of dental care (https://publications.aap.org/pediatrics/article/146/6/e2020034637/33536/Fluoride Use in Caries Prevention in the Primary). For those pediatric patients who do not have a dental home, the practice must share a list of MassHealth dental providers with the parent/caregiver as noted above. If there is a co located dental office or evidence that the dental office has already provided this service, such may substitute in this requirement for the relevant patients who have access to or have accessed these resources. Enrollees must be able to access this fluoride varnish on-site.
2	**Care Delivery**	**Brief intervention for BH conditions**	Provide brief interventions for patients with identified BH needs, as appropriate, such as Screening, Brief Intervention, and Referral to Treatment (SBIRT), brief Cognitive Behavioral Therapy (CBT), or an equivalent model. These may be provided by a front-line clinical provider or by an integrated member of the clinical team, such as a licensed independent clinical social worker (LICSW). While practices may offer some BH interventions for BH conditions virtually via telehealth, Enrollees must be able to access this requirement on-site.
2	**Care Delivery**	**Telehealth-capable BH referral partner**	Include at least one BH provider who is capable of providing services via a synchronous audio-video telehealth modality among its local and reasonably-accessible list of BH providers who are within the MassHealth network.
2	**Structure and Staffing**	**E-consults available in at least three (3) specialties**	Be capable of asynchronous, consultative, provider-to-provider communications within a shared Electronic Health Record (EHR) or web-based platform between primary care and specialist providers over a secure electronic medium that involves sharing of patient-specific information and discussing clarification or guidance regarding targeted clinical care. E-consults shall be available to clinical staff within the practice to discuss with specialists in at least three distinct and non-redundant American Board of Medical Specialties (ABMS)-recognized specialties. For example, offering e-consults to multiple specialties with board certification under the pathways of Internal Medicine, such as cardiology, endocrinology, and nephrology meets this requirement. On the other hand, multiple specialties with certification under a shared subspecialty would be considered redundant; for example, seeking to count e-consults in general cardiology, clinical cardiac electrophysiology, and interventional cardiology as three distinct specialties would not meet this requirement.
2	**Structure and Staffing**	**After-hours or weekend**	Offer at least four hours for in person or telehealth visits, with the practice's own providers or with providers from another of the Contractor's Network PCPs (ACPP) or Participating PCPs (PCACO) as further specified below, at least once per week within any of the following periods:

		session (at least 4)	o Monday through Friday: Outside the hours of 8:00 a.m. -5:00 p.m. o Saturday or Sunday: During any period These session(s) may be covered by the practice's own providers or with providers from another of the Contractor's Network PCPs (ACPP) or Participating PCPs (PCACO) such that one practice may cover the weekend or after hours sessions for a maximum of two other practices. If the practice utilizes another practice for this coverage, EOHHS encourages the Contractor to utilize practices that are located in close geographic proximity to the practice. In addition, any providers staffing such sessions (including those at another practice site) must have access to the practice's EHR and must document the visit within the practice's EHR. Sessions cannot be those offered by a third party or a group unaffiliated with the primary care practice as described above, unable to access the practice's EHR, or unaffiliated with thepractice's patient population. The required after hours or weekend session shall provide behavioral health referral with bi directional communication, tracking, and monitoring. Providers staffing after hours or weekend sessions shall communicate any visits during those sessions to the Enrollee's primary care provider. The Contractor or the practice shall communicate to Enrollees where to access after hours or weekend sessions.
2	**Structure and Staffing**	**Team-based staff role**	Maintain at least one (1) team based staff role dedicated to the specific primary care site. This role may be met virtually but must be on site at least monthly. If this role is offered virtually, the practice must have multimedia available for Enrollees to engage with the role from the practice. This role shall consist of any of the following or similar roles: o Community health worker (CHW) o Peer (Certified Peer Specialist, Recovery Coach, Family Partner, Family Navigator) o Social worker (licensed clinical social worker [LCSW], LICSW) or other master's prepared clinician such as a Master of Social Work (MSW) o Nurse case manager Such team based role shall: o Be available and doing work on behalf of the specific practice site for at least three or more equivalent 4 hour sessions (i.e., >0.3 FTE) per week, o Conduct activities such as but not limited to team based huddles, activities on behalf of patients at the site, or patient facing activities. o Participate in team activities such as team huddles, i.e., standing team meetings for the purpose of pre visit planning, population health management, process improvement, etc.
2	**Structure and Staffing**	**Maintain a consulting independent BH clinician**	Maintain a dedicated and accessible consulting BH clinician available to assist the practice with cases of moderate complexity. This role shall be a licensed BH provider, such as a psychiatrist, psychologist, psychiatric clinical nurse practitioner, LICSW, licensed mental health counselor (LMHC), or licensed marriage and family therapist (LMFT). This requirement may be fulfilled via a single role fulfilling both this requirement and the team-based staff role requirement above . o This resource shall be available to assist the practice with cases of moderate BH complexity on a regular basis and assist with co-management of referred cases that can otherwise remain anchored in the primary care setting. Where feasible, this resource shall also be available for team-based huddles and warm-handoffs to support patient care . o This resource may be virtually available to the practice and can utilize asynchronous means of communication inclusive of e-consult but shall be able to respond to queries within two business days.
2	**Pediatric Population**	**Staff with children, youth, and family-specific expertise**	Identify at least one non clinical team member with demonstrable experience addressing the BH and HRSN of children, youth, and families in a health care setting and/or possessing specialized training, degree, licensing, or certification in such work. This role may be met virtually but shall be on site at least monthly . This role shall be responsible for communicating with and being the site's primary and reliable point of contact to the CBHI program, Family Resource Centers (FRCs), and schools/early childhood settings.
2	**Pediatric Population**	**Provide SNAP and WIC assistance**	Provide patients and their families who are eligible for SNAP and WIC application assistance through the practice in order to assist patients and their families to apply for and engage those programs. While practices may offer some assistance virtually, Enrollees must be able to access this requirement on-site.

2	**Adult Population**	**LARC provision, at least one option**	Have the on-site ability to place at least one (1) type of long-acting reversible contraceptive (e.g., intrauterine device or subdermal implant). This service shall be available on-site during normal business hours at least one session every other week (i.e., twice monthly). This activity may occur either in the primary care office or from a co-located provider at the same practice site. Enrollees must be able to access this requirement on-site.
2	**Adult Population**	**Active Buprenorphine Availability**	Have at least one (1) individual provider actively prescribing buprenorphine for management of opioid use disorder to patients with opioid use disorder as clinically indicated. Actively prescribing means that a provider is either currently prescribing buprenorphine for Enrollees at the practice, or is willing and able to if and when any Enrollee is in need of this service, without having to refer the Enrollee to another location. This provider shall be dedicated and available to patients in the practice on-site or virtually on at least a weekly basis. Providing referrals to SUD care or maintaining agreements with other providers or practices that require the Enrollee to present at a different location does not meet this requirement.
2	**Adult Population**	**Active Alcohol Use Disorder (AUD) Treatment Availability**	At least one provider actively prescribing or willing and able to prescribe relevant medications for management of alcohol use disorder (e.g., Disulfiram, Acamprosate, Naltrexone, etc.). This requirement may be met virtually. However, providers must be capable of asynchronous, consultative, provider-to-provider communications within a shared Electronic Health Record (EHR) or web-based platform between primary care and specialist providers over a secure electronic medium that involves sharing of patient-specific information and discussing clarification or guidance regarding targeted clinical care.
3	**Care Delivery**	**Fulfill one of the following: clinical pharmacist visits OR group visits OR designated educational liaison for pediatric patients**	1) Clinical pharmacist visits: offer its patients the ability to conduct office based or virtual appointments with a licensed clinical pharmacist focused on medication management and teaching.This role may conduct its activities virtually. The clinical pharmacist shall be dedicated to the practice for a minimum of three (3) or more equivalent 4 hour sessions per week (i.e., >0.3 FTE) 2) Group visits: offer its patients the ability to participate in office based or virtual appointments at which services are provided to multiple patients for a shared condition and peer support is elicited (e.g., mental health, substance use disorder, antenatal care, etc.). These visits may be conducted virtually. Group visits shall be offered by staff that are dedicated to the practice for a minimum of three (3) or more equivalent 4 hour sessions per week (i.e., >0.3 FTE) OR 3) Designated Educational Liaison for pediatric patients:For practices serving pediatric patients, have dedicated staff member that serves as an office based or virtual resource for families navigating the intersection of the medical and educational systems. This role may conduct its activities virtually. The Educational Liaison shall have knowledge of education and special education systems, including early education settings, and shall create relationships with local schools and early education settings. The Educational Liaison shall provide support to patients with medical, developmental, and/or BH needs and shall be available to provide input to the educational team at schools as needed and shall be dedicated to the practice for a minimum of three (3) or moreequivalent 4 hour sessions per week (i.e., >0.3 FTE).
3	**Structure and Staffing**	**E-consults available in at least five (5) specialties**	Be capable of asynchronous, consultative, provider-to-provider communications within a shared EHR or web-based platform between primary care and specialist providers over a secure electronic medium that involves sharing of patient-specific information and discussing clarification or guidance regarding targeted clinical care. E-consults shall be available to clinical staff within the primary care practice to discuss with specialists in at least five (5) distinct and non-redundant ABMS-recognized specialties. For example, offering e-consults to multiple specialties with board certification under Internal Medicine, such as cardiology, endocrinology, and nephrology meets this requirement. On the other hand, multiple specialties with certification under a shared subspecialty would be considered redundant; for example, general cardiology, clinical cardiac electrophysiology, and interventional cardiology would not meet this requirement.
3	**Structure and Staffing**	**After-hours or weekend sessions (at least 12)**	Offer at least 12 hours for in-person or telehealth visits with the practice's own providers or with providers from another of the Contractor's Network PCPs (ACPP) or Participating PCPs (PCACO) as further specified below, falling within any of the following periods: o Monday through Friday: Outside the hours of 8:00 a.m.-5:00 p.m. o Saturday or Sunday: During any period of at least four hours These session(s) may be covered by the practice's own providers or with providers from another

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

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

MassHealth Included Code List

CPT Code	Definition
90460	Immunization administration through 18 years of age via any route of administration, with counseling by physician or other qualified health care professional; first or only component of each vaccine or toxoid administered
90461	Immunization administration through 18 years of age via any route of administration, with counseling by physician or other qualified health care professional; each additional vaccine or toxoid component administered (List separately in addition to code for primary procedure)
90471	Immunization administration (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); 1 vaccine (single or combination vaccine/toxoid)
90472	Immunization administration (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); each additional vaccine (single or combination vaccine/toxoid) (List separately in addition to code for primary procedure)
90473	Immunization administration by intranasal or oral route; 1 vaccine (single or combination vaccine/toxoid)
90474	Immunization administration by intranasal or oral route; each additional vaccine (single or combination vaccine/toxoid) (List separately in addition to code for primary procedure)
90882	Environmental intervention for medical management purposes on a psychiatric patient's behalf with agencies, employers, or institutions
90887	Interpretation or explanation of results of psychiatric, other medical examinations and procedures, or other accumulated data to family or other responsible persons, or advising them how to assist patient
96160	Administration of patient-focused health risk assessment instrument (e.g., health hazard appraisal) with scoring and documentation, per standardized instrument
96161	Administration of caregiver-focused health risk assessment instrument (e.g., depression inventory) for the benefit of the patient, with scoring and documentation, per standardized instrument
98966	Telephone assessment and management service provided by a qualified nonphysician health care professional to an established patient, parent, or guardian not originating from a related assessment and management service provided within the previous 7 days nor leading to an assessment and management service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion
98967	Telephone assessment and management service provided by a qualified nonphysician health care professional to an established patient, parent, or guardian not originating from a related assessment and management service provided within the previous 7 days nor leading to an assessment and management service or procedure within the next 24 hours or soonest available appointment; 11-20 minutes of medical discussion
98968	Telephone assessment and management service provided by a qualified nonphysician health care professional to an established patient, parent, or guardian not originating from a related assessment and management service provided within the previous 7 days nor leading to an assessment and management service or

	procedure within the next 24 hours or soonest available appointment; 21-30 minutes of medical discussion
99050	Services provided in the office at times other than regularly scheduled office hours, or days when the office is normally closed (e.g., holidays, Saturday or Sunday), in addition to basic service
99051	Service(s) provided in the office during regularly scheduled evening, weekend, or holiday office hours, in addition to basic service
99173	SCREENING TEST VISUAL ACUITY QUANTITATIVE BILAT
99202	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and straightforward medical decision making, when using time for code selection, 15-29 minutes of total time is spent on the date or the encounter.
99203	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and straightforward medical decision making, when using time for code selection, 30-44 minutes of total time spent on the date of the encounter.
99204	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and straightforward medical decision making, when using time for code selection, 45-59 minutes of total time spent on the date of the encounter
99205	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and straightforward medical decision making, when using time for code selection, 60-74 minutes of total time spent on the date of the encounter.
99211	Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician or other qualified health care professional. Usually, the presenting problem(s) are minimal.
99212	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making, when using time for code selection, 10-19 minutes of total time spent on the date of the encounter
99213	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making, when using time for code selection, 20-29 minutes of total time spent on the date of the encounter.
99214	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making, when using time for code selection, 30-39 minutes of total time spent on the date of the encounter.
99215	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making, when using time for code selection, 40-54 minutes of total time spent on the date of the encounter.
99241	Office consultation for a new or established patient, which requires these 3 key components: A problem focused history; A problem focused examination; and Straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are

	provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self-limited or minor. Typically, 15 minutes are spent face-to-face with the patient and/or family.
99242	Office consultation for a new or established patient, which requires these 3 key components: An expanded problem focused history; An expanded problem focused examination; and Straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low severity. Typically, 30 minutes are spent face-to-face with the patient and/or family.
99243	Office consultation for a new or established patient, which requires these 3 key components: A detailed history; A detailed examination; and Medical decision making of low complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate severity. Typically, 40 minutes are spent face-to-face with the patient and/or family.
99244	Office consultation for a new or established patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 60 minutes are spent face-to-face with the patient and/or family
99245	Office consultation for a new or established patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 80 minutes are spent face-to-face with the patient and/or family
99354	Prolonged evaluation and management or psychotherapy service(s) (beyond the typical service time of the primary procedure) in the office or other outpatient setting requiring direct patient contact beyond the usual service; first hour (List separately in addition to code for office or other outpatient Evaluation and Management or psychotherapy service)
99355	Prolonged evaluation and management or psychotherapy service(s) (beyond the typical service time of the primary procedure) in the office or other outpatient setting requiring direct patient contact beyond the usual service; each additional 30 minutes (List separately in addition to code for prolonged service)
99358	Prolonged evaluation and management service before and/or after direct patient care; first hour
99359	Prolonged evaluation and management service before and/or after direct patient care; each additional 30 minutes (List separately in addition to code for prolonged service)

99366	Medical team conference with interdisciplinary team of health care professionals, face-toface with patient and/or family, 30 minutes or more, participation by nonphysician qualified health care professional
99367	Medical team conference with interdisciplinary team of health care professionals, patient and/or family not present, 30 minutes or more; participation by physician
99368	Medical team conference with interdisciplinary team of health care professionals, patient and/or family not present, 30 minutes or more; participation by nonphysician qualified health care professional
99381	Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient; infant (age younger than 1 year)
99382	Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient; early childhood (age 1 through 4 years)
99383	Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient; late childhood (age 5 through 11 years)
99384	Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient; adolescent (age 12 through 17 years)
99385	Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient; 18-39 years
99386	Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient; 40-64 years
99387	Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient; 65 years and older
99391	Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, established patient; infant (age younger than 1 year)
99392	Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination,

	counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, established patient; early childhood (age 1 through 4 years)
99393	Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, established patient; late childhood (age 5 through 11 years)
99394	Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, established patient; adolescent (age 12 through 17 years)
99395	Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, established patient; 18-39 years
99396	Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, established patient; 40-64 years
99397	Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, established patient; 65 years and older
99401	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 15 minutes
99402	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 30 minutes
99403	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 45 minutes
99404	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 60 minutes
99406	Smoking and tobacco use cessation counseling visit; intermediate, greater than 3 minutes up to 10 minutes
99407	Smoking and tobacco use cessation counseling visit; intensive, greater than 10 minutes
99408	Alcohol and/or substance (other than tobacco) abuse structured screening (e.g., AUDIT, DAST), and brief intervention (SBI) services; 15 to 30 minutes
99409	Alcohol and/or substance (other than tobacco) abuse structured screening (e.g., AUDIT, DAST), and brief intervention (SBI) services; greater than 30 minutes
99411	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to individuals in a group setting (separate procedure); approximately 30 minutes
99412	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to individuals in a group setting (separate procedure); approximately 60 minutes

99417	Prolonged office or other outpatient evaluation and management service(s) beyond the minimum required time of the primary procedure which has been selected using total time, requiring total time with or without direct patient contact beyond the usual service, on the date of the primary service, each 15 minutes of total time (List separately in addition to codes 99205, 99215 for office or other outpatient Evaluation and Management services)
99421	Online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 5-10 minutes
99423	Online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 21 or more minutes
99441	Telephone evaluation and management service by a physician or other qualified health care professional who may report evaluation and management services provided to an established patient, parent, or guardian not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion
99442	Telephone evaluation and management service by a physician or other qualified health care professional who may report evaluation and management services provided to an established patient, parent, or guardian not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 11-20 minutes of medical discussion
99443	Telephone evaluation and management service by a physician or other qualified health care professional who may report evaluation and management services provided to an established patient, parent, or guardian not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 21-30 minutes of medical discussion
99484	Care management services for behavioral health conditions, at least 20 minutes of clinical staff time, directed by a physician or other qualified health care professional, per calendar month, with the following required elements: initial assessment or follow-up monitoring, including the use of applicable validated rating scales; behavioral health care planning in relation to behavioral/psychiatric health problems, including revision for patients who are not progressing or whose status changes; facilitating and coordinating treatment such as psychotherapy, pharmacotherapy, counseling and/or psychiatric consultation; and continuity of care with a designated member of the care team.
99492	Initial psychiatric collaborative care management, first 70 minutes in the first calendar month of behavioral health care manager activities, in consultation with a psychiatric consultant, and directed by the treating physician or other qualified health care professional, with the following required elements: outreach to and engagement in treatment of a patient directed by the treating physician or other qualified health care professional; initial assessment of the patient, including administration of validated rating scales, with the development of an individualized treatment plan; review by the psychiatric consultant with modifications of the plan if recommended; entering patient in a registry and tracking patient follow-up and progress using the registry, with appropriate documentation, and participation in

	weekly caseload consultation with the psychiatric consultant; and provision of brief interventions using evidence-based techniques such as behavioral activation, motivational interviewing, and other focused treatment strategies.
99493	Subsequent psychiatric collaborative care management, first 60 minutes in a subsequent month of behavioral health care manager activities, in consultation with a psychiatric consultant, and directed by the treating physician or other qualified health care professional, with the following required elements: tracking patient follow-up and progress using the registry, with appropriate documentation; participation in weekly caseload consultation with the psychiatric consultant; ongoing collaboration with and coordination of the patient's mental health care with the treating physician or other qualified health care professional and any other treating mental health providers; additional review of progress and recommendations for changes in treatment, as indicated, including medications, based on recommendations provided by the psychiatric consultant; provision of brief interventions using evidence-based techniques such as behavioral activation, motivational interviewing, and other focused treatment strategies; monitoring of patient outcomes using validated rating scales; and relapse prevention planning with patients as they achieve remission of symptoms and/or other treatment goals and are prepared for discharge from active treatment
99494	Initial or subsequent psychiatric collaborative care management, each additional 30 minutes in a calendar month of behavioral health care manager activities, in consultation with a psychiatric consultant, and directed by the treating physician or other qualified health care professional (List separately in addition to code for primary procedure)
99495	Transitional Care Management Services with the following required elements: Communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge Medical decision making of at least moderate complexity during the service period Face-to-face visit, within 14 calendar days of discharge
99496	Transitional Care Management Services with the following required elements: Communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge Medical decision making of high complexity during the service period Face-to-face visit, within 7 calendar days of discharge
G0009	ADMINISTRATION OF PNEUMOCCOCCAL VACCINE
G0396	ALCOHOL &/SUBSTANCE ABUSE ASSESSMENT 15-30 MIN
G0397	ALCOHOL &/SUBSTANCE ABUSE ASSESSMENT >30 MIN
G0442	ANNUAL ALCOHOL MISUSE SCREENING 15 MINUTES
G0443	BRIEF FACE-FACE BEHAV CNSL ALCOHL MISUSE 15 MIN
G0444	Annual depression screening
G0463	Hospital outpatient clinic visit for assessment and management of a patient
G0511	Rural health clinic or federally qualified health center (RHC or FQHC) only, general care management, 20 minutes or more of clinical staff time for chronic care management services or behavioral health integration services directed by an RHC or FQHC practitioner (physician, NP, PA, or CNM), per calendar month (Behavioral health integration; applies to all MassHealth community health centers)

G0512	Rural health clinic or federally qualified health center (RHC or FQHC) only, psychiatric collaborative care model (psychiatric COCM), 60 minutes or more of clinical staff time for psychiatric COCM services directed by an RHC or FQHC practitioner (physician, NP, PA, or CNM) and including services furnished by a behavioral health care manager and consultation with a psychiatric consultant, per calendar month (applies to all MassHealth community health centers)
T1015	Clinic visit/encounter, all-inclusive

More information available here: PC Cap Provider Facing Summary.pdf (wellsense.org)