




MassHealth
Managed Care Entity Bulletin 16
May 2019

TO: Accountable Care Organizations

FROM: Daniel Tsai, Assistant Secretary for MassHealth 

RE: Updated: Accountable Care Organization Primary Care Provider Changes Effective January 1, 2020

Overview

This bulletin is an update to Managed Care Entity Bulletin 14. The Executive Office of Health and Human Services (EOHHS), through its Accountable Care Organization Program, continues to invest in primary care and remains focused on delivering integrated behavioral and physical health care, care management for members with complex needs, coordinated transitions of care, and an improved member experience.

This bulletin details how Accountable Care Partnership Plans, Primary Care ACOs, and MCO-Administered ACOs (collectively referred to herein as ACOs) may propose to add new primary care providers (PCPs) or to remove current PCPs from their exclusive list of PCPs. EOHHS is allowing ACOs to propose PCP additions and removals at this time to further its goals of expanding the impact of the ACO Program and its benefits to additional members and providers, while allowing ACOs to make limited updates to reflect changes in PCP affiliations. EOHHS will not approve any proposed PCP removals that are based on the complexity or cost of the PCP's attributed member population.

Proposals to add or remove PCPs are due by **4 p.m. on Friday, June 14, 2019**. The effective date of any approved additions to or removals from ACOs' lists of exclusive PCPs will be January 1, 2020.

This process should only be used for changes to an ACO's exclusive list of PCPs that are being proposed for an effective date of January 1, 2020, and that do not qualify for the ACO Provider File Maintenance Request process.

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To ensure smooth transitions for members who are newly enrolled in ACOs through this process, ACOs are expected to comply with the provisions of Section 2.2.C.4 in the Accountable Care Partnership Contract or Section 2.2.A.5 in the Primary Care ACO Contract. Based on the type of ACO, these obligations include

- the provision of a 90-day Continuity of Care period beginning January 1, 2020;
- extended network and provider flexibilities beyond the initial 90-day period;
- payment to out-of-network providers during the Continuity of Care period and continued payment to such providers after the 90-day period in certain circumstances;
- ongoing collaboration with and support to EOHHS in working with members and their providers throughout and after the Continuity of Care period (e.g., participating on member-facing phone calls; identifying specific issues and working with EOHHS to resolve those issues; operating efficient credentialing processes); and
- focused efforts to ensure Continuity of Care for members with needs requiring specialized care, including but not limited to members who
 - are pregnant;
 - have significant health care needs or complex medical conditions;
 - have autism spectrum disorder (ASD) and are currently receiving ABA services;
 - are receiving ongoing services such as dialysis, home health, chemotherapy and/or radiation therapy;
 - are hospitalized; or
 - are receiving treatment for behavioral health or substance use, including Medication for Addiction Treatment (MAT) services.

EOHHS Review

In reviewing an ACO's request to add or remove PCPs through this process, EOHHS may approve, disapprove, or require modification, in whole or in part, of the ACO's request based on its reasonable judgment as to whether the proposed additions or removals will support the goals of the ACO program, be in the best interests of members, and meet the needs of EOHHS. In making such determination, EOHHS may consider factors that include but are not limited to

- impact on members;
- impact on enrollment choices for members;
- impact on network adequacy;
- the ACO's plans for notifying impacted parties, including members and providers;
- the ACO's proposed approach to ensuring Continuity of Care; and
- overall ACO geographic penetration in the Commonwealth.

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Additionally, in evaluating proposed additions, EOHHS may also consider factors such as the following:

- the demonstrated commitment by the PCP to participate, including whether the ACO and the proposed PCP have a contract in place;
- the prior relationship and ongoing collaboration between the ACO and the PCP;
- the ACO's proposed approach to integrating the PCP into the ACO governance or organizational structure, population health management strategy, Delivery System Reform Incentive Payment (DSRIP) investment plans, and value-based payment approach;
- the ACO's proposed approach to appropriate and effective data sharing and data integration between the ACO and the PCP; and
- the ACO's proposed approach to facilitating collaboration between the PCP and Community Partners.

For proposed removals, EOHHS may consider additional factors such as the following:

- demonstrated effort by the ACO to resolve any challenges with the PCP; and
- complexity of the PCP's attributed member populations.

Part 1: PCP Additions

Submission Process for Proposed PCP Additions

ACOs that are requesting to add PCPs whose participation will be effective January 1, 2020, must submit the information requested below to EOHHS by **4 p.m. on Friday, June 14, 2019**. ACOs must provide the information requested in the order in which it appears in this bulletin and must limit the response to a total of 20 pages. Attachments and other required documentation will not count toward the page limit. Where applicable, ACOs should use the templates provided by EOHHS.

Submissions must come from the party holding the ACO contract with EOHHS. As appropriate, in the case of an Accountable Care Partnership Plan (ACPP), the ACPP may respond to each item on behalf of itself and on behalf of its ACO Partner. For each item, the ACPP shall clearly designate whether it is responding on its own behalf or on behalf of its ACO Partner.

Submissions must include the following:

- A. A complete list of the PCPs the ACO proposes to add, using the template provided by EOHHS. An ACO's list of PCPs proposed for addition must be final at the time of submission of the proposal and may not be changed in any way unless requested by EOHHS. PCP additions proposed as part of this process and approved by EOHHS will be incorporated into the ACO's provider identification service location (PID/SL) list via contract amendment effective January 1, 2020.
- B. Signed contracts between the ACO and all proposed PCPs, demonstrating the intent of each PCP to affiliate or contract with the ACO.
 1. If the ACO or ACO Partner has legal authority to enter into agreements with any proposed PCPs on their behalf, the ACO may submit appropriate contracts and documentation to demonstrate this to EOHHS' satisfaction instead of signed contracts between the ACO and such PCPs.
 2. If a contract has not yet been executed between the ACO or ACO Partner and a proposed PCP, the ACO may provide a signed letter of intent or memorandum of understanding (MOU) in response to this section.
- C. A description of the relationship between the ACO and the proposed PCPs, including, at a minimum, descriptions of
 1. the shared organizational history, if any, between the ACO and the PCP;
 2. whether or not the ACO directly employs, owns, or controls the PCP;
 3. whether the PCP has joined a physician association or other organization that is in whole or in part participating in the ACO;
 4. other significant prior corporate relationship, including board participation by either entity on the other's board, if the ACO does not directly employ, own, or control the PCP;
 5. any current contracts, initiatives, or other efforts on which the ACO and the PCP collaborate. Please include the duration of the contracts, initiatives, or other efforts, the number of members involved, and the approximate dollar value of such contracts, initiatives, or efforts.
- D. A description of how the ACO proposes to integrate the PCP(s) into the ACO's governance and decision-making processes, including, at a minimum,
 1. a description of any changes to the following governance structures resulting from the addition of the PCP, including at a minimum, changes to the governance structure composition, decision-making process, voting rules, and charter:

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- a. Governing board;
 - b. Joint Operating Committee;
 - c. Quality Committee;
 - d. Patient Family Advisory Committee; and
 - e. Other similar governing body.
2. An explanation of how such changes in governance structure comply with EOHHS contract requirements (Section 2.3.A.1 of the Accountable Care Partnership Plan Contract; Section 2.1.A of the Primary Care ACO Contract and Section 2.1.A of the MCO-Administered ACO Contract);
 3. If no changes to the ACO's governance structure are anticipated, an explanation of
 - a. why the ACO believes the addition of the PCP does not require revisions to its governance structure;
 - b. how the PCP will otherwise participate in the ACO's organizational structure (e.g., as part of a physician association through affiliation mechanisms common to the ACO's existing PCPs).
- E. A description of why the ACO believes it and the PCP will maintain and strengthen their partnership throughout the term of the ACO Contract, including,
1. a description of the ACO's long term strategy and evidence of a demonstrated commitment between the ACO and the PCP to stay together;
 2. a description of the process the ACO and the PCP will use to resolve disagreements, including but not limited to disagreements related to any conflicts of fiduciary duty.
- F. A description of how the PCP will be integrated into the ACO's population health management strategy including, at a minimum, descriptions of
1. the PCP's existing population health management resources (e.g., care coordination/management, risk stratification capabilities, community-based programs) and how such resources will be incorporated into the ACO's existing population health management structure, as defined in the ACO's EOHHS-approved DSRIP Full Participation Plan and Performance Management Plan;

2. how the ACO will support the new PCP in making any necessary changes to its population health management approach (e.g., providing additional investments) such that members across the ACO have an aligned experience of care. Such description must include, at a minimum, how the ACO will ensure effective integration of the PCP into the ACO's relationship with its contracted Community Partners.
 3. how the ACO will assist the PCP in integrating with the Community Partners program to support new ACO members, including
 - a. a list of the CPs the new PCP(s) will need to establish relationships with;
 - b. for each such CP and PCP, a brief description of any progress that has been made in establishing such relationships;
 - c. the ACO's proposed strategy for establishing the necessary CP relationships for new PCP(s), including any planned staffing changes at the PCPs; and
 - d. how the ACO will incorporate the PCP into its broader strategy for making referrals and assignments to CPs.
- G. A description of the ACO's approach to ensuring appropriate data integration and data sharing capabilities between the ACO and the PCP including, at a minimum, descriptions of how the ACO and the PCP will share data for purposes of reporting requirements under the ACO Contract.
- H. A description of the ACO's value-based payment strategy relating to the proposed PCPs (e.g. compensation models, performance-based incentives, individual-level metrics), including, at a minimum, descriptions of
1. the PCP's current experience, if any, with value-based payments;
 2. how the PCP will be integrated into the ACO's value-based payment approach;
 3. how the ACO will support the PCP in transitioning to the ACO's value-based approach; and
 4. if the ACO is an Accountable Care Partnership Plan, any changes to the ACO Partner's financial accountability to the ACPP, including the maximum potential for performance-based gain- or loss-sharing by the ACO Partner resulting from the addition of the PCP, and indicate how such changes comply with Section 2.3.A.2.f.2 of the Accountable Care Partnership Plan Contract.
- I. A description of the ACO's proposed DSRIP investments for such PCP. Such description shall include, at a minimum, descriptions of
1. ACO's planned investments and the PCP's goals and opportunities to improve that the ACO's planned DSRIP investments are intended to address;

2. how the ACO plans to integrate such investments into the ACO's DSRIP Participation Plan.

The ACO's DSRIP investments related to PCP additions proposed as part of this process and approved by EOHHS must be incorporated into the ACO's DSRIP Participation Plan and Budget and Budget Narrative, as applicable and as further directed by EOHHS.

- J. A description of the most significant challenges the ACO has identified in integrating the PCP into the ACO and how the ACO plans to address those challenges. Such description should include how the ACO will assess any specific areas where the PCP will need assistance in integrating into the ACO (e.g., population health management, Community Partners), and how the ACO will address these areas. EOHHS will evaluate the inability to identify any challenges unfavorably.
- K. If the ACO is a Primary Care ACO or an MCO-Administered ACO, the ACO shall also provide a description of how the ACO will ensure Continuity of Care for members, including at a minimum, the ACO's approach to
 1. supporting EOHHS's and MCOs' efforts to ensure smooth transitions for members, including at a minimum identifying high-risk members, sharing data as appropriate, and transitioning complex care management (identifying lessons learned from initial launch or the addition of PCPs effective January 1, 2019, as applicable); and
 2. any other Continuity of Care efforts to ensure a smooth transition for any members who may switch plans as a result of the PCP additions proposed by the ACO (identifying lessons learned from initial launch or the addition of PCPs effective January 1, 2019, as applicable).
- L. If the ACO is an Accountable Care Partnership Plan (ACPP), the ACPP shall also describe how the ACPP will ensure Continuity of Care for members, addressing the following, and describing specific arrangements for categories such as behavioral health and pharmacy, (identifying lessons learned from initial launch or the addition of PCPs effective January 1, 2019, as applicable); where appropriate:
 1. A description of how the ACPP will extend existing prior authorizations for members, including coordinating with members' prior plans on sharing authorization information;
 2. A description of how the ACPP will ensure that members may continue to access current providers that may not currently participate in the ACPP's provider network, including at a minimum,

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- a. the ACPP's approach to identifying existing care relationships for members associated with the proposed PCPs;
 - b. the ACPP's approach to identifying gaps between the ACPP's provider network and the provider networks for any plan whose enrollees are likely to be enrolled in the ACPP as the result of the proposed PCP addition, and the ACPP's strategy for contracting with such providers where applicable; and
 - c. the identified gaps between the ACPP's network and the provider networks for any plan whose enrollees are likely to be enrolled in the ACPP as a result of the proposed PCP addition, and the ACPP's specific plans to contract where applicable, including addressing at a minimum,
 - 1) any affiliated providers of the proposed PCP (e.g., specialty physician groups and outpatient centers);
 - 2) any other providers listed in the directories for such other plans that do not participate in the ACPP's network and are considered high priority for contracting by the ACPP; and
 - 3) any other providers likely to serve members currently served by the proposed PCPs otherwise identified and considered high priority for contracting by the ACPP.
3. A description of how the ACPP will extend provider, network, and authorization flexibilities beyond 90 days and provide additional network arrangements (e.g., single case agreements) for any members not successfully transitioned to in-network providers by the end of that period (e.g., members with particular longstanding relationships with out-of-network specialty centers or professionals); and
 4. A description of how the ACPP will notify and communicate with members throughout the Continuity of Care process.

Part 2: PCP Removals

Submission Process for Proposed PCP Removals

ACOs that are requesting to remove PCPs effective January 1, 2020, including a PCP that is proposing to move to a different ACO through this process, must submit the below information to EOHHS by **4 p.m. on Friday, June 14, 2019**. ACOs must provide the information requested in the order in which it appears in this bulletin and must limit the response to a total of 20 pages. Attachments and other required documentation will not count toward the page limit. Where applicable, ACOs should use the templates provided by EOHHS.

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Submissions must come from the party holding the ACO contract with EOHHS. As appropriate, in the case of an Accountable Care Partnership Plan (ACPP), the ACPP may respond to each item on behalf of itself and on behalf of its ACO Partner. For each item, the ACPP shall clearly designate whether it is responding on its own behalf or on behalf of its ACO Partner.

If a PCP is “switching” ACOs (i.e., an ACO is requesting to add a PCP that is currently a PCP on another ACO’s exclusive list of PCPs), EOHHS expects to receive a response to this Bulletin from both the current ACO (seeking to remove the PCP) and from the proposed new ACO (seeking to add such PCP). EOHHS will contact an ACO whose current PCP is switching to a different ACO to ensure the sufficient receipt of information required in this bulletin.

Submissions must include the following:

- A. A complete list of the PCPs the ACO proposes to remove, using the template provided by EOHHS. An ACO’s list of PCPs proposed for removal must be final at the time of submission of the proposal and may not be changed in any way unless requested by EOHHS. PCP removals proposed as part of this process and approved by EOHHS will be incorporated into the ACO’s provider identification service location (PID/SL) list via contract amendment effective January 1, 2020.
- B. A description of how the ACO proposes to change or modify its current strategy and operations based on the removal, including, at a minimum:
 - 1. changes to the governance structure composition, decision-making process, voting rules, and charter, and an explanation of how such changes in governance structure comply with EOHHS contract requirements (Section 2.3.A.1 of the Accountable Care Partnership Plan Contract; Section 2.1.A of the Primary Care ACO Contract and Section 2.1.A of the MCO-Administered ACO Contract); and
 - 2. any changes to investment strategy, including DSRIP.

Changes to the ACO’s DSRIP investments related to PCP removals proposed as part of this process and approved by EOHHS must be incorporated into the ACO’s DSRIP Participation Plan and Budget and Budget Narrative, as applicable, pursuant to contract amendment to be effective January 1, 2020.

- C. A description of how the ACO will support Continuity of Care and care management transitions for members who receive care from any PCPs proposed for removal, including:
 - 1. The ACO’s commitment to and process for notifying members in advance of PCPs leaving the ACO;

2. For any members who are receiving active care coordination or management supports from the ACO, including any members enrolled in CPs, the ACO's plan for providing a "warm hand-off" to the members' new plan(s) or CPs, as applicable; and
 3. The estimated percentage of members attributed If the ACO is an ACPP, the ACO's commitment to and process for identifying and sharing information on authorizations and important providers with the members' new plan(s).
- D. A description of the PCP's attributed member population, including:
1. The number of members attributed to the PCP;
 2. Characteristics of the population, including but not limited to race, ethnicity, and homelessness status and how these characteristics differ from the rest of the ACO's member population, if at all;
 3. to the PCP with Special Health Care Needs, as defined in the ACO Contract, and how such percentage differs from the estimated percentage of members enrolled in the ACO with Special Health Care Needs, as defined in the ACO Contract, if at all
 4. A breakdown of the members attributed to the PCP by rating category; and
 5. The average risk score of members attributed to the PCP, and how the average risk score differs from the overall average risk score of the ACO's enrolled members, if at all
- E. A description of the reason for the proposed removal of the PCP and any resulting plans to modify the ACO's management approach to its PCPs;
- F. A description of the PCP's financial performance, including but not limited to, an estimation of the impact of the change on the ACO's Total Cost of Care if the PCP is removed;
- G. A description of any performance management efforts the ACO has undertaken with the PCP, and the outcomes of such efforts;
- H. Documentation indicating that the PCP has been notified that the ACO is requesting their removal and any response received from the PCP to such notification.

Questions

ACOs were given until May 17, 2019, to submit written questions concerning the process. EOHHS will review questions and may prepare written responses to questions which EOHHS determines to be of general interest. EOHHS also may accept questions during ACO office hours.

EOHHS may contact ACOs to clarify any information submitted in response to this Bulletin.

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