

Massachusetts Provider Orientation & Plan Overview

MassHealth MCO & ACO

Clarity plans

Special Kids Special Care



Topics



- Brand Change
- WellSense Overview
 - Who we are
 - Overview of our plans
 - ID cards
 - Eligibility
- Health Related Social Needs (HRSN) Services
- Special Kids Special Care (SKSC)
- Provider portal
- Care Management & Community Partners
- Claim and Appeal Information
- Provider Responsibilities
- Fraud, Waste and Abuse

Topics



- Updates and Reminder
- Provider Demographics
- Provider Contacts
- EFT
- EDI
- Clinical Vendors
- MassHealth Enrollment
- Questions

Brand Change



So, What's New? Brand Change!

- In May 2022, BMC HealthNet Plan rebranded and renamed ourselves to better reflect Plan growth and our statewide reach, so we are now known as, **WellSense Health Plan**.
- We look forward to continuing to work with you as a valued partner for the health of our shared members and patients under this new identity.
- Information and training regarding the impacts that our rebranding may have on your practice is available, if needed. We hope for a seamless transition with little to no impact to your practice or member care.
- Please be aware that re-contracting is not required and we will not have any changes to our remit ID, address, policies, contacts and company phone numbers.
- Let's get started ...



WellSense Overview

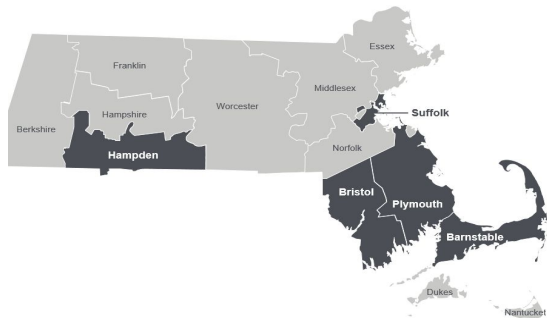


Who We Are...

- WellSense Health Plan is a non-profit managed care organization committed to providing the highest quality healthcare coverage to underserved populations.
- We operate in MA and NH
 - MA Medicaid or MassHealth (including ACO)
 - MA Clarity plans which include ConnectorCare
 - MA Senior Care Options (available in Barnstable, Bristol, Hampden, Plymouth & Suffolk counties)
 - NH Medicaid
 - NH Medicare Advantage

Our Member and Provider Network

Massachusetts



Over 600,000
Members across the
state



17,900 primary care,
specialists & behavioral
health providers

New Hampshire



Over 70,000
Members across
the state



Community resources

WellSense MCO and ACO plans include:

- **WellSense Essential MCO** – Primary Care within the WellSense MCO Network
- **WellSense Boston Children's Alliance (ACO)**– Primary Care within the WellSense Boston Children's Alliance ACO Network.
- **WellSense Beth Israel Lahey Alliance (ACO)**– – Primary Care within the WellSense Beth Israel Lahey Alliance ACO Network.
- **WellSense Care Alliance (ACO)**– – Primary Care within the WellSense Tufts Alliance ACO.
- **WellSense Community Alliance (ACO)**– – Primary Care within the WellSense Community Alliance ACO Network.
- **WellSense Mercy Alliance (ACO)**– – Primary Care within the WellSense Mercy Alliance ACO Network.

WellSense MCO and ACO plans include:

- **WellSense Signature Alliance (ACO)**– – Primary Care within the WellSense Signature Alliance ACO Network.
- **WellSense Southcoast Alliance (ACO)**– – Primary Care within the WellSense Southcoast Alliance ACO.
- **East Boston Neighborhood Health WellSense Alliance (ACO)** – Primary Care within the WellSense East Boston Neighborhood Health Alliance ACO Network.

WellSense's full network of MassHealth contracted facilities, specialists and ancillary services is available for all above Plans

WellSense ACO Partners

  WellSense BILH Performance Network ACO	  WellSense Community Alliance	  WellSense Boston Children's ACO	  East Boston Neighborhood Health WellSense Alliance
 Trinity Health Of New England Mercy Medical Center  WellSense Mercy Alliance	 SIGNATURE HEALTHCARE  WellSense Signature Alliance	 Southcoast [®] Health  WellSense Southcoast Alliance	  WellSense Care Alliance

Member ID Numbers – MassHealth ACOs

ACO Member ID numbers are sequenced according to plan type.

ACO plan	Prefix	ID numbering Scheme (note: the 00 is the suffix for all subscribers and will be on the ID card)
Community Alliance	20	2#####00
Mercy Alliance	30	3#####00
Signature Alliance	40	4#####00
Southcoast Alliance	50	5#####00

Member ID Numbers – MassHealth ACOs

ACO Member IDs have number sequencing according to the ACO they are assigned:

ACO	Prefix	ID numbering Scheme (note: the 00 is the suffix for all subscribers and will be on the ID card)
Boston Children’s ACO Alliance	71	71#####00
East Boston Neighborhood Health Alliance	72	72#####00
Beth Israel Lahey Health	70	70#####00
Tufts Medicine Care Alliance	73	73#####00

Member ID Numbers – MCO, Clarity & SCO

Member ID numbers are sequenced according to plan type.

Plan type	Prefix	ID numbering Scheme (note: the 00 is the suffix for all subscribers and will be on the ID card)
Masshealth MCO (including Special Kids Special Care)	B	B#####00
Clarity plans	C	C#####00
Senior Care Options	1	1#####00


MassHealth MCO ID cards

ID card callout

- Member ID cards begin with the letter “B” for our MassHealth MCO members, including Special Kids Special Care members.


Additional details


- **Network:** Statewide
- **Products include:**
 - MassHealth Standard / Disabled
 - Family Assistance
 - CarePlus A & B
 - *Note: Special Kids Special Care members may also qualify for MassHealth CommonHealth*

**WellSense**
HEALTH PLAN


Member Name

Member ID: B00123456 00
MassHealth ID: 12345678901

 **WellSense Essential (MCO)** A MassHealth Plan

 **Members** wellsense.org
Member Services Department
English: (888) 566-0010 | **Español:** (888) 566-0012 | **TTY:** 711

Mental Health/Substance Use:
Beacon Health Strategies (888) 217-3501
Pharmacy: Express Scripts (888) 566-0010
Emergency Care: Go to the ER or call 911

 **Providers**
Provider Services Department: (888) 566-0008
Behavioral Health: (866) 444-5155
Pharmacies: Express Scripts (877) 401-2069 **BIN:** 003858 **PCN:** MA
RxGRP: MAHLTH

MassHealth ACO Member ID cards

ID Card callout

- Member ID Cards begin with a number for **MassHealth ACO Plans**
- PCP Site logo will be included in the upper right corner of card

Additional details

- **Network:** Defined by each ACO
- **Products include:**
 - MassHealth Standard / Disabled
 - Family Assistance
 - CarePlus A & B



Clarity plan Member ID cards

ID card callout

- Member ID Cards begin with a “C” for **Clarity plans**

Additional details

- **Network:** Clarity network
- **Products include:**
 - ConnectorCare
 - Platinum
 - Gold
 - Silver
 - Bronze

**WellSense**
HEALTH PLAN

Member Name
Member ID: C00123456 00

**WellSense Clarity
Silver 2000 II**
Clarity Network

Deductible:
Ind/Fam: \$2,000/4,000
Medical Max Out-of-Pocket:
Ind/Fam: \$9,450/\$18,900

PCP: \$25
Specialist: \$60
Preventive: \$0
ER: \$350 AD



Memberswellsense.org

Member Services Department: (855) 833-8120 | TTY: 711
Mental Health/Substance Use:
Beacon Health Strategies (877) 957-5600

Find a doctor, hospital or pharmacy and see plan details at wellsense.org.

Your plan offers dental coverage for members 18 and under. For copay and coverage information visit wellsense.org or call Delta Dental at (844) 260-6097.

Providers

Provider Line: (888) 566-0008
Pharmacies: ExpressScripts (877) 401-2093 **BIN:** 003858 **PCN:** A4
RxGRP: BMCQHP





Senior Care Options(SCO) Member ID Cards

ID card callout

- **SCO for eligible members with MassHealth Standard only**
- ID Cards begin with the number “1” for our Senior Care Options members

Additional details

- **Network:** WellSense Senior Care Options
- **Products include:**
 - Members with MassHealth Standard only
 - HMO SNP for members also enrolled with Medicare A and B, dually eligible

 Member Name Member ID: 123456789 00 MassHealth ID: 12345678901  Senior Care Options (SCO)	 Members wellsense.org Member Services: (855) 833-8125 TTY: 711 Mental Health/Substance Abuse: (855) 833-8125 Emergency Care: Go to the ER or call 911  Providers Provider Services: (888) 566-0008 Mental Health/Substance Abuse: (855) 833-8125 Pharmacies: Express Scripts (877) 858-5958 BIN: 003858 PCN: MA RxGRP: MAHLTH
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Member Eligibility

- **MassHealth (ACO and MCO):** By accessing the MassHealth website at [@sso.hhs.state.ma.us/](https://sso.hhs.state.ma.us/) or the WellSense secure Provider Portal at wellsense.org or 888-566-0008
- **Clarity plans:** WellSense secure Provider Portal, wellsense.org or 888-566-0008
- **Senior Care Options:** WellSense secure Provider Portal, wellsense.org or 888-566-0008

*****Important Note*****

- **SCO Members** - Eligibility for SCO members changes on the first of the month, however we still recommend that you verify eligibility prior to the date of service. Member panel reports are not an accurate method for verifying eligibility. These reports are only intended to inform you of the member's assigned to your panel.
- **Clarity plans** - For Clarity plan members you are not able to verify eligibility via EVS, you must verify eligibility with WellSense directly
- Please check member eligibility on the date of service before delivering services and daily for inpatient admissions

Health Related Social Needs (HRSN) Services



Effective January 2025, MassHealth has transitioned CSP services and Flexible Services into a new service category called HRSN Services

Changes in terminology:

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

Changes in programming:

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

HRSN Housing Services	HRSN Nutrition Services
<ul style="list-style-type: none">• For members experiencing homelessness: Transitional Goods• For members at risk of homelessness: HRSN Housing Navigation• For members living in unhealthy, inaccessible, unsafe housing: Healthy Homes	<ul style="list-style-type: none">• Primary Services: Medically Tailored and Nutritionally Appropriate versions of (1) home-delivered meals, (2) food boxes, and (3) food prescriptions and vouchers.• Secondary Services (can only be provided in tandem with a Primary Service): Kitchen Supplies, Nutrition Education, Nutrition Counseling

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

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



Special Kids Special Care (SKSC)



Special Kids Special Care (SKSC) Program

- MassHealth and the Department of Children and Families (DCF) co-sponsor the Special Kids Special Care (SKSC) program medical program called for children with highly complex medical needs who are in foster care.
- WellSense welcomed approximately 100 members within this program to begin coverage on March 1, 2018. Today, our SKSC membership is over 125 members.
- Plan types include MH Standard, Standard Disabled, and MassHealth CommonHealth.
- SKSC members have access to the same medical benefits as our MCO and ACO members. They also have access to the following additional services:
 - Private Duty Nurses (PDN)
- SKSC members receive the same benefits and extras, with same restrictions, as our Medicaid members

Special Kids Special Care Program Eligibility

- Members must be 21.5 years or younger
- Reside in a foster home or other group setting, or in an adoptive or guardianship home once enrolled in the program
- Meet medical criteria that include requiring medical management by or under the supervision of a physician on a regular basis over a prolonged period of time, **and**
- Require direct administration of skilled nursing care that necessitates complex procedures (e.g., tube feedings, ostomy care, IV nutrition/medication, tracheotomy tube, ventilator care), **or**
- Require skilled assessment or monitoring related to an unstable medical condition that may necessitate advanced care or supervision



Special Kids Special Care Program Care Model & Contact Info

- The SKSC program includes dedicated Pediatric Nurse Practitioners (PNPs) and Pediatric Nurse Care Managers (PNCMs) who develop a plan of care and arrange the delivery of care for each qualified program participant.
- The PNPs and PNCMs collaborate with the member's PCP, specialists and other health care providers in addition to DCF, the foster family, guardians and birth parents.
- Care and services can be rendered in the member's home, doctor's office, hospital, outpatient facility, day care center or school.

☐ SKSC Members will have access to clinical staff at WellSense 24/7 365 days: (617) 638-7572

☐ SKSC members will call also have access to our MassHealth member line: (888) 566-0010

Provider Portal



WellSense Provider Portal

Our Provider Portal can be accessed from the login button at wellsense.org. When you log in, look out for:

1) Improved Claims Process: Providers can submit corrected claims, appeals, COB, EOB, and TPL review requests online and get reimbursed faster.

2) Streamlined Authorization Process: Our submission process is now more intuitive and allows providers to upload supporting documentation to their requests.

Skilled Hands should be spent with patients – not paperwork.



WellSense Provider Portal

Our Provider Portal is your one stop place to:

- Submit Prior Authorization and status inquiries
- Check Eligibility
- Submit Claims (professional only)
- Check Claims Status (mandated)
- Submit Appeals and Corrected Claims
- PCP Change Requests
- Member Demographic Changes (report member phone and address changes)

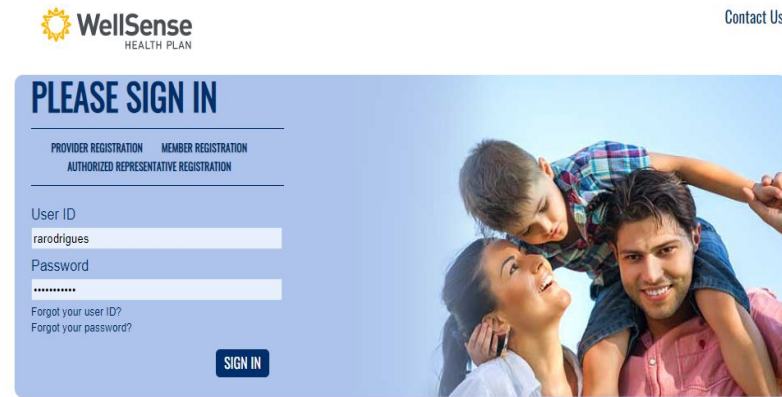
Provider Relations is here to train you on utilizing the Provider Portal to its fullest potential. Please reach out if training is needed in your office or if you need secure access.



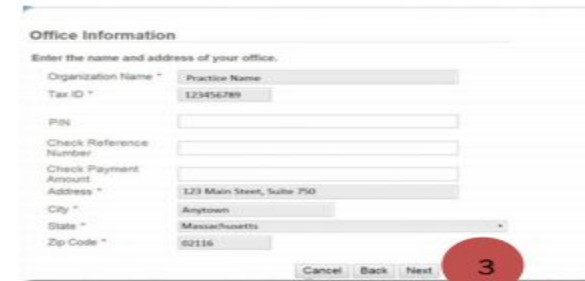
For providers who do not have an existing HealthTrio Connect account

- On the home page of the portal, under PLEASE SIGN IN, click Provider Registration.
- On the User Information page, fill in all fields and click Next
- On the Office Information page, fill in the information as requested and click Next.
- On the Registration Summary page, verify information and click Finish.
- Once registration is complete, all those registered from your provider office by the office administrator will be listed in a screen as pictured to the right.

If you do not have account access, please contact your designated office administrator.



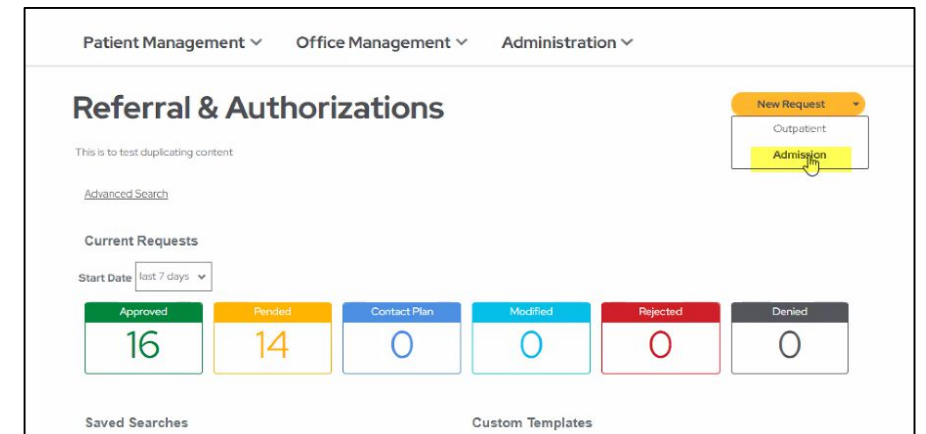
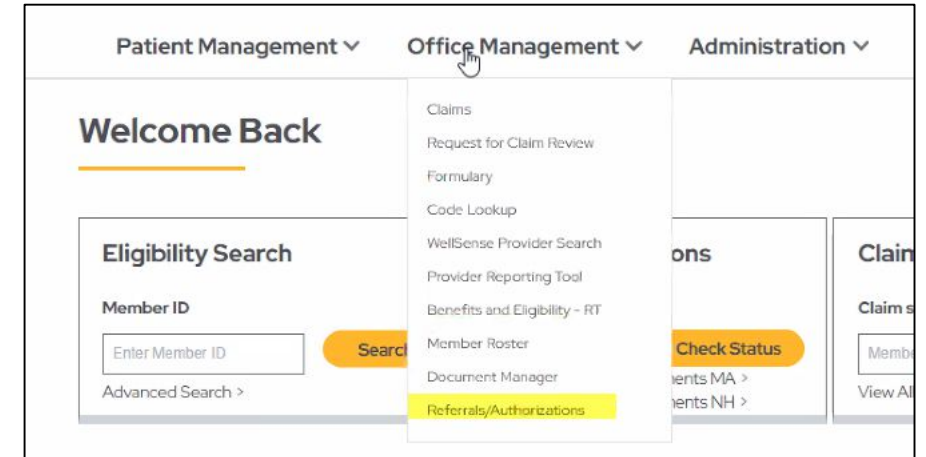
The image shows the 'PLEASE SIGN IN' screen of the WellSense Health Plan portal. At the top left is the WellSense Health Plan logo, and at the top right is a 'Contact Us' link. The main heading is 'PLEASE SIGN IN' in large blue letters. Below this, there are three tabs: 'PROVIDER REGISTRATION' (selected), 'MEMBER REGISTRATION', and 'AUTHORIZED REPRESENTATIVE REGISTRATION'. The 'User ID' field contains 'rarodrigues'. The 'Password' field is masked with dots. Below the password field are links for 'Forgot your user ID?' and 'Forgot your password?'. A blue 'SIGN IN' button is at the bottom right. The background of the sign-in area features a photograph of a smiling family (a man, a woman, and a child) against a blue sky.



The image shows the 'Office Information' form. The heading is 'Office Information' and the instruction is 'Enter the name and address of your office.' The form contains the following fields: 'Organization Name' (with a sub-field 'Practice Name'), 'Tax ID' (containing '123456789'), 'PIN', 'Check Reference Number', 'Check Payment Amount', 'Address' (containing '123 Main Street, Suite 750'), 'City' (containing 'Anytown'), 'State' (containing 'Massachusetts'), and 'Zip Code' (containing '02116'). At the bottom right, there are 'Cancel', 'Back', and 'Next' buttons. A red circle with the number '3' is overlaid on the bottom right corner of the form.

Authorization Submissions – Please submit via portal

- PA Submissions via the Portal vs. Paper – High area of focus for WellSense
 - Streamlined Process
 - Reduces paper, time and resources, resulting in efficiency.
 - Ability to check the status of your submitted request online
 - Faster & more secure than faxing
 - Submissions via the portal to be mandated in the future, become acquainted now!
- ** Online Submission of authorization requests will be mandated in the near future.



Care Management & Community Partners



Care Management Extra Help for Special Health Needs

CM Telephonic

- Care and Disease Management; Medical and Pharmacy
- Live referral line to accept incoming provider and member referrals to the program
- Community resources/support referrals
- Wellness and recover education

CM Select

- Complex Medical Care Management
 - Integrated model of care management involving Medical Clinicians, Pharmacists, Medical Directors and Coordinators
 - Face-to-Face and telephonic assessments
 - Intensive care coordination- follows the care of the member across the continuum- Outpatient to Inpatient
- Our Care Management Program is free for our members and is just a phone call away. Call **888-566-0010 (MassHealth members)** and **855-833-8120 (Clarity plan members)** to see if you are eligible for our programs.

“The Community Partner Program”

- The Community Partner Program impacts providers in accountable care organizations (ACO) and managed care organizations (MCO), as well as members with significant behavioral health and Long Term Services and Supports (LTSS) needs across Massachusetts.
- A Community Partner is a community-based organization that works with a member and his or her ACO's or MCO's primary care provider and health plan to help coordinate and manage health care services. Behavioral Health Community Partners support members with serious behavioral health needs. There are 18 Behavioral Health Community Partners agencies across the state. Long Term Services and Supports Community Partners work with members who need help meeting their needs for self-care and basic activities of daily living.

“The Community Partner Program”

- There are nine LTSS Community Partners across the state. Community Partners may be able to help assess members' needs, assist providers with planning the right treatments and services for members, work with providers to change the type of care a member receives (i.e. inpatient to outpatient care, manage and check medications, provide health and wellness information to members, identify community and social services programs that can support members, and assist members in selecting culturally sensitive providers.
- Each PCP practice must identify a care team point of contact responsible for communicating updates regarding the member's care to the Community Partners. In addition, each PCP practice must sign off on behavioral health or LTSS care plans. The required signatures must come from a PCP or PCP's designee such as an RN or other licensed medical professional, or a covering M.D., Nurse Practitioner, Physician Assistant or Doctor, D.O.

Claim and Appeal Information



Claims and Filing Limits

To expedite payment, we strongly encourage you to submit claims electronically and only submit paper claims when necessary

Filing Limits:

- | | |
|------------------------------|----------|
| ▪ MassHealth (including ACO) | 150 days |
| ▪ Clarity plans | 90 days |
| ▪ Senior Care Options | 150 days |

*Coordination of Benefits and other party liability rules apply

Electronic Claims:

- WellSense has partnered with TriZetto Provider Solutions (TPS) to manage our electronic data interchange (EDI) transactions exclusively. All clearinghouse service organizations and billing agencies that submit EDI transactions must send through TPS.

Paper Claims Mailing Address:

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

Payer ID: 13337

Professional Claims (only) can also be submitted via our Online Portal @ wellsense.org via *MyHealthNet*

Provider Administrative Claim Appeals

Provider administrative appeals include requests for reviews of denied claims, including but not limited to, untimely claims filing, level of compensation/reimbursement, no prior authorization/inpatient notification, member eligibility issues, clinical editing and coordination of benefits denials.

Provider Administrative Appeal

- If you wish to appeal a claim we have denied, **you must file a Provider Administrative Appeal** by completing a Claim Review on MY HealthNet
- You can also complete and submit the ***Universal Request for Claim Review Form***, which is available on our website (wellsense.org) in the Forms and Documents section.
- For questions about a Provider Administrative Claims Appeal, call the provider line at 1-888-566-0008, select option 2 to speak to a Provider Services Representative
- **WellSense provides ONE level of thorough review for administrative claims appeals that include all required information.** Decisions are made within 30 calendar days from the date the appeal is received at WellSense. If an administrative claims appeal is submitted without all required information, WellSense will dismiss the appeal and providers will be notified in writing.

If sending Provider Administrative Claims Appeals by mail, please use the following address:

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

Provider Administrative Claim Appeals

Timeframes for filing an Administrative Appeal

- For our MassHealth and SCO Plan products, Appeals must be filed with us within 150 calendar days from the original denial date and no later than 300 calendar days from the date of service
- For our Clarity plan products, Administrative Appeals must be filed within 90 calendar days from the original denial date and no later than 180 calendar days from the date of service.
- An administrative appeal filed after these timeframes will be denied, and WellSense will be held harmless. Retrospective adjustments (beyond the maximum 300 calendar days) will be denied or considered at WellSense's discretion.

Provider Administrative Claim Appeals

Providers who have questions on their claims appeal must contact the WellSense Customer Care/Provider Services Department where a representative will be happy to assist with inquiries.

➤ Provider Services Department 888-566-0008

- Please refer to our Provider Administrative Claim Appeals Policy, Number: O.5.019 for additional guidance on the provider administrative appeals process. The policy can be found on our website.
- Please also reference our Provider Manual, Billing & Reimbursement section for more information on filing provider administrative claims appeals

Member Appeals

WellSense strives to promptly resolve member appeals and grievances.

Difference Between Member Appeals and Provider Appeals:

- **Provider Administrative Claims Appeals** = a formal process for providers to request reviews of their denied claims pertaining to the areas mentioned on the previous slide.
- **Member Appeals** = a formal process for members or their Authorized Representatives, which includes providers, for reviews of denied services that have **not yet occurred***. When a prior authorization or inpatient stay is denied in advance of the member receiving the services, a Plan denial letter is issued to the member and requesting and servicing provider(s) and includes Member Appeal rights.

*The member appeals process also includes Plan applicable benefit reviews for excluded services/member reimbursements pertaining to out of pocket member liability. These are typically filed by members themselves.

Member Appeals

Member Appeals

WellSense has an efficient process in place to resolve member appeals. A member or authorized representative, which includes a provider acting on behalf of a member, may request three types of member appeals. Member internal appeals must be submitted to WellSense within 60 calendar days of the date of the notice of an adverse action.

- 1. Standard Internal Appeal** - resolved within 30 calendar days, unless extended. A signed Authorized Representative Form is required from the member for a provider or any other Authorized Representative to file the appeal on the member's behalf. The appeal is dismissed if this form is not received by the 30th calendar day.
- 2. Expedited Internal Appeal** - resolved within 72 hours unless extended. For WellSense records, a provider must formally assert that a member's health and/or life is in serious jeopardy awaiting the Standard Internal Appeal timeframe. If this is the case, a signed Authorized Representative Form from the member is not required for a provider to file the appeal on the member's behalf.
- 3. External EOHHS Hearing** - may be utilized only after the internal appeals process has been exhausted. These appeals must be filed within 120 calendar days of the date of the WellSense internal appeal denial letter.

Member Appeals

Information on the Member Appeals process is included in all initial denial letters sent to members and requesting/servicing providers and is located after the denial or partial approval rationale. The detailed information in the letter from WellSense includes but is not limited to:

- timeframes for filing member appeals
- methods and contact information for filing member appeals
- timeframes for processing of member appeals
- rights of the member throughout the appeal
- information on Authorized Representatives
- an informative member appeals insert
- an Authorized Representative Form

It is essential that providers/office staff review the denial or partial approval letter in its entirety to ensure any Member Appeals for prospective services are sent to the appropriate department at WellSense. This will allow us to process the member appeal as quickly as possible for the member.

Member Appeals

Provider Tips for effective and efficient Member Appeals process:

- Review the initial denial/partial approval rationale. The rationale for the decision will inform the provider which part(s) of the clinical criteria a member did not meet to qualify for coverage of the service/supply/medication/inpatient stay.
- If clinical information/documentation exists to prove the member meets the clinical coverage criteria but was not sent initially, be sure to include that information with the member appeal request.
- Include a written narrative supporting your member appeal on the member's behalf, including documentation of new/additional information being sent, reason(s) the member should be covered for the service/supply/medication/inpatient stay and any other information pertinent to the request*

*These Tips will reduce the number of follow-up phone calls required, based upon provider availability, and allow for faster processing of the member appeal.

Member Appeals

A Hearing through the Massachusetts EOHHS is an independent review by an EOHHS Hearing Officer (attorney) of a Plan internal appeal adverse action.

- A member may be eligible for an external Hearing Appeal only after they have exhausted the WellSense Internal Member Appeals process.
- The external Hearing Appeal must be filed within 120 calendar days of the date on the WellSense Internal Member Appeal adverse action notice.
- The member or their Authorized Representative, including providers filing on behalf of members, must be present for the EOHHS Hearing.
- Representatives from WellSense also participate in the Hearing.

Member Grievances

Member Grievances

Process where members or their Authorized Representative, including providers on a member's behalf, express dissatisfaction about the services they receive from WellSense and/or providers. Types of grievances include but are not limited to:

- Plan processes
- Plan staff
- provider and/or provider staff attitude/service
- quality of care
- quality of practitioner office site
- billing/financial issues
- access and availability

Member Grievances

- Providers may assist members or their Authorized Representatives in bringing forth grievances. Grievances may be filed with WellSense verbally through our Member Services department, via fax to the Member Appeals and Grievances department to 617-897-0805 or in writing to:

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

- If a member or their Authorized Representative files a grievance against a facility, provider and/or provider staff member, providers are expected to work with Plan staff by reviewing the expression of dissatisfaction and responding timely to the WellSense request for administrative and/or clinical information. The applicable information is crucial to a timely review and response to the member.

Provider Responsibilities



Provider Responsibilities - ACO

- Members will have a PCP within their ACO and must use that PCP for all primary care. Primary Care providers may only enroll in one ACO.
- The PCP will make efforts to direct members to specialists and other providers within the ACO or with whom there is an established relationship.
- However, members may go to any contracted specialist/other provider within the BMCHP network – subject to the specialist/provider obtaining a prior authorization for the service, if applicable.
- Non-PCP (Specialists, Facilities, Ancillary Services etc.) participation is not limited by ACO participation.
- There is no need for a new contract for non-PCP services for ACO participation; providers will remain contracted under their current MCO Agreement.

Provider Responsibilities- *ACO Community Partner Program*

MassHealth launched the Community Partners Program in 2018 to support the ACO initiative. This initiative impacts ACO & MCO providers, as well as, members with significant behavioral health and Long Term Services and Supports (LTSS) needs across Massachusetts.

What is a Community Partner?

- A Community Partner is a community-based organization that works with a member and his or her ACO's or MCO's primary care provider and health plan to help coordinate and manage health care services.
- Behavioral Health Community Partners support members with serious behavioral health needs. There are 18 Behavioral Health Community Partners agencies across the state.
- Long Term Services and Supports Community Partners work with members who need help meeting their needs for self-care and basic activities of daily living. There are nine LTSS Community Partners across the state.
- All Behavioral Health & LTSS Community Partners participate with MCOs. Relationships vary among ACOs due to regional access.

Provider Responsibilities- ACO Community Partner Program

What can Community Partners do?

Community Partners may be able to help:

- Assess members' needs
- Assist providers with planning the right treatments and services for members
- Work with providers to change the type of care a member receives, for example: inpatient to outpatient care
- Manage and check medications
- Provide health and wellness information to members
- Identify community & social services programs that can support members
- Assist members in selecting culturally sensitive providers

Who qualifies for participation in a Community Partners program?

- A portion of our membership will be eligible based on specific criteria.
- For Behavioral Health Community Partners there are approximately 3,500 eligible enrollees statewide. For LTSS Community Partners there are approximately 24,000 eligible enrollees statewide. *This means that a small percentage of your MassHealth panel will be eligible for Community Partners services.*
- MassHealth initially will assign members to specific Community Partners in the first six months. After that, ACOs and MCOs will be able to assign members to Community Partners.

Provider Responsibilities- ACO *Community Partner Program*

How does this affect PCP practices?

Community Partners care coordinators who want to speak with you about your patients. You'll work with the Community Partner as a member of your patient's care team and help develop the person-centered care plan.

The care coordinator can help you enhance your patient's treatment experience by:

- Increasing awareness of your patient's medical and functional needs
- Helping to connect you to your patient's other health care providers
- Helping your patient carry out goals of your patient's care plan
- Helping your patient better understand his or her care instructions
- Each PCP practice must identify a care team point of contact responsible for communicating updates regarding the member's care to the Community Partners. In addition, each PCP practice must sign off on behavioral health or LTSS care plans. The required signatures must come from a PCP or PCP's designee such as an RN or other licensed medical professional, or a covering MD, nurse practitioner, physician assistant or doctor DO.
- As is current practice, the patient's PCP makes referrals to medically necessary specialty care for which the ACO, MCO or MassHealth requires referrals. Conducting medication reconciliation is part of patient care transitions.

Provider Responsibilities

Responsibilities of Contracted Hospitals

- Hospitals are required to notify WellSense of emergency care and observation services rendered to patients.
- Hospitals must notify the Member's PCP within one business day of the Member's presentation at the emergency department. Notification may include a secure electronic notification of the visit.
- Hospitals must notify WellSense of newborn births.
- Coordinate with the WellSense hospital care coordinators on concurrent review and discharge planning activities for medical & surgical services.
- Adhere to Clinical Authorization Policies.

Provider Responsibilities

Senior Care Options Model of Care Training Requirement

- Our Senior Care Options (SCO) Model of Care requires that network providers receive WellSense-specific Model of Care training. Attesting to this training is required annually.
- A short, web-based training module regarding our Model of Care is available to you on our Provider Portal at wellsense.org, under Provider, Training.
- At the end of the training providers are asked to attest to having completed the training. NPI is required to attest

Provider Responsibilities - Verifying PCP; Requesting PCP Changes

Our MassHealth members may request a change in their PCP at any time; Clarity plans (including ConnectorCare) members may request a PCP change *up to* three times per year

* For ACO members, PCP changes outside of the members selection period can only be done within their assigned ACO.

Reminder: It is very important to check PCP assignment at every visit! If a provider has multiple affiliations you must verify that the member is assigned to the affiliation where services are being provided.

- Verify member assignment on date-of-service via our website, wellsense.org, or our provider hotline 800-900-1451
- Primary Care Provider (PCP) Change Requests should be submitted online via our Provider Portal, HealthTrio. Completed PCP Change forms may also be faxed to our Enrollment department. PCP Selection Form must be received before or on the date of service to avoid claim denial

Provider Responsibilities - PCP Member Transfer Policy

- Provide 60 days notice to member before effective date of member termination.
- Submit a **Member PCP Transfer Request Form** with appropriate documentation to help support the reason for your request to transfer the member, online through our Provider Portal, MyHealthNet.

Completed forms may also be faxed to our Enrollment Department: fax # 617-897-0838, if necessary.

- Plan will initiate member outreach and reassign member.
- Transition plan will be arranged to ensure there is no interruption in care.

Involuntary Member Transfer or Plan Disenrollment

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

Involuntary Member Transfer or Plan Disenrollment

Involuntary disenrollment of a member is reserved for rare and extraordinary circumstances only and will not be considered under the following circumstances:

- An adverse change in the member's health status
- The member's utilization of medical services
- The member's diminished mental capacity
- Missed appointments
- The member exercises their option to make treatment decisions with which the Provider or Plan disagrees, including the option to decline treatment or diagnostic testing
- The member's uncooperative or disruptive behavior resulting from his or her special needs (except when the member's enrollment seriously impairs the provider's and other staff's ability to furnish services to the particular member or other members)

Please refer to the Involuntary Member Transfer or Plan Disenrollment Policy on the WellSense provider website under Policies for the full guidance.

Provider Responsibilities – Wait Time Policies for MassHealth & Clarity plans

Appointment Type	Primary Care	Specialty Care
Urgent Care	48 Hours	48 Hours
Non-Urgent Symptomatic Care	10 Calendar Days	30 Calendar Days
Non-Symptomatic Care	45 Calendar Days	60 Calendar Days

Provider Responsibilities - Wait Time Policies for SCO

Appointment Type	Primary Care	Specialty Care
Urgent Care	48 Hours	48 Hours
Non-Urgent Symptomatic Care	10 Calendar Days	30 Calendar Days
Non-Symptomatic Care	45 Calendar Days	60 Calendar Days

Provider Responsibilities - Cultural Competency

WellSense encourages and expects providers to:

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

Provider Responsibilities - Primary Care Providers

Resources for training on the following topics are available on the WellSense provider portal and also via Massachusetts Health Quality Partners (MHQP) link:

<http://www.mhqp.org/>

- Issues concerning adult men and women & regular care they should receive
- Issues of adolescence
- Issues concerning women
- Issues concerning persons with disabilities
- Issues concerning other special populations including homeless, high-risk pregnant women, and children in the care and custody of DCF and youth affiliated DYS

Provider Responsibilities - Adult Prevention Guidelines SCO

Provide awareness and training for Fall Prevention to our SCO members

Falls are the leading cause of injury to the Elder Population. Every 17 seconds an elder will be treated in the ED for a Fall.

- Support members by providing awareness & training to your SCO members.
- Screen all members for Fall Risk by completing:
 - A full medication and functional assessment review
 - A screening for previous Falls to determine member risk
- Implement interventions based on Falls Risk
- Educate office staff on assessing & documenting previous member Falls, the cause and interventions put in place to prevent future Falls
- Evaluate the effectiveness of the Fall Prevention activities through a 30 day follow up

For Adult Preventive Guidelines & a Fall prevention checklist visit this link at the *Massachusetts Health Quality Partners* website:
http://www.mhqp.org/products_and_tools/?content_item_id=169#C9

Behavioral Health Services - Mental Health and Substance Abuse

Integrated Care (Medical and Behavioral Health)

- We partner with [Carelton](#) (formerly [Beacon Health Strategies](#)) to administer our behavioral health program for our members.
- **Early and Periodic Screening, Diagnosis and Treatment (EPSDT)**
Behavioral health screens are a normal and integral part of comprehensive well-child care. Along with MassHealth, we require primary care providers to offer a behavioral health screen to all MassHealth members under age 21 at every well child visit as part of the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) schedule.
- Please visit wellsense.org, Provider Resources, for a list of resources available, including but not limited to, the *PCP Tool Kit* or *Tips for CBHI Providers working with MCPAP*. We also provide a link to the MassHealth-approved screening tools.

Behavioral Health Services - Mental Health and Substance Abuse

Contact Information:

- For MassHealth members: 888-217-3501
- For Clarity plan members: 877-957-5600
- For SCO members: 855-833-8125

- For Providers: 866-444-5155
- For Claims: 888-249-0478

Fraud Waste and Abuse



Fraud, Waste and Abuse - Definitions

- **FRAUD**: intentionally making, or attempting to make, a false claim, representation or promise in an effort to receive payment or property to which one is not entitled. It can also be a concealment or omission of a material fact.
- **WASTE**: poor or inefficient practices occurring without intent to deceive that result in the provision of unnecessary health care services and subsequent expenditures.
- **ABUSE**: any activity that unjustly allows the perpetrator to obtain money or health care services to which he or she is not entitled but for which there is not the intent to deceive that is necessary for fraud to have occurred.

Common Fraud, Waste & Abuse - Schemes/Situations to Avoid

- Billing for services not rendered
- Billing for a non-covered service as a covered service
- Billing for medically unnecessary services
- Misrepresenting dates of service, locations of service, and/or provider of service
- Billing services performed by one professional under another professionals provider ID
- Waiving of deductibles and/or co-payments
- Incorrect reporting of diagnoses, modifiers or procedures
- Overutilization of services
- False or unnecessary issuance of prescription drugs

Common Fraud, Waste & Abuse - Schemes/Situations to Avoid, Cont.

- Up-coding services by billing for services at a higher complexity than services actually provided.
- Unbundling-billing for services included in a panel, global reimbursement, or capitation arrangement.
- Paying or receiving "Kickbacks" in Exchange for Referring Business
- Charging members out of pocket for covered services
- Cutting and pasting electronic medical records (cloning)
- Double billing for services
- Billing for a provider whose license has lapsed, is no longer in practice, is deceased, or is an ineligible Medicaid provider

Suspected Member Fraud -What should be reported

- Insurance card sharing
- Ineligible members (financial or geographical)
- Identity Theft (look for complaints of member's claiming they did not have a service with you, or that their ID was stolen; photo ID does not match individual seen in your office)
- Prescription fraud:
 - Allegations of forged prescriptions
 - Doctor shopping
 - Theft of prescription pads/paper

Fraud, Waste and Abuse

- Fraud, Waste and Abuse... Affects all of us!
- Under federal and state regulations, a dishonest provider or member may be subject to fines and/or imprisonment
- Fraud and abuse may include, but is not limited to, the following:
 - Charging in excess of usual, customary and reasonable fees
 - Performing unnecessary or inappropriate service
 - Billing a service that was not performed or misrepresenting a service
 - Billing duplicate claims
 - Unbundling claims
 - Collecting monies except for deductible amounts, coinsurance amounts, copayment amounts, and non-covered items
- Fraud or abuse does not need to be proven or investigated, but needs to be reported if suspected
- Report anonymously via the hotline number provided or leave detailed information if you desire follow-up
- Hotline is administered by Global Compliance

Fraud, Waste and Abuse

You must report any Provider, Pharmacy or Member who is suspected of committing Fraud, Waste or Abuse. You do not have to give your name to report an incident

–You can report an incident by calling the:

Compliance Hotline: 888-411-4959 or email FraudAbuse@bmchp-wellsense.org

–Or in writing to:

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

Limitations on Provider Marketing

- **Prohibition on Promoting BMCHP:** Providers should not encourage patients to enroll in BMCHP's products, or to *not* enroll or dis-enroll from another MCO. If a Provider is concerned that their communication with patients may be interpreted as promoting BMCHP, please consult your BMCHP Provider Relations Consultant.
- **Use of State-Approved Materials Exception:** Providers may post in their offices, marketing materials that have been approved by the applicable state-regulatory agency. SCO providers are also allowed to promote their affiliation with BMCHP to their patients using an approved letter which can be provided upon request.
- **Handout:** See document on guidance with communicating with patients about BMCHP.

Updates and Reminders



Provider Demographic Changes

It is critical to notify us of Provider Demographic Changes timely!

- Plan is required to keep provider information up to date and ensure plan online directory is kept current with the most accurate information.
- Providers are expected to notify WellSense of any provider changes or updates as they occur and regularly, by working with their Provider Consultant to verify their Provider Demographic Rosters.
- Demographic changes that you should notify us about include:
 - Payment Changes- *this affects payments and will delay or interrupt payment if incorrect*
 - Tax Identification Number or Entity Affiliation change (W-9 required)
 - Group Name or Affiliation change
 - National Provider Identifier
 - Mailing Address change
 - Telephone and/or Fax number update
 - Termination or Expiration
 - Provider updates in Panel Status

How to submit Provider Demographic Changes

Provider changes and updates are critical. Please submit within 60 days of change via the methods below.

Provider/Termination Change Form *can be emailed to* Provider.ProcessingCenter@wellsense.org. Please include a W9 for remittance changes.

Providers who appear in our directory will receive updates on our progress in rolling out DirectAssure.

Importance of Provider Contacts

To ensure you receive important updates and notices please be sure to keep your contact information up to date with us.

Please reach out to your Provider Relations Consultant to inform us of staff changes in your office to ensure you and they are receiving our important email notifications.

You can also reach us at Provider.Info@wellsense.org to request a General Contact Form so we can update your contacts as requested.

EFT Reminder

Make sure that your provider office takes advantage of Electronic Funds Transfer (EFT), a convenient and efficient option for claims payments.

EFT permits an electronic direct deposit of your WellSense claim reimbursements into the bank that you designate.

Advantages of EFT include:

- Prompt payment – no waiting for checks to clear
- Improved cash flow
- No lost checks or postal delays
- Administrative savings
- Reduced paperwork
- Secure payment environment

For more information about how to enroll in EFT, please call your dedicated Provider Relations Consultant or call the provider line at 888-566-0008.

EDI Reminder

Electronic Claim Submission

- To expedite payments, we suggest and encourage you to submit claims electronically. Providers can submit claims electronically directly to WellSense through our online portal or via a third party. You can register with Trizetto Payer Solutions or, use the following clearinghouses:
- Gateway EDI
- NEHEN (New England Healthcare EDI Network)

For more information about how to enroll in EDI, please call your dedicated Provider Relations Consultant or call the provider line at 888-566-0008.

SCO Model of Care – Required Annually

As with all Senior Care Options plan, WellSense's Model of Care requires that network providers receive annual training and attest on an annual basis.

For the convenience of our providers, we have prepared a short, web-based training module – Senior Care Options Model of Care Training which is available to you through our online portal.

wellsense.org/providers/ma/training-and-support

At the end of the training you will be asked to click through to attest that you have completed the training. To complete the attestation you must have your NPI number.

If you are a larger group practice, we suggest that you reach out to your Provider Relations Consultant who can assist with coordinating the training and attestation process.

Introduction to the WellSense Clinical Vendors

Carelon Behavioral Health, formerly Beacon Health Services - Behavioral Health

- Available 24/7 for members and providers.
- Manages inpatient and outpatient behavioral health and substance use services, and will be contracting on behalf of the ACO for BH Community Partner services.
- Prior authorization may be required for certain services.
- Visit the Carelon website for more resources or to find a provider
- Call Carelon Behavioral Health:
 - Clarity plan members: 888-217-3501
 - ACO and MCO members: 877-957-5600
 - SCO members: 855-833-8125

Northwood - Durable Medical Equipment, Prosthetics, and Orthotics

- Manages durable medical equipment, prosthetics, orthotics, and medical supplies (DMEPOS) network.
- Prior authorization is required for all DMEPOS dispensed and billed by a DMEPOS supplier.
- Visit: [Northwood, Inc.](#)
Call: 866-802-6471

Introduction to the WellSense Clinical Vendors

Express Scripts - Pharmacy Benefits

- Submit a coverage review request online through one of these ePA portals: [Surescripts](#), [CoverMyMeds](#), or [ExpressPAth](#).
- If you do not have access to an ePA system, you may contact Express Scripts to submit your request at 877-417-1822 (for MassHealth members) or 877-417-0528 (for Clarity plan members), or you can submit the [General Medication Request Form](#)

eviCore - High End Radiology, Musculoskeletal (MSK) and Genetic Testing

- Manages outpatient non-emergency high end radiology (MRI, CT, PET, Nuclear Cardiology)
 - Phone: 888-693-3211
 - Fax: 888-693-3210
- Manages authorizations for MSK and Genetic Testing
 - Phone: 844-725-4448
 - Fax: 855-744-1319
- Submit authorization requests via the portal at [eviCore.com](#)

AxisPoint Health - Nurse Advice Line

- Available 24/7 for members
- An audio health library of recorded information, by topic, can be accessed through the advice line
 - Clarity plans: 866-763-4695
 - MassHealth: 800-973-6273

Important Phone Numbers

**MassHealth
&
Clarity plans
888-566-0008**

- **Option 1:** Automated Eligibility and/or Claims Status
- **Option 2:** Claims or Provider Enrollment Status
- **Option 3:** Medical Services, Prior Authorizations and Notifications, other than BH & Pharmacy
- **Option 4:** Pharmacy Authorizations & Eligibility, other than Claims Status
- **Option 5:** DME Inquiries including authorization status

Requirement for Network Providers to enroll with MassHealth

- Changes in federal law (set forth at 42 CFR § 438.602) require all managed care entity (MCE) network providers, including WellSense network providers, to enroll with MassHealth. This means all WellSense network providers must have two provider contracts in place:
- A network provider contract with WellSense Health Plan; and
- A provider contract with MassHealth.
- MassHealth has developed the MassHealth Nonbilling Managed Care Entity (MCE) Network-only Provider Contract for MCE network providers who do not already have a provider contract with MassHealth. This specific MassHealth provider contract does not require the WellSense network providers to render services to MassHealth fee-for-service members.
- Visit <https://www.mass.gov/forms/submit-the-masshealth-nonbilling-managed-care-entity-network-only-provider-contract> to complete a MassHealth Nonbilling MCE Network-only Provider Contract under this requirement.

Should you have any additional questions please contact your dedicated Provider Relations Consultant or send your inquiry to our Provider Engagement Team at provider.info@wellsense.org.

Training Opportunities

Our Provider Engagement Team is here for you!

- New or “Refresher” Orientations
- HealthTrio Trainings/ “Refreshers”
- CPT-HCPCS Look-Up Tool Training
- Re-education
- Review of Policies and Procedures
- General Plan questions
- Inquiries on Participation status
- Requests to join our Plan
- Requests for materials
- Initiatives and other exciting ventures

Questions?

Thank you for your time!



Provider Engagement
WellSense Health Plan
provider.info@wellsense.org