MassHealth Provider Association Forum

Executive Office of Health & Human Services

July 12, 2017

Agenda

1. Welcome and Agenda Review – Felicia Clements, Manager, Provider Relations

2. Office of Long Term Services and Supports TPA Implementation – Elizabeth Cahn Goodman, Chief, OLTSS ,Thomas Lane, Director of Fee for Service Programs, OLTSS and Diane Schimmelbusch, Optum

3. Payment Reform – Derek Tymon, Director, Primary Care Clinician Plan

- Updates

4. New Mid-Level Provider Enrollment – Sina Eam, Sr. Provider Relations Specialist

5. Ordering, Referring and Prescribing Providers Project Update – Alison Kirchgasser, Director of Federal Policy Implementation

- PCC Referral Process Changes to support the ORP Implementation

6. Finger Printing – Keith West, Director, Provider Initiatives

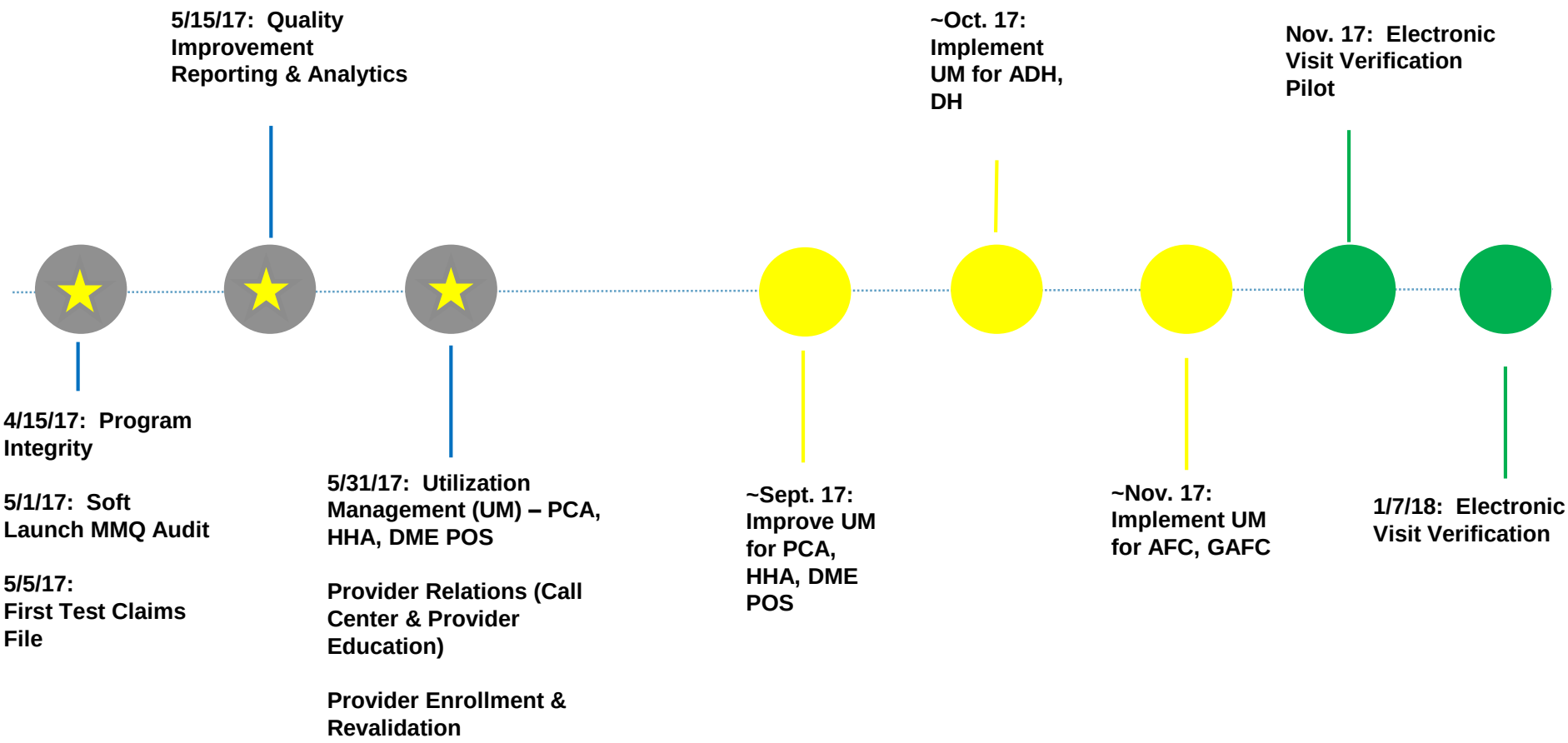
7. PERM Audit – Keith West, Director, Provider Initiatives

8. Updates – MassHealth Bulletins (March - July)

9. Next PAF Meeting : September 20th, 2017

OLTSS TPA Update
Presented by – Elizabeth Cahn Goodman, Thomas Lane and Diane Schimmelbusch

Implementation Dates for MA LTSS TPA Functions



LTSS TPA Metrics as of 6/26/2017

Service Center – Calls by LTSS Provider Types

- Answered 5,327 calls
- 6/26: 96.1% Service level, Average Speed of Answer 3 seconds, no abandoned call
- Answered 1,235 emails/faxes
- Provider types with the most calls: **Home Health> DME > Nursing Facility > Group Therapist**

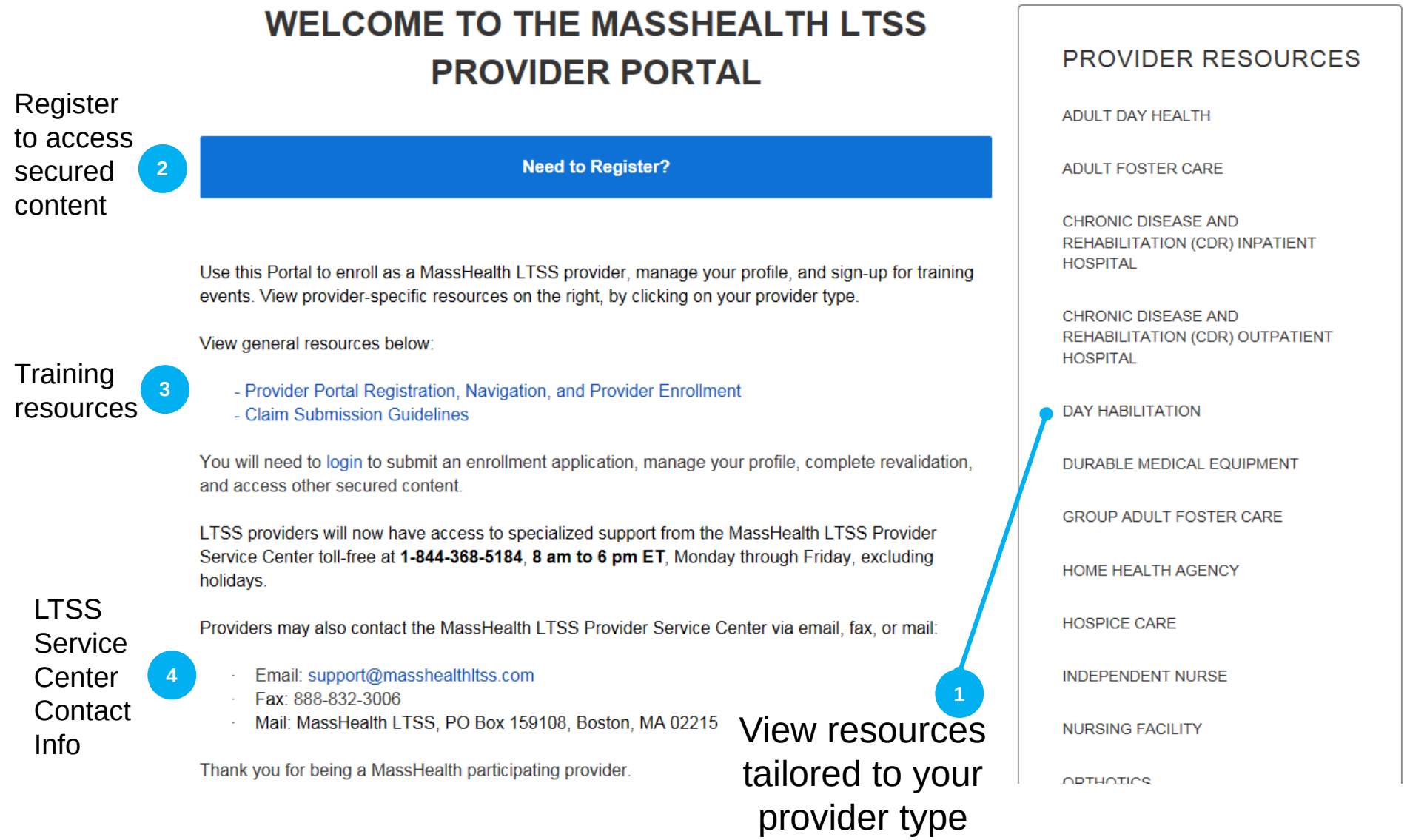
PA Metrics

- **2.7 Days***:* Average turn around time
- **89%**: Completed within 5 days, if no missing info

Provider Enrollment & Updates Metrics

- Provider Portal Registration: **294**
- Provider Applications: **62**
- Provider Updates: **83**

LTSS Provider Portal



Register to access secured content

2

Training resources

3

LTSS Service Center Contact Info

4

1

View resources tailored to your provider type

LTSS Provider Portal Benefits

- Provider resources organized by your provider type
  - One central location for information applicable to your provider type, including Provider Manual, Provider Bulletins, medical necessity guidelines, prior authorization forms, job aids, and training resources
  - Available 24/7
- Streamlined Enrollment and Revalidation process
  - Applications and forms tailored to your provider type
  - Real-time status monitoring and missing information alerts
  - Faster processing time

Provider Type Specific Resources

View the resources that apply to your provider type, including:

1. Provider Manual
    - Links to Subchapters 1-6
    - Applicable Appendices
2. Provider Responsibilities
3. POSC / EVS
    - Eligibility verification, claims submission, and claims edits resolution guides
4. Prior Authorization, if applicable
5. Enrollment
6. Revalidation

1. PROVIDER MANUAL

The *Day Habilitation Program Manual* contains the regulations, administrative and billing ins
providers. This link takes you to the **comprehensive manual** followed by links to sections w

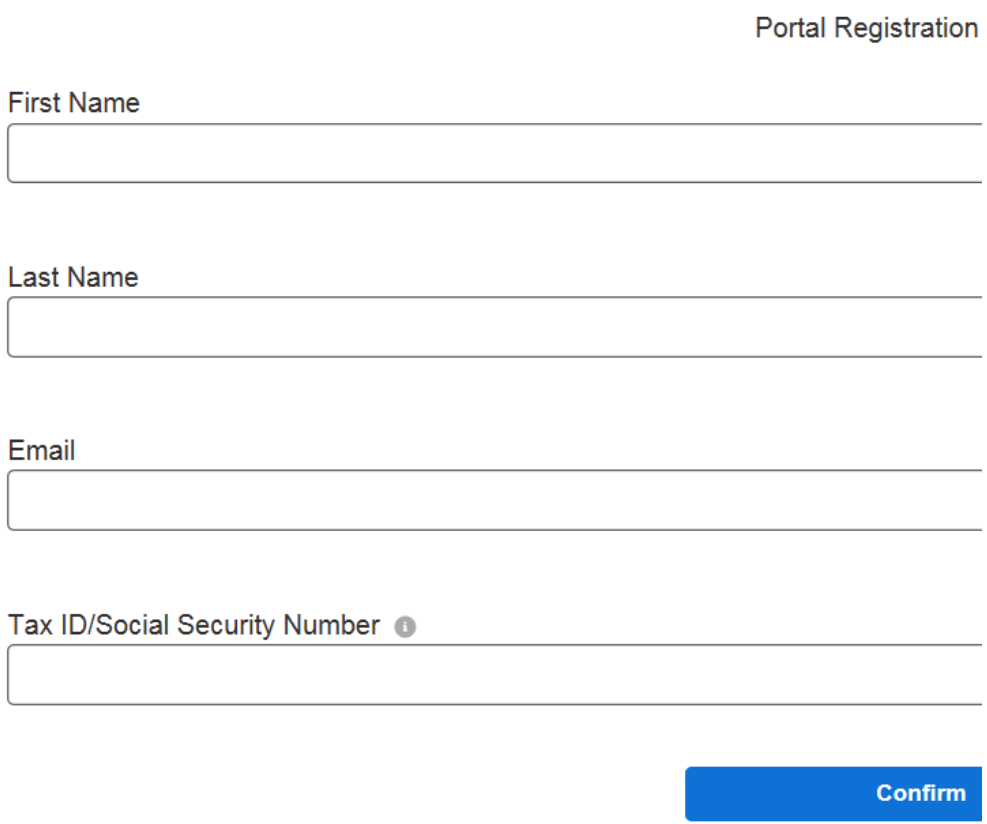
- Subchapters 1 through 3: Administrative and Billing Regulations (apply to all providers)
- **Subchapter 4: Day Habilitation Regulations*****
- Subchapter 5: Administrative and Billing Instructions
    - Part 1. Eligibility
    - Part 2. Prior Authorization
    - Part 3. Billing MassHealth
    - Part 4. Required Forms and Documentation
    - Part 5. Claim Status and Payment
    - Part 6. Claim Status and Correction
    - Part 7. Other Insurance
- **Subchapter 6: Day Habilitation Service Codes, Procedure Codes and Modifiers*****
- Appendix C: Third-Party-Liability Codes: organized by Commercial insurance carriers, follow
- Appendix U: DPH-Designated Serious Reportable Events
- Appendix Y: Eligibility Verification System (EVS) Codes/Messages

LTSS Provider Portal Registration

1. On the Provider Portal home page, click on the '**Need to Register**' button.

2. Enter in your First Name, Last Name, Email, and Tax ID. Click '**Confirm**.'

3. Once registered you will receive an email with your User Name and Password. You will be directed to update your Password.



Payment Reform
Presented by – Derek Tymon

Agenda

I. MassHealth Payment Reform, Brief Refresher Overview

II. ACOs Selected for Contract Negotiations

III. Timeline Updates

IV. Resources for Additional Information

1115 Demonstration Waiver Approvals

- On November 4, 2016, Massachusetts received federal approval of its request for an amendment and extension of the 1115 Demonstration Waiver, providing MassHealth additional flexibility to design and improve programs.
- The Waiver authorizes $52.4B in spending over five years, including $1.8B in Delivery System Reform Incentive Payments (DSRIP) to fund MassHealth's restructuring and transition to accountable care.
- In addition to MassHealth's existing Managed Care Organization (MCO) program and the Primary Care Clinician Plan (PCC Plan), the Waiver also recognizes two new types of entities, **Accountable Care Organizations (ACOs) and Community Partners (CPs).**
- ACOs are:
  - Groups of Primary Care Providers, and other providers with whom they work to better coordinate care
  - Responsible for coordinating care
  - Incentivized to invest in primary care
  - Rewarded for value – managing total cost of care and improving patient outcomes and member experience– not the volume of services provided
- CPs are:
  - Community based organizations, collaborating with ACOs to provide care coordination and care management supports to individuals with significant behavioral health issues and/or complex long term services and supports needs

Implementation of Payment and Care Delivery Reform

- Payment reform elements include:
  - ACO Pilot
  - MCO Reprocurement
  - ACO Full Rollout
  - Community Partners
  - DSRIP

- Full payment reform implementation will provide MassHealth managed care eligible members with new enrollment options, including the ACO Program. Specifically, these members will be able to choose among:
  - Accountable Care Partnership Plans in their service area
  - Primary Care ACOs
  - MCOs in their region; MCO enrollees may also choose primary care through an MCO-Administered ACO in their MCO's network
  - PCC Plan

Full Accountable Care Organization (ACO) Procurement

Under the 1115 Demonstration Waiver, MassHealth is authorized to move forward with development of three ACO models:

A. Accountable Care Partnership Plans

- Managed care organizations (MCOs) with a closely partnered ACO, or integrated entities meeting the requirements of both, that provide vertically integrated, coordinated care under a capitated rate

B. Primary Care ACOs

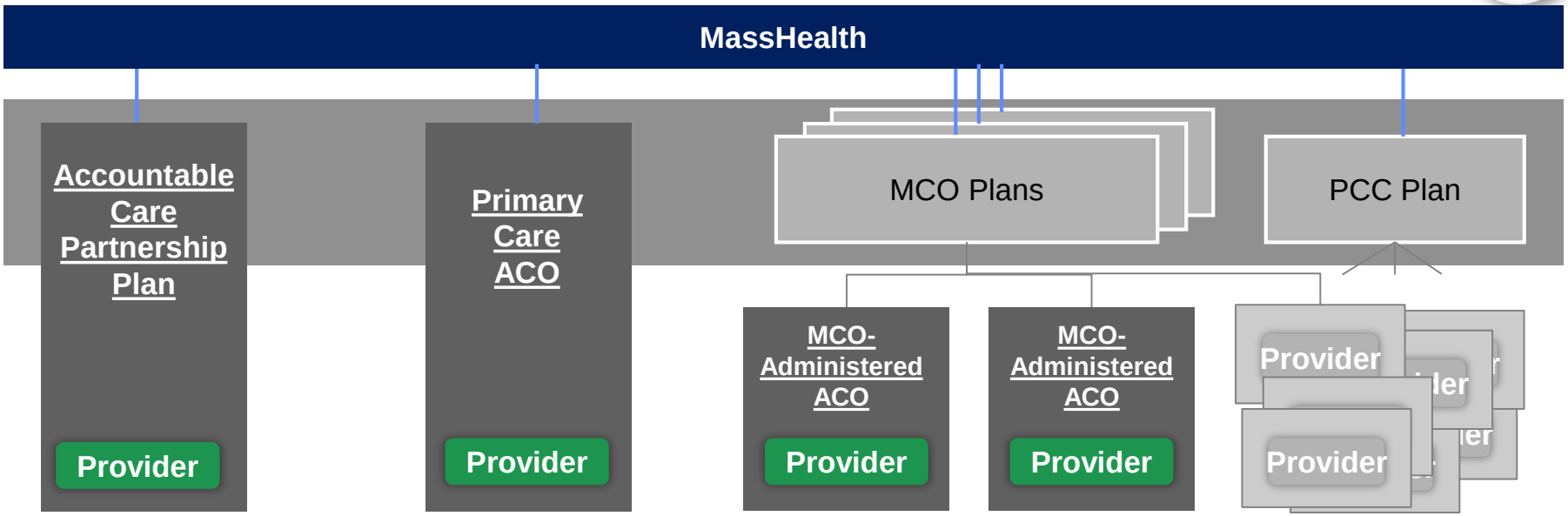
- ACOs that contract directly with MassHealth to take financial accountability for a defined population of enrolled members through retrospective shared savings and risk

C. MCO-Administered ACOs

- ACOs that contract directly with MassHealth MCOs to take financial accountability for the MCO enrollees they serve through retrospective shared savings and risk

MassHealth Restructuring

Member enrollment



Accountable Care Partnership Plan

- MCO and ACO have significant integration and provide covered services through a provider network
- Risk-adjusted, prospective capitation rate
- Takes on full insurance risk

Primary Care ACO

- ACO contracts directly with MassHealth for overall cost/ quality
- Based on MassHealth provider network/MBHP
- ACO may have referral circles
- Choice of level of risk; both include two-sided performance (not insurance) risk

MCO & MCO-Administered ACO

- MCO contracts with “MCO-Administered” ACO(s) as a part of their network
- MCO plays a larger role to support population health management
- Various levels of ACO risk; all include two-sided performance (not insurance) risk

PCC Plan

- Primary care Providers based on the PCC Plan network
- Specialists based on MassHealth network
- Behavior Health administered by Massachusetts Behavioral Health Partnership (MBHP)

MassHealth Entered into Contract Negotiations with 18 ACOs

These ACOs are expected to cover over **900,000** MassHealth members and include approximately **4,500** primary care providers.

The following is the full list of the MassHealth ACOs that have been selected for contract negotiation:

- Atrius Health with Tufts Health Public Plans
- Baystate Health Care Alliance with Health New England
- Beth Israel Deaconess Care Organization with Tufts Health Public Plans
- Boston Accountable Care Organization with Boston Medical Center HealthNet Plan
- Cambridge Health Alliance with Tufts Health Public Plans
- Central Massachusetts Accountable Care Organization with Tufts Health Public Plans
- Children's Hospital Integrated Care Organization with Tufts Health Public Plans
- Community Care Cooperative
- Health Collaborative of the Berkshires with Fallon Community Health Plan
- Lahey Health
- Mercy Health Accountable Care Organization with Boston Medical Center HealthNet Plan
- Merrimack Valley ACO with Neighborhood Health Plan
- Partners HealthCare ACO
- Reliant Medical Group with Fallon Community Health Plan
- Signature Healthcare Corporation with Boston Medical Center HealthNet Plan
- Southcoast Health Network with Boston Medical Center HealthNet Plan
- Steward Medicaid Care Network
- Wellforce with Fallon Community Health Plan

Provider Perspective (1 of 2): PCPs

"What are my ACO participation options and their implications?"

My options for ACO participation are . . .	And what it means for the MassHealth managed care-eligible members I can serve is . . .
Do not participate in an ACO	I need to **contract with the PCC Plan and/or MassHealth MCOs** in order to have any of their enrollees on my primary care panel*
Join a Partnership Plan as a Network PCP	I serve a panel of members who are **all enrolled in my ACO**. I cannot simultaneously have a PCP panel in any other products (i.e., the PCC Plan, an MCO, another ACO)
Join a Primary Care ACO as a Participating PCP	
Join an MCO-Administered ACO as a Participating PCP	My ACO will partner with one or more MCOs (in year 1, my ACO will partner with all the MCOs operating in its geography). I will be required to contract with those MCOs as a Network PCP for their enrollees, and all of their enrollees who are assigned to my panel will be considered part of my ACO's attributed population

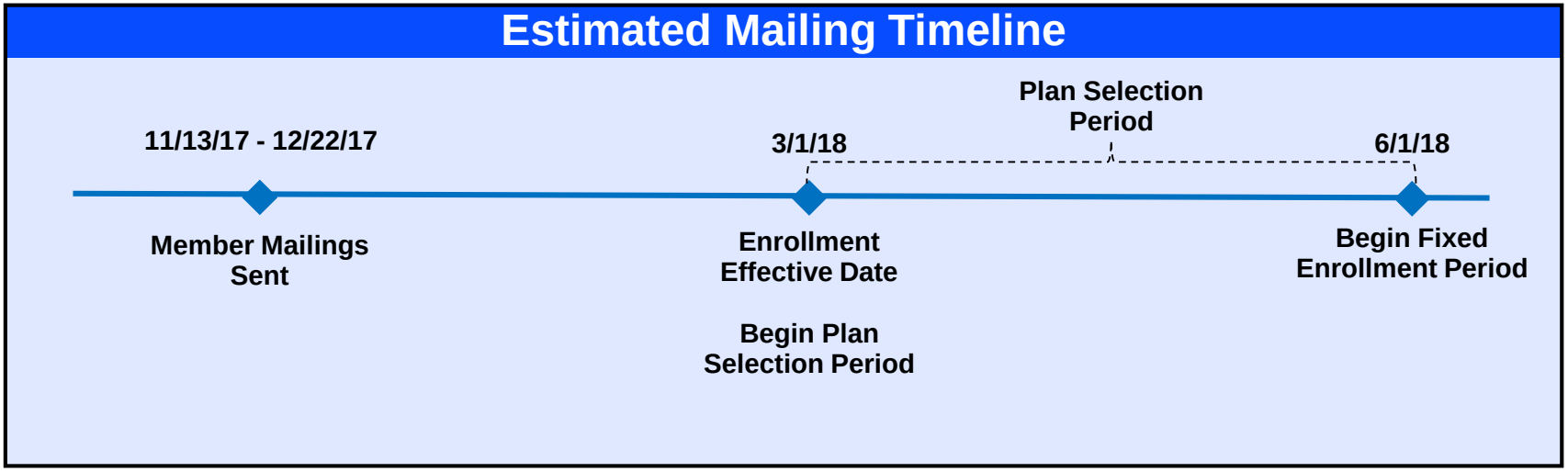
- *Primary care exclusivity is only with respect MassHealth managed care-eligible members. PCPs may provide primary care services to MassHealth Fee-For-Service members, including Dually Eligible MassHealth members, and they may also provide specialty services to MassHealth members in any delivery system.*
- *Primary care exclusivity is **site- /practice-level**, similar to PCC Plan enrollments or participating in the ACO Pilot.*
- *MassHealth will provide additional operational details of primary care provider enrollment/ACO affiliation to those providers participating with ACOs over the coming months.*

Provider Perspective (2 of 2): non-PCP providers

"What does ACO reform mean for my contracts and who I can see?"

		I want to see members enrolled in . . .			
		The PCC Plan	**A Primary Care ACO**	**An MCO** *(regardless of whether or not they are attributed to an MCO-Administered ACO)*	**A Partnership Plan**
I am a…	**Hospital**	Be in MassHealth's hospital network *(via the MassHealth hospital RFA)*		Contract with each MCO whose enrollees I want to see *(negotiated rate)*	Contract with each Partnership Plan whose enrollees I want to see *(negotiated rate)*
	Professional (e.g., specialist)	Be a MassHealth-participating provider *(via MH professional reg/fee schedule)*			
	Behavioral Health (BH) Provider	Be an in-network provider for MassHealth's BH Vendor *(via contract with the BH Vendor)*		Contract with each MCO (or that MCO's BH Vendor if they have one) whose enrollees I want to see *(negotiated rate)*	Contract with each Partnership Plan (or that Plan's BH Vendor if they have one) whose enrollees I want to see *(negotiated rate)*
	Long-Term Services and Supports (LTSS) Provider	Contract with MassHealth as an LTSS provider at the MassHealth fee schedule; LTSS is "wrapped" coverage directly by MassHealth		For years 1 and 2, contract with MassHealth as an LTSS provider at the MassHealth fee schedule; LTSS is "wrapped" coverage directly by MassHealth for all members, regardless of model	
				Starting on or about year 3, contract with each MCO whose enrollees I want to see *(negotiated rate)*	Starting on or about year 3, contract with each Partnership Plan whose enrollees I want to see *(negotiated rate)*
	Pharmacy	Contract with MassHealth as an in-network pharmacy provider		Contract with each MCO (or that MCO's pharmacy benefit manager as applicable) whose enrollees I want to see	Contract with each Partnership Plan (or that Plan's pharmacy benefit manager as applicable) whose enrollees I want to see

Member Noticing for Managed Care Eligible Population



Anticipated Key Payment Reform Dates

September 2016
- ✓ *Reconvene Technical Advisory Groups (TAGs)*
- ✓ *ACO procurement released*

October 2016
- ✓ *Responses due for Community Partner (CP) RFI*
- ✓ *MCO Plan Selection and Fixed Enrollment Periods begin*
- ✓ *PCC Plan referral changes begin*

December 2016
- ✓ *Pilot ACOs go live*
- ✓ *MCO Procurement released*

February 2017
- ✓ *ACO procurement responses due*

March 2017
- ✓ *CP procurement released*

Spring 2017
- *Release procurement for Technical Assistance to ACOs and CPs*
- *MCO procurement responses due*
- *ACO selections announced*
- *CP procurement responses due*

Summer 2017
- CP selections announced

Fall/Winter 2017
- MCO selections announced
- MCO and ACO Readiness Reviews begin
- Member enrollment guides distributed
- Members select or are assigned to new ACOs/MCOs for March 1st, 2018 effective date

2020/2021
- MCOs and ACOs accountable for LTSS on or around Year 3

Visit us at:

www.mass.gov/hhs/masshealth-innovations

E-mail us at

MassHealth.Innovations@state.ma.us

New Mid-Level Provider Enrollment
Presented by – Sina Eam

Midlevel Provider Enrollment

Effective August 1, 2017, MassHealth regulations will be amended to expand the types of providers eligible to participate in MassHealth to include all categories of state licensed advanced practice registered nurses and physician assistants. The regulations will also allow physician assistants to serve as primary care clinicians.

MassHealth Eligible Midlevel Provider Types:

- Physician Assistants (PA)
- Certified Registered Nurse Anesthetists (CRNA)
- Clinical Nurse Specialists (CNS)
- Psychiatric Clinical Nurse Specialists (PCNS)
- Certified Nurse Practitioners (NP)
- Nurse Midwives (NMW)

Key Points

- As a result of these new regulations, all MassHealth eligible midlevel provider types working for a group practice must participate in the MassHealth program in order for the group practice to receive payment for their services rendered.

- PAs must work for a group practice with at least one physician member in order to be eligible to participate in MassHealth. Payment for Physician Assistants will be made to MassHealth participating group practices that have at least one physician as a member. Group Practices without a physician member cannot bill for PA services. PA's must work for a group practice with at least one physician member in order to be eligible to participate in MassHealth.

- CRNAs, PCNSs, and CNSs will also be able to participate independently in MassHealth, and NPs and NMWs will continue to be able to do so.

- Physicians will no longer be able to bill using the physician's NPI for services of any of these provider types, with the exception of NPs, that are employed by an individual physician.

Key Points Continued

Some other highlights of these new regulations include:

- The following modifiers will be deactivated effective 8/1/17:
  - HN (Physician Assistant)
  - SB (Nurse Midwife)
- The following modifier remain active: SA (Nurse Practitioner)
- For Anesthesia billing, effective 8/1/17 Medical Direction by a physician is payable to a physician. Medical Supervision by a physician is not payable by MassHealth. See physician regulations at 130 CMR 433.454 (C) and (D) for definition of medical direction and medical supervision.
- The following modifiers are required when billing for anesthesia services effective 8/1/17: AA, QK, QY, QX, and QZ
- Updates to regulations found in 130 CMR 433.000, 450.000 and 508.000 for mid-level providers can be found at: http://www.mass.gov/eohhs/gov/laws-regs/masshealth/masshealth-proposed-regs.html

Provider Support

- To assist providers with the provider enrollment process and the billing changes under these new regulations, MassHealth will be hosting webinar sessions on the following dates:
  - Tuesday, June 20, 2017
  - Thursday, July 13, 2017
  - Tuesday, July 25, 2017
  - Tuesday, August 15, 2017
- To register for one of these webinars please visit www.masshealthtraining.com
- For questions or to request the application, please contact the MassHealth Customer Service Center by e-mail at providersupport@mahealth.net or by phone at 1-800-841-2900.

Provider Enrollment Procedures

- MassHealth has revised the Medical Practitioner and the Group Practice Organization enrollment forms in preparation of these new regulations.
- New midlevel providers are strongly encouraged to submit their enrollment applications prior to the anticipated effective date of 8/1/17.
- The new Medical Practitioner enrollment forms are available from the MassHealth Customer Service Center upon request by e-mail at providersupport@mahealth.net or by phone at 1-800-841-2900.
- For more information about the Ordering, Referring, and Prescribing Requirements, please visit: http://www.mass.gov/eohhs/provider/insurance/masshealth/aca/aca-section-6401enrollment-information.html
- To enroll in an upcoming webinar, please visit: www.masshealthtraining.com

Provider Enrollment Procedures (cont.)

- If a physician assistant or a nurse practitioner wishes to participate in the Primary Care Clinician (PCC) Program as a PCC, the following action is required:

- The provider must be fully enrolled with MassHealth. This includes submitting a completed documentation:
  - Medical Practitioner Application
  - Provider Contract Agreement
  - Data Collection Form (DCF)
  - Federally Required Disclosures Form (FRDF)
  - The PCC group practice must contact MassHealth to submit an update to Section 2 of their existing PCC application to identify the additional provider they would like to list as a PCP provider.

- The group practice must supply the following additional supporting documentation to MassHealth to enroll the individual provider as a PCP within the PCC plan:
  - Attach an attestation that the individual provider works a minimum of 20 hours at the service location.
  - Include a hospital letter designating hospital admitting privileges;
  - Attach a CV to verify board eligibility within family practice, internal medicine, obstetrics/gynecology or pediatrics.

- Providers can email providersupport@mahealth.net or call (800) 841-2900 to request an application packet from the MassHealth Customer Service Center.

Questions?

Ordering, Referring and Prescribing Requirements
Presented by – Alison Kirchgasser

Ordering and Referring (O&R) Requirements

Background

- ACA Section 6401 (b)
- States must require:
  - All ordering or referring physicians and other professionals be enrolled under the State [Medicaid] Plan…as a participating provider; and
  - The NPI of any ordering or referring physician or other professional…be specified on any claim for payment that is based on an order or referral of the physician or other professional.
- These requirements were effective March 25, 2011. Final Rule (42 CFR 455.410(b) and 42 CDR 455.440) was published in the Federal Register on Feb. 2, 2011. Subregulatory guidance was given to states on December 23, 2011.
- MassHealth is continuing its implementation efforts. In March 2016 we began providing informational messaging on certain impacted claims.

O&R Requirements

Provider Types (including interns and residents in those provider types) authorized to be included on a claim as the ordering, referring or prescribing provider

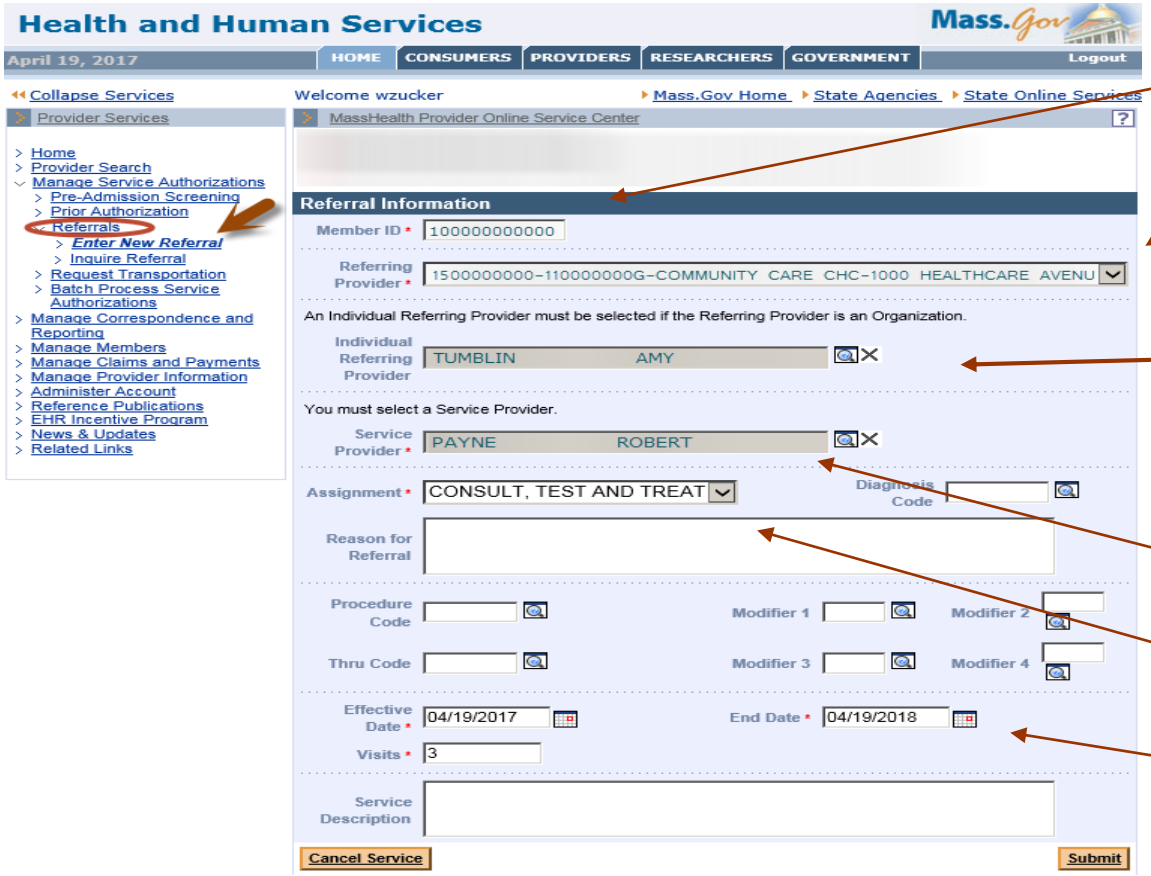
- Certified Nurse Midwife
- Certified Registered Nurse Anesthetist
- Clinical Nurse Specialist
- Dentist
- Licensed Independent Clinical Social Worker
- Nurse Practitioner
- Optometrist
- Pharmacist (if authorized to prescribe)
- Physician
- Physician Assistant
- Podiatrist
- Psychiatric Clinical Nurse Specialist
- Psychologist

State law requires these providers to apply to enroll with MassHealth, at least as a nonbilling ORP provider, to obtain or maintain state licensure. This requirement will go into effect upon promulgation of implementing regulations, scheduled for the summer/fall of 2017.

New requirement for PCC Referrals from PCC organizations, including group practices

- O&R requirements are that an *individual* provider must be listed on a claim as the ORP provider
- MassHealth allows organizational PCCs (CHC, HLHC, Indian Health Service (IHS), OPD, Group Practice) to make PCC referrals
- To ensure that billing providers will have an individual ORP provider to include on a claim, as of 6/19/17 organizational PCCs must select a qualifying Individual Referring physician or nurse practitioner or the organizational PCC's referral will not process.
- In order to qualify as an Individual Referring Provider for this process, the physician or NP must be:
  (1) *on-staff* at the PCC entity/service location,
  (2) board certified or board eligible (or in the case of a nurse practitioner, specialize) in family practice, pediatrics, internal medicine, obstetrics, or gynecology,
  (3) identified to MassHealth by the CHC, HLHC, IHS, OPD or group practice as a provider who may be assigned PCC Plan members pursuant to 130 CMR 450.118(C), (D), or (E), as applicable, and
  (4) *individually* enrolled with MassHealth at least as a non-billing ORP provider if on-staff at a CHC, HLHC, IHS, or OPD, or as a fully-participating provider if on-staff at a group practice.

POSC Referrals Page



Required Fields

Enter the Member's MassHealth ID Number

Enter the *Referring Provider* which could be either an Organization (CHC, HLHC, OPD, Group or Indian Health Service) or a Physician or an Independent Nurse Practitioner who has a signed PCC Contract.

Enter the Individual Referring Provider within the above Organization that is making the referral. (*Note: this is a required field only if the Referring Provider above is a CHC, HLHC, OPD, Group Practice or Indian Health Service. Leave this field BLANK if the Referring Provider above is a Physician or Independent Nurse Practitioner, and not an organization)

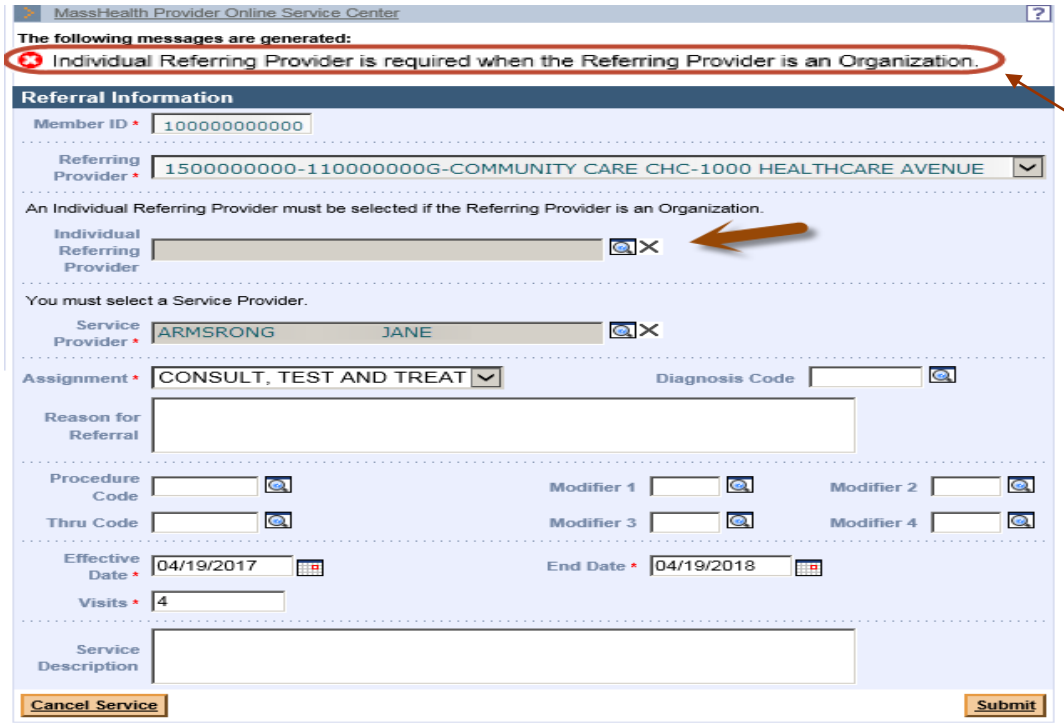
Enter the provider who will be performing the requested service

Choose the service to be rendered from the dropdown

Enter the start date, end date, and number of visits authorized for this service

POSC New Error Messaging You May See

This is an example of messaging you will see if you do not select an individual referring provider for an organization.



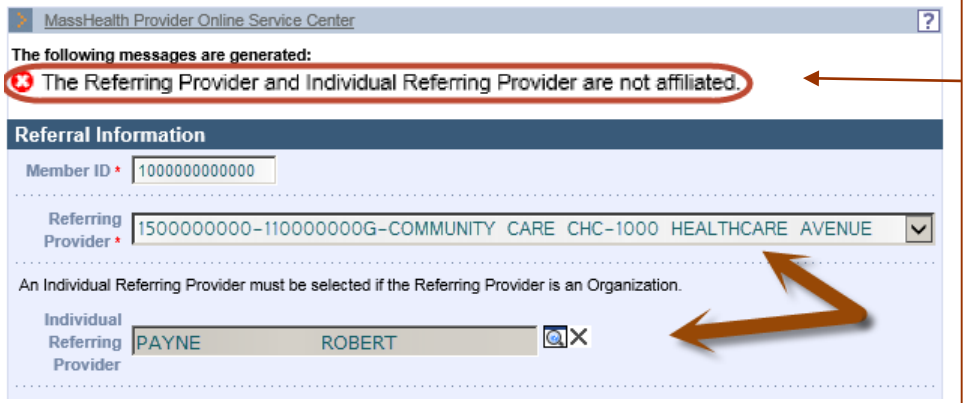
This Error Message will appear when you entered a PROVIDER ORGANIZATION (CHC, HLHC, OPD, Indian Health Services or Group Practice) as the REFERRING PROVIDER but have not entered an INDIVIDUAL REFERRING PROVIDER within that organization

To Correct:

Search for and select a qualifying Individual Referring Provider

POSC New Error Messaging You May See

This is an example of messaging you may see if there is a mismatch between the *Referring Provider* and the *Individual Referring Provider*.



If the *Individual Referring Provider* is not affiliated with the selected *Referring Provider* Organization (CHC, HLHC, OPD, Indian Health Services, or group practice) you will receive this error message.

This means that the Individual Referring Provider is not affiliated to the Referring Provider Organization(Service Location) by MassHealth

To Correct:

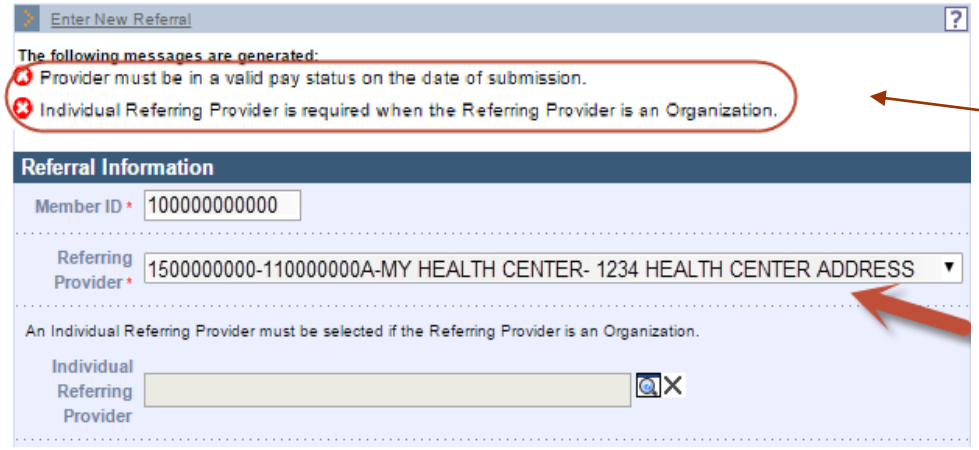
Contact MassHealth to identify the selected provider as qualified to be an Individual Referring Provider. MassHealth will then affiliate the provider with your Organization/Service Location.

OR

Search for and select a qualifying Individual Referring Provider that has already been identified to MassHealth.

POSC New Error Messaging You May See

This is an example of messaging you will see if the Individual Referring Provider is not an active MassHealth provider.



If the Referring Provider chosen is not in an Active Status with MassHealth as a nonbilling or fully participating provider you will receive this error message.

To Correct:

Search for and select an Individual Referring Provider that is an active MassHealth nonbilling or fully participating provider.

AND

Enroll on-staff PCPs into MassHealth

O&R Requirements

- MassHealth is implementing the O&R requirements in several phases.

- On 2/26/16 MassHealth posted Provider Bulletin 259 for billing providers regarding the ordering, referring and prescribing provider requirements and the implementation phases.

- Phase 1A
  - MassHealth began providing informational messages on certain claims for dates of service on or after March 7, 2016 that do not meet the O&R requirements listed below:

    - The ORP provider's NPI must be included on the claim.
    - The ORP provider must be one of the provider types listed on slide 3.
    - The ORP provider must be enrolled with MassHealth, at least as a nonbilling provider.

O&R Requirements

- Claims impacted in Phase 1A.
  - All professional claims (837P and CMS 1500) from the providers listed below (with noted exception)
    - Adult Day Health
    - Adult Foster Care
    - Durable Medical Equipment
    - Eyeglass supplier
    - Group Adult Foster Care
    - Independent Nurse
    - Orthotic
    - Oxygen and Respiratory
    - Pharmacy (DME claims only)
    - Prosthetic
    - Psychologist
    - Therapist (PT, OT, ST)
  - All professional claims (837P and CMS 1500) for the following services, regardless of billing provider type
    - Home Health
    - Psychological Testing
    - Therapies (OT, PT, ST)
  - Claims processed by the Pharmacy Online Processing System (POPS) (informational messaging began on 4/27/16)

O&R Requirements

- Claims impacted in Phase 1B (informational messaging is anticipated to begin in summer 2017).
  - All claims (professional and institutional - 837P, 837I, CMS 1500 and UB-04) that currently require a PCC referral, regardless of billing provider.
  - All professional claims (837P and CMS 1500) from certified Independent Labs and Diagnostic Testing Facilities.

- Phase 2
  - In Phase 2, effective date TBD, the claim types impacted in Phases 1A and 1B will not be payable if they do not meet O&R requirements.

- Phase 3 – Informational Messaging is anticipated to begin in summer 2017, claims denial date TBD
  - Institutional claims (837I and UB-04) for home health services
  - Professional claims (837P and CMS 1500) for certain PCA related procedure codes.
  - Institutional claims (837I & UB-04) for labs and diagnostic testing
  - All professional claims (837P and CMS 1500) for labs and diagnostic testing codes(such claims were included in Phase 1 only when billed by Labs and Diagnostic testing facilities).

Resources

- If you have any questions please contact the MassHealth Customer Service Center at 1-800-841-2900, e-mail your inquiry to providersupport@mahealth.net, or Fax your inquiry to 617-988-8974.

- For general instructions on how to submit, update, or inquire about a referral, please see the MassHealth POSC Job Aids at:

  http://www.mass.gov/eohhs/gov/newsroom/masshealth/providers/mmis-posc/training/get-trained.html

- For more information about the ordering, referring and prescribing requirements, please visit: www.mass.gov/eohhs/provider/insurance/masshealth/aca/aca-section-6401enrollment-information.html

- POSC Link
  https://newmmis-portal.ehs.state.ma.us/EHSProviderPortal/appmanager/provider/desktop

Update on Fingerprinting Requirements

Presented by – Keith West

Fingerprint Based Criminal Background Checks

- Section 6401 of the Affordable Care Act requires a fingerprint-based criminal background check as part of new screening requirements for all “high” risk providers and all persons with a 5% or greater direct or indirect ownership interest in such providers.
- A provider may be considered high risk based on three criteria
  - Provider type classified as high risk
    - Adult Foster Care & Group Adult Foster Care
    - DMEPOS & PERS Providers (newly enrolling on or after 8/1/2015 only)
    - Home Health Agencies (newly enrolling between 8/1/2015 and 2/10/2016)
  - Has a payment suspension based on a credible allegation of fraud, waste or abuse
  - Has an overpayment of $1,500 or more outstanding for more than 30 days

Fingerprint Based Criminal Background Checks

Criteria, continued

Providers “Bumped up” to High Risk

- Has had a payment suspension based on a credible allegation of fraud, waste or abuse since 8/1/15
- Has an overpayment of $1,500 or more outstanding for more than 30 days
- Newly enrolling within the first six months after an enrollment moratorium for that provider type is lifted
- Excluded by OIG or another state Medicaid program within the past 10 years

Fingerprint Based Criminal Background Checks

- MassHealth mailed 238 letters to providers who met the criteria for fingerprinting on May 25, 2017
- This represented 390 owners
- MassHealth mailed letters to each PID/SL or enrolled provider
- Providers and owners had until 6/24/2017 to be fingerprinted
- As of June 23, 2017 we had
  - 59 completed fingerprints
  - 17 had to be reviewed
  - 162 had not been completed

Fingerprint Based Criminal Background Checks

- We outreached providers who did not have their fingerprints completed via automated calling the week of July 3, 2017
- Follow up letters are scheduled to be mailed this week notifying providers that they or their owners missed the June deadline and if they or their owners were not fingerprinted in 30 days they could be terminated
- As of Friday, July 7, 2017, there are still 143 providers outstanding that haven't completed their fingerprinting

Provider Type	Count
AFC/GAFC	57
Physician	34
Group Practice	15
Home Health	13
DME	12
Nurse Practitioner	2
Orthotics	2
Prosthetics	2
Independent Nurse	1
Pharmacy	1
Mental Health Center	1
Rest Home	1
Transportation	1
Nursing Home	1
Grand Total:	**143**

PERM Audit
Presented by – Keith West

Payment Error Rate Measurement (PERM)

- A reminder that MassHealth is part of the CMS PERM for SFY 2016 and we are approaching the end of the audit
- The count of claim requests as of 6/27/2017:

Count	Status	Percent
1,668	Correct	92.8%
63	Errors PIT	3.5%
66	Pending	3.7% (working their way through the system)
1,797	**Total**	**100%**

Payment Error Rate Measurement (PERM)

Medical Records (MR) Report by Error Type as of 6/27/2017

Provider Type	Count
MR1 – No documentation	43
MR2 – Incomplete documentation	11
MR3 – Procedure code error	3
MR6 - # of units error	3
MR9 – Inadequate documentation	2
MTD – Medical technical deficiency	1
Total:	**63**

Payment Error Rate Measurement (PERM)

MR Report by Provider Type as of 6/27/2017

Provider Type	Count
Outpatient Hospital	12
Group Practices	11
Pharmacy	6
Dentists	5
Nursing Facility	5
Home Health	5
State Agency Services	4
HLHC	3
School-Based Medicaid	3
Adult Day Health	3
Fiscal Intermediary	2
Special Programs	1
Independent Lab	1
AFC/GAFC	1
CHC	1
Total:	**63**

Recent Bulletins

All Provider Bulletin 269: Amendments to All Provider Bulletin 251

This bulletin amends certain sections of the All Provider Bulletin 251, “Enhancements to the Claiming Process and New Certification Process for MassHealth Limited Program,” issued in August 2015. Starting June 1, 2017, MassHealth is revising the claim edits associated with the Limited program. This bulletin communicates the edits and reinforces the requirements for the submission of the new Certification of Treatment of Emergency Medical Condition form (the Certification form) used to appeal denied claims.

As clarified in the All Provider Bulletin 101, issued in June 1997, for MassHealth Limited Members, MassHealth covers only emergency services as detailed in 130 CMR 450.105 (F). MassHealth pays only for the treatment of a medical condition (including labor and delivery) that manifests itself by acute symptoms of sufficient severity (including severe pain) that the absence of immediate medical attention reasonably could be expected to result in a) placing the member’s health in serious jeopardy; b) serious impairment to bodily functions; or c) serious dysfunction of any bodily organ or part.

Limited coverage excludes organ transplants and care or services related to that procedure regardless of whether the treatment would otherwise meet the conditions of coverage set forth above. This definition must be met at the time of the provided medical service or the provided service will not be considered treatment for an emergency medical condition. Note that not all medically necessary services meet this regulatory definition under the Limited program of emergency medical condition.

http://www.mass.gov/eohhs/docs/masshealth/bull-2017/all-269.pdf

All Provider Bulletin 267:Fingerprint Based Criminal Background Checks

Section 6401 of the Affordable Care Act requires a fingerprint-based criminal background check as part of new screening and enrollment requirements for all “high” risk providers and all persons with a 5% or greater direct or indirect ownership interest in such providers. The final rule for Section 6401 assigned risk levels for provider types that are recognized by Medicare. MassHealth adopted those risk levels and assigned risk levels for Medicaid-only provider types. Provider screening and enrollment requirements are based on the risk level for a particular provider type or provider. In certain circumstances, MassHealth may rely on fingerprinting and background checks performed by Medicare.

The following is a list of the provider types that have been classified as high risk.

High Risk Providers:

- Adult Foster Care Providers
- Group Adult Foster Care Provider
- New enrollees in the following provider types:
  - Durable Medical Equipment Providers & Personal Emergency Response System (PERS) Providers (newly enrolling on or after August 1, 2015 only)
  - Home Health Agencies (newly enrolling on or after August 1, 2015 only)
  - Orthotics Providers (newly enrolling on or after August 1, 2015 only)
  - Oxygen & Respiratory Therapy Equipment Providers (newly enrolling on or after August 1, 2015 only)
  - Prosthetics Providers (newly enrolling on or after August 1, 2015 only)

Federal regulations also require that any provider that meets one of the following criteria be classified as high risk:

- Has had a payment suspension based on a credible allegation of fraud, waste, or abuse since 8/1/15;
- Excluded by OIG or another state Medicaid program within the past 10 years;
- Has a qualified overpayment and is enrolled or revalidated on or after August 1, 2015; or
- In a provider type that was previously subject to an enrollment moratorium and applies to enroll during the first six months after the moratorium is lifted.

http://www.mass.gov/eohhs/docs/masshealth/bull-2017/all-267.pdf

All Provider Bulletin 270: Third-Party Administrator Implementation for Long-Term Services and Supports (LTSS)

The Executive Office of Health and Human Services (EOHHS) has entered into a contract with Optum Government Solutions ("Optum") to provide third-party-administrator (TPA) services for MassHealth Long-Term Services and Supports (LTSS). The introduction of an LTSS TPA is part of the Commonwealth's efforts to increase MassHealth's capacity to deliver LTSS on a fee-for-service basis to eligible MassHealth members. Through the addition of the LTSS TPA, specific enhancements will be available to certain MassHealth providers involved in delivering LTSS services, while other administrative functions, including claims processing, will remain largely the same. The following MassHealth state-plan LTSS services/providers, when provided on a fee-for-service basis to eligible members, are within the scope of the LTSS TPA.

- Adult day health
- Adult foster care
- Chronic inpatient hospitals
- Chronic outpatient hospitals
- Day habilitation
- Durable medical equipment
- Group adult foster care
- Home health agency services
- Hospice
- Independent nurse (private duty nursing)
- Independent therapist
- Nursing facilities
- Orthotics
- Oxygen and respiratory therapy
- Personal care attendant
- Transitional living
- Prosthetics
- Rehabilitation centers
- Speech and hearing centers

Support for administrative entities, including fiscal intermediaries and personal care management agencies, is also within the scope of the LTSS TPA

http://www.mass.gov/eohhs/docs/masshealth/bull-2017/all-270.pdf

Questions?

Next PAF: September 20th 2017