Improving Care Coordination by using Mass HIway Direct Messaging

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Today’s Presenters

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This presentation has been reviewed and approved by the Mass HIway, and the presenters are acting as authorized representatives of the Mass HIway.

The information provided in this presentation is for general information purposes only, and in no way modifies or amends the statutes, regulations, and other official statements of policy and procedure that govern access to and use of the Mass HIway.
Mission: Enable Health Information Exchange by healthcare providers and other HIway users regardless of affiliation, location or differences in technology

HIway Direct Messaging
- Secure method of sending transmissions from one HIway User to another
- HIway connection for Massachusetts Public Health Reporting
- HIway does not use, analyze or share information in the transmissions and does not currently function as a clinical data repository

HIway Provider Directory
- Provider Directory listing in-state and out-of-state providers connected to HIE
- Contains information for 21,000+ HIway Users

HIway-Sponsored Services
- State-wide Event Notification Service (ENS) - anticipated to launch in 2019

HIway Adoption and Utilization Support (HAUS) Services
- Assistance for eligible organizations in the deployment of HIE to enhance care coordination
Meaningful Use (MU)

- Specified transaction level targets for Hospitals, Physicians, Specialists, NPs
- Does not include Behavioral Health (BH), Long Term Care, SUD programs, or Long Term Support Services (LTSS)

Quality Payment Program (QPP) – Value Based Payment

- Merit-based Incentive Program (MIPS) – Promoting Interoperability
- Advanced Alternative Payment Models (APM)

MA 1115 Waiver

- Focus on integrating Behavioral Health Community and Accountable Care Organizations
  - Mental health and substance use disorder treatment
  - Support for the social determinants of health
- Community Partners include LTSS and BH orgs which may not use C-CDA documents
  - Often don’t have electronic exchange capability. E.g.: may use PDF assessments
Secure method for transmitting messages between providers for wide variety of use cases

**Supported Use Case Categories**
- Public Health Reporting
- Provider-to-Provider Communications
- Payer Case Management
- Quality Reporting (as per the Mass HIway Policies & Procedures)

**User types**
- Physician practice
- Hospital
- BH, Long-term care and other providers
- Public health Health plans

**Connectivity options**
- EHR connects directly
- EHR connects via Connect Device
- EHR connects via HISP (Health Information Service Provider)
- User connects via webmail

**HIE Services**
Migration to Mass HIway 2.0 is in progress

Mass HIway 2.0 is a member of DirectTrust and is connected to many private HISPs. This offers a rich network for HIway Direct Messaging to MA providers.
The HIway is ‘content agnostic,’ and does not restrict message types

**Patient clinical information**
- Summary of Care / Transition of Care Record (TOC)
- Request for Patient Care Summaries
- Discharge Summaries
- Referral Summary Information
- Specialist Consult Notes
- Progress Notes

**Quality reporting**
- Reporting of clinical quality measures (CQMs)

**Public Health Reporting***
Securely comply with reporting regulations for the Massachusetts Department of Public Health (DPH)
- Massachusetts Immunization Information System (MIIS)
- Electronic Lab Reporting (ELR)
- Syndromic Surveillance (SS)
- Massachusetts Cancer Registry (MCR)
- Opioid Treatment Program (OTP)
- Childhood Lead Poisoning Prevention Program (CLPPP)
- Occupational Lead Poisoning Registry (Adult Lead)

* There is no cost for a HIway connection that is used exclusively for DPH reporting.
Example of Direct Messaging

Data holder sends patient information to recipient

Provider Directory

<table>
<thead>
<tr>
<th>Provider name</th>
<th>Local name</th>
<th>Institution</th>
<th>Direct address</th>
</tr>
</thead>
<tbody>
<tr>
<td>Smith, Marilyn M</td>
<td>Smith, Marilyn</td>
<td>Hospital</td>
<td><a href="mailto:Marilyn.Smith@direct.HospitalB.masshiway.net">Marilyn.Smith@direct.HospitalB.masshiway.net</a></td>
</tr>
<tr>
<td>Smith, Marilyn M</td>
<td>Smith, Mary</td>
<td>HPC Primary Care</td>
<td><a href="mailto:Marilyn.Smith@direct.HPC.masshiway.net">Marilyn.Smith@direct.HPC.masshiway.net</a></td>
</tr>
</tbody>
</table>

1. Patient Visit

2. Look up Provider Address (optional – depends on EHR vendor)

3. Send message

Specialist  PCP  Hospital A  Hospital B
Direct Messaging is encrypted email sent to secure Direct email addresses

**Individual Direct email address:**

Endpoint: Jane.Doe@direct.xyzrehabcenter.masshiway.net

**Organization Direct email address:**

XYZRehab@direct.xyzrehabcenter.masshiway.net

**Departmental Direct email address:**

PresurgicalTestingCenter@direct.abchospital.masshiway.net

**Third-Party HISP Direct email addresses:**

john.smith@practicename.eclinicaldirect.com
john.smith.x@xxxx.direct.athenahealth.com
johnsmith@xxxxx.allscriptsdirect.net
johnsmith@xxxxx.circlehealthdirect.org
Purpose of the Mass HIway PD

- Provides destination addresses for Direct messaging (i.e. Direct email address)
- In-state and out-of-state Direct addresses (requires HIway 2.0)
- Stores the specific details such as organization name, provider name, specialty, contact info, NPI and personal/organizational email address, Direct email address

Mass HIway PD contains over 21,000+ addresses

- Organization, department, and individual level addresses

Account Manager will assist you in operationalizing the Mass HIway PD

- Identify who of your trading partners are in the Mass HIway Community
- How to engage additional trading partners to exchange on the HIway

Participants can get on the distribution list by emailing us at masshiway@state.ma.us
# Use Case Categories

<table>
<thead>
<tr>
<th>Use Case Categories</th>
<th>Example Use Cases</th>
</tr>
</thead>
</table>
| **Provider-to-Provider Communications** | • Hospital sends a discharge summary to a Skilled Nursing Facility (SNF) or Long Term/Post Acute Care (LTPAC) facility  
• Primary Care Provider (PCP) sends a referral notice to a specialist  
• Specialist sends consult notes & updated medications list to patient’s PCP  
• Hospital ED requests a patient’s medical record from a PCP  
• PCP sends a CCD or C-CDA with Problems, Allergies, Medications, and Immunizations (PAMI) to a Hospital caring for their patient |
| **Payer Case Management**             | • ACO sends quality metrics to a payer  
• Provider sends lab results to a payer  
• Provider sends claims data to payer |
| **Quality Reporting**                 | • Provider sends clinical data to Business Associate for quality metrics analysis  
• Provider sends quality metrics to Business Associate for report preparation |
| **Public Health Reporting**           | **to DPH**  
• Massachusetts Immunization Information System (MIIS)  
• Syndromic Surveillance (SS)  
• Opioid Treatment Program (OTP)  
• Childhood Lead Paint Poison Prevention Program (CLPPP)  
**to other agencies**  
• Occupational Lead Poisoning Registry (Adult Lead)  
• Children’s Behavioral Health Initiative (CBHI) |
### Event: Transition of Care (TOC) and Referrals

**TOC**  
The movement of a patient from one setting of care to another  
- Hospital, ambulatory primary care practice, ambulatory specialty care practice, long-term care, home health, rehabilitation facility  

**Referrals**  
Cases where one provider refers a patient to another, but referring provider maintains care of the patient as well

### Content: Summary of Care

**Summary of Care**  
Key clinical information shared during a TOC, typically from an EHR  

**C-CDA**  
Consolidated Clinical Document Architecture, is a human and machine readable Summary of Care, e.g. CCD

### Transport: Must be Machine readable and HIPPA compliant

**Examples**  
- Direct Protocol – Mass HIway, 3rd party HISP  
- Secure email, Query based exchange
Improved Care Coordination
- Problems, Allergies, Medication Reconciliations, Med Allergies & Social History
- Care plans, Discharge instructions and Assessments

Improved Patient Experience
- Eliminate that patients and families have to chase down their records
- Avoid unnecessary or duplicative tests and other adverse situations
- Reduce readmission rates

Increased Efficiency, Reduced Costs, Security
- ~3.2 M avoided fax pages to process
  - 800,000 discharges per year * avg. 4 page discharge summary = ~213 trees in paper when printed
- Have the right info, securely, at the right time, and for the right patient

Significant opportunities to streamline the workflows
- Improved quality of data in summary of care documents
- Improved HIE compatibility across vendors to accept all documents
**Patient Scenario:**
1. Patient discharged from Hospital
2. Discharge C-CDA is sent via Mass HIway to PCP and/or other providers involved in follow up care
3. Patient sees PCP and other providers for follow up

**Information Flows:**
A. Hospital identifies patient’s PCP and other care team members
B. Hospital sends Discharge Summary to patient’s PCP and other care team members at discharge (may be automated or manual)
C. PCP receives information about the patient’s hospital visit that is critical to follow up care
Example: Specialist Referral

Transition of Care – Specialist Referral and Consult

**Patient Scenario:**
1. Patient sees PCP
2. PCP refers patient to a specialist
3. Patient sees specialist
4. Patient sees PCP for follow up care

**Information Flows:**
A. PCP sends Specialist a summary of care document via the Mass HIway
B. Specialist sends PCP a consult note via the Mass HIway
Example: ER, Inpatient & BH Exchange

Emergency Behavioral Health Assessment

**Patient Scenario:**
1. Patient arrives at hospital ED
2. Patient requires Behavioral Health assessment
3. Behavioral Health provider comes to ED and performs assessment
4. Patient admitted

**Information Flows:**
A. A behavioral health provider completes assessment (PDF) while the patient is in ER
B. BH health provider sends the assessment to the inpatient behavioral health unit
A. Upon discharge, Inpatient unit sends final assessment and discharge CCD to BH facility for follow-up

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[Diagram showing flow of information from ER, through ADT to BH, to Inpatient, Assessment, Discharge CCD, and Behavioral Health.]
Does the Summary of Care have the data that the next provider of care needs?

**Continuity of Care Documents, Discharge Summaries, and Referrals**

- C-CDA templates that can be changed to incorporate additional data sections
- What information is needed by who and when?
- Can the recipient find what they need? Too much history?
- Are the workflows and triggers for data capture and sending well understood?
- Are receiving organizations ready to consume summary of care?
- If not, how will the document be sent so the recipient can receive and view it?
- Have all the required document types been tested for consumption?
Focus on providing actionable health information at the point of care

- Collaborate with trading partners to encourage electronic exchange
- Optimize access to patient information across multiple/redundant systems
- Ensure published Direct addresses are active
- Ensure the owners of the HIE accounts have been trained to use them
- Engage the Mass HIway Account Management Team

This is NOT just an IT Project: Engage clinical & business operations

Important Notice: Participants must use active Mass HIway addresses and verify that the intended recipient is ready to receive the type of message the Participant is sending over the Mass HIway. If the Participant is made aware that the intended recipient is not ready to receive that message type over the Mass HIway, the Participant needs to find an alternative means to send the information.
Use Case: Cape Cod Healthcare Center

Develop a consistently reliable way to track and manage the process of sending clinical information to outside care providers when a patient is discharged

**Milestone 1**
Resolve connectivity issues, develop clinical documentation standards, test direct messaging, and finalize the standards

**Milestone 2**
Develop care coordination prototypes

**Milestone 3**
Streamline process improvement plans, develop reports to track performance, and correct process breakdowns

**Milestone 4**
Expand workflows with two collaborating orgs to create foundation for sustainability and expansion plans

**Challenges**
- Coordinating activities between so many different stakeholders and organizations with varying levels of sophistication
- Needing to update the system to transmit CCDAs electronically
- Collaborating organizations continuing to print CCDAs

**Feedback**
- Option to add data to the CCDA
- Ability to see a patient identifier in the transaction list before opening a file
- Capability to separate organizations that use the Mass HIway from those that do not
Outcomes

Before the project
No Data

Initial go-live
74% discharges include CCDA

Three months after go-live
81% Discharges include CCDA

Future objectives
100% discharges include CCDA

New workflows resulted in major improvement from previous methods of manual communication, accelerating exchange of messages between providers

Next Steps
Expanding the process to other organizations throughout Cape Cod
This will allow CCHC access to real-time medical information for all patients immediately upon admission
Use Case: Brockton Neighborhood Health Center

Develop care coordination improvements for

- Patients with behavioral health needs
- Patients in detox or inpatient SUD treatment who experience medical emergency
- Patients requiring Section 12 emergency psychiatric evaluation

Consent to release information
- Most time consuming issue
- Required revisions to release forms at multiple orgs
- Ultimately developed an eConsent module in EHR
  - Block transmission if consent is denied
  - Release form available in languages for the 1st time
### Use Case: Brockton Neighborhood Health Center

#### Accomplishments
- Established ability to exchange CCDs and electronic referrals between trade partners
- Developed streamlined workflows to better coordinate care and eliminate paper document exchange
- Implemented new Authorization to release info form via eConsent module
- Smaller volumes of CCDs/electronic referrals exchanged

#### Outcomes
- **Measure:** Repeat ED visits for all BH diagnoses
  - Baseline: 20.4%
  - Target: 18.4%
  - **Actual: 19.9%**
- **Measure:** Readmissions for all BH diagnoses
  - Baseline: 11%
  - Target: 9%
  - **Actual: 5.3%**

#### Lessons Learned
- Collaboration is key
- Evaluating consent to release information is extremely important
- Clinicians like being able to send info electronically
- Working with EHR and HISP vendors can be a challenge
- Competing IT priorities can hinder implementation
- Implementing new workflows is challenging in emergency situations

### Next Steps
- BNHC hopes to continue its work with Brockton Hospital’s psychiatric unit
- Connect directly with CCBC Crisis team via similar workflow
- Connect with Gosnold Treatment Center
- Continue community-wide efforts to coordinate care for behavioral health patients
## Multiple Use Cases: Circle Health

### Integration
**Circle Health to Atrius Health**
- Approximately 1000-1100 ADTs sent per week from LGH over the Mass HIway
- Atrius Health creates admit/discharge encounters from the ADT feed in their EMR to notify the providers when their patients have been seen at LGH
- Reports distributed to case management and nursing for post acute care workflows

### Live
**CCDs and ADT notifications**
- **Tufts Medical Center to Lowell General PHO Practices**
  - LIVE at 17 practices
  - Currently receive both notifications and faxes
  - Goal is to eliminate fax
  - Office staff matches the patient and forwards Direct message to the provider (saves time)
  - Helps staff in making sure patients come in timely to see their PCP
  - Plan is to roll-out to other Circle Health affiliated practices with ability to receive ADTs

### Testing
**Integration**
- **Circle Health Mother Infant Unit and Tufts L&D Dept**
  - Reports and clinical documents sent to Tufts Specialists
  - Old process involves sending 50 pages by fax per patient for consults and transfers
  - NST reports, Consult documents, OB notes
  - Future state process of utilizing Direct messaging will streamline workflows
  - Goal is to replace fax workflows with HIE-based workflows

### Live
**Integration**
- **LGH Medical Group, Women Health and Tufts Maternal Fetal Medicine**
  - Referrals for Level 2 Ultrasounds
  - Current process involves multi-page fax per patient
  - Referral letter, Labs, Imaging results, OB notes
  - Future state process of utilizing Direct messaging would help streamline the workflow

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**circlehealth**

*Complete connected care™*
Challenges

- Direct messaging workflow – multiple Direct addresses
- Practice workflow – Message Pool vs. Provider inbox
- Variation between EMRs and workflows
  - Standards (no “Direct” standards from non CCDA exchange)
  - Type of documents that can be exchanged
- Transmission problems (certificate issues, technical challenges to exchange info among up to 4 vendors)
- Data reconciliation (meds reconciliation, lack of data consistency, SNOMED vs. ICD-10, clinical workflow)
- Organizational challenges – competing priorities, lack of resources to devote to interoperability projects

Lessons Learned

- Achievable goals driven by use cases
- Transitions of care
- ADT notifications
- Secure communication
- Consult requests between physicians
- IT knowledge base
- Governance
- Emphasis on value
- Patients think we already have this capability

Use Case: Circle Health
1. **Ask your EHR vendor** if they are connected to, or able to connect to, the HIway

2. **Contact us.** We will connect you with a Mass HIway Account Manager to get your organizations enrolled and connected

3. **Develop and deploy a Use Case to Exchange** with your trading partners!

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The Massachusetts Health Information Highway (Mass HIway)

*Phone:* 1.855.MA-HIWAY (1.855.624.4929)

*Email for General Inquires:* MassHIway@state.ma.us

*Email for Technical Support:* MassHIwaySupport@state.ma.us

*Website:* www.MassHIway.net
Front-line Mass HIway support to get you enrolled, connected and using Direct Messaging

- Enrollment
- Use case identification
- Trading partner identification
- HIE best practices

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Enroll, Connect, and Actively Use of HIE

- Assess HIE opportunities and barriers for your organization and providers
- Identify viable exchange trading partners and relevant use cases
- Engage, facilitate and manage electronic exchange across trading partners
- Operationalize mutually agreed upon, testing protocols, workflows and processes
- Get the right information, securely, to the right provider, at the right time
- Streamline/Optimize workflows – internal & external
- HIE Educational services to all levels of the organization
- Share lessons learned among the various HIE participants
Mass HIway offers HAUS Services to assist organizations in the deployment of electronic health information exchange to enhance care coordination

HAUS Account Management team will assist organizations with

- Technical Connectivity Assessment
- New or improved utilization of HIE in care coordination, through the development and implementation of HIE-supported use cases
- HIE Technology and Workflow Project Plan

Two tracks available to receive HAUS Services

- HAUS for MassHealth Accountable Care Organizations (ACOs), Community Partners (CPs), and Community Service Agencies (CSAs), in partnership with MassHealth
- HAUS for other healthcare organizations that need to connect to the Mass HIway for the purposes of meeting the regulations
Who is connected to the Mass HIway?

An interactive Mass HIway Participant Map is available on Mass HIway website*
It includes over 1,400 participants across the care continuum

* Find the map on the Mass HIway website: www.masshiway.net. Under the Resources drop-down menu, select Participant List. The map is maintained in partnership with MeHI, the Massachusetts eHealth Institute.
Establishes requirements for organizations that use the Mass HIway

Implements state requirement for providers to connect to Mass HIway, which is referred to as the HIway Connection Requirement

Establishes mechanism to allow patients to opt-in and opt-out of Mass HIway

Regulations went into effect on February 10, 2017

- Require information be transmitted via HIway Direct Messaging in compliance with applicable federal and state privacy laws and implementing regulations

Supporting documentation available on Mass HIway website

- Mass HIway Regulations Summary
- Mass HIway Regulations FAQs
- Mass HIway Policies & Procedures (version 3)
- Mass HIway Fact Sheet for Patients
- Mass HIway Education Webinars
The statutory requirement that Provider Organizations implement “interoperable EHR systems” that connect to the Mass HIway will be fulfilled by implementing HIway Direct Messaging.

How organizations must fulfill the HIway Connection Requirement is phased in over 4 years

1. The connection requirement gets progressively stricter in each year of implementation
2. Penalties for not meeting the HIway Connection requirement begin in Year 4 of implementation
3. The 4 year phase-in period is based on when the Provider Organizations must be connected

<table>
<thead>
<tr>
<th>Organization Type</th>
<th>Year 1</th>
<th>Year 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute Care Hospital</td>
<td>2017</td>
<td>2020</td>
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<tr>
<td>Large and Medium Medical Ambulatory Practices</td>
<td>2018</td>
<td>2021</td>
</tr>
<tr>
<td>Large Community Health Centers</td>
<td>2018</td>
<td>2021</td>
</tr>
<tr>
<td>Small Community Health Centers</td>
<td>2019</td>
<td>2022</td>
</tr>
</tbody>
</table>

Provider types not yet specified in the regulations are anticipated to be required to connect at a future date. Guidance to the affected providers will be provided with at least one year notice.
The 4 year phase-in approach progressively encourages providers to use the Mass HIway for **Provider-to-Provider communications** via bi-directional exchange of health information.

**Progressive HIway Connection Requirements**

**Year 1**  
*Send or receive* HIway Direct Messages for at least one use case  
○ Can be from any use case category listed below

**Year 2**  
*Send or receive* HIway Direct Messages for at least one use case  
○ Must be a **Provider-to-Provider Communications** use case

**Year 3**  
*Send* HIway Direct Messages for at least one use case, and  
*Receive* HIway Direct Messages for at least one use case  
○ Both must be **Provider-to-Provider Communications** use cases

**Year 4**  
Meet Year 3 requirement, or be subject to penalties if requirement isn’t met  
○ Penalties go into effect in the applicable Year 4 (E.g. Jan 2020 for Acute Care Hospitals)

**Additional ENS Requirement for Acute Care Hospitals Only**

*Send* Admission Discharge Transfer notifications (ADTs) to HIway within 12 months of ENS launch

**Use Case Categories:**

1. Public Health Reporting  
2. Provider-to-Provider Communications  
3. Quality Reporting  
4. Payer Case Management
## Mass HIway Pricing Rates

<table>
<thead>
<tr>
<th>Tier</th>
<th>Category</th>
<th>Description</th>
<th>One-time set-up fee (per node)</th>
<th>Direct Messaging Service</th>
<th>Annual Services Fee (per node)</th>
<th>Annual Services Fee + LAND (per node)</th>
<th>Annual Services Fee Webmail (per mailbox)</th>
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</thead>
<tbody>
<tr>
<td>Tier 1</td>
<td>1a</td>
<td>Large hospitals/Health Systems</td>
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<td></td>
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<tr>
<td></td>
<td>1c</td>
<td>Multi-entity HIE or Technical Integrator (see 14.1.1)</td>
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<td></td>
<td>$1,000</td>
<td>$10,000</td>
<td>$15,000</td>
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<tr>
<td></td>
<td>1d</td>
<td>Commercial imaging centers &amp; labs</td>
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<tr>
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<td>Small hospitals</td>
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<td></td>
<td>2b</td>
<td>Large ambulatory practices (50+ licensed providers)</td>
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<td>$1,000</td>
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<td>Ambulance and Emergency Response</td>
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<td>Business associate affiliates</td>
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<td>Local government/Public Health</td>
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<td>MassHealth ACO, CP, or CSA Technical Integrator (see 14.1.1)</td>
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<td>Large FQHCs (10+ licensed providers)</td>
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<td>Medium ambulatory practices (10-49 licensed providers)</td>
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<td></td>
<td>4c</td>
<td>Small FQHCs (&lt;10 licensed providers)</td>
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<td>4d</td>
<td>Small ambulatory practices (3-9)</td>
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<td>Community Service Agency (CSA)</td>
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<td>Very Small ambulatory practices (1-2)</td>
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<td>$25</td>
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Thank you!

The Massachusetts Health Information Highway (Mass HIway)

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