COMMONWEALTH OF MASSACHUSETTS ~ STANDARD CONTRACT FORM

This form is jointly issued and published by the Executive Office for Administration and Finance (ANF), the Office of the Comptroller (CTR) and the Operational Services Division (OSD) as the default contract for all Commonwealth Departments when another form is not prescribed by regulation or policy. Any changes to the official printed language of this form shall be void. Additional non-conflicting terms may be added by Attachment. Contractors may not require any additional agreements, engagement letters, contract forms or other additional terms as part of this Contract without prior Department approval. Click on hyperlinks for definitions, instructions and legal requirements that are incorporated by reference into this Contract. An electronic copy of this form is available at www.mass.gov/osc under Guidance For Vendors - Forms or www.mass.gov/osd under OSD Forms.

CONTRACTOR LEGAL NAME: Massachusetts Behavioral Health Partnership (and d/b/a):	**COMMONWEALTH DEPARTMENT NAME**: Exec. Off. of Health and Human Services **MMARS Department Code**: EHS
Legal Address: (W-9, W-4,T&C): 1000 Washington St., Ste. 310, Boston, MA 02118-5002	**Business Mailing Address**: One Ashburton Place, 11th Floor, Boston, MA, 02108
Contract Manager: Carol Kress	**Billing Address** (if different): 600 Washington Street, Boston, MA 02111
E-Mail: Carol.kress@valueoptions.com	**Contract Manager**: Stephanie J. Brown
Phone: 617-790-4144 Fax:	**E-Mail**: Stephanie.J.Brown@state.ma.us
Contractor Vendor Code: VC6000182737	**Phone**:617-573-1759 Fax:
Vendor Code Address ID (e.g. "AD001"): AD001 (Note: The Address Id Must be set up for EFT payments.)	**MMARS Doc ID(s):** N/A **RFR/Procurement or Other ID Number**:11LCEHSPCCPLANBHPMSSRFR

___ **NEW CONTRACT** **PROCUREMENT OR EXCEPTION TYPE**: (Check one option only) __ **Statewide Contract** (OSD or an OSD-designated Department) __ **Collective Purchase** (Attach OSD approval, scope, budget) __ **Department Procurement** (includes State or Federal grants 815 CMR 2.00) (Attach RFR and Response or other procurement supporting documentation) __ **Emergency Contract** (Attach justification for emergency, scope, budget) __ **Contract Employee** (Attach Employment Status Form, scope, budget) __ **Legislative/Legal or Other**: (Attach authorizing language/justification, scope and budget)	_X_ **CONTRACT AMENDMENT** Enter **Current Contract End Date *Prior*** to Amendment: 8/31/2017 . Enter **Amendment Amount**: $ **No Change.** (or "no change") **AMENDMENT TYPE**: (Check one option only. Attach details of Amendment changes.) x **Amendment to Scope or Budget** (Attach updated scope and budget) __ **Interim Contract** (Attach justification for Interim Contract and updated scope/budget) __ **Contract Employee** (Attach any updates to scope or budget) __ **Legislative/Legal or Other:** (Attach authorizing language/justification and updated scope and budget)

The following COMMONWEALTH TERMS AND CONDITIONS (T&C) has been executed, filed with CTR and is incorporated by reference into this Contract.

_x_ Commonwealth Terms and Conditions __ Commonwealth Terms and Conditions For Human and Social Services

COMPENSATION: (Check ONE option): The Department certifies that payments for authorized performance accepted in accordance with the terms of this Contract will be supported in the state accounting system by sufficient appropriations or other non-appropriated funds, subject to intercept for Commonwealth owed debts under 815 CMR 9.00.

x **Rate Contract** (No Maximum Obligation. Attach details of all rates, units, calculations, conditions or terms and any changes if rates or terms are being amended.)

__ **Maximum Obligation Contract** Enter Total Maximum Obligation for total duration of this Contract (or ***new*** Total if Contract is being amended). $ _____.

PROMPT PAYMENT DISCOUNTS (PPD): Commonwealth payments are issued through EFT 45 days from invoice receipt. Contractors requesting **accelerated** payments must identify a PPD as follows: Payment issued within 10 days __% PPD; Payment issued within 15 days __ % PPD; Payment issued within 20 days __ % PPD; Payment issued within 30 days __% PPD. If PPD percentages are left blank, identify reason: __agree to standard 45 day cycle __ statutory/legal or Ready Payments (G.L. c. 29, § 23A); __ only initial payment (subsequent payments scheduled to support standard EFT 45 day payment cycle. See Prompt Pay Discounts Policy.)

BRIEF DESCRIPTION OF CONTRACT PERFORMANCE or REASON FOR AMENDMENT: (Enter the Contract title, purpose, fiscal year(s) and a detailed description of the scope of performance or what is being amended for a Contract Amendment. Attached all supporting documentation and justifications.) **This First Amended and Restated Contract** is for the purposes of amending and restating the contract entered into October 1, 2012, to be inclusive of all amendments made to date (1-32), as well as updating for federal rules and policy changes for Contract Year 6A.

ANTICIPATED START DATE: (Complete ONE option only) The Department and Contractor certify for this Contract, or Contract Amendment, that Contract obligations:

x 1. may be incurred as of the Effective Date (latest signature date below) and **no** obligations have been incurred **prior** to the Effective Date.

__ 2. may be incurred as of _____, 20___, a date **LATER** than the Effective Date below and **no** obligations have been incurred **prior** to the Effective Date.

__3. were incurred as of _____, 20___ , a date **PRIOR** to the Effective Date below, and the parties agree that payments for any obligations incurred prior to the Effective Date are authorized to be made either as settlement payments or as authorized reimbursement payments, and that the details and circumstances of all obligations under this Contract are attached and incorporated into this Contract. Acceptance of payments forever releases the Commonwealth from further claims related to these obligations.

CONTRACT END DATE: Contract performance shall terminate as of **12/31/2017,** with no new obligations being incurred after this date unless the Contract is properly amended, provided that the terms of this Contract and performance expectations and obligations shall survive its termination for the purpose of resolving any claim or dispute, for completing any negotiated terms and warranties, to allow any close out or transition performance, reporting, invoicing or final payments, or during any lapse between amendments.

CERTIFICATIONS: Notwithstanding verbal or other representations by the parties, the **"Effective Date"** of this Contract or Amendment shall be the latest date that this Contract or Amendment has been executed by an authorized signatory of the Contractor, the Department, or a later Contract or Amendment Start Date specified above, subject to any required approvals. The Contractor makes all certifications required under the attached Contractor Certifications (incorporated by reference if not attached hereto) under the pains and penalties of perjury, agrees to provide any required documentation upon request to support compliance, and agrees that all terms governing performance of this Contract and doing business in Massachusetts are attached or incorporated by reference herein according to the following hierarchy of document precedence, the applicable Commonwealth Terms and Conditions, this Standard Contract Form including the Instructions and Contractor Certifications, the Request for Response (RFR) or other solicitation, the Contractor's Response, and additional negotiated terms, provided that additional negotiated terms will take precedence over the relevant terms in the RFR and the Contractor's Response only if made using the process outlined in 801 CMR 21.07, incorporated herein, provided that any amended RFR or Response terms result in best value, lower costs, or a more cost effective Contract.

AUTHORIZING SIGNATURE FOR THE CONTRACTOR: X: Carol Kress . Date: 8/31/17 (Signature and Date Must Be Handwritten At Time of Signature) **Print Name:** Carol Kress **Print Title:** Vice President, Client Partnerships, MBHP	**AUTHORIZING SIGNATURE FOR THE COMMONWEALTH:** X: _____ . Date: _____ . (Signature and Date Must Be Handwritten At Time of Signature) **Print Name:** Daniel Tsai **Print Title:** Assistant Secretary for MassHealth

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CONTRACTOR LEGAL NAME: Massachusetts Behavioral Health Partnership (and d/b/a):	**COMMONWEALTH DEPARTMENT NAME: Exec. Off. of Health and Human Services** **MMARS Department Code: EHS**
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Contract Manager: Carol Kress	**Billing Address (if different): 600 Washington Street, Boston, MA 02111**
E-Mail: Carol.kress@valueoptions.com	**Contract Manager: Stephanie J. Brown**
Phone: 617-790-4144 **Fax:**	**E-Mail: Stephanie.J.Brown@state.ma.us**
Contractor Vendor Code: VC6000182737	**Phone:617-573-1759** **Fax:**
Vendor Code Address ID (e.g. "AD001"): AD001 **(Note: The Address Id Must be set up for EFT payments.)**	**MMARS Doc ID(s): N/A** **RFR/Procurement or Other ID Number:11LCEHSPCCPLANBHPMSSRFR**

___ NEW CONTRACT

PROCUREMENT OR EXCEPTION TYPE: (Check one option only)

__ **Statewide Contract** (OSD or an OSD-designated Department)
__ **Collective Purchase** (Attach OSD approval, scope, budget)
__ **Department Procurement** (includes State or Federal grants 815 CMR 2.00) (Attach RFR and Response or other procurement supporting documentation)
__ **Emergency Contract** (Attach justification for emergency, scope, budget)
__ **Contract Employee** (Attach Employment Status Form, scope, budget)
__ **Legislative/Legal or Other**: (Attach authorizing language/justification, scope and budget)

_X_ CONTRACT AMENDMENT

Enter **Current Contract End Date *Prior*** to Amendment: **8/31/2017** .
Enter **Amendment Amount**: $ **No Change**. (or "no change")

AMENDMENT TYPE: (Check one option only. Attach details of Amendment changes.)

x **Amendment to Scope or Budget** (Attach updated scope and budget)
__ **Interim Contract** (Attach justification for Interim Contract and updated scope/budget)
__ **Contract Employee** (Attach any updates to scope or budget)
__ **Legislative/Legal or Other:** (Attach authorizing language/justification and updated scope and budget)

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__3. were incurred as of _____, **20**___ , a date **PRIOR** to the Effective Date below, and the parties agree that payments for any obligations incurred prior to the Effective Date are authorized to be made either as settlement payments or as authorized reimbursement payments, and that the details and circumstances of all obligations under this Contract are attached and incorporated into this Contract. Acceptance of payments forever releases the Commonwealth from further claims related to these obligations.

CONTRACT END DATE: Contract performance shall terminate as of **12/31/2017,** with no new obligations being incurred after this date unless the Contract is properly amended, provided that the terms of this Contract and performance expectations and obligations shall survive its termination for the purpose of resolving any claim or dispute, for completing any negotiated terms and warranties, to allow any close out or transition performance, reporting, invoicing or final payments, or during any lapse between amendments.

CERTIFICATIONS: Notwithstanding verbal or other representations by the parties, the **"Effective Date"** of this Contract or Amendment shall be the latest date that this Contract or Amendment has been executed by an authorized signatory of the Contractor, the Department, or a later Contract or Amendment Start Date specified above, subject to any required approvals. The Contractor makes all certifications required under the attached Contractor Certifications (incorporated by reference if not attached hereto) under the pains and penalties of perjury, agrees to provide any required documentation upon request to support compliance, and agrees that all terms governing performance of this Contract and doing business in Massachusetts are attached or incorporated by reference herein according to the following hierarchy of document precedence, the applicable Commonwealth Terms and Conditions, this Standard Contract Form including the Instructions and Contractor Certifications, the Request for Response (RFR) or other solicitation, the Contractor's Response, and additional negotiated terms, provided that additional negotiated terms will take precedence over the relevant terms in the RFR and the Contractor's Response only if made using the process outlined in 801 CMR 21.07, incorporated herein, provided that any amended RFR or Response terms result in best value, lower costs, or a more cost effective Contract.

AUTHORIZING SIGNATURE FOR THE CONTRACTOR:	**AUTHORIZING SIGNATURE FOR THE COMMONWEALTH:**
X: _____. **Date:** _____.	**X:** _____. **Date:** 8/31/17
(Signature and Date Must Be Handwritten At Time of Signature)	**(Signature and Date Must Be Handwritten At Time of Signature)**
Print Name: Carol Kress	**Print Name:** Daniel Tsai MATT KLITUS
Print Title: Vice President, Client Partnerships, MBHP	**Print Title:** ~~Assistant Secretary for MassHealth~~ CFO

INSTRUCTIONS AND CONTRACTOR CERTIFICATIONS

The following instructions and terms are incorporated by reference and apply to this Standard Contract Form. Text that appears underlined indicates a "hyperlink" to an Internet or bookmarked site and are unofficial versions of these documents and Departments and Contractors should consult with their legal counsel to ensure compliance with all legal requirements. Using the Web Toolbar will make navigation between the form and the hyperlinks easier. Please note that not all applicable laws have been cited.

CONTRACTOR LEGAL NAME (AND D/B/A): Enter the **Full Legal Name** of the Contractor's business as it appears on the Contractor's W-9 or W-4 Form (Contract Employees only) **and** the applicable Commonwealth Terms and Conditions If Contractor also has a "doing business as" (d/b/a) name, BOTH the legal name and the "d/b/a" name must appear in this section.

Contractor Legal Address: Enter the Legal Address of the Contractor as it appears on the Contractor's W-9 or W-4 Form (Contract Employees only) **and** the applicable Commonwealth Terms and Conditions, which must match the legal address on the 1099I table in MMARS (or the Legal Address in HR/CMS for Contract Employee).

Contractor Contract Manager: Enter the authorized Contract Manager who will be responsible for managing the Contract. The Contract Manager should be an Authorized Signatory or, at a minimum, a person designated by the Contractor to represent the Contractor, receive legal notices and negotiate ongoing Contract issues. The Contract Manager is considered "Key Personnel" and may not be changed without the prior written approval of the Department. If the Contract is posted on COMMBUYS, the name of the Contract Manager must be included in the Contract on COMMBUYS.

Contractor E-Mail Address/Phone/Fax: Enter the electronic mail (e-mail) address, phone and fax number of the Contractor Contract Manager. This information must be kept current by the Contractor to ensure that the Department can contact the Contractor and provide any required legal notices. Notice received by the Contract Manager (with confirmation of actual receipt) through the listed address, fax number(s) or electronic mail address will meet any written legal notice requirements.

Contractor Vendor Code: The Department must enter the MMARS **Vendor Code** assigned by the Commonwealth. If a Vendor Code has not yet been assigned, leave this space blank and the Department will complete this section when a Vendor Code has been assigned. The Department is responsible under the Vendor File and W-9s Policy for verifying with authorized signatories of the Contractor, as part of contract execution, that the legal name, address and Federal Tax Identification Number (TIN) in the Contract documents match the state accounting system.

Vendor Code Address ID: (e.g., "AD001") The Department must enter the MMARS Vendor Code Address Id identifying the payment remittance address for Contract payments, which MUST be set up for EFT payments PRIOR to the first payment under the Contract in accordance with the Bill Paying and Vendor File and W-9 policies.

COMMONWEALTH DEPARTMENT NAME: Enter the full Department name with the authority to obligate funds encumbered for the Contract.

Commonwealth MMARS Alpha Department Code: Enter the three (3) letter MMARS Code assigned to this Commonwealth Department in the state accounting system.

Department Business Mailing Address: Enter the address where all formal correspondence to the Department must be sent. Unless otherwise specified in the Contract, legal notice sent or received by the Department's Contract Manager (with confirmation of actual receipt) through the listed address, fax number(s) or electronic mail address for the Contract Manager will meet any requirements for legal notice.

Department Billing Address: Enter the Billing Address or email address if invoices must be sent to a different location. Billing or confirmation of delivery of performance issues should be resolved through the listed Contract Managers.

Department Contract Manager: Identify the authorized Contract Manager who will be responsible for managing the Contract, who should be an authorized signatory or an employee designated by the Department to represent the Department to receive legal notices and negotiate ongoing Contract issues.

Department E-Mail Address/Phone/Fax: Enter the electronic mail (e-mail) address, phone and fax number of the Department Contract Manager. Unless otherwise specified in the Contract, legal notice sent or received by the Contract Manager (with confirmation of actual receipt) through the listed address, fax number(s) or electronic mail address will meet any requirements for written notice under the Contract.

MMARS Document ID(s): Enter the MMARS 20 character encumbrance transaction number associated with this Contract which must remain the same for the life of the Contract. If multiple numbers exist for this Contract, identify all Doc Ids.

RFR/Procurement or Other ID Number or Name: Enter the Request for Response (RFR) or other Procurement Reference number, Contract ID Number or other reference/tracking number for this Contract or Amendment and will be entered into the Board Award Field in the MMARS encumbrance transaction for this Contract.

NEW CONTRACTS (left side of Form):

Complete this section ONLY if this Contract is brand new. (Complete the CONTRACT AMENDMENT section for any material changes to an existing or an expired Contract, and for exercising options to renew or annual contracts under a multi-year procurement or grant program.)

PROCUREMENT OR EXCEPTION TYPE: Check the appropriate type of procurement or exception for this Contract. Only one option can be selected. See State Finance Law and General Requirements, Acquisition Policy and Fixed Assets, the Commodities and Services Policy and the Procurement Information Center (Department Contract Guidance) for details.

Statewide Contract (OSD or an OSD-designated Department). Check this option for a Statewide Contract under OSD, or by an OSD-designated Department.

Collective Purchase approved by OSD. Check this option for Contracts approved by OSD for collective purchases through federal, state, local government or other entities.

Department Contract Procurement. Check this option for a Department procurement including state grants and federal sub-grants under 815 CMR 2.00 and State Grants and Federal Subgrants Policy, Departmental Master Agreements (MA). If multi-Department user Contract, identify multi-Department use is allowable in Brief Description.

Emergency Contract. Check this option when the Department has determined that an unforeseen crisis or incident has arisen which requires or mandates immediate purchases to avoid substantial harm to the functioning of government or the provision of necessary or mandated services or whenever the health, welfare or safety of clients or other persons or serious damage to property is threatened.

Contract Employee. Check this option when the Department requires the performance of an Individual Contractor, and when the planned Contract performance with an Individual has been classified using the Employment Status Form (prior to the Contractor's selection) as work of a Contract Employee and not that of an Independent Contractor.

Legislative/Legal or Other. Check this option when legislation, an existing legal obligation, prohibition or other circumstance exempts or prohibits a Contract from being competitively procured, or identify any other procurement exception not already listed. Legislative "earmarks" exempt the Contract solely from procurement requirements, and all other Contract and state finance laws and policies apply. Supporting documentation must be attached to explain and justify the exemption.

CONTRACT AMENDMENT (Right Side of Form)

Complete this section for any Contract being renewed, amended or to continue a lapsed Contract. All Contracts with available options to renew must be amended referencing the original procurement and Contract doc ids, since all continuing contracts must be maintained in the same Contract file (even if the underlying appropriation changes each fiscal year.) "See Amendments, Suspensions, and Termination Policy.)

Enter Current Contract End Date: Enter the termination date of the Current Contract being amended, even if this date has already passed. (Note: Current Start Date is not requested since this date does not change and is already recorded in MMARS.)

Enter Amendment Amount: Enter the amount of the Amendment increase or decrease to a Maximum Obligation Contract. Enter "no change" for Rate Contracts or if no change.

AMENDMENT TYPE: Identify the type of Amendment being done. Documentation supporting the updates to performance and budget must be attached. **Amendment to Scope or Budget.** Check this option when renewing a Contract or executing any Amendment ("material change" in Contract terms) even if the Contract has lapsed. The parties may negotiate a change in any element of Contract performance or cost identified in the RFR or the Contractor's response which results in lower costs, or a more cost-effective or better value performance than was presented in the original selected response, provided the negotiation results in a better value within the scope of the RFR than what was proposed by the Contractor in the original selected response. Any "material" change in the Contract terms must be memorialized in a formal Amendment even if a corresponding MMARS transaction is not needed to support the change. Additional negotiated terms will take precedence over the relevant terms in the RFR and the Contractor's Response only if made using the process outlined in 801 CMR 21.07, incorporated herein, provided that any amended RFR or Response terms result in best value, lower costs, or a more cost effective Contract.

Interim Contracts. Check this option for an Interim Contract to prevent a lapse of Contract performance whenever an existing Contract is being re-procured but the new procurement has not been completed, to bridge the gap during implementation between an expiring and a new procurement, or to contract with an interim Contractor when a current Contractor is unable to complete full performance under a Contract.

Contract Employee. Check this option when the Department requires a renewal or other amendment to the performance of a Contract Employee.

Legislative/Legal or Other. Check this option when legislation, an existing legal obligation, prohibition or other circumstance exempts or prohibits a Contract from being competitively procured, or identify any other procurement exception not already listed. Legislative "earmarks" exempt the Contract solely from procurement requirements, and all other Contract and state finance laws and policies apply. Attach supporting documentation to explain and justify the exemption and whether Contractor selection has been publicly posted.

COMMONWEALTH TERMS AND CONDITIONS

Identify which Commonwealth Terms and Conditions the Contractor has executed and is incorporated by reference into this Contract. This Form is signed only once and recorded on the Vendor Customer File (VCUST). See Vendor File and W-9s Policy.

COMPENSATION

Identify if the Contract is a **Rate Contract** (with no stated Maximum Obligation) or a **Maximum Obligation Contract** (with a stated Maximum Obligation) and identify the Maximum Obligation. If the Contract is being amended, enter the new Maximum Obligation based upon the increase or decreasing Amendment. The Total Maximum Obligation must reflect the total funding for the dates of service under the contract, including the Amendment amount if the Contract is being amended. The Maximum Obligation must match the MMARS encumbrance. Funding and allotments must be verified as available and encumbered prior to incurring obligations. If a Contract includes both a Maximum Obligation component and Rate Contract component, check off both, specific Maximum Obligation amounts or amended amounts and Attachments must clearly outline the Contract breakdown to match the encumbrance.

PAYMENTS AND PROMPT PAY DISCOUNTS

Payments are processed within a 45 day payment cycle through EFT in accordance with the Commonwealth Bill Paying Policy for investment and cash flow purposes. Departments may NOT negotiate accelerated payments and Payees are NOT entitled to accelerated payments UNLESS a prompt payment discount (PPD) is provided to support the Commonwealth's loss of investment earnings for this earlier payment, or unless a payments is legally mandated to be made in less than 45 days (e.g., construction contracts, Ready Payments under G.L. c. 29, s. 23A). See Prompt Pay Discounts Policy. PPD are identified as a percentage discount which will be automatically deducted when an accelerated payment is made. Reduced contracts rates may not be negotiated to replace a PPD. If PPD fields are left blank please identify that the Contractor agrees to the standard 45 day cycle; a statutory/legal exemption such as Ready Payments (G.L. c. 29, § 23A); or only an initial accelerated payment for reimbursements or start up costs for a grant, with subsequent payments scheduled to support standard EFT 45 day payment cycle. Financial hardship is not a sufficient justification to accelerate cash flow for *all* payments under a Contract. Initial grant or contract payments may be accelerated for the *first* invoice or initial grant installment, but subsequent periodic installments or invoice payments should be scheduled to support the Payee cash flow needs and the standard 45 day EFT payment cycle in accordance with the Bill Paying Policy. Any accelerated payment that does not provide for a PPD must have a legal justification in Contract file for audit purposes explaining why accelerated payments were allowable without a PPD.

BRIEF DESCRIPTION OF CONTRACT PERFORMANCE

Enter a brief description of the Contract performance, project name and/or other identifying information for the Contract to specifically identify the Contract performance, match the Contract with attachments, determine the appropriate expenditure code (as listed in the Expenditure Classification Handbook) or to identify or clarify important information related to the Contract such as the Fiscal Year(s) of performance (ex. "FY2012" or "FY2012-14"). Identify settlements or other exceptions and attach more detailed justification and supporting documents. Enter "Multi-Department Use" if other Departments can access procurement. For Amendments, identify the purpose and what items are being amended. Merely stating "see attached" or referencing attachments without a narrative description of performance is insufficient.

ANTICIPATED START DATE

The Department and Contractor must certify WHEN obligations under this Contract/Amendment may be incurred. Option 1 is the default option when performance may begin as of the Effective Date (latest signature date and any required approvals). If the parties want a new Contract or renewal to begin as of the upcoming fiscal year then list the fiscal year(s) (ex. "FY2012" or "FY2012-14") in the Brief Description section. Performance starts and encumbrances reflect the default Effective Date (if no FY is listed) or the later FY start date (if a FY is listed). Use Option 2 only when the Contract will be signed well in advance of the start date and identify a specific future start date. Do not use Option 2 for a fiscal year start unless it is certain that the Contract will be signed prior to fiscal year. Option 3 is used in lieu of the Settlement and Release Form when the Contract/Amendment is signed late, and obligations have already been incurred by the Contractor prior to the Effective Date for which the Department has either requested, accepted or deemed legally eligible for reimbursement, and the Contract includes supporting documents justifying the performance or proof of eligibility, and approximate costs. Any obligations incurred outside the scope of the Effective Date under any Option listed, even if the incorrect Option is selected, shall be automatically deemed a settlement included under the terms of the Contract and upon payment to the Contractor will release the Commonwealth from further obligations for the identified performance. All settlement payments require justification and must be under same encumbrance and object codes as the Contract payments. Performance dates are subject to G.L. c.4, § 9.

CONTRACT END DATE

The Department must enter the date that Contract performance will terminate. **If the Contract is being amended and the Contract End Date is not changing, this date must be re-entered again here.** A Contract must be signed for at least the initial duration but not longer than the period of procurement listed in the RFR, or other solicitation document (if applicable). No new performance is allowable beyond the end date without an amendment, but the Department may allow a Contractor to complete minimal close out performance obligations if substantial performance has been made prior to the termination date of the Contract and prior to the end of the fiscal year in which payments are appropriated, provided that any close out performance is subject to appropriation and funding limits under state finance law, and CTR may adjust encumbrances and payments in the state accounting system to enable final close out payments. Performance dates are subject to G.L. c.4, § 9.

CERTIFICATIONS AND EXECUTION

See Department Head Signature Authorization Policy and the Contractor Authorized Signatory Listing for policies on Contractor and Department signatures.

Authorizing Signature for Contractor/Date: The Authorized Contractor Signatory must (in their own handwriting and in ink) sign AND enter the date the Contract is signed. See section above under "Anticipated Contract Start Date". Acceptance of payment by the Contractor shall waive any right of the Contractor to claim the Contract/Amendment is not valid and the Contractor may not void the Contract. **Rubber stamps, typed or other images are not acceptable.** Proof of Contractor signature authorization on a **Contractor Authorized Signatory Listing** may be required by the Department if not already on file.

Contractor Name /Title: The Contractor Authorized Signatory's name and title must appear legibly as it appears on the **Contractor Authorized Signatory Listing**.

Authorizing Signature For Commonwealth/Date: The Authorized Department Signatory must (in their own handwriting and in ink) sign AND enter the date the Contract is signed. See section above under "Anticipated Start Date". **Rubber stamps, typed or other images are not accepted.** The Authorized Signatory must be an employee within the Department legally responsible for the Contract. See Department Head Signature Authorization. The Department must have the legislative funding appropriated for all the costs of this Contract or funding allocated under an approved Interdepartmental Service Agreement (ISA). A Department may not contract for performance to be delivered to or by another state department without specific legislative authorization (unless this Contract is a Statewide Contract). For Contracts requiring Secretariat signoff, evidence of Secretariat signoff must be included in the Contract file.

Department Name /Title: Enter the Authorized Signatory's name and title legibly.

CONTRACTOR CERTIFICATIONS AND LEGAL REFERENCES

Notwithstanding verbal or other representations by the parties, the "Effective Date" of this Contract or Amendment shall be the latest date that this Contract or Amendment has been executed by an authorized signatory of the Contractor, the Department, or a later Contract or Amendment Start Date specified, subject to any required approvals. The Contractor makes all certifications required under this Contract under the pains and penalties of perjury, and agrees to provide any required documentation upon request to support compliance, and agrees that all terms governing performance of this Contract and doing business in Massachusetts are attached or incorporated by reference herein:

Commonwealth and Contractor Ownership Rights. The Contractor certifies and agrees that the Commonwealth is entitled to ownership and possession of all "deliverables" purchased or developed with Contract funds. A Department may not relinquish Commonwealth rights to deliverables nor may Contractors sell products developed with Commonwealth resources without just compensation. The Contract should detail all Commonwealth deliverables and ownership rights and any Contractor proprietary rights.

Qualifications. The Contractor certifies it is qualified and shall at all times remain qualified to perform this Contract; that performance shall be timely and meet or exceed industry standards for the performance required, including obtaining requisite licenses, registrations, permits, resources for performance, and sufficient professional, liability; and other appropriate insurance to cover the performance. If the Contractor is a business, the Contractor certifies that it is listed under the Secretary of State's website as licensed to do business in Massachusetts, as required by law.

Business Ethics and Fraud, Waste and Abuse Prevention. The Contractor certifies that performance under this Contract, in addition to meeting the terms of the Contract, will be made using ethical business standards and good stewardship of taxpayer and other public funding and resources to prevent fraud, waste and abuse.

Collusion. The Contractor certifies that this Contract has been offered in good faith and without collusion, fraud or unfair trade practices with any other person, that any actions to avoid or frustrate fair and open competition are prohibited by law, and shall be grounds for rejection or disqualification of a Response or termination of this Contract.

Public Records and Access The Contractor shall provide full access to records related to performance and compliance to the Department and officials listed under Executive Order 195 and G.L. c. 11, s.12 seven (7) years beginning on the first day after the final payment under this Contract or such longer period necessary for the resolution of any litigation, claim, negotiation, audit or other inquiry involving this Contract. Access to view Contractor records related to any breach or allegation of fraud, waste and/or abuse may not be denied and Contractor can not claim confidentiality or trade secret protections solely for viewing but not retaining documents. Routine Contract performance compliance reports or documents related to any alleged breach or allegation of non-compliance, fraud, waste, abuse or collusion may be provided electronically and shall be provided at Contractor's own expense. Reasonable costs for copies of non-routine Contract related records shall not exceed the rates for public records under 950 C.M.R. 32.00.

Debarment. The Contractor certifies that neither it nor any of its subcontractors are currently debarred or suspended by the federal or state government under any law or

regulation including, Executive Order 147; G.L. c. 29, s. 29F G.L. c.30, § 39R, G.L. c.149, § 27C, G.L. c.149, § 44C, G.L. c.149, § 148B and G.L. c. 152, s. 25C.

Applicable Laws. The Contractor shall comply with all applicable state laws and regulations including but not limited to the applicable Massachusetts General Laws; the Official Code of Massachusetts Regulations; Code of Massachusetts Regulations (unofficial); 801 CMR 21.00 (Procurement of Commodity and Service Procurements, Including Human and Social Services); 815 CMR 2.00 (Grants and Subsidies); 808 CMR 1.00 (Compliance, Reporting and Auditing for Human And Social Services); AICPA Standards; confidentiality of Department records under G.L. c. 66A; and the Massachusetts Constitution Article XVIII if applicable.

Invoices. The Contractor must submit invoices in accordance with the terms of the Contract and the Commonwealth Bill Paying Policy. Contractors must be able to reconcile and properly attribute concurrent payments from multiple Departments. Final invoices in any fiscal year must be submitted no later than August 15th for performance made and received (goods delivered, services completed) prior to June 30th, in order to make payment for that performance prior to the close of the fiscal year to prevent reversion of appropriated funds. Failure to submit timely invoices by August 15th or other date listed in the Contract shall authorize the Department to issue an estimated payment based upon the Department's determination of performance delivered and accepted. The Contractor's acceptance of this estimated payment releases the Commonwealth from further claims for these invoices. If budgetary funds revert due to the Contractor's failure to submit timely final invoices, or for disputing an estimated payment, the Department may deduct a penalty up to 10% from any final payment in the next fiscal year for failure to submit timely invoices.

Payments Subject To Appropriation. Pursuant to G.L. c. 29 § 26, § 27 and § 29, Departments are required to expend funds only for the purposes set forth by the Legislature and within the funding limits established through appropriation, allotment and subsidiary, including mandated allotment reductions triggered by G.L. c. 29, § 9C. A Department cannot authorize or accept performance in excess of an existing appropriation and allotment, or sufficient non-appropriated available funds. Any oral or written representations, commitments, or assurances made by the Department or any other Commonwealth representative are not binding. The Commonwealth has no legal obligation to compensate a Contractor for performance that is not requested and is intentionally delivered by a Contractor outside the scope of a Contract. Contractors should verify funding prior to beginning performance.

Intercept. Contractors may be registered as Customers in the Vendor file if the Contractor owes a Commonwealth debt. Unresolved and undisputed debts, and overpayments of Contract payments that are not reimbursed timely shall be subject to intercept pursuant to G.L. c. 7A, s. 3 and 815 CMR 9.00. Contract overpayments will be subject to immediate intercept or payment offset. The Contractor may not penalize any state Department or assess late fees, cancel a Contract or other services if amounts are intercepted or offset due to recoupment of an overpayment, outstanding taxes, child support, other overdue debts or Contract overpayments.

Tax Law Compliance. The Contractor certifies under the pains and penalties of perjury tax compliance with Federal tax laws; state tax laws including but not limited to G.L. c. 62C, G.L. c. 62C, s. 49A; compliance with all state tax laws, reporting of employees and contractors, withholding and remitting of tax withholdings and child support and is in good standing with respect to all state taxes and returns due; reporting of employees and contractors under G.L. c. 62E, withholding and remitting child support including G.L. c. 119A, s. 12; TIR 05-11; New Independent Contractor Provisions and applicable TIRs.

Bankruptcy, Judgments, Potential Structural Changes, Pending Legal Matters and Conflicts. The Contractor certifies it has not been in bankruptcy and/or receivership within the last three calendar years, and the Contractor certifies that it will immediately notify the Department in writing **at least 45 days prior** to filing for bankruptcy and/or receivership, any potential structural change in its organization, or if there is **any risk** to the solvency of the Contractor that may impact the Contractor's ability to timely fulfill the terms of this Contract or Amendment. The Contractor certifies that at any time during the period of the Contract the Contractor is required to affirmatively disclose in writing to the Department Contract Manager the details of any judgment, criminal conviction, investigation or litigation pending against the Contractor or any of its officers, directors, employees, agents, or subcontractors, including any potential conflicts of interest of which the Contractor has knowledge, or learns of during the Contract term. Law firms or Attorneys providing legal services are required to identify any potential conflict with representation of any Department client in accordance with Massachusetts Board of Bar Overseers (BBO) rules.

Federal Anti-Lobbying and Other Federal Requirements. If receiving federal funds, the Contractor certifies compliance with federal anti-lobbying requirements including 31 USC 1352; other federal requirements; Executive Order 11246; Air Pollution Act; Federal Water Pollution Control Act and Federal Employment Laws.

Protection of Personal Data and Information. The Contractor certifies that all steps will be taken to ensure the security and confidentiality of all Commonwealth data for which the Contractor becomes a holder, either as part of performance or inadvertently during performance, with special attention to restricting access, use and disbursement of personal data and information under G.L. c. 93H and c. 66A and Executive Order 504. The Contractor is required to comply with G.L. c. 93I for the proper disposal of all paper and electronic media, backups or systems containing personal data and information, provided further that the Contractor is required to ensure that any personal data or information transmitted electronically or through a portable device be properly encrypted using (at a minimum) Information Technology Division (ITD) Protection of Sensitive Information, provided further that any Contractor having access to credit card or banking information of Commonwealth customers certifies that the Contractor is PCI compliant in accordance with the Payment Card Industry Council Standards and shall provide confirmation compliance during the Contract, provide further that the Contractor shall immediately notify the Department in the event of any security breach including the unauthorized access, disbursement, use or disposal of personal data or information, and in the event of a security breach, the Contractor shall cooperate fully with the Commonwealth and provide access to any information necessary for the Commonwealth to respond to the security breach and shall be fully responsible for any damages associated with the Contractor's breach including but not limited to G.L. c. 214, s. 3B.

Corporate and Business Filings and Reports. The Contractor certifies compliance with any certification, filing, reporting and service of process requirements of the Secretary of the Commonwealth, the Office of the Attorney General or other Departments as related to its conduct of business in the Commonwealth; and with its incorporating state (or foreign entity).

Employer Requirements. Contractors that are employers certify compliance with applicable state and federal employment laws or regulations, including but not limited to G.L. c. 5, s. 1 (Prevailing Wages for Printing and Distribution of Public Documents); G.L. c. 7, s. 22 (Prevailing Wages for Contracts for Meat Products and Clothing and Apparel); minimum wages and prevailing wage programs and payments; unemployment insurance and contributions; workers' compensation and insurance, child labor laws, AGO fair labor practices; G.L. c. 149 (Labor and Industries); G.L. c. 150A (Labor Relations); G.L. c. 151 and 455 CMR 2.00 (Minimum Fair Wages); G.L. c. 151A (Employment and Training); G. L. c. 151B (Unlawful Discrimination); G.L. c. 151E (Business Discrimination); G.L. c. 152 (Workers' Compensation); G.L. c.153 (Liability for Injuries); 29 USC c. 8 (Federal Fair Labor Standards); 29 USC c. 28 and the Federal Family and Medical Leave Act.

Federal And State Laws And Regulations Prohibiting Discrimination including but not limited to the Federal Equal Employment Oppurtunity (EEO) Laws the Americans with Disabilities Act,; 42 U.S.C Sec. 12,101, et seq., the Rehabilitation Act, 29 USC c. 16 s. 794; 29 USC c. 16. s. 701; 29 USC c. 14, 623; the 42 USC c. 45; (Federal Fair Housing Act); G. L. c. 151B (Unlawful Discrimination); G.L. c. 151E (Business Discrimination); the Public Accommodations Law G.L. c. 272, s. 92A; G.L. c. 272, s. 98 and 98A, Massachusetts Constitution Article CXIV and G.L. c. 93, s. 103; 47 USC c. 5, sc. II, Part II, s. 255 (Telecommunication Act; Chapter 149, Section 105D, G.L. c. 151C, G.L. c. 272, Section 92A, Section 98 and Section 98A, and G.L. c. 111, Section 199A, and Massachusetts Disability-Based Non-Discrimination Standards For Executive Branch Entities, and related Standards and Guidance, authorized under Massachusetts Executive Order or any disability-based protection arising from state or federal law or precedent. See also MCAD and MCAD links and Resources.

Small Business Purchasing Program (SBPP). A Contractor may be eligible to participate in the SBPP, created pursuant to Executive Order 523, if qualified through the SBPP COMMBUYS subscription process at: www.commbuys.com and with acceptance of the terms of the SBPP participation agreement.

Limitation of Liability for Information Technology Contracts (and other Contracts as Authorized). The Information Technology Mandatory Specifications and the IT Acquisition Accessibility Contract Language are incorporated by reference into Information Technology Contracts. The following language will apply to Information Technology contracts in the U01, U02, U03, U04, U05, U06, U07, U08, U09, U10, U75, U98 object codes in the Expenditure Classification Handbook or other Contracts as approved by CTR or OSD. Pursuant to Section 11. Indemnification of the Commonwealth Terms and Conditions, the term "other damages" shall include, but shall not be limited to, the reasonable costs the Commonwealth incurs to repair, return, replace or seek cover (purchase of comparable substitute commodities and services) under a Contract. "Other damages" shall not include damages to the Commonwealth as a result of third party claims, provided, however, that the foregoing in no way limits the Commonwealth's right of recovery for personal injury or property damages or patent and copyright infringement under Section 11 nor the Commonwealth's ability to join the contractor as a third party defendant. Further, the term "other damages" shall not include, and in no event shall the contractor be liable for, damages for the Commonwealth's use of contractor provided products or services, loss of Commonwealth records, or data (or other intangible property), loss of use of equipment, lost revenue, lost savings or lost profits of the Commonwealth. In no event shall "other damages" exceed the greater of $100,000, or two times the value of the product or service (as defined in the Contract scope of work) that is the subject of the claim. Section 11 sets forth the contractor's entire liability under a Contract. Nothing in this section shall limit the Commonwealth's ability to negotiate higher limitations of liability in a particular Contract, provided that any such limitation must specifically reference Section 11 of the Commonwealth Terms and Conditions. In the event the limitation of liability conflicts with accounting standards which mandate that there can be no cap of damages, the limitation shall be considered waived for that audit engagement. These terms may be applied to other Contracts only with prior written confirmation from the Operational Services Division or the Office of the Comptroller. The terms in this Clarification may not be modified.

Northern Ireland Certification. Pursuant to G.L. c. 7 s. 22C for state agencies, state authorities, the House of Representatives or the state Senate, by signing this Contract the

Contractor certifies that it does not employ ten or more employees in an office or other facility in Northern Ireland and if the Contractor employs ten or more employees in an office or other facility located in Northern Ireland the Contractor certifies that it does not discriminate in employment, compensation, or the terms, conditions and privileges of employment on account of religious or political belief; and it promotes religious tolerance within the work place, and the eradication of any manifestations of religious and other illegal discrimination; and the Contractor is not engaged in the manufacture, distribution or sale of firearms, munitions, including rubber or plastic bullets, tear gas, armored vehicles or military aircraft for use or deployment in any activity in Northern Ireland.

Pandemic, Disaster or Emergency Performance. In the event of a serious emergency, pandemic or disaster outside the control of the Department, the Department may negotiate emergency performance from the Contractor to address the immediate needs of the Commonwealth even if not contemplated under the original Contract or procurement. Payments are subject to appropriation and other payment terms.

Consultant Contractor Certifications (For Consultant Contracts "HH" and "NN" and "U05" object codes subject to G.L. Chapter 29, s. 29A). Contractors must make required disclosures as part of the RFR Response or using the Consultant Contractor Mandatory Submission Form.

Attorneys. Attorneys or firms providing legal services or representing Commonwealth Departments may be subject to G.L. c. 30, s. 65, and if providing litigation services must be approved by the Office of the Attorney General to appear on behalf of a Department, and shall have a continuing obligation to notify the Commonwealth of any conflicts of interest arising under the Contract.

Subcontractor Performance. The Contractor certifies full responsibility for Contract performance, including subcontractors, and that comparable Contract terms will be included in subcontracts, and that the Department will not be required to directly or indirectly manage subcontractors or have any payment obligations to subcontractors. .

EXECUTIVE ORDERS

For covered Executive state Departments, the Contractor certifies compliance with applicable Executive Orders (see also Massachusetts Executive Orders), including but not limited to the specific orders listed below. A breach during period of a Contract may be considered a material breach and subject Contractor to appropriate monetary or Contract sanctions.

Executive Order 481. Prohibiting the Use of Undocumented Workers on State Contracts. For all state agencies in the Executive Branch, including all executive offices, boards, commissions, agencies, Departments, divisions, councils, bureaus, and offices, now existing and hereafter established, by signing this Contract the Contractor certifies under the pains and penalties of perjury that they shall not knowingly use undocumented workers in connection with the performance of this Contract; that, pursuant to federal requirements, shall verify the immigration status of workers assigned to a Contract without engaging in unlawful discrimination; and shall not knowingly or recklessly alter, falsify, or accept altered or falsified documents from any such worker

Executive Order 130. Anti-Boycott. The Contractor warrants, represents and agrees that during the time this Contract is in effect, neither it nor any affiliated company, as hereafter defined, participates in or cooperates with an international boycott (See IRC § 999(b)(3)-(4), and IRS Audit Guidelines Boycotts) or engages in conduct declared to be unlawful by G.L. c. 151E, s. 2. A breach in the warranty, representation, and agreement contained in this paragraph, without limiting such other rights as it may have, the Commonwealth shall be entitled to rescind this Contract. As used herein, an affiliated company shall be any business entity of which at least 51% of the ownership interests are directly or indirectly owned by the Contractor or by a person or persons or business entity or entities directly or indirectly owning at least 51% of the ownership interests of the Contractor, or which directly or indirectly owns at least 51% of the ownership interests of the Contractor.

Executive Order 346. Hiring of State Employees By State Contractors Contractor certifies compliance with both the conflict of interest law G.L. c. 268A specifically s. 5 (f) and this order; and includes limitations regarding the hiring of state employees by private companies contracting with the Commonwealth. A privatization contract shall be deemed to include a specific prohibition against the hiring at any time during the term of Contract, and for any position in the Contractor's company, any state management employee who is, was, or will be involved in the preparation of the RFP, the negotiations leading to the awarding of the Contract, the decision to award the Contract, and/or the supervision or oversight of performance under the Contract.

Executive Order 444. Disclosure of Family Relationships With Other State Employees. Each person applying for employment (including Contract work) within the Executive Branch under the Governor must disclose in writing the names of all immediate family related to immediate family by marriage who serve as employees or elected officials of the Commonwealth. All disclosures made by applicants hired by the Executive Branch under the Governor shall be made available for public inspection to the extent permissible by law by the official with whom such disclosure has been filed.

Executive Order 504. Regarding the Security and Confidentiality of Personal Information. For all Contracts involving the Contractor's access to personal information, as defined in G.L. c. 93H, and personal data, as defined in G.L. c. 66A, owned or controlled by Executive Department agencies, or access to agency systems containing such information or data (herein collectively "personal information"), Contractor certifies under the pains and penalties of perjury that the Contractor (1) has read Commonwealth of Massachusetts Executive Order 504 and agrees to protect any and all personal information; and (2) has reviewed all of the Commonwealth **Information Technology Division's Security Policies.** Notwithstanding any contractual provision to the contrary, in connection with the Contractor's performance under this Contract, for all state agencies in the Executive Department, including all executive offices, boards, commissions, agencies, departments, divisions, councils, bureaus, and offices, now existing and hereafter established, the Contractor shall: (1) obtain a copy, review, and comply with the contracting agency's Information Security Program (ISP) and any pertinent security guidelines, standards, and policies; (2) comply with all of the Commonwealth of Massachusetts Information Technology Division's "Security Policies") (3) communicate and enforce the contracting agency's ISP and such Security Policies against all employees (whether such employees are direct or contracted) and subcontractors; (4) implement and maintain any other reasonable appropriate security procedures and practices necessary to protect personal information to which the Contractor is given access by the contracting agency from the unauthorized access, destruction, use, modification, disclosure or loss; (5) be responsible for the full or partial breach of any of these terms by its employees (whether such employees are direct or contracted) or subcontractors during or after the term of this Contract, and any breach of these terms may be regarded as a material breach of this Contract; (6) in the event of any unauthorized access, destruction, use, modification, disclosure or loss of the personal information (collectively referred to as the "unauthorized use"): (a) immediately notify the contracting agency if the Contractor becomes aware of the unauthorized use; (b) provide full cooperation and access to information necessary for the contracting agency to determine the scope of the unauthorized use; and (c) provide full cooperation and access to information necessary for the contracting agency and the Contractor to fulfill any notification requirements. Breach of these terms may be regarded as a material breach of this Contract, such that the Commonwealth may exercise any and all contractual rights and remedies, including without limitation indemnification under Section 11 of the Commonwealth's Terms and Conditions, withholding of payments, Contract suspension, or termination. In addition, the Contractor may be subject to applicable statutory or regulatory penalties, including and without limitation, those imposed pursuant to G.L. c. 93H and under G.L. c. 214, § 3B for violations under M.G.L c. 66A.

Executive Orders 523, 524 and 526. Executive Order 526 (Order Regarding Non-Discrimination, Diversity, Equal Opportunity and Affirmative Action which supersedes Executive Order 478). Executive Order 524 (Establishing the Massachusetts Supplier Diversity Program which supersedes Executive Order 390). Executive Order 523 (Establishing the Massachusetts Small Business Purchasing Program.) All programs, activities, and services provided, performed, licensed, chartered, funded, regulated, or contracted for by the state shall be conducted without unlawful discrimination based on race, color, age, gender, ethnicity, sexual orientation, gender identity or expression, religion, creed, ancestry, national origin, disability, veteran's status (including Vietnam-era veterans), or background. The Contractor and any subcontractors may not engage in discriminatory employment practices; and the Contractor certifies compliance with applicable federal and state laws, rules, and regulations governing fair labor and employment practices; and the Contractor commits to purchase supplies and services from certified minority or women-owned businesses, small businesses, or businesses owned by socially or economically disadvantaged persons or persons with disabilities. These provisions shall be enforced through the contracting agency, OSD, and/or the Massachusetts Commission Against Discrimination. Any breach shall be regarded as a material breach of the contract that may subject the contractor to appropriate sanctions.

COMMONWEALTH OF MASSACHUSETTS
EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES

First Amended and Restated Contract for

The MassHealth PCC Plan's Comprehensive Behavioral Health Program and Management Support Services, and Behavioral Health Specialty Programs

EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES
1 ASHBURTON PLACE
BOSTON, MA 02108

and

THE MASSACHUSETTS BEHAVIORAL HEALTH PARTNERSHIP
1000 WASHINGTON STREET
BOSTON, MA 02118

September 1, 2017

This First Amended and Restated Contract, entered into effective this first day of September 2017, is by and between the Massachusetts Executive Office of Health and Human Services ("EOHHS," or "MassHealth") and the Massachusetts Behavioral Health Partnership (MBHP), a general partnership under BeaconHealth Options Inc., of Boston, MA, with principal offices at 1000 Washington Street, Boston, MA 02118 ("Contractor").

WHEREAS, The Massachusetts Executive Office of Health and Human Services (EOHHS) is the single state agency responsible for administering the Medicaid program and the state's Children's Health Insurance Program (CHIP) within Massachusetts (collectively, MassHealth), pursuant to M.G.L. c.118E, Title XIX of the Social Security Act (42 U.S.C. § 1396 et seq.), Title XXI of the Social Security Act (42 U.S.C. § 1397aa et seq.), and other applicable laws and waivers; and

WHEREAS, EOHHS seeks and the Contractor agrees to provide innovative, cost-effective, high-quality care management services, network management services, quality management activities and comprehensive Behavioral Health Services for certain MassHealth members, including but not limited to a Care Management Program for individual Enrollees with complex medical and/or behavioral health conditions; and

WHEREAS, EOHHS seeks and the Contractor agrees to continue and enhance recovery, resiliency, family-centered and strength-based approaches to the provision of care; and

WHEREAS, EOHHS seeks and the Contractor agrees to develop a robust medical and behavioral health system of care, that is integrated both at both a the system level and at the individual level in order to improve health care outcomes for MassHealth members; and

WHEREAS, EOHHS seeks to implement the Commonwealth's payment reform initiatives to promote the most efficient and effective use of resources; and

WHEREAS, the parties agree that the following document is a restatement of the original Contract effective October 1, 2012, incorporating all provisions of Amendments 1-32, and

WHEREAS, the parties agree that the rates and terms stated herein are subject to the approval of the federal Centers for Medicare and Medicaid Services (CMS);

NOW, THEREFORE, in consideration of the mutual covenants and agreements herein contained, the Contractor and EOHHS agree as follows:

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LIST OF APPENDICES

SECTION 1. DEFINITIONS AND ACRONYMS

Section 1.1 Definitions

The following terms appearing capitalized throughout this Contract and its Appendices have the following meanings, unless the context clearly indicates otherwise.

N.B.: The word "day," whenever it appears in these documents, refers to a calendar day unless otherwise specified.

Adjustment – a compromise between the Contractor and the Covered Individual reached at any time after an Adverse Action but before the BOH issues a decision on a BOH Appeal.

Administrative Component of the BH Covered Services Capitation Rate – a Per-Member (Covered Individual) Per-Day rate paid by EOHHS to the Contractor for the administration of the PCC Plan's BHP.

Adverse Action – any one of the following actions or inactions by the Contractor shall be considered an Adverse Action:

(1) the failure to provide MassHealth Covered Services in a timely manner in accordance with the accessibility standards in **Section 3.1.G.8**;

(2) the denial or limited authorization of a requested service, including the determination that a requested service is not a MassHealth Covered Service;

(3) the reduction, suspension, or termination of a previous authorization by the Contractor for a service;

(4) the denial, in whole or in part, of payment for a service, where coverage of the requested service is at issue; provided that procedural denials for requested services do not constitute Adverse Actions, including but not limited to denials based on the following:

- failure to follow prior authorization procedures;
- failure to follow referral rules;
- failure to file a timely Claim;

(5) the failure to act within the timeframes in **Section 4.2.A.2.e** for making authorization decisions; and

(6) the failure to act within the timeframes in **Section 7.6.B.4** for reviewing an Internal Appeal and issuing a decision.

Alternative Formats – provision of Covered Individual Information in a format that takes into consideration the special needs of those who, for example, are visually limited or have limited reading proficiency. Examples of Alternative Formats shall include, but not be limited to, Braille, large font, audio tape, video tape, and Covered Individual Information read aloud to a Covered Individual by Covered Individual services representative.

Alternative Lock Up Programs -- Human service agencies contracted with the Commonwealth of Massachusetts Department of Children and Families to provide a temporary placement resource for the Commonwealth of Massachusetts state and local police departments in their efforts to comply with federal and state regulations regarding the placement of juveniles in their custody for either status or non-violent delinquent offenses.

Annual Payment Amount for the Care Management Program – the amount equal to the sum of all the Engagement PPPM payments plus the sum of all CMP outcomes measurements incentive payments plus any amount that the Contractor includes for the CMP in the Administrative Component of the BH Covered Services Capitation Rate.

Appeal Representative - any individual that the Contractor can document has been authorized by the Covered Individual in writing to act on the Covered Individual's behalf with respect to all aspects of a Grievance, Internal Appeal, or BOH Appeal. The Contractor must allow a Covered Individual to give a standing authorization to an Appeal Representative to act on his/her behalf for all aspects of Grievances and Internal Appeals. Such standing authorization must be done in writing according to the Contractor's procedures, and may be revoked by the Covered Individual at any time. When a minor is able, under law, to consent to a medical procedure, that minor can request an appeal of the denial of such treatment without parental/guardian consent and appoint an Appeal Representative without the consent of a parent or guardian.

Applied Behavioral Analysis – A MassHealth service that focuses on the analysis, design, implementation, and evaluation of social and other environmental modifications to produce meaningful changes in human behavior. This service provides for the performance of behavioral assessments; interpretation of behavior analytic data; development of a highly specific treatment plan; supervision and coordination of interventions; and training other interveners to address specific objectives or performance goals in order to treat challenging behaviors that interfere with a youth's successful functioning.

Behavioral Health (BH) – mental health and substance use disorder.

Behavioral Health Clinical Assessment – the comprehensive clinical assessment of a Covered Individual that includes a full bio-psycho-social and diagnostic evaluation that informs Behavioral Health treatment planning. It is performed when a Covered Individual begins Behavioral Health treatment and is reviewed and updated during the course of treatment. Behavioral Health Clinical Assessments provided to Covered Individuals under the age of 21 require the use of the CANS Tool to document and communicate assessment findings.

Behavioral Health Covered Services (or **BH Covered Services**) – the services the Contractor is responsible for providing to Covered Individuals, as applicable and as described in **Appendix A-1**.

Behavioral Heath Covered Services Capitation Rate – a Per-Member (Covered Individual) Per-Day (PMPD) and a Per-Member (Covered Individual) Per-Month rate paid by EOHHS to the Contractor for the provision of BH Covered Services to Covered Individuals. This actuarially sound capitation rate, as described in 42 CFR 438.4, is developed in accordance with generally accepted actuarial principles and practices, is appropriate for the populations to be covered and the services to be furnished under the Contract, has been certified as meeting the requirements of

42 CFR 438.4 by actuaries who meet the qualification standards established by the American Academy of Actuaries and follow the practice standards established by the Actuarial Standards Board, and has been approved by the Centers for Medicare and Medicaid Services (CMS).

Behavioral Health Network Provider (or **Network Provider**) – a provider that has contracted with the Contractor to provide Behavioral Health Covered Services under the BH Program.

Behavioral Health Program (BHP) – that portion of the Contract related to the administration, coordination, delivery and management of the BH Covered Services described in **Appendix A-1**.

BH Rate – the portion of the CPCP Rate paid to Tier 2 or Tier 3 PCPR Providers by the Contractor for Behavioral Health Covered Services provided to PCC Panel Enrollees. The BH Rate is a Per-Member Per-Month amount specific to a Participating Site.

Board of Hearings (BOH) – the Board of Hearings within the Executive Office of Health and Human Services' Office of Medicaid.

BOH Appeal – a written request to the BOH, made by a Covered Individual or Appeal Representative, to review the correctness of an Internal Appeal decision by the Contractor.

Care Coordination – management of care activities performed by the Contractor on behalf of a Covered Individual to improve health outcomes and may include medical, behavioral health, and pharmacy management and medication reconciliation among providers, agencies, and community social supports, as described in **Section 5.3**.

Care Management Program (CMP) – the administration and provision of certain clinical management and support activities to certain Enrollees and Providers, as described in **Section 6.2**.

Care Team – a group of individuals led by the care coordinator or care manager, including the Covered Individual, the Primary Care Clinician (PCC), and any other medical or behavioral health provider, case manager from another state agency, and any family member or other individual requested as part of the team by the Covered Individual.

Centers for Medicare and Medicaid Services (CMS) – the federal agency which oversees states' Medical Assistance programs and states' Children Health Insurance Programs (CHIP) under Titles XIX and XXI of the Social Security Act and waivers thereof.

Child and Adolescent Needs and Strengths (CANS) Tool – a tool that provides a standardized way to organize information gathered during Behavioral Health Clinical Assessments and during the discharge planning process from Inpatient Psychiatric Hospitalizations, Intensive Community-Based Acute Treatment Services, and Community-Based Acute Treatment Services. A Massachusetts version of the CANS Tool has been developed and is intended to be used as a treatment decision support tool for Behavioral Health Providers serving MassHealth Members under the age of 21.

CANS IT System – a web-based application accessible through the EOHHS Virtual Gateway into which Behavioral Health Providers serving MassHealth Members under the age of 21 will

input: (1) the information gathered using the CANS Tool; and (2) the determination whether or not the assessed Member is suffering from a Serious Emotional Disturbance.

Children's Behavioral Health Initiative (CBHI) – an interagency undertaking by EOHHS and MassHealth whose mission is to strengthen, expand and integrate Behavioral Health services for MassHealth Members under the age of 21 into a comprehensive system of community-based, culturally competent care.

Children's Behavioral Health Initiative Services (or **CBHI Services)** – any of the following services: Intensive Care Coordination (ICC), Family Support and Training, In-Home Behavioral Services (including Behavior Management Therapy and Behavior Management Monitoring) and Therapeutic Mentoring Services, In-Home Therapy Services (including Therapeutic Clinical Intervention and Ongoing Therapeutic Training and Support), and Youth Mobile Crisis Intervention.

Children in the Care and/or Custody of the Commonwealth – children who are Covered Individuals and who are in the care or protective custody of the Department of Children and Families (DCF), or in the custody of the Department of Youth Services (DYS). Children in the Care and/or Custody of the Commonwealth are eligible to receive services through the BHP without being required to enroll in the PCC Plan; however, any such children who are enrolled in the PCC Plan are considered Enrollees.

Claim – a Provider's bill for services, a line item of service, or all services for one Covered Individual or Uninsured Individual.

Clean Claim – a Claim that can be processed without obtaining additional information from the provider of the service or from a third party. It may include a Claim with errors originating from the Contractor's claims system. It does not include a Claim from a Provider who is under investigation for fraud or abuse or a Claim under review for Medical Necessity.

Clinical Criteria – the criteria used to determine the most clinically appropriate and necessary Level of Care, and intensity of services, to ensure the provision of Medically Necessary Behavioral Health Covered Services.

Cold-call Marketing – any unsolicited personal contact by the Contractor, its employees, Network Providers, agents or Material Subcontractors with a Member who is not enrolled in the PCC Plan or its BHP that EOHHS can reasonably interpret as influencing the Member to enroll in the PCC Plan or its BHP or either not to enroll in, or to disenroll from, a MassHealth managed care organization, accountable care organization, or the PCC Plan's BHP. Cold-call Marketing shall not include any personal contact between a Network Provider and a Member who is a prospective, current or former patient of that Network Provider regarding the provisions, terms or requirements of MassHealth as they relate to the treatment needs of that particular Member.

Community Service Agency (CSA) – a community-based Behavioral Health provider organization whose function is to facilitate access to the continuum of Behavioral Health services by providing an organized pathway to care for children and families where the child is referred for Intensive Care Coordination. A primary mechanism through which CSAs serve this function is as the provider of Intensive Care Coordination and Family Support and Training Services, which are defined as a BH Covered Service.

Comprehensive Primary Care Payment (CPCP) – a risk-adjusted, per-PCC Panel Enrollee, per-month payment to a PCPR Provider for a defined set of Primary Care services and Behavioral Health Covered Services.

CPCP Rate – the rate paid to PCPR Providers for provision of the CPCP Covered Services.

CPCP Covered Services – the set of services specified in **Appendix J-5.**

CPCP Tier – one of three options for the CPCP, each of which includes a different set of services.

Continuing Services –BH Covered Services that were previously authorized by the Contractor and are the subject of an Internal Appeal or BOH Appeal, if applicable, involving a decision by the Contractor to terminate, suspend, or reduce the previous authorization and which are provided by the Contractor pending the resolution of the Internal Appeal or BOH Appeal, if applicable.

Contract – this agreement executed between the Contractor and EOHHS pursuant to EOHHS's Request for Responses (RFR) for the PCC Plan's Comprehensive Behavioral Health Program and Management Support Services, and Behavioral Health Specialty Programs, issued in 2011, and any amendments thereto. The Contract incorporates by reference all attachments and appendices thereto, including the Contractor's response to the RFR.

Contractor – the entity that executes this Contract with EOHHS.

Contract Year – except for Contract Year One and Contract Year 6A, the 12-month period beginning on July 1 of each year.

Contract Year One – the period that begins on the Service Start Date and ends on June 30, 2013.

Contract Year 6A – the six-month period from July 1, 2017, through December 31, 2017.

Coverage Type -- a scope of medical services, other benefits, or both, that are available to individuals who meet specific MassHealth eligibility criteria. Coverage Types for this Contract include MassHealth Standard, CommonHealth, Family Assistance, and CarePlus. See 130 CMR 450.105 for an explanation of each Coverage Type.

Covered Individuals – MassHealth Members who are eligible to receive Behavioral Health Covered Services under the BHP, including PCC Plan Enrollees, MFP Waiver Participants, Children in the Care and/or Custody of the Commonwealth and children in MassHealth Standard or CommonHealth with other health insurance.

Covered Individual Information – information about the Contractor for Covered Individuals that includes, but is not limited to, a Provider directory that meets the requirements of **Section 7.2.B.2**., and a Covered Individual handbook that meets the requirements of **Section 7.2.A.11**.

Credentialing Criteria – criteria that a Provider must meet to be qualified as a Network Provider.

Crisis Prevention Plan – a plan directed by the Covered Individual, or in the case of Covered Individuals under age 18, their legal guardian, designed to expedite a consumer- or family-focused clinical disposition in the event of a psychiatric crisis, based on the experience gained from past treatment. The Crisis Prevention Plan provides a thorough checklist of the triggers that may lead to or escalate a psychiatric crisis. The plan also includes potential clinical presentations and a preferred disposition and treatment plan for each of these presentations as well as the Covered Individual's preferences with respect to involvement of the Covered Individual, his/her family and other supports, such as behavioral health providers, community social service agencies, and natural community supports. With the Covered Individual's consent, the plan may be implemented by an ESP, other BH Network Provider, the PCC, the staff from the CSA, or another provider. This type of plan may also be referred to as a Wellness Recovery Action Plan (WRAP) for adults with Severe and Persistent Mental Illness (SPMI), and a Risk Management Safety Plan for children with Severe Emotional Disturbance (SED) and their families.

Culturally and Linguistically Appropriate Services – Health care services that are respectful of and responsive to cultural and linguistic needs, and that are characterized by cultural and linguistic competence, as described in the Culturally and Linguistically Appropriate Services (CLAS) standards set forth by the Office of Minority Health of the U.S. Department of Health and Human Services. More detail on CLAS standards may be found here: http://minorityhealth.hhs.gov/assets/pdf/checked/finalreport.pdf

Date of Action – the effective date of an Adverse Action.

Department of Mental Health (DMH) – the department within the Massachusetts Executive Office of Health and Human Services designated as the Commonwealth's mental health authority pursuant to M.G.L. c. 19 and M.G.L. c. 123, et seq.

DMH Administrative Budget – the total dollar amount paid to the Contractor for the DMH Specialty Programs Administrative Compensation Rate, covering the administrative costs for ESP for Uninsured Individuals and persons covered by Medicare only, Forensic Evaluations, and MCPAP.

DMH Case Management – Targeted Case Management (TCM) provided by DMH to DMH clients. The core elements of DMH Case Management Services include assessment, development of a care plan, service coordination and referral, monitoring, and client advocacy.

DMH Clients – Covered Individuals whom EOHHS identifies to the Contractor as being eligible for and recipients of DMH services.

DMH Service Authorization – the process by which a Member is found to be eligible and approved for a service provided through DMH.

DMH Specialty Programs – programs the Contractor manages under the Contract on behalf of DMH, including the Emergency Services Program (ESP) for Uninsured Individuals and persons covered by Medicare only, and Forensic Evaluations.

DMH Specialty Programs Administrative Compensation Rate – a dollar amount to be paid monthly by EOHHS to the Contractor for the administration of ESP Services for Uninsured Individuals including persons covered by Medicare only and the Forensic Evaluation program.

DMH Specialty Programs Total Compensation Rate Payment – the amount paid by EOHHS to the Contractor pursuant to **Section 10.9** and **10.10**, which includes the DMH Specialty Programs Services Compensation Rate Payment plus the DMH Specialty Programs Administrative Compensation Rate.

DMH Specialty Programs Service Compensation Rate – the amount paid by EOHHS to the Contractor pursuant to **Section 10.10** for the provision of DMH Specialty Programs services.

Designated Forensic Professional – a physician or psychologist designated by the Department of Mental Health as qualified to perform a clinical assessment of the mental status of a prisoner and provide recommendations to an on-call judge regarding the need for brief psychiatric hospitalization or commitment. See M.G.L. c. 123, § 18(a).

Direct Costs – Contractor-incurred costs directly related to the administration of the Contract. Direct Costs include but are not limited to: clinical, administrative, technical and support staff assigned to the Contract; and related administrative expenses. Direct Costs do not include federal and state taxes except sales tax and taxes attributable to personnel.

Direct Service Reserve Account (DSRA) – an interest-bearing trust account maintained by the Contractor in a bank located in Massachusetts and approved by EOHHS in accordance with the provisions of the Contract, into which payments to the Contractor are deposited when paid by EOHHS.

Discharge Planning – the evaluation of a Covered Individual's medical and Behavioral Health care needs and coordination of any other support services in order to arrange for safe and appropriate care after discharge from one Level of Care to another Level of Care, including referral to appropriate services.

Dual Diagnosis – co-occurring mental health and substance abuse conditions.

Earnings – the Contractor's revenue or profit related DMH Specialty Programs Administrative Budget of this Contract. Earnings are an agreed-upon amount of the DMH Specialty Programs Administrative Budget, as described in **Section 10** and **Appendix H-1.**

Effective Date of Enrollment – as of 12:01 a.m. on the first day, as determined by EOHHS, on which the Contractor is responsible for providing Behavioral Health Covered Services, to an Enrollee and as reflected in the HIPAA 834 Outbound Enrollment File.

Eligible Days – depending on the context, the total number of days in a month for which Covered Individuals were eligible for Behavioral Health Covered Services, as determined by EOHHS; or the total number of days in a month for which Enrollees were eligible for the PCC Plan, as determined by EOHHS.

Eligibility Verification System (EVS) – EOHHS's computerized system for verifying MassHealth Member eligibility.

Emergency Medical Condition – a medical condition, whether physical or mental, manifesting itself by acute symptoms of sufficient severity, including severe pain, that, in the absence of prompt medical attention, could reasonably be expected by a prudent layperson who possesses an

average knowledge of health and medicine to result in placing the health of a beneficiary or another person or, in the case of a pregnant woman, the health of the woman or her unborn child, in serious jeopardy, serious impairment to bodily function, or serious dysfunction of any body organ or part; or, with respect to a pregnant woman, as further defined in section 1867(e)(1)(B) of the Social Security Act. (42 U.S.C. § 1395dd(e)(1)(B).)

Emergency Service Programs (ESPs) – the Network Providers, identified in **Appendix A-3**, that provide ESP Services as described in **Appendix A-1, Part III** in accordance with the requirements of the Contract.

ESP Amount – the total amount paid for ESP Services provided under the Contract to Uninsured Individuals and persons covered by Medicare only.

Emergency Services – MassHealth Covered Services that are furnished to a Covered Individual by a provider qualified to furnish such services under Title XIX of the Social Security Act, and that are needed to evaluate or stabilize a Covered Individual's Emergency Medical Condition.

Encounter – a professional contact between a patient and a provider who delivers health care services.

Engagement – in-person or telephonic encounters(s) with an Enrollee, for the purposes of completing a comprehensive health assessment, and creating and implementing an Individual Care Plan (ICP).

Engagement Rate – the number of Participants in the Care Management Program as a percent of the total number of Enrollees for whom the Contractor conducts outreach for the CMP.

Engagement Target – the minimum projected number of Enrollees in each Tier the Contractor is required to successfully enroll in the CMP each Contract Year.

Enrollee – a person determined eligible for MassHealth who is enrolled in the PCC Plan, either by choice or by assignment by EOHHS.

Enrollee Days – the sum of the number of days each Enrollee is enrolled in the PCC Plan.

Enrollment Broker – the EOHHS-contracted entity that provides MassHealth Members with assistance in enrollment into MassHealth Managed Care plans, including the PCC Plan.

EPSDT Periodicity Schedule – the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Medical and Dental Protocol and Periodicity Schedules that appears in Appendix W of all MassHealth provider manuals and is developed and periodically updated by MassHealth in consultation with the Massachusetts Chapter of the American Academy of Pediatrics, Massachusetts DPH, dental professionals, the Massachusetts Health Quality Partners, and other organizations concerned with children's health. The Schedule consists of screening procedures arranged according to the intervals or age levels at which each procedure is to be provided.

Estimated Administrative Payment – a prospective monthly payment made by EOHHS to the Contractor for the administration of the BHP, based on an approximation of the number of

Covered Individuals eligible for services under the Contract for that month multiplied by the applicable PMPD Administrative Component of the BH Capitation Rate.

Estimated Capitation Payment– a prospective monthly payment made by EOHHS to the Contractor, based on an approximation of the number of Covered Individuals eligible for services under the Contract for that month multiplied by the applicable PMPD Capitation Rate. The payment is made regardless of whether the Covered Individual receives services during the period covered by the payment.

Estimated PCC Plan Management Support Services Payment – a prospective monthly payment made by EOHHS to the Contractor, based on an approximation of the number of Enrollees in the PCC Plan multiplied by the PMPD PCC Plan Support Services Rate.

Executive Office of Health and Human Services (EOHHS) – the executive agency within Massachusetts that is the single state agency responsible for the administration of the MassHealth program (Medicaid), pursuant to M.G.L. c. 118E, Titles XIX and XXI of the Social Security Act, and other applicable laws and waivers thereto.

Expected External Service Provision Adjustment (EESPA) – a factor determined by EOHHS for use in calculating the CPCP, to reflect PCPR Panel Enrollees' receipt of CPCP Covered Services from health care providers other than the Contractor's Network Providers or certain Voluntary Pooled PCPR Providers.

External Quality Review Activities (EQR Activities) – activities performed by an entity with which EOHHS contracts in accordance with 42 CFR 438.350 through 42 CFR 438.370.

External Quality Review Contractor (EQR Contractor) – the entity with which EOHHS contracts to perform External Quality Review Activities.

Federal Financial Participation (FFP) – the federal share of the costs associated with states' administration of entitlement programs such as the Medicaid program.

Forensic Evaluation Services – a clinical assessment of the mental status of a prisoner, performed by a physician or psychologist designated by the Department of Mental Health as qualified to perform such examination in accordance with M.G.L. c. 123, § 18(a). Such examination shall including recommendations to an on-call judge regarding the need for brief psychiatric hospitalization or commitment, if so indicated.

Grievance – any expression of dissatisfaction by a Covered Individual or Appeal Representative about any action or inaction by the Contractor other than an Adverse Action. Possible subjects for Grievances include, but are not limited to, quality of care or services provided, aspects of interpersonal relationships such as rudeness of a Provider or employee of the Contractor, or failure to respect the Covered Individual's rights.

Health Care Acquired Conditions (HCACs) – conditions occurring in an inpatient hospital setting, which Medicare designates as hospital-acquired conditions (HACs) pursuant to Section 1886 (d)(4)(D)(iv) of the Social Security Act (SSA)(as described in Section 1886(d)(D)(ii) and (iv) of the SSA), with the exception of deep vein thrombosis (DVT)/pulmonary embolism (PE) as related to total knee replacement or hip replacement surgery in pediatric and obstetric patients.

Healthcare Effectiveness Data and Information Set (HEDIS) – a standardized set of health plan performance measures developed by the National Committee for Quality Assurance (NCQA) and utilized by EOHHS and other purchasers and insurers.

Health Insurance Portability and Accountability Act of 1996 (HIPAA) – federal legislation (Pub. L. 104-191, as amended), enacted to improve the continuity of health insurance coverage in group and individual markets, combat waste, fraud, and abuse in health insurance and health-care delivery, simplify the administration of health insurance and protect the confidentiality and security of individually identifiable health information.

Health Needs Assessment – a tool that identifies and quantifies an Enrollee's physical and Behavioral Health status and needs based on morbidity and mortality risk, derived from the collection and review of demographic, physical and Behavioral Health and lifestyle information.

Health Safety Net – unpaid hospital charges, as defined in M.G.L. c. 118G, for Medically Necessary services provided to: (1) patients deemed financially unable to pay, in whole or in part, for their care; (2) uninsured patients who receive Emergency care for which the costs have not been collected after reasonable efforts; or (3) patients in situations of medical hardship where major expenditures for health care have been depleted or can reasonably be expected to deplete the financial resources of the individual to the extent that medical services will be unpaid.

Hold Harmless Payment – a payment made by the Contractor to PCPR Providers as compensation in the case where PCPR Provider incurs costs in excess of those compensated for by the CPCP, as calculated in Section 4.1 of the Primary Care Payment Reform Initiative Contract Addendum to the Fourth Amended and Restated Primary Care Clinician Plan Provider Contract (**Appendix J-1**).

Homeless – individuals who lack regular, fixed, and adequate nighttime residence, and who, on a temporary or permanent basis, have a primary residence that is a shelter or similar facility, or who have no primary residence and utilize public areas for sleep, shelter, and daily living activities.

Indian Enrollee – An individual who is an Indian (as defined in section 4(c) of the Indian Health Care Improvement Act of 1976 (25 U.S.C. 1603(c)).

Indian Health Care Provider – an Indian Health Care Provider or an Urban Indian Organization as defined in the American Recovery and Reinvestment Act of 2009.

Indirect Costs – costs charged to the Contractor by its parent to support administration of the Contract, including management, financial or other corporate functions provided to support operation of the program, and exclusive of Direct Costs. Indirect Costs do not include federal and state taxes except sales tax and taxes attributable to personnel.

Individual Care Plan (ICP) – the plan of care developed by a Clinical Care Manager in conjunction with an individual's Care Team, when appropriate and possible. The ICP includes: (1) the individual's detailed and comprehensive needs assessment; (2) identified short-term and long-term treatment goals; (3) a service plan to meet those goals; and (4) the creation of a defined course of action to enhance the individual's functioning and quality of life.

Internal Appeal – a request by a Covered Individual or Appeal Representative made to the Contractor for review of an Adverse Action.

Level of Care – a differentiation of services depending on the setting in which care is delivered and the intensity of the services.

Marketing – any communication from the Contractor, its employees, Network Providers, agents or Material Subcontractors to a Member who is not enrolled in the PCC Plan or its BHP that EOHHS can reasonably interpret as influencing the Member to enroll in the PCC Plan or its BHP or either not to enroll in, or to disenroll from, a MassHealth managed care organization, accountable care organization, or the PCC Plan's BHP. Marketing shall not include any personal contact between a Provider and a Member who is a prospective, current or former patient of that Provider regarding the provisions, terms or requirements of MassHealth as they relate to the treatment needs of that particular Member.

Marketing Materials –materials that are produced in any medium, by or on behalf of the Contractor, and that EOHHS can reasonably interpret as Marketing to Members. This includes the production and dissemination by or on behalf of the Contractor of any promotional material or activities by any medium including, but not limited to, oral presentations and statements, community events, print media, audio visual tapes, radio, television, billboards, Yellow Pages, and advertisements that explicitly or implicitly refer to MassHealth Managed Care or Title XIX and Title XXI of the Social Security Act, and are targeted in any way toward Members.

Massachusetts Behavioral Health Access System – a web-based searchable database maintained by the Contractor that contains up-to-date information on the number of available beds or available service capacity for certain MassHealth Behavioral Health services, including psychiatric hospitals, Community-Based Acute Treatment Providers, and providers of Intensive Home and Community-Based Services.

MassHealth – the Medicaid program of the Commonwealth of Massachusetts, administered by EOHHS pursuant to M.G.L. c. 118E, Titles XIX and XXI of the Social Security Act, and other applicable laws and waivers thereto.

MassHealth CarePlus – a MassHealth Coverage Type that offers health benefits to certain individuals at least the age of 21 and under the age of 65 who qualify under EOHHS's MassHealth CarePlus eligibility criteria.

MassHealth CommonHealth – a MassHealth Coverage Type that offers health benefits to certain disabled children under age 18, and certain working or non-working disabled adults between the ages of 18 and 64.

MassHealth Covered Services – medical and behavioral health services or related care provided to Covered Individuals, in accordance with the lists of covered services associated with the MassHealth Coverage Type specified in 130 CMR 505.001 through 505.009.

MassHealth Family Assistance – a MassHealth Coverage Type that offers health benefits to certain eligible Members, including families and children under the age of 18.

MassHealth Provider – a participating individual, facility, agency, institution, organization, or other entity that has appropriate credentials and licensure and has entered into an agreement with EOHHS for the delivery of MassHealth Covered Services to MassHealth Members.

MassHealth Managed Care – the provision of Primary Care, Behavioral Health, and other medical services through a contracted managed care organization, accountable care organization, or the PCC Plan, in accordance with the provisions of 130 CMR 450.117 et seq. and 130 CMR 508.000 et seq.

MassHealth Member (Member) – any individual determined by EOHHS to meet the requirements of 130 CMR 505.002 or 130 CMR 505.005.

MassHealth Standard – a MassHealth Coverage Type that offers a full range of health benefits to certain eligible Members, including families, children under age 18, pregnant women, and disabled individuals under age 65.

Material Subcontractor – any entity from which the Contractor procures, reprocures, or proposes to subcontract with, for the provision of all or part of its Administrative Services for any program area or function that relates to the delivery, management or payment of BH Covered Services, including but not limited to claims processing, the Care Management Program and other care management activities, PCC Plan Management Support Services, and Utilization Management.

MCPAP for Moms – a statewide program in the Commonwealth to assist medical professionals in supporting a mother's emotional and mental health during pregnancy and the year following birth or adoption. Service includes phone consultations with a MCPAP for Moms psychiatrist to discuss treatment options, personalized recommendations by a psychiatrist, community-based mental health resources and assistance in identifying and/or scheduling community-based mental health services that may include therapy, a psychiatrist, or a support group.

MCPAP Teams – multiple units of contracted and credentialed MCPAP Providers with each unit responsible for specific geographic centers across the state. Each unit shall include MCPAP Providers experienced in providing pediatric mental health and substance use disorder consultation.

Medicaid – see MassHealth.

Medicaid Management Information System (MMIS) – the management information system of software, hardware, and manual procedures used to process Medicaid claims and to retrieve and produce eligibility information, service utilization and management information for Members.

Medical Home Load – the portion of the CPCP Rate that provides compensation for transformation costs associated with non-billable services, as described in **Section 4.1.A.2.a** of **Appendix J-1**.

Medically Necessary (or Medical Necessity) – a service is "Medically Necessary" if:

(1) it is reasonably calculated to prevent, diagnose, prevent the worsening of, alleviate, correct, or cure conditions in the Member that endanger life, cause suffering or pain, cause physical deformity or malfunction, threaten to cause or to aggravate a handicap, or result in illness or infirmity; and
(2) there is no other medical service or site of service, comparable in effect, available, and suitable for the Member requesting the service, that is more conservative or less costly to the MassHealth agency. Services that are less costly to the MassHealth agency include, but are not limited to, health care reasonably known by the provider, or identified by the MassHealth agency pursuant to a prior-authorization request, to be available to the member through sources described in 130 CMR 450.317(C), 503.007, or 517.007. See, 130 CMR 450.204.

Medication Reconciliation – the process of avoiding inadvertent inconsistencies in medication prescribing that may occur in transition of a patient from one care setting to another (e.g., at hospital admission or discharge, or in transfer from a hospital intensive care unit to a general ward) by reviewing the patient's complete medication regimen at the time of admission, transfer and discharge and comparing it with the regimen being considered for the new care setting.

Member – a person determined by EOHHS to be eligible for MassHealth.

Member Identification Number (MID) – the 10-digit identification number assigned to each MassHealth Member.

Money Follows the Person (MFP) Demonstration – A MassHealth demonstration program pursuant to a federal grant received by EOHHS that seeks to assist eligible Members residing in long-term care facility settings to transition to community-based settings where they can receive home and community-based services. See definition of "Money Follows the Person Waivers," below.

Money Follows the Person (MFP) Waivers – Massachusetts waivers approved by CMS under Section 1915(c) and 1915(b) of the Social Security Act. Massachusetts operates three separate MFP Waivers. Each MFP waiver has different covered services and eligibility requirements. The two 1915(c) Home and Community-Based Services (HCBS) waivers are the Money Follows the Person Residential Supports (MFP-RS) waiver and the Money Follows the Person Community Living (MFP-CL) waiver. The third waiver is the 1915(b) Money Follows the Person Behavioral Health Managed Care (MFP-BH) waiver. The MFP-BH waiver will serve all individuals enrolled in the MFP-RS and MFP-CL waivers who are not otherwise eligible for managed Behavioral Health benefits.

MFP Transitional Assistance Services – Behavioral health services necessary for the MFP Waiver Participant to successfully transition from a nursing facility or hospital to a community living arrangement. MFP Transitional Assistance Services are limited to services provided prior to the date of facility discharge.

MFP Waiver Participant – a Covered Individual who is eligible for services pursuant to one of the MFP Waivers.

MFP Waiver Case Manager/Service Coordinator – an individual designated by EOHHS who is responsible for performing an assessment to determine the MFP Waiver Participant's care needs in the community. Based upon the MFP Waiver Case Manager/Service Coordinator's

assessment, the MFP Waiver Case Manager/Service Coordinator will engage in a person-centered planning process with the MFP Waiver Participant, and develop an individual service plan. It is the MFP Waiver Case Manager/Service Coordinator's responsibility to monitor the provision of services pursuant to the MFP Waiver Participant's individual service plan, and also communicate the individual service plan to the appropriate agencies, organizations and providers; and coordinate the provision of services.

Network (or **Provider Network)** – the collective group of Network Providers who have entered into Provider Agreements with the Contractor for the delivery of BH Covered Services.

Other Provider Preventable Condition (OPPC) – a condition that meets the requirements of an "Other Provider Preventable Condition" pursuant to 42 C.F.R. 447.26(b). OPPCs may occur in any health care setting and are divided into two subcategories:

1. National Coverage Determinations (NCDs) – The NCDs are mandatory OPPCs under 42 C.F.R. 447.26(b) and consist of the following:
   a. Wrong surgical or other invasive procedure performed on a patient;
   b. Surgical or other invasive procedure performed on the wrong body part;
   c. Surgical or other invasive procedure performed on the wrong patient.

   For each of a. through c., above, the term "surgical or other invasive procedure" is defined in CMS Medicare guidance on NCDs.
2. Additional Other Provider Preventable Conditions (Additional OPPCs) – Additional OPPCs are state-defined OPPCs that meet the requirements of 42 C.F.R. 447.26(b). EOHHS has designated certain conditions as "Additional OPPCs."

Outreach Target -- the projected number of Enrollees the Contractor will attempt to Engage annually for Enrollment in the Care Management Program each Contract Year.

Participant -- an Enrollee who is enrolled in the Care Management Program with an ICP.

Participating Site – a physical location from which a PCPR Provider provides the Primary Care Services required by the Primary Care Payment Reform Initiative. Participating Sites are listed in **Appendix J-3**.

Patient-Centered Medical Home Initiative (PCMHI) Clinical Care Management Services – services provided by a licensed nurse care manager employed by an EOHHS PCMHI participating practice. The services include stratification of the practice patient population, having contact with patients identified as high-risk no less frequently than every 30 days, case review and planning, including completing, analyzing, and updating as necessary medical bio-psychosocial support and self-management support assessments, and providing intensive medical and medication management.

Pay for Performance (P4P) – Performance Incentive Arrangement payments the Contractor may earn as described in Contract **Sections 8** and **10**.

Payment Month – the month in which an Estimated Capitation Payment is issued to the Contractor.

Peer Support – activities to support recovery and rehabilitation provided to consumers of Behavioral Health services by other individuals with personal experience with Behavioral Health conditions and services.

Per-Member (Enrollee or **Covered Individual) Per-Day (PMPD) –** the average daily amount to be paid per Enrollee or Covered Individual, depending on context.

Per-Member (Enrollee or **Covered Individual) Per-Month (PMPM)** – the average monthly payment per Enrollee or Covered Individual, depending on context.

Performance Incentive Arrangement – a payment mechanism under which the Contractor may earn payments for meeting targets in the Contract. See 42 CFR 438.6(b).

Pilot Accountable Care Organization (Pilot ACO) – Entities that enter into contracts with EOHHS pursuant to Request for Responses for Accountable Care Organization Pilot.

Plan Type – an identifier used by MassHealth's MMIS to identify the Rating Category in which a Covered Individual is enrolled in the BHP.

Positive Parenting Program® (Triple P) – an evidence-based family intervention program, developed by Triple P America, designed to prevent and treat behavioral and emotional problems in children and adolescents and create a family environment that encourages children and adolescents to realize their potential. Triple P draws on social learning and cognitive behavioral and developmental theory as well as research on risk factors associated with the development of social and behavioral problems in children to provide a multi-level parenting and family support training system. The goal of Triple P is to equip parents with the skills and confidence they need to be self-sufficient and to be able to manage family issues without ongoing support.

Post-stabilization Care Services – Covered Inpatient and Outpatient Services, related to an Emergency medical condition that are provided after a Covered Individual is stabilized in order to maintain the stabilized condition, or when covered pursuant to 42 CFR 438.114(e) to improve or resolve the Covered Individual's condition.

Potential Enrollee – a MassHealth Member who is subject to mandatory enrollment or who might voluntarily enroll in one of the Commonwealth's managed care entities but is not yet an enrollee of the managed care entity.

Practice Based Care Management (PBCM) – A model of Integrated Care Management that is delivered by Primary Care Providers to improve member experience, improve care coordination and improve integration of physical and behavioral health care.

Practice Guidelines – systematically developed descriptive tools or standardized specifications for care to assist provider and patient decisions about appropriate health care for specific circumstances. Practice Guidelines are typically developed through a formal process and are based on authoritative sources that include clinical literature and expert consensus.

Pre-Arraignment Protocol (PAP) – a protocol that sets forth a legal-clinical assessment process which allows local police departments to obtain psychiatric hospitalizations, where appropriate, for persons who are arrested but not yet arraigned when the court is closed.

Prevalent Languages – those languages spoken by a significant percentage of potential Enrollees and Enrollees. EOHHS has determined the current Prevalent Languages spoken by potential Enrollees and Enrollees are Spanish and English. EOHHS may identify additional or different languages as Prevalent Languages at any time during the term of the Contract.

Primary Care – all health care services and laboratory services customarily furnished by or through a family physician, internal medicine physician, obstetrician/gynecologist, pediatrician, or nurse practitioner, to the extent the furnishing of those services is legally authorized by the Commonwealth, as further described in 130 CMR 450.101.

Primary Care Activity Level (PCAL) – a factor determined by EOHHS for use in calculating the CPCP, to reflect the age, sex, diagnoses or other characteristics of PCPR Providers' PCC Panel Enrollees.

Primary Care Clinician (PCC) – an EOHHS-contracted Primary Care Practitioner participating in the Managed Care program pursuant to 130 CMR 450.118. PCCs provide comprehensive Primary Care and certain other medical services to PCC Plan Enrollees and function as the referral source for most other MassHealth services.

PCC Hotline – the toll-free telephone line maintained by the Contractor to answer or refer PCC or other PCC Plan provider inquiries. Such inquiries may include, but are not limited to, questions about: the Contractor's responsibilities related to the PCC Plan, including reporting, quality management, operations, PCCs participating in PCMHI, the PCC Provider Contract (see **Appendix C-2**), and other topics as directed by EOHHS.

PCC Member-Level Report – a component of the PCC Plan Management Support Services. The reports shall contain clinical data about specific Enrollees to help PCCs and their service locations monitor and manage Enrollees' care in accordance with recommended guidelines.

PCC Panel Enrollee – an Enrollee who is assigned to the PCPR Provider. Panel Enrollees do not include MassHealth Members enrolled with an OneCare Plans or who have third-party insurance.

PCC Performance Dashboard – a component of the PCC Plan Management Support Services. These PCC-specific and/or PCC service location-specific reports shall contain agreed upon indicators to help PCCs and their service locations monitor their performance and to identify opportunities for quality improvement.

PCC Plan – a MassHealth Managed Care option, which includes EOHHS's network of PCCs, specialty care providers and the BHP.

PCC Plan Management Support Services (MSS) – services designed to support MassHealth in managing the PCC Plan in a cohesive fashion with a focus on quality management and operational support.

PCC Plan Management Support Materials – educational materials distributed by the Contractor to PCCs (and other providers as appropriate) to promote improvement in the delivery of health care services and in Enrollee health outcomes.

PCC Plan Support Managers – Contractor staff dedicated solely to the Contract, with appropriate network management, QM, provider relations, and relevant clinical background and experience.

PCC Provider Contract – a PCC's written agreement with EOHHS to be a PCC in the PCC Plan. The PCC may hold a contract for one or more PCC Service Locations.

PCC Service Location – the site at which an Enrollee is enrolled once an Enrollee chooses or is assigned to the PCC Plan. A PCC Service Location is denoted by a Provider Identification and Service Location (PID/SL) number which is system-generated by the EOHHS MMIS. A PCC may have one Service Location or multiple Service Locations.

Primary Care Payment Reform Initiative (PCPRI or **PCPR Initiative)** – an EOHHS care delivery program to begin in calendar year 2014 and ending December 31, 2016 to improve access to care, member experience, quality of care, and overall efficiency in service delivery by emphasizing Patient-Centered Medical Homes, the integration of Primary Care services with Behavioral Health services and MassHealth's use of an alternative payment mechanism for participating providers.

PCPR Provider – a Primary Care Clinician that has signed the Primary Care Payment Reform Initiative Contract Addendum to the Fourth Amended and Restated Primary Care Clinician Plan Provider Contract to participate in PCPR with MassHealth, a model of which is included as **Appendix J-1**. A list of PCPR Providers providing Tier 2 and Tier 3 PCPR Covered Services is included as **Appendix J-3**.

Primary Care Practitioner (PCP) – a health care professional who provides Primary Care services.

Privacy Rule – the standards for privacy of individually identifiable health information required by the Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191 (HIPAA), and the associated regulations (45 CFR parts 160 and 164, as currently drafted and subsequently amended).

Protected Health Information (PHI) – any information in any form or medium: i) relating to the past, present or future, physical or mental condition of an Individual; the provision of health care to an Individual; or the past, present or future payment for the provision of health care to an Individual, and ii) identifying the Individual or with respect to which there is a reasonable basis to believe can be used to identify the Individual. PHI shall have the same meaning as used in the Privacy Rule. PHI constitutes Personal Data as defined in M.G.L. c. 66A, § 1.

Provider – an individual, group, facility, agency, institution, organization, or business that furnishes or has furnished medical services to Covered Individuals.

Provider Agreement – a binding agreement between the Contractor and a BH Network Provider that includes, among other things, all of the provisions set forth in **Section 3.1.C**.

Provider Preventable Conditions (PPC) – as identified by EOHHS through bulletins or other written statements policy, which may be amended from time to time, a condition that meets the

definition of a "Health Care Acquired Condition" or an "Other Provider Preventable Condition" as defined by CMS in federal regulations at 42 C.F.R. 447.26(b).

Quality Management (QM) – the process of reviewing, measuring and continually improving the outcomes of care delivered.

Rating Category (RC) – a specific group of Covered Individuals for which a discrete BH Covered Services Capitation Rate applies, as described in **Section 10.2**.

Reportable Adverse Incident – an occurrence that represents actual or potential serious harm to the well-being of a Covered Individual, or to others by the actions of a Covered Individual, who is receiving services managed by the Contractor or has recently been discharged from services managed by the Contractor.

Screening, Brief Intervention and Referral to Treatment (SBIRT) – an evidence based approach addressing adolescent substance use/abuse in health care settings.

Serious Emotional Disturbance (SED) – a Behavioral Health condition that meets the definition set forth in the Individuals with Disabilities Education Act (IDEA), 20 U.S.C. § 1401(3)(A)(i) and its implementing regulations or the definition set forth in regulations governing the Substance Abuse and Mental Health Services Administration (SAMHSA) of the United States Department of Health and Human Services, 58 Fed. Reg. 29422-02 (May 10, 1993), as currently drafted and subsequently amended.

Serious Mental Illness – a substantial disorder of thought, mood, perception, orientation or memory in an adult, which: significantly impairs judgment, behavior, capacity to recognize reality or the ability to meet the ordinary demands of life; has lasted or is expected to last at least one year; has resulted in functional impairment that substantially interferes with or limits the performance of one or more major life activities; meets diagnostic criteria specified within the *Diagnostic and Statistical Manual of Mental Disorders* (4th ed., text revision) American Psychiatric Association, Washington, DC (2000), as currently drafted and subsequently amended; and is not based on symptoms primarily caused by substance use, mental retardation or organic disorders.

Serious and Persistent Mental Illness (SPMI) – a mental illness that includes a substantial disorder of thought, mood, perception, which grossly impairs judgment, behavior, capacity to recognize reality or the ability to meet the ordinary demands of life; and is the primary cause of a functional impairment that substantially interferes with or limits the performance of one or more major life activities, and is expected to do so in the succeeding year; and meets diagnostic criteria specified within the *Diagnostic and Statistical Manual of Mental Disorders* (4th ed., text revision) American Psychiatric Association, Washington, DC (2000), which indicates that the individual has a serious, long term mental illness that is not based on symptoms primarily caused by: (a) developmental disorders usually first diagnosed in infancy, childhood or adolescence, such as mental retardation or pervasive developmental disorders; or (b) cognitive disorders, including delirium, dementia or amnesia; or (c) mental disorders due to a general medical condition not elsewhere classified; or (d) substance-related disorders.

Serious Reportable Event (SRE) – an event that is specified as such by EOHHS.

Service Compensation Rate – a dollar amount to be paid monthly by EOHHS to the Contractor for the delivery of ESP Services to Uninsured Individuals and persons covered by Medicare only, Forensic Evaluation services and MCPAP services as set forth in this Contract.

Service End Date – the date, as determined by EOHHS, on which the Contractor's responsibility for the administration, delivery and coordination of the functions and responsibilities described in this Contract shall terminate.

Service Start Date – the date, as determined by EOHHS, on which the Contractor assumes responsibility for the administration, delivery and coordination of the functions and responsibilities described in this Contract.

Southeast Area – is comprised of Bristol, Plymouth, Barnstable, Dukes, Nantucket and a portion of Norfolk counties and includes the following municipalities:

Abington	Dennis	Harwich	Onset	Swansea
Acushnet	Dighton	Holbrook	Orleans	Taunton
Aquinnah	Duxbury	Hyannis	Osterville	Tisbury
Attleboro	East Bridgewater	Kingston	Pembroke	Truro
Avon	Easton	Lakeville	Plymouth	Vineyard Haven
Barnstable	Eastham	Mansfield	Plympton	Wareham
Berkley	Edgartown	Marion	Pocasset	Wellfleet
Bourne	Fairhaven	Marshfield	Provincetown	West Bridgewater
Brewster	Fall River	Mashpee	Raynham	Westport
Bridgewater	Falmouth	Mattapoisett	Rehoboth	West Tisbury
Brockton	Freetown	Middleborough	Rochester	Whitman
Carver	Gay Head	Nantucket	Rockland	Woods Hole
Chatham	Gosnold	New Bedford	Sandwich	Yarmouth
Chilmark	Halifax	North Attleboro	Seekonk	
Cotuit	Hanover	Norton	Somerset	
Dartmouth	Hanson	Oak Bluffs	Stoughton	

Third-Party Liability (TPL) – other insurance resources, such as Medicare and commercial insurance, available for services delivered to MassHealth Members.

Tier – a division or category within the Care Management Program's system of stratification.

Tier 1 Billable Services Rate – the portion of the CPCP for payment of Tier 1 medical services.

Tier 1 CPCP Covered Services – medical expenses included within the CPCP Covered Services as detailed in **Appendix J-5**.

Tier 2 CPCP Covered Services – a minimum set of Behavioral Health Covered Services included within the CPCP Covered Services as detailed in **Appendix J-5.**

Tier 3 CPCP Covered Services – a maximum set of Behavioral Health Covered Services included within the CPCP Covered Services as detailed in **Appendix J-5.**

Uninsured Individuals – those individuals who are not MassHealth eligible for any reason, and do not have commercial insurance.

Urgent Care Services – services that are not Emergency Services or routine services.

Utilization Management (UM) – the process of evaluating the clinical necessity, appropriateness, and efficiency of care and services. This may include service authorizations and prospective, concurrent, and retrospective review of services and care delivered by Providers.

Virtual Gateway – an internet portal designed and maintained by EOHHS to provide the general public, medical providers, community-based organizations, MassHealth Managed Care contractors, and EOHHS staff with online access to health and human services.

Voluntary Pooled PCPR Providers – PCPR Providers that aggregate the number of PCC Panel Enrollees in each PCPR Provider's panel by choice, in accordance with the PCPR Provider's PCC Plan Contract with EOHHS.

Wellness Programs – programs that promote an active process to help individuals become aware of and learn to make healthy choices that lead toward a longer and more successful existence.

Section 1.2 Acronyms

The following acronyms are commonly used in the health care industry and/or frequently found throughout this Contract and its Appendices:

ABA	Applied Behavioral Analysis
ACA (or PPACA)	Patient Protection and Affordable Care Act of 2010
ACO	Accountable Care Organization
ALP	Alternative Lock-up Programs
AND	Administratively Necessary Days
BBA	Balanced Budget Act of 1997
BH	Behavioral Health
BHP	Behavioral Health Program
BOH	Board of Hearings
BORIM	Board of Registration in Medicine
CANS	Child and Adolescent Needs and Strengths
CBHI	Children's Behavioral Health Initiative
CFR	Code of Federal Regulations
CMP	Care Management Program
CMR	Code of Massachusetts Regulations
CMS	the federal Centers for Medicare and Medicaid Services
CPCP	Comprehensive Primary Care Payment
CSA	Community Service Agency
CSMP	Controlled Substance Management Program
D/HoH	Deaf and/or Hard of Hearing
DCF	the Massachusetts Department of Children and Families
DDS	the Massachusetts Department of Developmental Services

DHCFP	the Massachusetts Division of Health Care Finance and Policy
DMH	the Massachusetts Department of Mental Health
DPH	the Massachusetts Department of Public Health
DPH/BSAS	Bureau of Substance Abuse Services of the Mass. Department of Public Health
DRM	Document Review Measure
DSRA	Direct Service Reserve Account
DUR	drug utilization review
DYS	the Massachusetts Department of Youth Services
ECC	Enhanced Care Coordination
ED	emergency department
EESPA	Expected External Service Provision Adjustment
EOHHS	the Massachusetts Executive Office of Health and Human Services
EPSDT	Early and Periodic Screening, Diagnosis and Treatment
ESP	Emergency Services Program
EQR	external quality review
EVS	Eligibility Verification System
FFP	Federal Financial Participation
FFS	fee-for-service
FTE	full-time equivalent
FY	fiscal year
HCBS	Home and Community-Based Services
HEDIS	Healthcare Effectiveness Data and Information Set
HIPAA	Health Insurance Portability and Accountability Act of 1996
HNA	Health Needs Assessment
IBNR	incurred but not reported
ICC	intensive care coordination
ICM	intensive clinical management
ICMP	Integrated Care Management Program
LEIE	Office of the Inspector General List of Excluded Individuals Entities
MBR	MassHealth benefit request (application) form
MCO	managed care organization
MCPAP	Massachusetts child psychiatry access project
MFD	Medicaid Fraud Division
MFP	Money Follows the Person
MGL	Massachusetts General Laws
MID	Member Identification Number
MIS	management information system
MLR	PCC Member-Level Report
MMIS	Medicaid Management Information System
MSS	PCC Plan Management Support Services
NCQA	National Committee for Quality Assurance
NPI	national provider identifier
OCA	Office of Clinical Affairs
P4P	Pay For Performance
PAP	Pre-Arraignment Protocol

PBCM	Practice Based Care Management
PBHMI	Pediatric Behavioral Health Medication Initiative
PCAL	Primary Care Activity Level
PCC	Primary Care Clinician
PCMHI	Patient-Centered Medical Home Initiative
PCP	Primary Care Practitioner
PCPRI	Primary Care Payment Reform Initiative
PD	PCC Performance Dashboard
PHI	Protected Health Information
PID/SL	provider identification and service location
PIHP	Prepaid Inpatient Health Plan
PMPD	Per Member (Enrollee or Covered Individual) Per Day
PMPM	Per Member (Enrollee or Covered Individual) Per Month
POPS	Pharmacy Online Processing System
PPC	Provider Preventable Conditions
PPHSD	Preventive Pediatric Health-Care Screening and Diagnosis
PPPM	per participant (in the Care Management Program) per month
QI	quality improvement
QIP	Quality Improvement Program
QM	Quality Management
RC	Rating Category
S2BI	Screening to Brief Intervention
SBIRT	Screening, Brief Intervention, and Referral to Treatment
SED	Serious Emotional Disturbance
SPMI	Serious and Persistent Mental Illness
SRE	Serious Reportable Event
TCM	Therapeutic Class Management
TPL	Third-Party Liability
UM	Utilization Management
VG	Virtual Gateway

SECTION 2. GENERAL ADMINISTRATIVE REQUIREMENTS

Section 2.1 Transition to the Contractor

A. Transfer of Responsibilities

The Contractor shall:

1. Ensure that there is no interruption of Behavioral Health Covered Services to Covered Individuals and Uninsured Individuals.

2. Ensure that the existing toll-free telephone number (800-495-0086), is operative at the Contractor's office as of midnight (Eastern Time) on the Service Start Date and remains operative for the duration of the Contract, unless otherwise directed or agreed to by EOHHS. The number shall continue to offer all appropriate menu options to provide Contract-related information to PCCs, Network Providers, and Covered Individuals, including the PCC Plan Hotline. (See **Section 9.7** for specific telephone system requirements.)

3. At least 30 days prior to the Service Start Date, obtain all records, reports and data related to the previous PCC Plan's Behavioral Health Program contract ("previous BHP contract") in the manner and method specified by EOHHS, including but not limited to information pertaining to:

    a. Utilization:

        1) Preauthorization and continuing stay (concurrent review) files for all Levels of Care; and

        2) Management reports identifying the next scheduled concurrent review and discharge review dates;

    b. Care Management, including all current authorizations, individual care plans, clinical case notes and utilization history for individuals receiving Care Coordination, Targeted Outreach, and Intensive Clinical Management, including as of 14 calendar days before the end of the previous BHP contract;

    c. Prior authorizations for all Levels of Care:

        1) Inpatient Services admissions for the last 30 calendar days of the previous BHP contract;

        2) Outpatient Services authorizations ending on or before 30 calendar days after the last calendar day of the previous BHP contract;

        3) Diversionary Services for the last 30 calendar days of the previous BHP contract;

d. Clinical notes and individual case information;

e. Provider credentialing;

f. Provider fraud investigations;

g. Complaints from Covered Individuals;

h. Grievances from providers and Covered Individuals;

i. Adverse Incident investigations;

j. Quality Management plan;

k. Quality Improvement Project records;

l. Information on the previous BHP provider network, including:

1) A provider list containing the provider's name, type of provider, address, administrative contact person and clinical contact person;

2) The previous BHP contract's network management plan with provider files and improvement goals; and

3) All Appeals and Claim reviews filed under the previous BHP contract and not yet investigated and resolved.

B. Implementation

The Contractor shall:

1. Develop and submit to EOHHS for approval, no later than 14 days after notification that EOHHS has selected it for Contract negotiations, a detailed work plan and timeline for performing the obligations set forth in the Contract for the first Contract Year, including the readiness activities for the Service Start Date.

2. Provide EOHHS with updates to the initial work plan and timeline, identifying adjustments that have been made to either, and describing the Contractor's current state of readiness to perform all Contract obligations. Until the Service Start Date, the Contractor shall provide an update every two weeks to the work plan and timeline, and thereafter as often as EOHHS determines is necessary.

3. Ensure that all workplace requirements EOHHS deems necessary, including but not limited to office space, post office boxes, telephones and equipment, are in place and operative as of the Service Start Date.

4. Establish its Provider Network and maintain existing Provider Agreements with such Providers, all in accordance with the provisions set forth in **Section 3.1.C**.

5. Perform all functions described in the Contract as of the Service Start Date, unless otherwise specified or agreed to by EOHHS.

C. Clinical Transition Plan

The Contractor shall:

1. Prepare to assume responsibility as of the Service Start Date for the clinical management, service authorization, and Claims payment functions for Covered Individuals who are receiving Inpatient Services or have open Outpatient or Diversionary Service authorizations or registrations on the Service Start Date.

2. No later than one month prior to the Service Start Date, prepare to accept transfer of all authorizations that are valid for dates of service after the Service Start Date; and each business day beginning 30 days prior to the Service Start Date, transfer from the previous BHP contract information on all services that were registered the previous day and that are valid for dates of service after the Service Start Date.

3. Prior to the Service Start Date, ensure that sufficient staff have been recruited, hired and trained to perform all requirements of the Contract on the Service Start Date, unless otherwise agreed to by the parties.

4. Prior to the Service Start Date, provide written instructions to those network and non-network providers from the previous BHP contract regarding any changes from the previous BHP contract to the Contractor's service authorization requirements and procedures for using the service authorization system, and schedule training sessions with Network Providers to review policies and procedures for any such changes, as necessary.

5. For Covered Individuals who have registered or prior-authorized BH Covered Services in place by the day before the Service Start Date, honor all such authorizations through their end dates.

6. For any Covered Services authorized under the previous BHP contract, adjudicate and pay claims from BH Network Providers under the previous BHP contract for services provided on or after the Service Start Date.

D. Contract Requirements for EOHHS Readiness Review

1. Prior to the Service Start Date, and no later than 60 days prior to enrollment of Covered Individuals into the Contractor's Plan, and at other times during the Contract period at the discretion of EOHHS, EOHHS will conduct the Readiness Review to verify the Contractor's assurances that the Contractor is ready and able to meet its obligations under the Contract. EOHHS reserves the right to conduct an additional Readiness Review in the event that additional populations become managed care eligible. The EOHHS Readiness Review may include on-site review. The Contractor shall demonstrate to EOHHS satisfaction that all elements required for readiness are in place, including but not limited to:

a. All deliverables that EOHHS has specified must be in place prior to the Service Start Date, as set forth in **Appendix B**;

b. Network Provider composition and access;

c. Staffing, including Key Personnel and functions directly impacting on Enrollees;

d. Capabilities of Material Subcontractors;

e. Care Management capabilities;

f. Content of Provider Agreements, including any Provider performance incentives;

g. Enrollee Services capability (materials, processes and infrastructure, e.g., call center capabilities);

h. Comprehensiveness of quality management/quality improvement and Utilization Management strategies;

i. Internal Grievance and Appeal policies;

j. Fraud and Abuse detection and protocols, Third-Party Liability Benefit Coordination and Recovery and program integrity;

k. Financial solvency;

l. Information systems, including claims payment system performance, interfacing and reporting capabilities, validity testing of Encounter Data, IT testing and security assurances.

2. Covered Individuals may not be enrolled with the Contractor until EOHHS determines that the Contractor is ready and able to perform its obligations under the Contract as demonstrated during the Readiness Review.

3. If, for any reason, the Contractor does not fully satisfy EOHHS that it is ready and able to perform its obligations under the Contract prior to the Service Start Date, and EOHHS does not agree to postpone the Contract Service Start Date or extend the date for full compliance with the applicable Contract requirement, then EOHHS may terminate the Contract and shall be entitled to recover damages from the Contractor.

Section 2.2 Contractor's Organization

A. Organizational Philosophy

The Contractor shall maintain and make available to EOHHS upon request an organizational statement that describes the Contractor's philosophy, operating history, mission,

organizational structure, ownership structure, and plans for future growth and development of its organization.

B. Location

The Contractor shall:

1. Unless the parties agree otherwise, maintain for the term of the Contract a principal place(s) of business in Massachusetts that is acceptable to EOHHS.

2. Maintain for the term of the Contract a backup site, separate from its principal place of business, that fulfills the Contract requirements for disaster recovery described in **Section 13.36**.

3. Notify EOHHS and obtain EOHHS's approval of any proposed change to the location of the Contractor's principal place(s) of business, at least 30 calendar days before making the proposed change.

4. Upon EOHHS's request for good cause, and upon adequate notice, work with EOHHS to identify an alternative location for the Contractor's principal place(s) of business, and, as agreed to by the parties, move its operation to said location.

C. Contract Officer

1. The Contractor shall:

   a. Designate a qualified individual dedicated solely to the Contract to serve as Contract Officer who shall act as the liaison between the Contractor and EOHHS, authorized and empowered to represent the Contractor in all matters pertaining to the Contract. Such designation may be changed during the period of the Contract only by written notice to and approval by EOHHS.

   b. Ensure that the Contract Officer holds an executive-level key personnel position in the Contractor's organization, except that the Contractor may propose for EOHHS's prior review and approval an alternate structure for the Contract Officer position.

2. The Contract Officer's responsibilities shall include:

   a. Ensuring the Contractor's compliance with the terms of the Contract, including securing and coordinating resources necessary for such compliance;

   b. Overseeing the Contractor's implementation of all EOHHS-approved plans, policies and timelines;

c. Overseeing all Contract-related activities by the Contractor, each Material Subcontractor and all other subcontractors, including coordinating with the Contractor's key personnel as described in **Section 2.2.F.1**;

d. Receiving and responding to all inquiries and requests made by EOHHS related to the Contract, in the time frames and formats specified by EOHHS;

e. Meeting with EOHHS's Contract Manager(s) on a routine basis as agreed upon by the parties, to discuss issues of mutual interest or concern;

f. Coordinating requests and activities among the Contractor, all subcontractors, and MassHealth/DMH staff;

g. Working to promptly resolve any Contract-related issues identified by the Contractor or EOHHS; and

h. Tracking the compliance of all Contract requirements and deliverables and maintaining records of all compliance activities and compliance dates using an electronic software tool or other similar mechanism such as a spreadsheet. Tracking of Contract compliance shall be in a format that can be shared with EOHHS upon request or an agreed-upon reporting schedule. All deliverables, reports, contracts, subcontracts, agreements and any other documents subject to EOHHS approval shall be provided to EOHHS in accordance with Contract requirements.

D. Communications

1. Access to Administrative Personnel

The Contractor shall:

a. Maintain a local telephone line for administrative personnel, for communicating with EOHHS in an effective and timely manner and ensuring that EOHHS is informed of all circumstances that materially affect service delivery or the management and administration of the Contract;

b. Ensure that its system for communicating with EOHHS includes direct telephone access, voice mail and electronic mail capacity for, at a minimum, all of the Contract's key personnel and senior-level management staff;

c. Require all staff to utilize a voice mail messaging system to inform callers of all planned and unplanned absences from work, to check their messages periodically when working offsite, and to identify a designee who will handle their calls in their absence;

d. Provide to EOHHS, when available and whenever changes occur, a list of telephone numbers, titles and e-mail addresses of, at a minimum, the Contractor's key personnel and senior-level management staff; and

e. Ensure that the Contractor utilizes the EOHHS secure e-mail system for all communications involving Protected Health Information (PHI).

2. Quality Oversight of Written Materials

The Contractor shall submit all materials intended for general distribution to Covered Individuals, Uninsured Individuals, Providers and Primary Care Clinicians (PCCs) up to the standards of professional business standards, and in compliance with 42 CFR 438.10, before submitting them to EOHHS for review and approval and prior to publication.

E. Organizational Structure and Staffing

The Contractor shall:

1. Submit to EOHHS for approval, at least 60 calendar days prior to the Service Start Date an organizational chart depicting the functions and reporting relationships for the performance of the Contract;

2. Notify EOHHS in writing at least 30 calendar days prior to making any significant changes to its internal organizational structure;

3. Recruit and maintain an appropriately qualified and diverse workforce, sufficient in number for the efficient execution of all Contract responsibilities;

4. Recruit and maintain an adequate number of appropriately qualified staff in order to perform Network Management activities efficiently in the communities across the Commonwealth, so that Covered Individuals and BH Network Providers, PCCs and Providers have timely access to Contractor staff in all regions of Massachusetts;

5. Make best efforts to maintain a staff that reflects the cultural, linguistic and demographic characteristics of Covered Individuals, including a sufficient number of bilingual staff capable of communicating in English and Spanish, and other languages as appropriate; and

6. Ensure that it properly allocates and tracks the time expended by Key Personnel and, as appropriate, other personnel among the administration of the PCC Plan's BHP, PCC Plan Management Support Services and DMH Specialty Programs administration.

F. Key Personnel and Senior Management Staff

The Contractor shall identify key personnel and senior-level management staff with clearly delineated authority over all functions of the Contract.

1. Key Personnel

The Contractor shall:

a. Employ the following or similarly titled or functional full-time personnel designated as key personnel under the Contract, employed in the key personnel position only upon review by EOHHS:

1) Chief Executive Officer;

2) Chief Financial Officer;

3) Chief Operating Officer;

4) Chief Information Officer;

5) Chief Medical Officer (see **Section 4.1.B.4**);

6) Associate Medical Directors (see **Section 4.1.B.4**);

7) Behavioral Health Plan Network Management Director;

8) PCC Plan Management Support Services Director (see **Section 5.2.A.1**)

9) Contract Officer (see **Section 2.2.C**).

EOHHS further reserves the right to be informed of a decision by the Contractor to dismiss any of the key personnel.

b. Develop and maintain detailed job descriptions for each key personnel position that will have ongoing responsibility for Contract functions.

c. Designate the Chief Executive Officer as the person responsible for the Contract in its entirety and who ensures that there is coordination and integration, as appropriate, of functions across the activities related to BH services, administrative services related to the PCC Plan, the full range of Care Management activities, and Specialty Services managed by the Contractor.

d. Submit the name, title and curriculum vitae of each person holding a key personnel position to EOHHS prior to the Service Start Date and whenever a change occurs.

2. Non-Performance

The Contractor shall:

a. Respond promptly to any EOHHS concerns regarding the performance of any key personnel under the Contract.

b. Take any action related to any personnel that the Contractor reasonably determines is necessary to ensure full compliance with the terms of the Contract, and notify EOHHS of such actions.

3. Contract Representative(s) and Liaison(s)

Prior to the Service Start Date and whenever a change occurs, the Contractor shall submit to EOHHS the name(s) and titles(s) of a senior-level or executive individual(s) who will have responsibility for ongoing administrative, clinical, fiscal and programmatic interaction with EOHHS, DMH central and area offices, and DCF central and regional offices.

G. Staff Training

The Contractor shall:

1. Develop, and submit to EOHHS for review and approval prior to the Service Start Date, a training program and curriculum that provides its staff with the knowledge and skills they require to effectively, correctly and competently perform their functions under the Contract.

2. Thereafter maintain the training program and update it at EOHHS's request. In addition, EOHHS reserves the right to require additional training programs at its discretion.

3. Evaluate the effectiveness of the training program on an annual basis or as directed by EOHHS

H. Material Subcontractors

The Contractor shall:

1. By the Service Start Date and subsequently at least 60 days prior to the date the Contractor expects to execute a contract for a Material Subcontractor, submit to EOHHS for review and approval the identity of any Material Subcontractors the Contractor has hired to perform any of the requirements of the Contract and the names of their principals, along with the Material Subcontractor Checklist and completed federally required disclosure forms (see **Appendix B-4**), if required in accordance with **Section 13.2.** The Contractor shall request such approval in writing and submit with that request a completed Material Subcontractor Checklist using the template provided by EOHHS and attached hereto as **Appendix B-3**, as may be modified by EOHHS from time to time. The Contractor must describe the process for selecting the Material Subcontractor, including the selection criteria used. The Contractor shall provide EOHHS with any additional

information requested by EOHHS in addition to the information required in the Material Subcontract Checklist;

2. Maintain all agreements and subcontracts relating to this Contract in writing. All such agreements and subcontracts shall fulfill applicable requirements of 42 CFR Part 438, and shall contain all relevant provisions of this Contract appropriate to the subcontracted service or activity, specifically including but not limited to the provisions related to privacy and confidentiality (**Section 14**) and record retention (**Section 13.21**);

3. Remain fully responsible for meeting all of the requirements of the Contract regardless of whether the Contractor subcontracts for the performance of any Contract responsibility. No subcontract will operate to relieve the Contractor of its legal responsibility under the Contract;

4. Actively monitor the quality of care provided to Covered Individuals under any Provider Agreements and any other subcontracts;

5. Prior to contracting with a Material Subcontractor, the Contractor shall evaluate the prospective Material Subcontractor's ability to perform the activities to be subcontracted;

6. Have a written agreement with the Material Subcontractor that specifies the activities and obligations, and related reporting responsibilities, delegated to the Material Subcontractor, and provides for revoking delegation or imposing other sanctions if the Material Subcontractor's performance is inadequate;

7. Require Material Subcontractors to comply with all applicable Medicaid laws, regulations, and subregulatory guidance;

8. Include in all subcontracts a requirement that the Material Subcontractor comply with the audit and inspection requirements set forth in 42 CFR 438.230(c)(3). Specifically, each such subcontract must provide that:

    a. The State, CMS, HHS Inspector General, the Comptroller General, or their designees, have the right to audit, evaluate, and inspect any records or systems that pertain to any activities performed or amounts payable under this Contract. This right exists through 10 years from the final date of the contract or from the date of completion of any audit, whichever is later; provided, however, that if any of the entities above determine that there is a reasonable possibility of fraud or similar risk, they may audit, evaluate, and inspect at any time; and

    b. The Material Subcontractor will make its premises, facilities, equipment, records, and systems available for the purposes of any audit, evaluation, or inspection described in this section;

9. Monitor the Material Subcontractor's performance on an ongoing basis and subject it to formal review annually. If any deficiencies or areas for improvement

are identified, the Contractor and the Material Subcontractor shall take corrective action;

10. Notify EOHHS in writing immediately upon notifying any Material Subcontractor of the Contractor's intention to terminate any such subcontract;

11. Submit annually to EOHHS a list of all Material Subcontractors. Such annual report shall include notification if any of its Material Subcontractors are certified Minority Business Enterprises. The Contractor shall submit an updated list at least 30 days in advance of any changes to the list or as otherwise directed by EOHHS;

12. Maintain ultimate responsibility for adhering to and otherwise fully complying with all terms and conditions of this Contract, notwithstanding any relationship the Contractor may have with a subcontractor, including Material Subcontractors.

I. Organizational Certifications, Requirements and Prohibitions

EOHHS shall have the sole discretion and authority to determine whether the Contractor has satisfied the requirements of **subsections 1** and **2** below.

1. Certification of Readiness to Perform

The Contractor hereby represents and warrants that as of the Service Start Date it has performed all of the requirements set forth in **Section 2.1** of this Contract; and has submitted to EOHHS for review and approval all deliverables as agreed to by the parties, including but not limited to those identified in **Appendix B-1**, that are required to be submitted by the Service Start Date; and that on the Service Start Date and at all times during the term of the Contract it is ready, willing and able to perform all of the requirements of the Contract without modification.

2. Business Requirements and Representations and Warranties

a. The following definitions apply to this **Section 2.2.I**:

1) **Related Entity** – any and all of the Contractor's partners, Parents, subsidiaries, and any other entity directly or indirectly related to the Contractor, as well as any and all of the Contractor's Material Subcontractors, and such Material Subcontractors' partners, Parents, subsidiaries, and any other entity directly or indirectly related to any such Material Subcontractor.

2) **Restricted Activity** – an activity that involves directly or indirectly owning or controlling any interest in, or operating, managing, or otherwise engaging in any business activity with any entity in Massachusetts, New Hampshire, Rhode Island, Vermont, Maine, Connecticut or New York that delivers or manages the delivery of BH Covered Services listed in **Appendix A-1** of this Contract to Covered Individuals or Uninsured Individuals.

b. The Contractor shall comply with each of the following requirements and hereby represents and warrants that it does so comply and will continue to so comply at all times during the term of this Contract:

1) The Contractor and each Material Subcontractor, if any, is organized primarily for the purpose of administering and coordinating the delivery of health care services.

2) Neither the Contractor nor any Related Entity engages in a Restricted Activity.

3) Notwithstanding the provisions of **subsection 2)**, the Contractor or a Related Entity may engage in a Restricted Activity, as specified by EOHHS, if the Contractor has requested and received EOHHS's prior written approval to do so, in accordance with **subsection 3**, below.

3. Request for Contractor or Related Entity to Engage in Restricted Activity and Plan to Assure against Conflict

The Contractor shall request in writing EOHHS's approval of any proposal under which the Contractor or any Related Entity would engage in a Restricted Activity. EOHHS may in its sole discretion approve, modify or deny, in whole or in part, the Contractor's request or any proposed plan. Such request shall:

a. Specifically describe the Restricted Activity in which the Contractor or Related Entity proposes to engage;

b. Specifically describe the reasons for the request;

c. Include a statement certifying that the Contractor's proposed plan ensures that the Contractor is in compliance with all applicable state and federal laws and regulations; and

d. Contain a complete description of the Contractor's specific plan to ensure that the Contractor will not favor any Network Provider with which the Contractor or a Related Entity proposes to engage in a Restricted Activity. To favor such a provider includes without limitation:

1) preferentially, disproportionately or inappropriately utilizing that Network Provider's services;

2) offering that Network Provider preferential rates or any other preferential form of remuneration;

3) applying lower performance, quality of care, or any other standards to that Network Provider; or

4) otherwise treating that Network Provider in any preferential or disparately advantageous way.

4. General Prohibition against Conflicts with Contractual Obligations

The Contractor and its Material Subcontractor(s) shall have no interest, including without limitation financial, legal or other business interest, nor shall the Contractor or its Material Subcontractor(s) engage in any activity at any time during the term of this Contract that, in EOHHS's sole determination, conflicts with any of the Contractor's obligations hereunder, specifically including the performance of services required under this Contract. Without limiting the generality of the foregoing, EOHHS requires that:

a. Neither the Contractor nor any Material Subcontractor have any financial, legal contractual or other business interest in EOHHS's Customer Services vendor or such vendor's subcontractors, if any; and

b. Neither the Contractor nor any Material Subcontractor nor any Related Entity engage in any Restricted Activity, except in accordance with this **Section 2.2.I**.

5. Required Termination of Agreements with Certain Providers and Other Entities

If EOHHS in its sole discretion determines that the Contractor has failed to comply with or otherwise satisfy the requirements of **subsections 3** and **4**, above, EOHHS may require the Contractor to terminate:

a. Any such Network Providers from its Network; or

b. Any agreements or other arrangements with non-Network Providers or other entities in which or with which the Contractor has an interest or engages in an activity that is inconsistent with the terms of this Contract.

6. EOHHS Approval of Contractor's Corporate Policies

The Contractor shall, upon EOHHS's request, provide for review and approval any internal policies, procedures or practices developed by the Contractor, its Parent(s) or affiliates that may affect the Contractor's performance of its obligations under the Contract, including without limitation:

a. Policies that could affect the Contractor's ability to provide adequate staff to perform its Contract obligations;

b. Choice of vendors for administrative services;

c. The imposition of limits on administrative spending; and

d. Those related to the Contractor's purchase of supplies, materials, and telephone and information systems necessary to perform its obligations under the Contract.

7. Requirements Related to the Contractor's Financial Condition and Structure

a. The Contractor hereby represents and warrants that the Contractor and each of its Material Subcontractors is in sound financial condition and will remain so at all times during the term of this Contract.

b. As a condition of the Contract, the Contractor shall comply and shall ensure that each Material Subcontractor complies with each of the following requirements, and hereby represents and warrants that it and each Material Subcontractor does so comply and will continue to so comply at all times during the term of this Contract.

1) If the Contractor or any Material Subcontractor is organized as a partnership or joint venture:

a) All entities that constitute the partners that the Contractor comprises as of the date of the execution of the Contract shall sign the Contract and shall be jointly and severally liable for all obligations under and relating to the Contract for the duration of the Contract and all additional periods required thereunder, notwithstanding any inconsistent act or agreement by or among any of the partners;

b) Upon request, the Contractor and each Material Subcontractor shall immediately submit to EOHHS its partnership agreements, any amendments thereto, and any other documents related to its partnership obligations as they relate to the Contract;

c) During the term of the Contract, the Contractor and each Material Subcontractor shall submit to EOHHS all proposed changes to their respective partnership agreements for EOHHS's prior review and approval prior to execution, including but not limited to changes related to adding to or otherwise changing the partners that the Contractor and each Material Subcontractor comprised as of the date of Contract execution;

d) The Contractor shall provide to EOHHS, on or before the day the Contract is signed, an executed guarantee agreement from the Parent, if any, of each and every business partner in order to guarantee and secure any obligations set forth in this Contract.

2) If the Contractor or any Material Subcontractor is a publicly traded corporation:

a) All filings submitted to the Securities and Exchange Commission by the Contractor or Material Subcontractors shall contemporaneously be submitted to EOHHS.

b) All ownership interests of 5 percent or more in the Contractor or Material Subcontractor shall be disclosed to EOHHS.

c) The Contractor and each Material Subcontractor shall be in good standing with the Secretary of State's office in the state where it is incorporated.

d) The Contractor shall provide to EOHHS, on or before the day the Contract is signed, an executed guarantee agreement from the Parent(s) of the Contractor, if any, in order to guarantee and secure any obligations set forth in this Contract.

3) If the Contractor or any Material Subcontractor is a closely held corporation:

a) All ownership interests of 5 percent or more in the Contractor or Material Subcontractor shall be disclosed to EOHHS.

b) The Contractor and each Material Subcontractor shall be in good standing with the Secretary of State's office in the state where it is incorporated.

c) The Contractor shall provide to EOHHS, on or before the day the Contract is signed, an executed guarantee agreement from the Parent(s), if any, of the Contractor in order to guarantee and secure any obligations set forth in this Contract.

c. At the request of EOHHS, the Contractor shall provide and shall require each Material Subcontractor to provide EOHHS with documentation relating to organizational and financial structure, including but not limited to:

1) the name(s) and address(es) of any Parent organization(s), all partially or wholly owned subsidiary(ies) and/or any other organization(s) related directly or indirectly to the Contractor; and

2) the names and occupations of the members of the Contractor's Board of Directors, and of the subsidiary(ies) and/or any other organization(s) related directly or indirectly to the Contractor.

d. The Contractor hereby represents and warrants that its provision against the risk of insolvency is adequate to ensure that Covered Individuals will not be liable for the Contractor's debts if the Contractor becomes insolvent.

8. Requirements Related to the Contractor's Compliance with HIPAA

The Contractor represents and warrants that:

a. It will conform to all applicable Health Insurance Portability and Accountability Act (HIPAA) requirements and regulations, including but not limited to those contained in **Section 14**, no later than the compliance date of each of those requirements or regulations;

b. It shall at all times subsequent to the applicable compliance dates be in compliance with such requirements and regulations; and

c. It shall work cooperatively with EOHHS on all activities related to compliance with HIPAA requirements, as directed by EOHHS.

9. Certification of Capacity to Meet Access Standards

The Contractor hereby represents and warrants that at all times during the term of the Contract it has the capacity to service expected enrollment of Covered Individuals in accordance with the access standards specified in **Sections 3.1.G.6** and **3.1.G.7**.

10. Certification of NCQA Accreditation Status

The Contractor will submit current NCQA status including the schedule for accreditation and/or the schedule for remedies necessary for accreditation.

J. Compliance with Data Certification, Program Integrity and Prohibited Affiliation Requirements

As a condition of receiving payment under this Contract, the Contractor must comply with all applicable data certification, program integrity and prohibited affiliation requirements at 42 CFR 438.600 et seq., and as described in **Sections 3.7.H, 11.1** and **11.2**.

Section 2.3 Delivery of Services and Coordination of Services

A. Delivery of Services to Covered Individuals

The Contractor shall:

1. Be responsible for ensuring the delivery of all BH Covered Services as they are described in **Appendix A-1** to all Covered Individuals that are eligible on the date of service, in accordance with the requirements of this Contract, and in an amount, duration, and scope that is no less than the amount, duration, and scope for the same services furnished to Members under MassHealth FFS, as set forth in

42 CFR 440.230, and, for Covered Individuals under the age of 21, as set forth in 42 CFR 440 subpart B.

2. Arrange, coordinate, authorize and pay for the provision of all Medically Necessary BH Covered Services.

3. Inform Covered Individuals of the MassHealth-established access standards for and the availability of all Medically Necessary BH Covered Services and how to obtain such services.

4. Incorporate the provisions of 130 CMR 450.204 into all criteria for BH Covered Services.

5. Provide all BH Covered Services that are Medically Necessary, including but not limited to those BH Covered Services that:

    a. prevent, diagnose, or treat the Covered Individual's disease, condition, and/or disorder that results in health impairments and/or disability;

    b. assist the Covered Individual to achieve age-appropriate growth and development; and

    c. allow the Covered Individual to attain, maintain, or regain functional capacity.

6. Not arbitrarily deny or reduce the amount, duration, or scope of a required BH Covered Service solely because of diagnosis, type of illness, or condition of the Covered Individual. The Contractor may place appropriate limits on a BH Covered Services on the basis of:

    a. Medical Necessity; or

    b. Utilization management, provided that (1) the furnished services can reasonably be expected to achieve their purpose, and (2) services supporting Covered Individuals with ongoing or chronic conditions or who require long-term services and supports are authorized in a manner that reflects the Covered Individual's ongoing need for such services and supports.

7. Any such limitation shall be considered an Adverse Action.

8. Orient the provision of BH Covered Services to the Covered Individual's strengths and preferences, his/her aspirations for recovery, and encouragement of overall health and wellness. For Covered Individuals under age 18, actively involve parent(s) or legal guardian(s) in treatment.

9. Allow each Enrollee to choose his or her health professional to the extent possible and appropriate.

B. Delivery of Services to the Uninsured

The Contractor shall provide Uninsured Individuals and persons covered by Medicare only with Medically Necessary ESP Services without regard to enrollment in the BHP.

C. Third-Party Liability Benefit Coordination and Recovery

The Contractor shall:

1. By the Service Start Date, develop and submit to EOHHS for approval a work plan for Third-Party Liability (TPL) benefit coordination and recovery that:

    a. Ensures that MassHealth is the payer of last resort for the BH Covered Services provided under this Contract;

    b. Ensures recovery of funds inappropriately paid to Network Providers;

    c. Avoids payment for all Claims or services that are subject to third-party payment;

    d. Ensures that the Contractor identifies and determines the legal liability of third parties to pay for services furnished to Covered Individuals and Uninsured Individuals, including persons covered by Medicare only;

    e. Includes tasks and time frames associated with the plan; and

    f. Addresses systems and resources required to perform at a minimum the following activities:

        1) Identification of Covered Individuals and Uninsured Individuals who have other health insurance, and notification of EOHHS with respect to Covered Individuals; and

        2) Reporting to EOHHS information on cost avoidance and recovery amounts.

2. Retain any payments recouped from Network Providers as a result of the discovery of TPL, deposit them into the Direct Service Reserve Account (DSRA) (see **Section 10.12.A**) and use all such recoveries to offset BHP expenditures related to the delivery of BH Covered Services.

3. Unless otherwise directed by EOHHS, coordinate the Behavioral Health benefits of Covered Individuals with TPL with the other insurance resource, such as Medicare or commercial insurance, as described in **Section 2.3.D.1**. In order to meet this requirement, the Contractor shall have all necessary changes to its operations in place by the Service Start Date, and shall continue to make all appropriate changes to its operations in compliance with any new policies from the EOHHS TPL Unit, including but not limited to changes to the following:

a. Management information systems;

b. Claims authorization systems;

c. Claims payment systems;

d. Staffing within the Claims Operation Department; and

e. Reporting.

D. Claims Payment Requirements for Covered Individuals under Age 21 with TPL

1. The Contractor shall ensure that:

   a. Providers who provide BH Covered Services to Covered Individuals with TPL make diligent efforts to identify and obtain payment from all other liable parties, including insurers, as described in 130 CMR 450.316;

   b. If a third-party resource is identified after the Provider has already billed and received payment from the Contractor, the Provider promptly returns any payment it received from the Contractor and ensure that the Provider bills all third-party resources before resubmitting a Claim to the Contractor;

   c. Providers who submit Claims for Covered Individuals who have Medicare in addition to Medicaid:

      1) bill the Medicare fiscal intermediary or carrier in accordance with their billing rules, including using the appropriate Medicare claim form and format;

      2) accept assignment according to Medicare instructions; and

      3) follow the Contractor's billing instructions, including any billing instructions specific to Medicare crossover claims.

   d. It does <u>not</u> pay Providers:

      1) who do not make diligent efforts to obtain payment from other liable parties; or

      2) for services provided to a Covered Individual, if on the date of service the Covered Individual had other health insurance, including Medicare, that may have covered the service, and the Provider did not participate in or resort to the Covered Individual's other insurance plan, including Medicare.

2. The Contractor shall establish the following payment limitations:

a. Payment shall not exceed the Covered Individual's liability, including co-insurance, deductibles and copayments; or the Provider's charges or the Contractor's payment amount, whichever is less; and

b. For Covered Individuals under 21 with Medicare, the payment amount shall not exceed the coinsurance and deductible amounts as reported on the explanation of benefits or remittance advice from Medicare; the Contractor's payment amount, or the Medicare-approved amount.

3. The terms of this **Section 2.3.D.** apply to Applied Behavioral Analysis services provided to Covered Individuals.

E. Covered Individuals – No Liability for Payment

1. The Contractor shall ensure, in accordance with 42 USC § 1396u-2(b)(6) and 42 CFR 438.106, that a Covered Individual is not held liable for:

   a. Debts of the Contractor, in the event of the Contractor's insolvency;

   b. BH Covered Services provided to the Covered Individual in the event that:

      1) the Contractor fails to receive payment from EOHHS for such services; or

      2) a Provider fails to receive payment from EOHHS or the Contractor for such services; or

   c. Payments to a Network Provider in excess of the amount that would be owed by the Covered Individual if the Contractor had directly provided the services.

2. Any cost sharing imposed on Covered Individuals shall be in accordance with 42 CFR 447.50 through 447.82.

F. Provider Preventable Conditions

The Contractor shall develop and implement policies and procedures for the identification, reporting, and non-payment of Provider Preventable Conditions. Such policies and procedures shall be consistent with federal law, including but not limited to 42 CFR 434.6(a)(12), 42 CFR 438.3(g)(2), and 42 CFR 447.26, and guidance and be consistent with EOHHS policies, procedures, and guidance on Provider Preventable Conditions. The Contractor's policies and procedures shall also be consistent with the following:

1. The Contractor shall <u>not</u> pay a Provider for a Provider Preventable Condition.

2. The Contractor shall require, as a condition of payment from the Contractor, that all Providers comply with reporting requirements on Provider Preventable Conditions as described at 42 CFR 447.26(d) and as may be specified by the Contractor and/or EOHHS.

3. The Contractor shall not impose any reduction in payment for a Provider Preventable Condition when the condition defined as a Provider Preventable Condition for a particular Enrollee existed prior to the Provider's initiation of treatment for that Enrollee.

4. A Contractor may limit reductions in Provider payments to the extent that the following apply:

    a. The identified Provider Preventable Condition would otherwise result in an increase in payment.

    b. The Contractor can reasonably isolate for nonpayment the portion of the payment directly related to treatment for, and related to, the Provider Preventable Condition.

5. The Contractor shall ensure that its non-payment for Provider Preventable Conditions does not prevent Enrollee access to services.

G. In lieu of services or settings

1. The Contractor may cover the Inpatient Services set forth in Sections I.A., II.A., and III.A. of **Appendix A-1** delivered in Institutions for Mental Disease (IMD), as defined in Section 1095(i) of the Act, as an in lieu of service or setting for Enrollees between the ages of 21-64, provided that:

    a. The Contractor does not require enrollees to receive services in an IMD;

    b. Use of an IMD is a medically appropriate and cost effective substitute for delivery of the service; and

    c. The length of stay for any Enrollee is no more than 15 days in a calendar month.

2. For any Enrollee between the ages of 21-64 who received the Inpatient Services set forth in Sections I.A., II.A., and III.A of **Appendix A-1** in an IMD for more than 15 days in any calendar month, the Contractor shall:

    a. Report to EOHHS, in a form and format and at a frequency to be determined by EOHHS:

        1) The Enrollee's rating category;

        2) The length of stay in the IMD in that calendar month; and

        3) Any other information requested by EOHHS; and

    b. As further specified and directed by EOHHS, reconcile the capitation payment received by the Contractor pursuant to **Section 10** and **Appendix H-1** for the calendar month in which the Enrollee received the Inpatient

Services set forth in Sections I.A., II.A., and III.A of **Appendix A-1** in an IMD for more than 15 days.

Section 2.4 Reporting

The Contractor shall submit to EOHHS all required reports related to the Contract's general administrative requirements, as described in this **Section 2** or in **Appendix E-1**, in accordance with specified timetables, definitions, formats and assumptions, as well as any ad hoc reports required by EOHHS in accordance with **Section 11.2.B**. The Contractor shall also provide to EOHHS, in accordance with the timeframes and other requirements specified by EOHHS, all reports, data or other information EOHHS determines necessary for compliance with the program report requirements set forth in 42 CFR 438.66(e).

Section 2.5 Covered Individual Rights

A. The Contractor must:

1. Have written policies regarding Covered Individual rights;
2. Comply with any applicable federal and state laws that pertain to Covered Individual rights; and
3. Ensure that its staff and affiliated Providers take those rights into account when furnishing services to Covered Individuals.

B. Covered Individual rights shall include:

1. The right to receive the information required pursuant to this Contract;
2. The right to be treated with respect and with due consideration for his or her dignity and privacy;
3. The right to receive information on available treatment options and alternatives, presented in a manner appropriate to his or her condition and ability to understand;
4. The right to receive a second opinion and have the Contractor pay for such second opinion consultation visit;
5. The right to participate in decisions regarding his or her health care, including the right to refuse treatment;
6. The right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation;
7. The right to freely exercise his or her rights without adversely affecting the way the Contractor and its Providers treat the Covered Individual;

8. The right to request and receive a copy of his or her medical records and request that they be amended or corrected, as specified in 45 CFR 164.524 and 164.526; and

9. The right to be furnished BH Covered Services in accordance with this Contract.

SECTION 3. BEHAVIORAL HEALTH NETWORK RESPONSIBILITIES

Overview

The Contractor shall establish, operate and manage a Behavioral Health Provider Network to meet the Behavioral Health needs of Covered Individuals. The Contractor shall assure timely access for all Covered Individuals to the full range of BH Covered Services including outpatient, inpatient, 24-hour Diversionary, community Diversionary, and Emergency Services.

The Contractor shall manage its Provider Network in accordance with the Contract between the Contractor and EOHHS, as well as with the terms of its Provider Agreements with the Network Providers in its Behavioral Health Provider Network.

The Contractor shall meet its responsibilities under this Contract while adhering to the following key principles of Behavioral Health Provider Network management:

- The use of data in decision-making;
- Adherence to a continuous quality improvement process between the Contractor and Network Providers that focuses on access, quality, value and Covered Individual outcomes;
- Promoting collaboration and alignment with state and federally funded services and programs and support of state agency missions;
- Recognizing the capacity of Covered Individuals and their families to access their strengths as part of their treatment and eventual recovery;
- Supporting and incorporating EOHHS health care reform initiatives, including PCMHI and those associated with payment reform;
- Improving the ability of the Behavioral Health Provider Network to meet all of the health needs of Covered Individuals through strengthened collaboration with PCCs, Emergency departments, specialty medical providers, pharmacies and inpatient hospital providers.

The Contractor shall actively solicit best practice models that achieve and exemplify these principles in its programs and shall submit to EOHHS proposals to establish and replicate such programs.

Section 3.1 Network Development

A. Management Strategy

The Contractor shall:

1. Beginning on the Service Start Date, develop and implement a strategy to manage the Provider Network with an emphasis on the following:

    a. Access to care for Covered Individuals;

    b. Quality of care;

c. Application of principles of rehabilitation and recovery to service planning and service delivery;

d. Reduction of health disparities (see **Section 3.1.H)**;

e. Measurement of outcomes for Covered Individuals over the course of receiving Behavioral Health Covered Services. The outcomes can range across the Covered Individual's full life domain;

f. Integration of Behavioral Health Covered Service delivery with medical services provided by the Enrollee's PCC or other key health care Providers; and

g. Cost-effectiveness of the delivery of BH Covered Services.

2. Ensure that its management strategy includes at least the following:

a. A systematic plan for utilizing Network Provider profiling and benchmarking data to identify and manage Network Providers who fall below established benchmarks and performance standards, and to replicate practices of Network Providers who consistently exceed benchmarks and performance standards;

b. A system for the Contractor and Network Providers to identify and establish improvement goals and periodic measurements to track Network Providers' progress toward improvement goals;

c. Utilization of on-site visits to Network Providers at all Levels of Care, to support quality improvement efforts and benchmarking data; and

d. Steps to ensure Network Provider compliance with the Contractor's performance specifications for each BH Covered Service.

3. Take appropriate management action, including the development and monitoring of corrective action plans for Network Providers whose performance is determined by the Contractor to be in need of improvement.

4. Take appropriate action related to Network Providers who are also MassHealth Providers, as follows:

a. Upon the Contractor's awareness of any disciplinary action or sanction taken against a Network Provider, either internally by the Contractor or by any oversight agency or any source outside of the Contractor's organization, such as the Board of Registration in Medicine, the Division of Registration, and the federal Centers for Medicare and Medicaid Services (CMS), immediately inform EOHHS's Customer Services vendor's Provider Enrollment and Credentialing Department of such

action taken and work collaboratively with the Customer Services vendor to maintain a process to share such information.

b. If notified that MassHealth or another state Medicaid agency has taken an action or imposed a sanction against a Medicaid provider, including disenrollment of any such provider from the Medicaid program, review the Provider's performance related to this Contract and take any action or impose any sanction that the Contractor determines is appropriate, including disenrollment from the Contractor's Provider Network.

5. In collaboration with and as further directed by EOHHS, develop and implement Network Provider quality improvement activities directed at ensuring that Network Providers:

   a. use the CANS Tool (see **Section 3.5.B**) in their Behavioral Health Clinical Assessments and during the Discharge Planning process from Inpatient Psychiatric Hospitalizations and Community-Based Acute Treatment Services for Covered Individuals under the age of 21; and

   b. access and utilize the CANS IT System to input information gathered using the CANS Tool to identify whether or not the assessed Covered Individual is suffering from a Serious Emotional Disturbance.

6. Propose by the Service Start Date, and implement subject to EOHHS approval, a Network management strategy to engage with PCCs, specialty Providers, high-volume prescribers, and hospital Emergency departments to improve access for Covered Individuals who may be under- or over-utilizing Behavioral Health services. The proposal shall include but is not limited to:

   a. Ways to complement current EOHHS efforts, including the Controlled Substance Management Program, DPH's Prescription Monitoring Program and other programs initiated by the MassHealth Pharmacy Program; and

   b. Methods for the Contractor's staff and its Behavioral Health Network Providers to use to identify Enrollees who may benefit from participation in the Care Management Program described in **Section 6.2**;

7. Propose methods the Contractor will use to engage foster parents and other individuals with physical custody of Children in the Care and/or Custody of the Commonwealth in such children's health care needs to ensure that they obtain Early and Periodic Screening, Diagnosis and Treatment (EPSDT), periodic and inter-periodic screens and Medically Necessary follow-up medical dental and Behavioral Health services; and

8. Propose methods the Contractor will use to establish and maintain specific supports for Providers of Behavioral Health, Primary Care, and specialty health care who provide MassHealth Covered Services to Children in the Care and/or

Custody of the Commonwealth to ensure continuity of care for Children in the Care and/or Custody of the Commonwealth who change Providers due to changes in their foster care arrangements or for other reasons.

The Contractor's proposal may be accepted, rejected, or modified by EOHHS in whole or in part.

B. Establishment of Behavioral Health Provider Network

As of the Service Start Date, the Contractor shall have in effect and maintain a Network of Providers for the delivery of BH Covered Services set forth in **Appendix A-1**, in accordance with the terms of this Contract. To the extent that any provider in the Contractor's provider network is subject to the Emergency Medical Treatment and Labor Act (EMTALA), it must comply with the Act, which requires:

- Qualified hospital medical personnel provide appropriate medical screening examinations to any individual who "comes to the emergency department," as defined in 42 C.F.R. 489.24(b).
- As applicable, provide individuals stabilizing treatment or, if the hospital lacks the capability or capacity to provide stabilizing treatment, conduct appropriate transfers.

The Contractor shall:

1. Make best efforts to ensure that all network providers from the previous BHP contract continue to participate in the Contractor's Provider Network and, accordingly, renew prior to the Service Start Date Provider Agreements with all such network providers.

2. Ensure that all Provider Agreements the Contractor initially executes with network providers from the previous BHP contract are for a term of at least one year.

3. Enter into Provider Agreements with each ESP identified in **Appendix A-3** to provide ESP Services and Youth Mobile Crisis Intervention Services and each Community Service Agency (CSA) identified in **Appendix A-2** to provide Intensive Care Coordination and Family Support and Training Services.

4. No later than one month prior to the Service Start Date, or as otherwise agreed to by EOHHS, submit to EOHHS for its review and approval the Contractor's initial Provider Network.

5. Ensure that in the event that network providers contracted with the previous BHP vendor refuse to participate in the Contractor's Network, there are sufficient Network Providers to deliver all BH Covered Services in accordance with the terms of this Contract.

6. Ensure that its Provider Network includes sufficient numbers of Network Providers with experience and expertise with the following Behavioral Health conditions:

a. Dual Diagnosis;

b. Serious and Persistent Mental Illness;

c. Post-traumatic stress disorder, especially among children and adolescents;

d. Severed Emotional Disturbance (SED) among children and adolescents;

e. Sex-offending behaviors;

f. Eating disorders; and

g. Autism.

7. Ensure its Provider Network includes sufficient numbers of Network Providers with experience and expertise with the following populations of Covered Individuals:

a. Persons with physical disabilities;

b. Persons with chronic illness(es);

c. Children, adolescents and their families;

d. Persons who are homeless, including children and families;

e. Children in the Care and/or Custody of the Commonwealth;

f. Young adults who are transitioning out of state-sponsored programs as they turn 22;

g. Persons with developmental disabilities;

h. Persons with brain injuries;

i. Persons with HIV/AIDS;

j. Pregnant women who are substance abusers;

k. Young children;

l. Older adults;

m. Persons from diverse cultural backgrounds, including persons whose primary language is not English;

n. Persons who are deaf or hard of hearing; and

o. Persons who are blind or visually impaired.

8. Provide coverage across all regions of the state.

9. Ensure the availability of the full range of BH Covered Services.

10. Provide access to BH Covered Services according to the standards set forth in **Section 3.1.G**.

11. Make best efforts to ensure that women- and minority-owned or -controlled agencies and organizations are represented in the Provider Network, and submit to EOHHS an annual written assessment of the results of such efforts each Contract Year.

12. In establishing the Provider Network, consider the following:

    a. The anticipated MassHealth enrollment for Covered Individuals;

    b. The expected utilization of services, taking into consideration the characteristics and health care needs of specific MassHealth populations enrolled with the Contractor;

    c. The numbers and types (in terms of training, experience, and specialization) of Network Providers required to furnish the BH Covered Services;

    d. The numbers of Network Providers who are not accepting new Covered Individuals; and

    e. The geographic location of Network Providers and Covered Individuals, considering distance, travel time, the means of transportation ordinarily used by Covered Individuals, and whether the location provides physical access for Covered Individuals with disabilities. (See also **Section 3.1.G.**)

13. At its discretion, create a plan, subject to EOHHS review and approval, to selectively procure a Provider Network.

    a. Ensure that such plan provides for procuring the Network in a fair and equitable manner, and in accordance with the requirements set forth in **subsections 12.a-e**, above.

    b. Allow all interested providers, including independently practicing licensed social workers, licensed mental health counselors Licensed Alcohol and Drug Counselors 1 (LADC1), and licensed marriage and family therapists, to apply to become Network Providers.

14. Submit to EOHHS for review and approval the new Provider Network following a reprocurement.

15. Share with MassHealth-contracted Managed Care Organizations (MCOs) any changes and/or updates to the ESP Provider network prior to disseminating that

information to all Covered Individuals. This provision does not require the Contractor to share with the MassHealth-contracted MCOs any information that pertains solely to individuals who are Covered Individuals or Uninsured Individuals or persons with Medicare only.

16. Share with MassHealth-contracted Managed Care Organizations (MCOs) any changes and/or updates to the list of CSAs prior to disseminating that information to all Covered Individuals. This provision does not require the Contractor to share with the MassHealth-contracted MCOs any information that pertains solely to individuals who are Covered Individuals.

17. Ensure the following payment provisions are met:

    a. Payments to Federally Qualified Health Centers (FQHCs) for services to Covered Individuals are greater than or equal to the payment amounts described in 42 USC § 1396a(bb). In order to comply with this requirement, the Contractor shall pay to Federally Qualified Health Care Centers with which it contracts at least the amount MassHealth would pay for such services on a fee-for-service basis as specified in 114.3 CMR 6.03, excluding any supplemental rate paid by MassHealth to FQHCs.

    b. If the amount paid by a managed care entity to an Indian Health Care Provider that is not a Federally Qualified Health Center for services provided by the provider to an Indian Enrollee with the managed care entity is less than the rate that applies to the provision of such services by the provider under the State plan, the plan shall provide for payment to the Indian Health Care Provider, whether the provider is a participating or nonparticipating provider with respect to the entity, of the difference between such applicable rate and the amount paid by the managed care entity to the provider for such services.

18. The Contractor shall ensure its payments to any licensed hospital facility operating in the Commonwealth that has been designated as a critical access hospital under 42 U.S.C. 1395i-4 are in an amount equal to at least 101 percent of allowable costs under the Contractor's plan, as determined by utilizing the Medicare cost-based reimbursement methodology, for both inpatient and outpatient services

19. In Contract Year 2, the Contractor shall provide an aggregate rate increase totaling not less than Five Million Dollars ($5,000,000.00) to Network Providers. Such rate increases shall be effective no later than January 1, 2014. By April 15, 2014, the Contractor and EOHHS shall agree on a method of validating that the Contractor has established and is paying such increased rates. The Contractor shall take corrective action measures approved by EOHHS if EOHHS determines rate increases have not been implemented in accordance with this section.

20. In the initial procurement of ESP services for the Southeast Area:

a. the Contractor shall issue a Request for Proposal (RFP) to procure ESP services for the Southeast;

b. the Contractor will select winning bidders;

c. at the direction of EOHHS, the Contractor shall execute provider agreements with each winning bidder for the Southeast Area that require providers to:

1) ensure that certain qualified, regular employees or former employees of DMH are offered positions, if such employees:

a) provided ESP services; and

b) were terminated as a result of DMH ceasing to provide such ESP services.

2) provide health insurance to each employee hired in accordance with this section, and each employee's spouse and dependents, so long as such employee works 20 hours or more each week. The provider shall pay not less than the current percentage paid by the Commonwealth for health insurance to its employees.

3) pay wages to those hired in accordance with this section that are not less than the minimum wage rate for those positions for which the duties are substantially similar to the duties performed by regular agency employees, as follows:

ESP Core Staffing Position	Substantially Comparable DMH Position(s)	UFR Position(s)	Minimum Wage Rate under MGL c.7 §54(2)
ESP Director	Clinical Social Worker (D) Psychologist IV	Program Director (UFR Title 102)	$62,202.14
QM/ RM Director	Manager VI	Supervising Professional (UFR Title 104)	$52,399.08
Program Manager	Clinical Social Worker (D)	Program Function Manager (UFR Title 101)	$62,202.14
Clinical Supervisor	Clinical Social Worker (C) Human Services Coordinator (D)	Supervising Professional (UFR Title 104)	$52,399.08
Nursing Manager RN	Registered Nurse IV Registered Nurse V	N. Midwife, N.P., Psych N. , N.A., R.N. – MA (UFR Title 107)	$62,225.86
		R.N. – Non-Masters (UFR Title 108)	**$51,552.04**
Nursing RN	Registered Nurse II	R.N. – Non-Masters (UFR	$51,552.04

ESP Core Staffing Position	Substantially Comparable DMH Position(s)	UFR Position(s)	Minimum Wage Rate under MGL c.7 §54(2)
	Community Psychiatric MH Nurse	Title 108)	
Nursing LPN	Licensed Practical Nurse I Licensed Practical Nurse II	L.P.N. (UFR Title 109)	$40,513.20
Certified Peer Specialist	Mental Health Coordinator I	Direct Care/Prog. Staff Supervisor (UFR Title 133)	$39,276.49
		Direct Care/Prog. Staff III (UFR Title 134)	$36,751.40
		Direct Care/Prog. Staff II (UFR Title 135)	$28,429.14
		Direct Care/Prog. Staff I (UFR Title 136)	**$27,741.38**
BS w/CPS preferred	Human Services Coordinator (A/B)	Direct Care/Prog. Staff Supervisor (UFR Title 133)	$39,276.49
		Direct Care/Prog. Staff III (UFR Title 134)	$36,751.40
		Direct Care/Prog. Staff II (UFR Title 135)	$28,429.14
		Direct Care/Prog. Staff I (UFR Title 136)	**$27,741.38**
BS Milieu	Mental Health Worker I Mental Health Worker II	Direct Care/Prog. Staff Supervisor (UFR Title 133)	$39,276.49
		Direct Care/Prog. Staff III (UFR Title 134)	$36,751.40
		Direct Care/Prog. Staff II (UFR Title 135)	$28,429.14
		Direct Care/Prog. Staff I (UFR Title 136)	**$27,741.38**
BS Milieu w/ CPS preferred	Human Services Coordinator (A/B)	Direct Care/Prog. Staff Supervisor (UFR Title 133)	$39,276.49
		Direct Care/Prog. Staff III (UFR Title 134)	$36,751.40
		Direct Care/Prog. Staff II (UFR Title 135)	$28,429.14
		Direct Care/Prog. Staff I (UFR Title 136)	**$27,741.38**
Paraprofessional	Mental Health Coordinator I	Direct Care/Prog. Staff	$39,276.49

ESP Core Staffing Position	Substantially Comparable DMH Position(s)	UFR Position(s)	Minimum Wage Rate under MGL c.7 §54(2)
(Family Partner)		Supervisor (UFR Title 133)	
		Direct Care/Prog. Staff III (UFR Title 134)	$36,751.40
		Direct Care/Prog. Staff II (UFR Title 135)	$28,429.14
		Direct Care/Prog. Staff I (UFR Title 136)	**$27,741.38**
MS Triage Clinician	Human Services Coordinator (C) Social Worker (C)	Case Worker/Manager – Masters (UFR Title 131)	$54,152.00
		Case Worker/Manager (UFR Title 132)	$54,152.00
		Cert. Alch. &/or Drug Abuse Counselor (UFR Title 129)	$58,084.71
		Clinician (formerly Psych Masters) (UFR Title 123)	**$36,516.16**
		Counselor (UFR Title 130)	$46,882.08
		Licensed Counselor (UFR Title 127)	$46,882.08
		Social Worker LCSW, LSW (UFR Titles 125 & 126)	$46,083.53
		Social Worker LICSW (UFR Title 124)	$53,934.40
MS Clinicians	Human Services Coordinator (C)	Case Worker/Manager – Masters (UFR Title 131)	$54,152.00
		Case Worker/Manager (UFR Title 132)	$54,152.00
		Cert. Alch. &/or Drug Abuse Counselor (UFR Title 129)	$58,084.71
		Clinician (formerly Psych Masters) (UFR Title 123)	**$36,516.16**
		Counselor (UFR Title 130)	$46,882.08
		Licensed Counselor (UFR Title 127)	$46,882.08
		Social Worker LCSW, LSW	$46,083.53

ESP Core Staffing Position	Substantially Comparable DMH Position(s)	UFR Position(s)	Minimum Wage Rate under MGL c.7 §54(2)
		(UFR Titles 125 & 126)	
		Social Worker LICSW (UFR Title 124)	$53,934.40
MS Clinician Mobile	Human Services Coordinator (C) Clinical Social Worker (A/B) Clinical Social Worker (C)	Case Worker/Manager – Masters (UFR Title 131)	$54,152.00
		Case Worker/Manager (UFR Title 132)	$54,152.00
		Cert. Alch. &/or Drug Abuse Counselor (UFR Title 129)	$58,084.71
		Clinician (formerly Psych Masters) (UFR Title 123)	**$36,516.16**
		Counselor (UFR Title 130)	$46,882.08
		Licensed Counselor (UFR Title 127)	$46,882.08
		Social Worker LCSW, LSW (UFR Titles 125 & 126)	$46,083.53
		Social Worker LICSW (UFR Title 124)	$53,934.40
Safety Staff	Mental Health Worker I	Direct Care/Prog. Staff II (UFR Title 135)	$28,429.14
		Direct Care/Prog. Staff I (UFR Title 136)	**$27,741.38**
Admin. Assistant	Administrative Assistant I Clerk III	Program Secretarial/ Clerical Staff (UFR Title 137)	**$27,543.92”**

4) comply with a policy of nondiscrimination and equal opportunity for all persons protected by chapter one hundred and fifty-one B, and take affirmative steps to provide such equal opportunity for all such persons.

5) submit quarterly payroll records to EOHHS, listing the name, address, social security number, hours worked and the hourly wage paid for each employee in the previous quarter who provides ESP services for the Southeast Area.

21. Pay Network Providers a 15-minute rate for Case Consultation and Family Consultation services for Covered Individuals under the age of 21 and for Collateral Contact services at or above one quarter of the 60-minute rate the

Contractor pays Network Providers for Outpatient Individual Treatment. Such rates shall be effective for services rendered on or after October 1, 2016. The Contractor shall revise procedure codes, service definitions, medical necessity criteria, and authorization parameters for Case Consultation, Family Consultation, and Collateral Contact Services in consultation with and as directed by EOHHS.

22. During Contract Year 6A, establish a network of Substance Use Disorder Level III.1 service providers, including Transitional Support Services and Residential Rehabilitation Services, as specified by EOHHS. In establishing such network, the Contractor shall, as further specified by EOHHS:

    a. Communicate, support, and provide technical assistance to the existing network of Level III.1 providers contracted with the Department of Public Health (DPH) as necessary to credential and contract with those providers;

    b. Develop performance specifications and medical necessity criteria for Level III.1 services;

    c. Establish rates of reimbursement for Level III.1 services; and

    d. Perform any additional activities, as directed by EOHHS or DPH, necessary to credential and contract with Level III.1 providers that are not currently contracted with DPH but that are otherwise willing and qualified to provide Level III.1 services to Covered Individuals.

C. Contract Provisions of Behavioral Health Provider Network

The Contractor shall:

1. Effective January 1, 2014, the Contractor shall implement all Current Procedural Terminology (CPT) evaluation and management codes for Behavioral Health Covered Services as most recently adopted by the American Medical Association and CMS; and shall pay no less than the MassHealth rate for such CPT codes. Except as otherwise provided in this Contract, develop proposed Network Provider payment rates for all services;

2. Unless otherwise agreed to by EOHHS, inform EOHHS of proposed rate changes prior to implementing them, executing Provider Agreements, or entering into any other arrangements with Network Providers;

3. Execute and maintain for the term of the Contract written Provider Agreements with a sufficient number of appropriately credentialed, licensed or otherwise qualified Network Providers to provide Covered Individuals with all Medically Necessary BH Covered Services;

4. Prior to distributing or executing any Provider Agreements or any amendments thereto, submit standard language for any such Agreement to EOHHS for approval;

5. Ensure that all Provider Agreements include provisions:

   a. requiring Network Providers to accept as payment in full the Contractor's payment for BH Covered Services provided to Covered Individuals;

   b. prohibiting Network Providers from charging Covered Individuals in full or in part for any service provided under the Contract or imposing any financial penalties on them, including charges for canceling or missing appointments, and as further set forth in **Section 2.3.E**;

   c. stating the following:

      "Providers shall not seek or accept payment from any Covered Individuals for any BH Covered Service rendered, nor shall providers have any claim against or seek payment from EOHHS. Instead, providers shall look solely to the (Contractor's name) for payment with respect to BH Covered Services rendered to Covered Individuals. Furthermore, providers shall not maintain any action at law or in equity against any Covered Individuals or EOHHS to collect any sums that are owed by the (Contractor's name) under the Contract for any reason, even in the event that the (Contractor's name) fails to pay for or becomes insolvent or otherwise breaches the terms and conditions of the Contract (where "Contract" refers to the agreement between the Contractor and any subcontractor and where "provider" refers to the subcontractor, including Network Providers and non-Network Providers with whom the Contractor is contracting)."

   d. notwithstanding the provisions of **subsections 5.a** and **b**, requiring Network Providers to charge Covered Individuals copayments in accordance with EOHHS's copayment regulations, at the direction of EOHHS;

   e. prohibiting Network Providers from denying any BH Covered Service to a Covered Individual for failure or inability to pay any charge, or to a Covered Individual who, prior to becoming eligible for MassHealth services, incurred a bill that has not been paid;

   f. requiring any Network Provider to notify the Contractor if it has reason to be considering insolvency or is otherwise financially unsound. The Contractor shall notify EOHHS within one business day of receipt of such financial notification;

   g. requiring Network Providers of mental health Inpatient Services to accept for admission all Covered Individuals in need of inpatient admissions who are referred by ESPs, regardless of the availability of insurance, capacity to private pay, or clinical presentation;

   h. prohibiting Network Providers from engaging in any practice with respect to any Covered Individual that constitutes unlawful discrimination on the

basis of health status, need for health care, race, color, national origin, or any other basis that violates any state or federal law or regulation, including but not limited to 45 CFR Part 80, 45 CFR Part 84, and 45 CFR Part 90; and

i. requiring Network Providers to collaborate with EOHHS health care reform initiatives, including but not limited to payment reform and the Patient-Centered Medical Home Initiative, as directed by the Contractor.

j. clearly stating the Provider's EMTALA obligations and are not creating any conflicts with hospital actions required to comply with EMTALA.

6. As directed by EOHHS, ensure that all Provider Agreements with Network Provider clinicians who provide Behavioral Health services to Covered Individuals under the age of 21 in certain Levels of Care (including Diagnostic Evaluation for Outpatient Therapy (Individual Counseling, Group Counseling, and Couples/Family Counseling), Inpatient Psychiatric Services, and Community-Based Acute Treatment Services) require that they:

   a. Become certified in the use of the Child and Adolescent Needs and Strengths (CANS) Tool for Behavioral Health diagnostic evaluations (see also **Section 3.5**), and recertified in its use every two years;

   b. Use the CANS Tool whenever they deliver a Behavioral Health Clinical Assessment for a Covered Individual under the age of 21, which shall include using the CANS Tool during initial Behavioral Health Clinical Assessments and, at a minimum, every 90 days thereafter during ongoing treatment, and also as part of the Discharge Planning process from Inpatient Psychiatric Hospitalizations, and Community-Based Acute Treatment Services as described in **Appendix A-1**; and

   c. Subject to consent, if required, by the Covered Individual, parent, guardian, custodian, or other authorized individual, as applicable, input into the CANS IT System the information gathered using the CANS Tool and the determination whether or not the assessed Covered Individual is suffering from a Serious Emotional Disturbance.

   Clinicians covered by this requirement include psychiatrists, psychiatric nurse mental health clinical specialists, psychologists, licensed independent clinical social workers (LICSWs), licensed mental health counselors (LMHCs), licensed marriage and family therapists (LMFTs), licensed clinical social workers (LCSWs), Licensed Alcohol and Drug Counselors 1 (LADC1), and unlicensed master's-level clinicians working under the supervision of a licensed clinician. If EOHHS determines that other types of clinicians who provide Behavioral Health Covered Services to Covered Individuals under the age of 21 in additional Levels of Care are also subject to the provisions of this section, the Contractor shall also

include these provisions in such clinicians' Network Provider Agreements, as directed by EOHHS.

7. Ensure that all Provider Agreements with Community Service Agencies require that all intensive care coordinators of all levels:

    a. Become certified in the use of the CANS Tool and recertified every two years;

    b. Use the CANS Tool during the comprehensive home-based assessment that is part of the initial phase of intensive care coordination and, at a minimum, every 90 days thereafter during ongoing care coordination, and as part of Discharge Planning from the Intensive Care Coordination service; and

    c. Subject to consent by the Covered Individual, parent, guardian, custodian or other authorized individual, as applicable, enter into the CANS IT System the information gathered using the CANS Tool and the intensive care coordinator's determination of whether the assessed Covered Individual is suffering from a Serious Emotional Disturbance.

8. When requested, provide for a second opinion from a qualified health care professional within the Provider Network or arrange for the Covered Individual to obtain one outside the Provider Network, if a qualified in-network health care professional is not available, at no cost to the Covered Individual;

9. Ensure that its Network Providers comply with state and federal regulations that prohibit a health care facility from charging or seeking payment for services provided as a result of the occurrence of certain Serious Reportable Events, as well as any additional requirements or limitations placed on payment by EOHHS;

10. Ensure that its Provider Agreements specify that:

    a. No payment shall be made by the Contractor to a Provider for a Provider Preventable Condition; and

    b. As a condition of payment, the Provider shall comply with the reporting requirements as set forth in 42 CFR 447.26(d) and as may be specified by the Contractor.

D. Contract Provisions for Network Providers that Perform Behavioral Health Clinical Assessments

The Contractor shall:

1. Require of all Network Providers that have clinicians who provide Behavioral Health Clinical Assessments and conduct Discharge Planning from Inpatient Psychiatric Hospitalizations and Community-Based Acute Treatment Services, using the CANS Tool in accordance with **Sections 3.1.C.6** and **7,** that they have

Virtual Gateway accounts and a high-speed internet or satellite internet connection to access the CANS IT System; except that the Contractor may have policies and procedures approved by EOHHS to grant temporary waivers of these requirements on a case-by-case basis.

2. Require of all Network Providers that provide Behavioral Health Clinical Assessments and perform Discharge Planning from Inpatient Psychiatric Hospitalizations and Community-Based Acute Treatment Services, using the CANS Tool in accordance with **Sections 3.1.C.6** and **7**, that they seek consent from the Covered Individual, parent, guardian, custodian or other authorized individual, as applicable, using the form of consent approved by EOHHS, before entering the information gathered using the CANS Tool into the CANS IT System.

3. Require Network Providers that obtain such consent to enter the information gathered using the CANS Tool and the determination of whether or not the assessed Covered Individual is suffering from a Serious Emotional Disturbance into the CANS IT System.

4. Require Network Providers that do not obtain such consent to enter only the determination of whether or not the assessed Covered Individual is suffering from a Serious Emotional Disturbance into the CANS IT System.

E. Health Care Reform, Including Payment Reform

The Contractor shall collaborate with EOHHS upon request on the development and implementation of payment reform initiatives for its Network Providers. Such initiatives may include

1. Global payments rather than Fee-for-Service payments;

2. Primary Care Payment Reform initiatives;

3. Pay for Performance; and

4. Other outcome-based payment methods.

F. Non-Network Providers

The Contractor shall:

1. Permit Covered Individuals who reside in a rural service area, as identified by EOHHS in accordance with the provisions of 42 CFR 412.62(f)(1)(ii) (currently, Dukes County and Nantucket County), to obtain Medically Necessary BH Covered Services from non-Network Providers under the following circumstances:

a. The Covered Individual is unable to obtain the same service or to access a Network Provider with the equivalent training, experience, and specialization within the Provider Network;

b. The Network Provider from whom the Covered Individual seeks the service is the main source of service to the Covered Individual, except that the Covered Individual shall have no right to obtain services from a Provider outside the Provider Network if the Contractor gave the Provider the opportunity to participate in the Provider Network under the same requirements for participation applicable to other Providers and the Provider chose not to join the Provider Network or did not meet the necessary requirements to join the Provider Network;

c. The only Network Provider available to the Covered Individual in the Provider Network does not, because of moral or religious objections, provide the service the Covered Individual seeks; or

d. The Covered Individual's Network Provider or other provider determines that the Covered Individual needs a service(s), and that the Covered Individual would be subjected to unnecessary risk if he/she received the needed services separately and not all of the related services are available within the Provider Network.

2. Adequately and timely provide all Covered Individuals with access to non-Network Providers for BH Covered Services for as long as the Contractor is unable to provide them. The Contractor shall negotiate and execute written single-case agreements or arrangements with non-Network Providers, when necessary, to assure access to BH Covered Services.

3. Ensure that non-Network Providers' agreements or arrangements include the provisions required in **Section 3.1.C.4**.

4. Ensure that service authorizations and Utilization Management protocols, Claims submissions and Internal Appeals policies for non-Network Providers are consistent with the terms in the Contractor's Network Provider Agreements.

5. Coordinate payment with out-of-network providers and ensure that the cost to the Covered Individual is no greater than it would be if the services were furnished within the Network.

G. Access and Availability of Behavioral Health Provider Network

The Contractor shall:

1. Permit Covered Individuals to self-refer to any Network Provider of their choice for Medically Necessary Behavioral Health Covered Services.

2. Ensure adequate physical and geographic access to BH Covered Services for Covered Individuals.

3. Ensure Covered Individuals have access to a choice of at least two Network Providers who provide BH Covered Services to the extent that qualified, willing Network Providers are available.

4. Through the execution of Provider Agreements, maintain and monitor a Network of appropriate providers that is sufficient to provide adequate access to all BH Covered Services for all Covered Individuals, including those with limited English proficiency or physical or mental disabilities. When directed by EOHHS, such Providers must be enrolled with MassHealth as specified by EOHHS;

5. Assure EOHHS that it has the capacity to service expected enrollment of Covered Individuals in accordance with the access standards specified in this **Section 3.1.G.** by submitting the access and availability reports specified in **Appendix E-1.**

    a. The Contractor must submit these reports on a quarterly basis and whenever there is a significant change in operations that would affect the adequacy and capacity of services. Such significant changes include, but are not limited to:

        1) changes in MassHealth Covered Services;

        2) enrollment of a new population in the Contractor's plan;

        3) changes in benefits; and

        4) changes in Network Provider payment methodology.

    b. In these reports, the Contractor must demonstrate that it

        1) maintains a Provider Network that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of Covered Individuals in each of the State's regions; and

        2) offers an appropriate range of specialty services that is adequate for the anticipated number of Covered Individuals in each of the State's regions.

    If the Contractor does not comply with the access standards specified in this **Section 3.1.G**, the Contractor shall take corrective action necessary to comply with such access standards.

6. Ensure that Network Providers provide physical access, communication access, accommodations, and accessible equipment for Covered Individuals with physical or mental disabilities.

7. Monitor the practice of creating waiting lists for Covered Individuals who seek outpatient BH Covered Services. If the Contractor determines that a Network Provider has established a waiting list, the Contractor shall create a plan to

identify such Network Providers and help them reduce such waiting lists, with the goal of eliminating them. Such activity shall include but not be limited to the Contractor directly assisting Covered Individuals to find an appropriate alternative Provider. The Contractor shall further ensure that:

a. Waiting lists are established and maintained in such a way as to not violate the provisions of M.G.L. c. 151(B), including waiting for appointments after the initial appointment; and

b. Network Providers with waiting lists refer Covered Individuals to other qualified Network Providers who do not have waiting lists.

8. Maintain a sufficiently broad and robust Provider Network to ensure that, at a minimum, 90 percent of Covered Individuals have access to all Medically Necessary Behavioral Health Covered Services according to the following standards:

a. Inpatient Services within 60 miles or 60 minutes' travel time from the Covered Individual's residence, whichever requires less travel time;

b. ESP Services as available based on the ESP Provider list in **Appendix A-3**; and

c. Intensive Care Coordination and Family Support and Training Services provided by Community Service Agencies as available based on the CSA Provider list in **Appendix A-2**;

d. Other Intensive Home and Community-Based Services, which require Network Providers to travel to the Covered Individual's residence for services, must be available in all cities and towns in the Commonwealth; and

e. All other BH Covered Services within 30 miles or 30 minutes' travel time from the Covered Individual's residence, whichever requires less travel time.

Notwithstanding the generality of the foregoing, the Contractor shall ensure access to at least one Network Provider, except ESPs, of each BH Covered Service in every geographic region of the state with more than 2.5 percent of Covered Individuals or, as determined by EOHHS, to the extent that qualified, interested Providers are available.

9. Ensure that access to BH Covered Services for Covered Individuals is consistent with the degree of urgency, as follows:

a. Emergency Services shall be provided immediately (respond to call with a live voice; face-to-face within 60 minutes) on a 24-hour basis, seven days a week, with unrestricted access, to individuals who present at any

qualified Provider, whether a Network Provider or a non-Network Provider.

b. ESP Services shall be provided immediately on a 24-hour basis, seven days a week, with unrestricted access, to individuals who present, including covered individuals, uninsured individuals and persons covered by Medicare only.

c. Urgent Care Services shall be provided within 48 hours.

d. All other care shall be provided in accordance with usual and customary community standards and in all cases within 14 calendar days.

e. In accordance with 42 CFR 438.206(c)(1)(iii), the Contractor shall make BH Covered Services available 24 hours a day, seven days a week when medically necessary.

10. Offer Covered Individuals who require readmission to Inpatient Mental Health Services readmission to the same Network Provider when there is a bed available in that facility.

11. Ensure that Network Providers offer hours of operation that are no less than the hours of operation offered to individuals with commercial insurance, or comparable to Medicaid Fee-for-Service if the Network Provider serves only MassHealth Members.

12. The Contractor may request an exception to the access standards set forth in this **Section 3.1.G** by submitting a written request to EOHHS. EOHHS will grant such a request only if:

    a. Such request includes alternative standards that are equal to or better than the usual and customary community standards for accessing care and the standards specified in this **Section 3.1.G**.

    b. Upon approval by EOHHS, the Contractor shall notify Covered Individuals in writing of such alternative access standards.

H. Health Disparities

The Contractor shall ensure that:

1. Multilingual Network Providers and, to the extent that such capacity exists in a region, all Network Providers understand and comply with their obligations under state and federal law to assist Covered Individuals with skilled medical interpreters and the resources that are available to assist Network Providers to meet these obligations.

2. Network Providers and interpreters/translators are available for those who are deaf or hearing-impaired, to the extent that such capacity exists within each region.

3. Its Network Providers are responsive to the linguistic, cultural, ethnic, or other unique needs of members of minority groups, the Homeless, disabled individuals and other special populations served under the Contract.

4. Perform at the beginning of the Contract, and thereafter at least every three years, an in-depth demographic analysis with Network Providers, as well as more robust data analysis, to identify health disparities and develop mitigation strategies based on current Network Provider capacity as described in **subsections 1-3**, above; and build additional Network capacity based on the analysis.

5. Implement the identified mitigation strategies as approved by EOHHS.

I. Network Provider Credentialing

1. Credentialing Process

The Contractor shall implement written policies and procedures that comply with the EOHHS requirements set forth below regarding the selection, retention, and exclusion of Providers from the Provider Network. Such written policies and procedures shall, at a minimum:

a. Require Network Providers to meet the Credentialing Criteria approved by EOHHS, unless the Contractor establishes that such criteria should be waived pursuant to **Section 3.1.I.3**.

b. Maintain appropriate, documented processes for the credentialing and re-credentialing of physician Network Providers and all other licensed or certified Network Providers who participate in the Contractor's Provider Network. At a minimum, the scope and structure of the processes shall be consistent with recognized managed care industry standards such as those provided by the National Committee for Quality Assurance (NCQA) and relevant state regulations, including regulations issued by the Board of Registration in Medicine (BORIM) at 243 CMR 3.13. The basic components of these processes shall include a review of the following:

1) licensing, accreditation, certification, training, specialty board eligibility or certification;

2) current status of professional license, restrictions, and history of any loss of licensure in any state;

3) DEA number and copy of certification, where applicable;

4) hospital privileges, name of hospitals, and scope of privileges, where applicable;

5) malpractice insurance, carrier name, amount of coverage, copy of the face sheet, and scope of coverage;

6) malpractice history, pending claims, and successful claims against the Provider;

7) record of continuing professional education;

8) Medicare, Medicaid, federal tax identification number, and Social Security numbers;

9) location, service area and telephone numbers of all offices, hours of operation, and provisions for Emergency care and backup;

10) areas of special experience, skills and training;

11) cultural and linguistic capabilities;

12) review of Covered Individual satisfaction and any complaints made or Grievances filed against the Network Provider within the past two years;

13) physical accessibility for persons with disabilities;

14) reference check;

15) for facility-based Network Providers, a site visit and evidence of a training program for staff on the appropriate and safe use of restraint and seclusion to the extent that the facility's license permits the use of seclusion;

16) for Network Providers of 24-hour services, evidence of a training program for staff on the appropriate and safe use of restraint and seclusion.

c. Ensure that all Network Providers are credentialed prior to becoming Network Providers and that a site visit is conducted with recognized managed care industry standards such as those provided by the National Committee for Quality Assurance (NCQA) and relevant state regulations;

d. Ensure that physician Network Providers and other licensed or certified professional Network Providers maintain current knowledge, ability, and expertise in their practice area(s) by, at minimum, obtaining continuing education units (CEUs) and participating in other training opportunities, as appropriate.

e. Ensure that Network Providers are recredentialed every three years, at a minimum, and take into consideration various forms of data, but not

limited to, Grievances, results of quality reviews, Covered Individual satisfaction surveys, and Utilization Management information.

f. Designate the Contractor's department(s) and staff who will be directly responsible for credentialing and recredentialing Network Providers.

g. To the extent permitted by law and upon request, provide Covered Individuals or their legal guardians with information in the Network Provider database, with the exception of the information described in **subsections b.5)**, **6)**, **8)**, **14)**, **15)** and **16)** above.

h. Ensure that that the credentialing process does not discriminate against particular Providers that serve high-risk populations or specialize in conditions that require costly treatment.

i. Not authorize any Network Providers terminated or suspended from participation in MassHealth, Medicare or from another state's Medicaid program, to treat Covered Individuals, and deny payment to such Network Providers for any service provided.

1) The Contractor shall, at a minimum, check the BORIM website at least once per month and the U.S. Department of Health and Human Services Office of the Inspector General's (OIG) List of Excluded Individuals Entities (LEIE) or Medicare Exclusion Database (MED) websites before the Contractor contracts with a Provider to become part of its Provider Network, at the time of a Provider's credentialing and recredentialing, and at least monthly.

2) The Contractor shall notify a Network Provider within three business days that, due to its MassHealth, Medicare, or another state's Medicaid program termination or suspension or a state or federal licensing action, such Network Provider is terminated or suspended, as appropriate, from the Contractor's Provider Network, and is no longer eligible to treat Covered Individuals. The Contractor shall have a process in place to immediately effectuate such termination or suspension.

3) When the Contractor terminates or suspends a Network Provider from its Network, or rejects a potential provider's application to join the Network, based on such Provider's termination or suspension with MassHealth, Medicare, or another state's Medicaid program, a state or federal licensing action, or based on any other independent action, the Contractor shall notify EOHHS of the Network Provider termination, suspension or rejection, and the reason thereof, within three business days.

4) On an annual basis, the Contractor shall submit to EOHHS a certification checklist confirming that it has implemented the actions necessary to comply with this section.

5) This section does not preclude the Contractor from suspending or terminating Network Providers for cause prior to such Network Provider's ultimate suspension and/or termination by EOHHS from participation in MassHealth.

j. Not employ or contract with a Provider, or otherwise pay for any items or services furnished, directed or prescribed by a Provider that has been excluded from participation in federal health care programs by the OIG under either section 1128 or section 1128A of the Social Security Act, or that has been terminated from participation under Medicare or another state's Medicaid program, except as permitted under 42 CFR 1001.1801 and 1001.1901.

k. Ensure that no Network Provider engages in any practice with respect to any Covered Individual that constitutes unlawful discrimination under any other state or federal law or regulation, including but not limited to practices that violate the provisions of 45 CFR Part 80, 45 CFR Part 84, and 45 CFR Part 90.

l. Search for the names of parties disclosed during the credentialing process in the BORIM, OIG LEIE, and Medicare MED exclusion or debarment databases and the MassHealth exclusion list, and do not contract with parties that have been terminated from participation under Medicare or another state's Medicaid program.

m. Notify EOHHS when a Network Provider fails credentialing or re-credentialing because of a program-integrity reason, including those reasons described in this **Section 3.1.I.1**, and provide information required by EOHHS or state or federal laws, rules, or regulations.

n. Demonstrate to EOHHS, by reporting annually in accordance with **Appendix E-1**, that all Network Providers within the Contractor's Provider Network are credentialed according to this **Section 3.1.I.1**.

2. Network Provider Qualifications

The Contractor shall:

a. Execute Provider Agreements or enter into other arrangements for BH Covered Services only with facility-based Providers that satisfy the following criteria:

1) They are financially stable, as determined by the Contractor;

2) They have established and maintain a Quality Management program, as described in **Section 8**;

3) They comply with policies and regulations with respect to patient rights and privileges, as applicable;

4) They maintain records consistent with current professional standards and EOHHS regulations, as well as systems for accurately documenting the following information for each Covered Individual receiving BH Covered Services:

   a) demographic information;

   b) clinical history;

   c) Behavioral Health Clinical Assessments;

   d) treatment plans;

   e) services provided;

   f) contacts with Covered Individuals' family, guardians, or significant others; and

   g) treatment outcomes;

5) Are responsive to linguistic, cultural and other unique needs of any member of a cultural, racial or linguistic minority, or other special population in the region in which they provide services;

6) Have the capacity to communicate with Covered Individuals in languages other than English, when necessary, as well as with those who are deaf or hearing-impaired;

7) Satisfy all federal and state requirements for affirmative action;

8) Satisfy all federal and state legal requirements regarding the Provider's physical plant and premises;

9) Comply with all applicable anti-discrimination requirements described in 42 CFR 438.6(d)(3) and (4);

10) Comply with all other applicable state and federal laws;

11) Meet the Credentialing Criteria, unless the Contractor establishes that such criteria should be waived pursuant to **Section 3.1.I.3**; and

12) Have been credentialed pursuant to the policies and procedures specified in **Section 3.1.I.1**.

b. Ensure that, in addition to the criteria set forth in **subsection a**, above, those facility-based Network Providers that are Network Providers of Inpatient Services are fully licensed by DMH and by DPH as applicable. In addition, ensure that such Providers:

1) Comply with DMH regulations concerning human rights set forth in 104 CMR 27.13 and 14 and 104 CMR 28.11, including ensuring that that human rights activities are overseen by a human rights committee and officer, and provide training for staff and education for Covered Individuals regarding human rights. To the extent permissible under **Section 14**, notify EOHHS and DMH when issues of non-compliance come to the attention of the Contractor whether through the discovery of Serious Reportable Events, or by other means, including but not limited to complaints, Grievances, or Network management activities;

2) Comply with DMH's regulations concerning restraint and seclusion (see **Section 3.2.A**, below). To the extent permissible under **Section 14**, notify EOHHS and DMH when issues of non-compliance come to the attention of the Contractor whether through the discovery of Serious Reportable Events, or by other means, including but not limited to complaints, Grievances, or Network management activities;

3) Submit to the Contractor evidence of implementation of the training programs described in **subsections b.2)** and **3)** as part of investigations of Serious Reportable Events, implementation of corrective action plans that involve human rights, and the use of restraint and seclusion;

4) Notify the DMH Licensing Unit of an inpatient Provider's non-compliance with these requirements and collaboratively determine whether additional Contractor action is appropriate; and

5) Develop organizational and clinical linkages with each of the high-volume referral source ESPs, as identified by EOHHS, hold regular meetings, and communicate with the ESPs on clinical and administrative issues, as needed, to enhance continuity of care for Covered Individuals;

Contractor activities to ensure compliance include informing the DMH Licensing Unit of inpatient units' non-compliance with these requirements and collaboratively determining if additional action by the Contractor is appropriate.

c. Preferentially execute Provider Agreements or enter into other arrangements for the provision of BH Covered Services with Providers

that demonstrate a commitment to the principles of rehabilitation and recovery from mental illness and addiction, including a focus on recovery-oriented services, consumer and family involvement in program management, a strength-based approach to working with children and their families, and training for staff on such principles.

3. Credentialing Waiver Process

The Contractor shall:

a. Develop a proposal for a credentialing waiver process to allow certain Providers who do not meet all of the Contractor's Credentialing Criteria to be included in the Provider Network when there is an objective need for including those Providers (e.g., the Provider fills a cultural, linguistic, or geographic access need).

b. Ensure that no BH Covered Service is rendered at any time during the term of the Contract by any person, facility, agency or organization that does not meet all Credentialing Criteria under this Contract, or any applicable law or regulation, unless EOHHS specifically waives in writing an applicable Credentialing Criterion, to the extent such waiver is within the authority of EOHHS.

Section 3.2 Additional Behavioral Health Provider Network Requirements

A. Use of Restraint and Seclusion Techniques

1. The Contractor shall require Network Providers to have all applicable licenses and comply with all applicable laws and regulations concerning restraint and seclusion, including without limitation:

   a. DMH regulations concerning seclusion and restraint at 104 CMR 27.12 and physical restraint at 104 CMR 28.05, or any successive regulation; and

   b. Federal regulations at 42 CFR 441.151 subpart D and 42 CFR 483 subpart G.

2. The Contractor shall monitor the Network Providers' compliance with the requirements of the laws and regulations set forth by DMH, as well as all other applicable laws and regulations.

   a. To the extent permissible under **Section 14**, the Contractor shall notify EOHHS and the DMH Licensing Unit of non-compliance; and

   b. The Contractor shall take all necessary corrective actions to correct non-compliance by Network Providers in collaboration with the DMH Licensing Unit.

B. Linkage with Consumer Initiatives, Recovery Initiatives, Natural Community Supports and Anonymous Recovery Programs

The Contractor shall manage the Behavioral Health Provider Network to align with other programs and services that support and complement Covered Individuals' participation in BH Covered Services and that promote Covered Individuals' recovery, empowerment, and use of their strengths and the family's strengths in achieving their clinical goals and improving their health outcomes.

1. The Contractor shall actively manage Network Providers to complement and integrate with the following formal and informal resources and programs:

    a. Consumer Initiatives;

    b. Rehabilitation programs that promote skill-building, supported employment and full competitive employment for Covered Individuals;

    c. Natural community supports for Covered Individuals and their families; and

    d. Anonymous recovery programs (e.g., 12-step programs) for Covered Individuals and their families.

2. The Contractor shall also work with its Network Providers to actively collaborate with other EOHHS-funded programs, including but not limited to:

    a. DMH-funded programs, such as Community-Based Flexible Supports;

    b. DCF-funded programs that support the safety, permanency and well-being of Children in the Care and Custody of the Commonwealth;

    c. BSAS-funded programs for Covered Individuals, such as recovery homes to promote continuity of services for substance abuse from acute care to supportive and rehabilitative care and recovery supports;

    d. DDS programs that involve rehabilitative and habilitative services for persons with developmental disabilities;

    e. DYS programs that help clients stay in the community and avoid recidivism to DYS;

    f. Other programs and initiatives within EOHHS, MassHealth and DPH related to PCC coordination and pharmacy management, including federal and state grant programs; and

    g. Prevention and wellness programs at the state, regional and local level.

3. The Contractor shall demonstrate through its Network management plan and individual Network Provider Agreements the continued effort to work with Network Providers to access these resources and supports.

C. Compliance with Section 1202 of the ACA and 42 U.S.C 1396a(13)(C)

This **Section 3.2.C** implements Section 202 of the Affordable Care Act (ACA).

In the event that this Contract provides for payment of Primary Care services or vaccine administration, as defined in said Section 1202 and related regulations and subregulatory guidance, then the Contractor shall comply as follows:

> As directed by EOHHS, and for services rendered on or after January 1, 2013, the Contractor shall set payment rates for primary care services provided by eligible Providers and for pediatric vaccines in accordance with Section 1202 of the ACA and 42 U.S.C. 1396a(13)(C), EOHHS policies, and all applicable federal and state laws, regulations, rules, and policies related to the implementation of such requirement. In the manner and frequency directed by EOHHS, the Contractor shall submit reports relating to this **Section 10.1.A.6**.

Notwithstanding the generality of the foregoing, the Contractor shall, in accordance with 42 CFR 438.6(c)(5)(vi), for payments for primary care services in calendar years 2013 and 2014 furnished to Enrollees under 42 CFR Part 447, subpart G:

1. Make payments to those specified physicians (whether directly or through a capitated arrangement) at least equal to the amounts set forth and required under 42 CFR Part 447, subpart G; and

2. Provide documentation to EOHHS, sufficient to enable EOHHS and CMS to ensure that provider payments increase as required by **subsection 1**.

Section 3.3 Compliance with Federal BBA Requirements

A. Subcapitation and Physician Incentive Plans

1. The Contractor may, subject to EOHHS's prior review and approval and all applicable state and federal rules and regulations, including but not limited to the provisions of 42 CFR 438.3(i), 42 CFR 422.208 and 422.210, negotiate and enter into arrangements to pay Network Providers on a subcapitated basis or operate a physician incentive plan.

2. The Contractor shall not engage in risk-sharing payment methodologies (i.e., non-Fee-for-Service arrangements) with its Network Providers without first submitting the proposed payment methodology to EOHHS for review and approval. Any Network Provider payment methodology that the Contractor proposes to EOHHS must satisfy the following minimum requirements:

   a. Balance cost incentives with access and quality incentives; and

b. Ensure that those Network Providers for whom the Contractor proposes to use such payment methodologies are able to demonstrate the managerial, operational and financial capability to manage the proposed risk arrangement.

3. The Contractor shall comply, and shall ensure that its subcontractors comply, with all applicable requirements governing subcapitation arrangements and physician incentive plans. In accordance with the requirements of 42 U.S.C. § 1396b(m)(2)(A)(x), 42 CFR Parts 417, 422, 434, 438, and 1003, the Contractor shall ensure that:

   a. No specific payment is made directly or indirectly to a Provider, physician, or physician group as an inducement to reduce or limit Medically Necessary services furnished to a Covered Individual; and

   b. The applicable stop-loss protection, Covered Individual survey, and disclosure requirements of 42 CFR Part 417 are met.

B. Emergency and Post-stabilization Care Service Coverage

1. The Contractor must cover and pay for Behavioral Health Covered Services for treatment of a Behavioral Health Emergency medical condition in accordance with 42 CFR 438.114 and M.G.L. c. 118E, § 17A.

2. The Contractor must cover and pay for Behavioral Health Covered Services for treatment of a Behavioral Health Emergency medical condition regardless of whether the Provider that furnishes the services has a contract with the Contractor.

3. The Contractor may not deny payment for Behavioral Health Covered Services for treatment of a Behavioral Health Emergency medical condition, including cases in which the absence of immediate medical attention would not have:

   a. placed the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;

   b. resulted in serious impairment to bodily functions; or

   c. resulted in serious dysfunction of any bodily organ or part.

4. The Contractor may not deny payment for Behavioral Health Covered Services for treatment of a Behavioral Health Emergency medical condition if a representative of the Contractor instructed the Covered Individual to seek Emergency services.

5. The Contractor may not limit what constitutes a Behavioral Health Emergency medical condition on the basis of lists of diagnoses or symptoms;

6. The Contractor may require Network Providers to notify the Covered Individual's PCC of the Covered Individual's screening and treatment, but may not refuse to cover MassHealth Behavioral Health Covered Services for treatment of a Behavioral Health Emergency medical condition based on their failure to do so;

7. A Covered Individual who has an Emergency medical condition may not be held liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the patient;

8. The attending emergency physician, or the Provider actually treating the Covered Individual, is responsible for transfer or discharge, and that determination is binding on the Contractor, if such transfer or discharge order:

   a. is consistent with generally accepted principles of professional medical practice; and

   b. is a covered benefit under the Contract.

9. The Contractor shall cover and pay for Post-stabilization Care Services that are MassHealth Covered Services in accordance with 42 CFR 438.114, 42 CFR 422.113(c), and M.G.L. c. 118E, § 17A.

C. Non-Network Emergency Service Coverage

The Contractor shall pay a non-Network Provider of Emergency Services an amount equal to the amount allowed under the state's Fee-for-Service rates less any payments for indirect costs of medical education and direct costs of graduate medical education. The Contractor shall ensure that the Covered Individual is not balance billed for the difference, if any, between such rate and the non-Network Provider's charges.

Section 3.4 ESP Services

A. ESP Policies and Procedures

For ESP Providers under contract with the Contractor, the Contractor shall:

1. Ensure that the ESP Providers set forth in **Appendix A-3** provide all ESP Services as set forth in **Appendix A-1**, consistent with the Contractor's performance specifications;

2. Ensure that Covered Individuals and Uninsured Individuals and persons covered by Medicare only are provided with unrestricted access to ESP Services, including Adult and Youth Mobile Crisis Intervention, immediately in response to a Behavioral Health crisis, on a 24-hour basis, seven days a week;

3. Ensure that the response time for face-to-face evaluations by ESPs does not exceed one hour from notification of the need, or, in the case of referrals from hospital emergency departments, from the notification of readiness for evaluation by the ESP;

4. Ensure the 24-hour-a-day access or availability of clinicians in the ESPs who have special training or experience in providing Behavioral Health services for:

    a. the full array of Behavioral Health conditions;

    b. children and adolescents (clinicians providing ESP Services to children and adolescents must be child-trained clinicians who meet Youth Mobile Crisis Intervention competency standards as defined in the Contractor's performance specifications);

    c. individuals with substance abuse disorders or a Dual Diagnosis;

    d. individuals with intellectual disabilities, developmental disabilities, or autism spectrum disorders; and

    e. the elderly.

5. Establish policies and procedures to ensure that ESPs provide Crisis Assessment and Intervention Services to all Covered Individuals prior to hospital admissions for Inpatient Mental Health Services to ensure that the Covered Individuals have been evaluated for diversion or referral to the least restrictive appropriate treatment setting. The Contractor's policies and procedures shall include:

    a. requiring that the ESP located in the geographic area where the individual is physically located perform the Crisis Assessment and Intervention;

    b. not requiring ESPs to obtain prior authorization to provide a Crisis Intervention and Assessment;

    c. developing Contract standards, reviewed and approved by EOHHS annually, and monitoring the ESP Provider network's performance on diversion and inpatient admission rates, timeliness of assessment, and rate of community-based Emergency Encounters by establishing minimum standards and target/goals for diversionary rates; and

    d. authorizing Medically Necessary BH Covered Services following a Crisis Assessment and Intervention.

6. Require and ensure that ESPs have arrangements, agreements or procedures to coordinate care with Network Providers, DMH area and site offices, DCF regional offices and DYS regional offices in the geographic area they serve;

7. For children and adolescents, have in place the following the ESP policies and procedures:

    a. Ensure that each ESP has policies and procedures that include Youth Mobile Crisis Intervention Service;

b. Ensure that each ESP has arrangements with the major providers of children's residential services in the DMH, DCF, and DYS systems, as identified by the relevant agency's director for the applicable ESP service area; and

c. Require ESPs to arrange for Specialing Services, when children or adolescents are awaiting admission to a 24-hour Level of Care in a hospital Emergency Department setting, if such services are Medically Necessary to ensure safety when a youth is at risk of harming self or others. Specialing Services are a professional service provided by appropriately credentialed staff. For payment purposes, the Contractor shall not treat such Specialing Services as an ESP Encounter. If an overnight stay is required while the provider is searching for an inpatient bed, the Contractor shall consider requests from the ESP or Mobile Crisis Intervention (MCI) Provider, in consultation with the ED, for authorization to board the Covered individual on a pediatric medical unit.

8. Require and ensure that ESPs make all reasonable attempts to work with local police to develop models of mutual response to Behavioral Health Emergencies when needed.

B. ESP Administrative Oversight

The Contractor shall coordinate the administration and management of the ESP services for the Contractor's contracted ESP Providers under guidance from DMH and EOHHS. In this role, the Contractor shall:

1. Ensure that all ESP Provider Agreements require ESPs to provide the services described in **Appendix A-1, Part III** to any individual who presents for such services in the following payer categories:

   a. MassHealth (PCC Plan; MassHealth MCOs; FFS),

   b. Commonwealth Care,

   c. Uninsured Individuals, and

   d. Medicare.

2. Facilitate annually, at minimum, six (6) in a 12-month Contract Year, or monthly if the Contract Year is less than 12 months, statewide meetings with Contractor-contracted ESP or MCI providers, and invite the participation of the DMH-operated ESP/MCI providers, to support consistency in service delivery.

3. Require ESPs to refer adult Uninsured Individuals and persons with Medicare-only to available beds in psychiatric units of general hospitals first, if beds in such hospitals are available and clinically appropriate, before referring them to psychiatric hospitals;

4. After a court clinician has conducted a psychiatric evaluation pursuant to M.G.L. c. 123 § 12(e), ensure that upon request of such court clinician:

    a. ESPs provide Crisis Assessment and Intervention Services to all Covered Individuals (including onsite mobile evaluations at the court).

    b. Identify to the court clinician appropriate diversions from inpatient hospitalization, and assist court clinicians to develop any plan to utilize such diversions. Nothing in this provision shall be construed as establishing a court clinician evaluation as a prerequisite to an onsite mobile evaluation at the court; and

    c. If the court orders the admission of an individual under M.G.L. c. 123 § 12(e), ESPs conduct a search for an available bed, making best efforts to locate such a bed for the individual by 4:00 p.m. on the day of the issuance of such commitment order. If a bed is not found by 4:00, the ESP will work with the court clinician to ensure appropriate disposition and transfer of the individual to a safe place outside of the court setting.

5. Adopt the existing Massachusetts Behavioral Health Access System, or develop and implement its own process that helps ESPs and hospital Emergency departments to search on-line for available Inpatient Mental Health Services Inpatient Substance Abuse Services, 24-hour Diversionary Services and CBHI Services.

    a. The system shall provide on-line web access on a 24-hour basis seven days a week.

    b. The Contractor shall ensure that the web-based system is updated at least once every eight hours for 24-hour services, and at least weekly for CBHI Services (Intensive Care Coordination, In-Home Behavioral Services, Therapeutic Mentoring, In-Home Therapy).

    c. The Contractor shall develop an annual report (with specifications subject to EOHHS review and prior approval) that tracks utilization of the Massachusetts Behavioral Health Access System and other data as agreed to by the parties.

6. Encounter Forms

The Contractor shall:

    a. Create an ESP Encounter form to report on ESP Services described in **Appendix A-1**;

    b. Require ESPs to complete and submit the electronic EOHHS-approved ESP Encounter form for each individual they serve; and

c. Work with EOHHS to transfer the records from the existing Encounter database, which includes the information contained in the ESP Encounter forms.

7. The Contractor shall continue the ESP Opioid Overdose Response Pilot Program to respond to substance use crises, specifically opioid overdoses that result in care in emergency departments. Payment shall be made pursuant to the terms set forth in **Appendix H-1** and subject to available funding. As part of the ESP Opioid Overdose Response Pilot Program:

   a. Three ESP teams shall hire Recovery Coaches.

   b. Eligible ESPs must respond to at least 2 emergency departments in their catchment area.

   c. The ESP's Recovery Coach will be on-site at an ED (primary ED) within the ESPs catchment area for a minimum of one 8 hour shift per day, 7 days per week.

   d. Shift selected will take into account data indicating which time periods experience the highest number of overdoses (e.g. late afternoon/evening).

   e. The ESPs Recovery Coach will mobile to another ED (secondary ED) within the ESPs catchment area as needed and if there is no current need for their service at the primary ED.

8. Recovery Coaches shall provide non-judgmental, non-clinical recovery support and shall:

   a. Be a member of the ESP team and provide only non-clinical support. Recovery Coaches shall not be used in a clinical capacity;

   b. Be peers, preferably, with lived addiction experience;

   c. Complete the Bureau of Substance Abuse Services (BSAS) Recovery Coach Academy or the Connecticut Community Addiction Recovery (CCAR) training prior to working with individuals in the ED and within one month of hire;

   d. Meet with the individuals who present in an ED and have received treatment for an overdose if the individual agrees;

   e. Obtain necessary releases of information signed by the individual in order to provide short term follow-up support;

   f. Provide education on overdose prevention and the use of naloxone to the individual and offer the individual an overdose prevention kit;

g. Provide short-term telephonic (or text) follow-up support and coaching and assist the individual into treatment or recovery support services if agreed upon by the individual;

h. Know the Substance Use Disorder (SUD) service system and be able to link the individual to treatment and recovery resources including but not limited to Acute Treatment Services (ATS), housing, benefits, and Narcan education.

i. Do a warm handoff of the individual to appropriate treatment or recovery services including a Community Support Program (CSP) to encourage continued treatment and recovery support in the community; and

j. Provide education to patients and, with patient consent, family members on the recovery process.

9. Recovery Coach Qualifications: Recovery Coach candidates must:

a. Have a high school diploma.

b. Be 18 years or older.

c. Demonstrate an understanding of community resources.

d. Demonstrate an understanding and belief in the recovery process and Recovery Oriented Systems of Care model, as defined by the Substance Abuse and Mental Health Services Administration.

e. Have a valid driver's license.

f. Demonstrate knowledge of basic crisis intervention, motivational interviewing, and case management techniques.

g. Demonstrate an ability to act as an advocate for the needs of the patient.

10. The ESP Opioid Overdose Response Pilot Program shall:

a. Orient primary and secondary ED to the ESP Opioid Overdose Response Pilot Program and develop mutually agreed upon protocols to support the activities of the pilot project;

b. Establish working relationship with CSPs in the area and establish protocols with local CSPs that support the success of this pilot program;

c. Keep agreed upon data and submit reports determined by the Contractor, EOHHS and BSAS;

d. Meet regularly with the Contractor, EOHHS and BSAS to evaluate services, refine the pilot program, and make changes as necessary to best meet the needs of participants;

e. Participate in a learning collaborative sponsored by EOHHS and BSAS to share information and evaluate the project; and

f. The Recovery coach will develop a follow up plan after meeting with the patient and will communicate effectively and respectfully with hospital ED staff to obtain information regarding the patient for purposes of developing a follow up plan.

11. In Contract Year 6A, at the direction of EOHHS, the Contractor shall execute the public service campaign to increase public awareness of the Emergency Services Program and the Mobile Crisis Intervention program developed during Contract Year 5.

12. In Contract Year 6A, the Contractor shall continue the pilot program for improving ESP/MCI services for Covered Individuals who are deaf or hard of hearing as directed by EOHHS, subject to available funding.

Section 3.5 Children's Behavioral Health Initiative (CBHI)

A. CBHI Training and Quality Improvement

1. The Contractor shall, as directed by EOHHS, take all steps and perform all activities necessary to improve the CBHI, which shall include, without limitation, participation in meetings and workgroups, including joint workgroups with all MassHealth Managed Care payers to develop coordinated network management and quality improvement strategies for all payers on these services and other tasks as directed.

2. With EOHHS approval, the Contractor may secure consultant resources to support ongoing implementation, training and quality improvement of CBHI Services. Such consultant resources may recommend network management, Utilization Management and Quality Management strategies or identify strategies to improve the quality of Network Provider organizations in their delivery of CBHI Services. Consultants may also provide trainings or coaching to Providers of CBHI Services, including to providers within the networks of MassHealth Managed Care entities who provide CBHI Services, or perform outreach and education to prospective families in need of CBHI Services.

B. Use of the CANS Tool

The Contractor shall ensure the continued use of the CANS Tool by all Behavioral Health Service providers that are required to use it (see **Section 3.1.C.6**), as directed by EOHHS. The Contractor shall:

1. Propose for EOHHS approval rates for initial Behavioral Health Clinical Assessments using the CANS Tool for Covered Individuals under the age of 21; Contractor shall allow Network Providers to bill two units of this service to allow for the additional time required to complete this type of evaluation.

2. Ensure that it pays only Network Providers whose servicing clinicians are certified in the CANS Tool for providing Behavioral Health Clinical Assessments using the CANS Tool;

3. Ensure that Providers of Behavioral Health Clinical Assessments using the CANS Tool bill for these assessments. The review and updating of the CANS assessment that is required at a minimum every 90 days for Covered Individuals in ongoing individual, group, or family therapy is part of the treatment planning and documentation, and as such, is not a separately billable service.

4. Ensure that its customer services representatives who respond to questions from Network Providers are informed about the requirements and process for applicable Network Providers to become trained and certified in administering the CANS Tool and can respond to questions from Network Providers about these requirements and processes. The Contractor shall provide training to its newly hired and existing customer services representatives about when, where and how Network Providers obtain CANS training and certification, and shall provide refresher trainings as directed by EOHHS and as the Contractor determines is necessary.

5. Ensure that its customer services representatives who are assigned to respond to inquiries from Covered Individuals are informed about the use of the CANS and other CBHI Services, and can respond to Covered Individuals' questions about them. The Contractor shall provide training to its newly hired and existing customer services representatives about the CANS Tool and how it is generally used in Behavioral Health Clinical Assessments and during the Discharge Planning process from Inpatient Psychiatric Hospitalizations, Intensive Community-Based Acute Treatment Services, and Community-Based Acute Treatment Services, and Transitional Care Units.

6. As directed by EOHHS, ensure that Covered Individual materials, including but not limited to the Handbook for Covered Individuals, describe the CANS Tool and its use in Behavioral Health Clinical Assessments and during the Discharge Planning process from Inpatient Psychiatric Hospitalizations, Intensive Community-Based Acute Treatment Services, and Community-Based Acute Treatment Services for Covered Individuals under the age of 21.

7. As directed by EOHHS, ensure that appropriate Network Provider materials exist to describe the CANS Tool, the requirements and process for CANS Tool training and certification, and the CANS IT System.

8. Be able to access and use the CANS IT System and data contained therein to integrate with clinical data, and use in reporting as directed by EOHHS.

9. Participate in any testing or development processes necessary for EOHHS to develop and refine the CANS IT System.

C. CBHI Service Rates

1. As directed by EOHHS, the Contractor shall contract by the Service Start Date with the existing network of Providers to provide the following CBHI Services, when Medically Necessary, to Covered Individuals in the Coverage Types specified, unless otherwise directed by EOHHS. For each of these services the Contractor shall establish Network Provider rates at or above the rate floor set by EOHHS and shall use procedure codes as directed by EOHHS to provide payment for such services.

    a. Intensive Care Coordination: to Covered Individuals under age 21 who are in MassHealth Standard and CommonHealth;

    b. Family Support and Training Services: to Covered Individuals under age 21 who are in MassHealth Standard and CommonHealth;

    c. In-Home Behavioral Services (including Behavior Management Therapy and Behavior Management Monitoring) to Covered Individuals under age 21 who are in MassHealth Standard and CommonHealth;

    d. Therapeutic Mentoring Services: to Covered Individuals under age 21 who are in MassHealth Standard and CommonHealth; and

    e. In-Home Therapy Services (including Therapeutic Clinical Intervention and Ongoing Therapeutic Training and Support) to all Covered Individuals under age 21.

2. As directed by EOHHS, the Contractor shall contract with ESP Providers to provide Youth Mobile Crisis Intervention Services, when Medically Necessary, to all Covered Individuals under the age of 21. For this service, the Contractor shall establish Network Provider rates at or above the rate floor set by EOHHS and shall use procedure codes as directed by EOHHS to provide payment for such services.

D. CBHI Service Authorization

1. The Contractor shall inform EOHHS in writing of its authorization procedures for Behavioral Health Covered Services for Covered Individuals under 21 who are receiving CBHI Services, and of any changes to such authorization procedures prior to their implementation. The Contractor shall assist Network Providers in learning how to utilize Contractor's authorization procedures for CBHI Services. The Contractor shall monitor its authorization procedures to ensure that the procedures provide for timely access to services. In the event that Contractor's authorization procedures for CBHI Services result in delays or barriers to accessing Medically Necessary BH Covered Services, the Contractor shall modify

such authorization procedures. The Contractor shall coordinate with other MassHealth payers to publish a single document that describes the authorization procedures for all MassHealth payers for these services.

2. The Contractor shall ensure that the authorization procedures established for Intensive Care Coordination (ICC) and Family Support and Training (FS and T) allow for at least the first 28 days of services to be provided without prior approval. The Contractor may establish notification or registration procedures during the first 28 days of ICC.

3. The Contractor shall ensure that its authorization procedures comply with all provisions of **Section 4.2** of the Contract and, in addition, that all authorization approvals for ICC and FS and T are provided telephonically or electronically.

E. Management of CBHI Service Provision

The Contractor shall:

1. Ensure that Network Providers of CBHI Services provide each such service in accordance with all EOHHS-approved CBHI Services performance specifications and CBHI Services Medical Necessity criteria.

2. Ensure that appropriate members of Providers' staffs participate in CBHI training, coaching, and mentoring as approved by EOHHS for CBHI training. The Contractor shall ensure that such members of Providers' staffs complete CBHI training, and utilize their new skills in service delivery. If the Provider is not participating in CBHI training, the Contractor shall engage in Provider Network management activities to increase training.

3. Develop operational manuals for selected CBHI services, including but not limited to Mobile Crisis Intervention.

4. Perform quality assurance and training activities for CBHI services as directed by EOHHS. These activities shall include providers within the networks of MassHealth Managed Care entities who provide CBHI Services.

5. Work collaboratively with all MassHealth payers to manage the network of all CBHI Service providers, including the Community Service Agencies (CSAs) that provide ICC and Family Support and Training, as well as the providers of In-Home Therapy, In-Home Behavioral Services and Therapeutic Mentoring, by:

    a. Coordinating regional and statewide meetings for all CBHI service types that include all MassHealth payers, at a frequency agreed to annually by EOHHS. Contractor is responsible for coordination and administrative costs associated with such meetings; and

    b. Coordinating with all MassHealth payers to provide joint technical assistance and network management to specific CBHI providers as

necessary to address quality improvement and ensure full program implementation.

6. Manage the existing Community Service Agencies that are contracted to deliver ICC and FS and T services. Any changes to the CSA network must be approved in advance by EOHHS.

7. Maintain, revising as necessary and submitting to EOHHS for approval whenever revised, the Intensive Care Coordination and Family Support and Training Operations Manual (ICC Ops Manual). The Contractor shall ensure that the ICC Ops Manual conforms to the EOHHS-approved performance specifications for ICC and FS and T. The Contractor shall distribute the EOHHS-approved ICC Ops Manual to all CSAs in the Network.

8. Ensure that CSAs provide ICC and FS and T services according to both the EOHHS-approved performance specifications and the EOHHS-approved ICC Ops Manual. In the event that there are discrepancies between the two documents, the performance specifications shall control and the Contractor shall notify EOHHS of any discrepancies and submit a correction for EOHHS approval.

9. Assign a point of contact for management for each CSA and identify such individual to EOHHS prior to the Service Start Date. Responsibilities shall include, but are not limited to, providing technical assistance to CSAs to answer questions regarding authorization of services and assisting CSAs in facilitating and ensuring that Network Providers engaged in a Covered Individual's treatment participate in ICC Individual Care Plan meetings.

10. Require CSAs to track and report monthly to the Contractor on ICCs and referrals to ICC services according to the template provided in the ICC Ops Manual. The reported data shall include de-identified information for all MassHealth Members using these services, regardless of which plan they are in.

11. Require CSAs to provide the Contractor with EOHHS-required data for a particular month in sufficient time to submit such reports to EOHHS by the 30th of the following month (or by the next business day after the 30th if the 30th falls on a weekend day).

12. Ensure that each CSA coordinates and maintains a local Systems of Care committee to support the CSA's efforts to establish and sustain collaborative partnerships among families and community stakeholders in its geographic area. The Contractor shall assign a staff person to oversee the local Systems of Care committees; the staff person's responsibilities shall include but are not limited to:

    a. attending meetings of the Systems of Care committees on a quarterly basis;

    b. monitoring System of Care committees' activities and issues on a monthly basis through review of meeting minutes; and

c. conducting network management meetings with the CSAs.

13. In collaboration with, and as further directed by EOHHS, develop a plan to ensure that the quality of ICC and FS and T services is measured using tools that are consistent with national Wraparound standards, such as the Wraparound Fidelity Index tool and the Team Observation measure ("fidelity tools"), and provide CSAs with such fidelity tools at no cost to the CSAs. In addition, use tools such as the MA DRM (Document Review Measure) to review medical files in both ICC and IHT.

14. In collaboration with and as further directed by EOHHS, develop a process to monitor the quality of services using tools such as the MA DRM or another tool approved by EOHHS to evaluate the adequacy of medical record keeping for both ICC and In-Home Therapy Services (IHT). The Contractor shall apply the approved quality-assessing tool at least annually on a mix of ICC and IHT services provided across all of the Contractor's regions. The Contractor shall use the approved quality assessing tool(s) to evaluate at least 10% of the Covered Individuals who have received ICC or IHT during the applicable Contract Year, except that the Contractor shall not be required to review more than 25 Covered Individuals medical files per region per Contract Year.

F. CBHI Access Reporting

The Contractor shall ensure that the web-based Behavioral Health Service Access System or the Contractor's equivalent system, as referenced in **Section 3.4.A.12** above, is updated at least once a week for CBHI Services (ICC, IHBS, TM and IHT) to show access and availability.

1. CBHI Service reporting must be available to the public on the system.

2. CBHI access and availability reports must be reported monthly from this system.

Section 3.6 Special Service Initiatives

During the term of the Contract, the Contractor shall propose for EOHHS's review and approval special new services and programs for Covered Individuals for which the Contractor may need to adapt its Provider Network. The Contractor shall perform a cost-benefit analysis for any new service it proposes to develop, as directed by EOHHS, including whether the proposed services would have an impact on Base PMPM Capitation Rates or the Administrative Component of the MassHealth Capitation Payment.

The Contractor shall implement new special services and programs as approved by EOHHS.

Section 3.7 Network Administration

A. Network Provider Database

The Contractor shall maintain:

1. An up-to-date database that contains, at a minimum, the following information on Network Providers:

    a. Network Provider name;

    b. contracted services;

    c. site address(es) (street address, town, ZIP code, region of the state);

    d. site telephone numbers;

    e. site hours of operation;

    f. Emergency/after-hours provisions;

    g. professional qualifications and licensing;

    h. areas of specialty relating to Behavioral Health conditions and MassHealth populations listed in **Sections 3.1.B.6** and **3.1.B.7** above;

    i. cultural and linguistic capabilities;

    j. malpractice insurance coverage and malpractice history;

    k. credentialing status;

    l. status as women- or minority-owned or -controlled organization; and

    m. Provider e-mail address.

2. A list of Network Providers, sorted by type of service and by Network Providers' capability to communicate with Covered Individuals in their primary languages. This list shall be available to the Contractor's clinical staff at all times, and available to Network Providers, PCC Plan Enrollees, EOHHS, DMH and other interested parties upon their request and at no charge.

B. Network Provider Policy and Procedure Manual

The Contractor shall:

1. Prior to the Service Start Date, develop and submit to EOHHS for approval a Provider policy and procedure manual, and, following EOHHS approval, publish the manual on Contractor's website and electronically distribute a hyperlink to the manual to all Network Providers. At a Network Provider's request, also electronically distribute the manual to the Providers. The manual shall include, at a minimum, information on:

    a. The Contract, the Contractor, and program priorities;

b. How to verify a Covered Individual's eligibility for MassHealth Behavioral Health Covered Services;

c. Network Provider Credentialing Criteria;

d. Provider Network management;

e. Procedures for service authorization, concurrent review, extensions of lengths of stay, and retrospective reviews for all BH Covered Services;

f. Clinical Criteria for admission, continued stay, and discharge for each BH Covered Service;

g. Administrative and billing instructions, including a list of procedure codes, units and payment rates;

h. How to appeal payment and service denial decisions;

i. Reporting requirements for Serious Reportable Events and Reportable Adverse Incidents; and

j. Performance specifications for each Behavioral Health Covered Service.

2. As necessary, modify or supplement the policy and procedure manual by distributing periodic notices to Network Providers;

3. Review the manual at least biannually and amend it, if necessary, in consultation with EOHHS; and

4. Redistribute the amended portions of the manual to Network Providers.

C. Performance Specifications

The Contractor shall:

1. Require all Network Providers to accept the Contractor's performance specifications that have been approved by EOHHS;

2. Develop and maintain performance specifications for Network Providers and develop performance specifications for new BH Covered Services; and

3. At least annually, review and update as necessary the performance specifications including any new performance specifications that have been developed, and submit any proposed changes to EOHHS for prior review and approval.

D. Network Provider Protocols

1. The Contractor shall develop, maintain and utilize EOHHS-approved Network Provider protocols. The protocols must address the following:

a. How the Contractor intends to ensure, for a particular Covered Individual's needs, that a qualified and clinically appropriate Network or non-Network Provider:

1) is available to provide the particular BH Covered Service;

2) is accessible within the access standards required by the Contract, taking into account the availability of public transportation;

3) is accessible to individuals with physical disabilities, if appropriate (see **Sections 3.1.B.7** and **3.1.G** and **H**); and

4) has the ability, either directly or through a skilled medical interpreter, to communicate with the Covered Individual in his/her primary language (see **Sections 3.1.B.7** and **3.1.G** and **H**).

b. How the Contractor intends to facilitate communication between Network Providers and the Contractor, and between Network Providers and PCCs, in a manner that engages the Providers and overcomes barriers to communication.

2. The Contractor shall require Network Providers to submit to the Contractor a written report of all Reportable Adverse Incidents, using the form found in **Appendix F** or other similar form acceptable to EOHHS, according to the following guidelines:

a. Network Providers of 24-hour BH Covered Services shall, within 24 hours of their occurrence, report to the Contractor all Reportable Adverse Incidents involving a Covered Individual.

b. Network Providers of non-24-hour BH Covered Services shall, within 24 hours of their occurrence, report to the Contractor all Reportable Adverse Incidents involving a Covered Individual.

c. The Contractor shall require Network Providers to coordinate MassHealth Covered Services with the Covered Individual's care manager where the Covered Individuals are receiving Care Management services through the Contractor and/or the case manager when the Covered Individual is receiving case management through a state agency (e.g., DMH, DCF, DDS, and DYS).

3. The Contractor shall require Network Providers to comply with DPH's regulations barring payment for services related to a Serious Reportable Event.

4. The Contractor shall require Network Providers to comply with all of the following Massachusetts regulations and DMH policy memorandums:

a. DMH Policy 14-01 of September 29, 2014, on informed consent, found at http://www.mass.gov/eohhs/docs/dmh/policy/policy-14-01.pdf, or any successive policy or regulation;

b. DMH regulations on human rights and restraint & seclusion at 104 CMR 27 and 104 CMR 28, or any successive regulation; and

c. M.G.L. c. 123, § 23.

5. The Contractor shall require its Network Providers of Community-Based Acute Treatment Services and Transitional Care Units to comply with Department of Early Education and Care (DEEC) standards for the licensure or approval of residential programs serving Members under 18, as set forth in 102 CMR 3.00, et seq. For those CBAT and TCU Providers that are not located in a site licensed by DEEC, the Contractor shall ensure that these programs are located in a facility that is licensed by DMH and/or DPH.

6. The Contractor shall require its Network Providers to inform Covered Individuals of their rights under DMH regulations concerning human rights**.**

7. The Contractor shall comply with EOHHS protocols to ensure access to Behavioral Health Covered Services and tracking in the EOHHS Data Warehouse and MMIS systems by adhering to the following requirements:

a. Maintain a unique Network Provider identification number for each Network Provider, as described in **Section 9.3.A**.

b. Submit to EOHHS's Customer Services vendor's Provider Enrollment and Credentialing Department by the Service Start Date a list of all Network Providers who are both MassHealth Providers and Network Providers (dual Providers). The Contractor shall inform EOHHS's Enrollment Broker upon enrolling or disenrolling any dual Provider from its Provider Network.

c. Inform EOHHS's Customer Services vendor's Provider Enrollment and Credentialing Department immediately upon enrolling any Provider who is not also a MassHealth Provider in its Provider Network. Such notification shall include the following data elements:

1) Network Provider name, address and telephone number;

2) Legal entity's name, address and phone number of the practice (i.e., "doing business as," or d/b/a, name), if different from the above;

3) Network Provider or legal entity's tax identification number; and

4) Effective date of the Network Provider's enrollment in the Provider Network.

The Contractor shall submit to the Customer Services vendor all updates to the list or its data elements whenever they occur.

E. Network Provider Administrative Education and Training

The Contractor shall develop an education and training plan that provides appropriate information and learning sessions for Network Providers and their staff. Such education and training plan shall be submitted to EOHHS for approval and shall include, at a minimum:

1. A schedule for the development and release of educational materials;
2. A schedule for the development and timing of training sessions;
3. Regional training opportunities for Network Providers' clinical and administrative staff; and
4. Proposed education and training topics, including but not limited to:
    a. new changes to policies and procedure prior to their implementation;
    b. basics of MassHealth coverage and payment requirements; and
    c. quality improvement efforts and the Network Provider's role, include linkages across Behavioral Health and physical health services.

F. Claims Handling

The Contractor shall:

1. Unless otherwise approved by MassHealth, operate from the Contractor's principal Massachusetts place of business a Claims review, processing and payment system for Network Providers that furnish BH Covered Services;
2. Pay all Clean Claims for all Behavioral Health Covered Services authorized by the Contractor and furnished to Covered Individuals and Uninsured Individuals, including persons covered by Medicare only, within one month of receipt from Network Providers, unless the Contractor and Network Providers agree to an alternate payment schedule;
3. Prior to the Service Start Date, develop a procedure for denying Claims that includes a coding system for Claim denials and Claims that are pending, and incorporates the following policies:
    a. Denial of reimbursement for Claims for any services that were not authorized by the Contractor, where service authorization is required;

b. Denial of reimbursement for Claims that are not submitted in compliance with the Contractor's administrative and billing submission requirements;

c. Denial of Claims for BH Covered Services provided to individuals who are neither Covered Individuals nor Uninsured Individuals or persons covered by Medicare only who have received ESP Services;

d. Denial of Claims for Covered Individuals when such services are paid for by Medicare or other health insurance; and

e. Where a Claim review results in a denial, preparation and mailing of the Claim denial to the Network Provider within two months of receipt of the Claim;

4. Develop an Internal Appeal process for reviewing and resolving denied Claims and payment disputes, and implement it as of the Service Start Date. The Internal Appeal process shall include the following:

a. Written policies and procedures for the filing, receipt, prompt resolution and documentation of all Internal Appeals brought by a Network Provider;

b. A means for assessing and categorizing the denied Claims and payment disputes;

c. Time frames for resolution and response by the Contractor; and

d. A definitive statement that Network Providers do not have a right to review or appeal a denied Claim directly to EOHHS.

G. Retrospective Utilization and Review of Network Providers

The Contractor shall:

1. Develop a description of its approach to retrospective utilization review of Network Providers and submit it to EOHHS for approval no later than six months after the Service Start Date. Such approach shall include a system to identify utilization patterns of all Network Providers by significant data elements and established outlier criteria for both Inpatient and Outpatient Services.

2. Conduct retrospective and peer reviews of a sample of Network Providers to ensure that the services furnished by Network Providers were provided to Covered Individuals, were appropriate and Medically Necessary, and were authorized and billed in accordance with the Contractor's requirements.

H. Program Integrity, Fraud and Abuse Prevention, Detection and Reporting

1. General Provisions

The Contractor shall:

a. Comply with all applicable federal and state program integrity laws and regulations regarding fraud, waste and abuse, including, but not limited to, the Social Security Act and 42 CFR Parts 438, 455, and 456.

b. Have adequate Massachusetts-based staffing and resources to assist the Contractor in preventing and detecting potential fraud, waste, and abuse. All of the Contractor's employees that work, in whole or in part, on program integrity activities shall be familiar with federal and state regulations (including those promulgated by MassHealth) governing fraud, waste, and abuse.

c. Develop and implement written internal controls, policies, and procedures in place that are designed to prevent, detect, reduce, investigate, correct, and report known or suspected fraud, waste, and abuse.

d. In accordance with Section 6032 of the federal Deficit Reduction Act of 2005, make available written fraud and abuse policies to all of its employees. If the Contractor has an employee handbook, the Contractor shall include specific information about Section 6032 of the Deficit Reduction Act of 2005, the Contractor's fraud and abuse policies, and the rights of employees to be protected as whistleblowers.

e. Meet with EOHHS at least quarterly to discuss fraud, waste and abuse, as well as audits and overpayments.

2. Program Integrity Requirements – Internal Controls

In accordance with 42 CFR 438.608, the Contractor shall have administrative and management arrangements or procedures, including a mandatory compliance plan, which are designed to guard against fraud and abuse. The arrangements or procedures must include the following:

a. Written policies, procedures, and standards of conduct that articulate the Contractor's commitment to comply with all applicable requirements and standards under the Contract, and all applicable federal and state requirements;

b. The designation of a compliance officer who is responsible for developing and implementing policies, procedures, and practices designed to ensure compliance with the requirements of this Contract and who reports directly to the Contractor's Chief Executive Officer and its board of directors;

c. The establishment of a regulatory compliance committee on the Contractor's board of directors and at the senior management level charged with overseeing the organization's compliance program and its compliance with the requirements under this Contract;

d. Adequate Massachusetts-based staffing and resources to investigate incidents and develop and implement plans to assist the Contractor in preventing and detecting potential fraud, waste, and abuse activities;

e. A system for training and educating the Contractor's compliance officer, senior management, and employees regarding applicable federal and state law and regulations, and the requirements under this Contract;;

f. Effective lines of communication between the compliance officer and the Contractor's employees;

g. Enforcement of standards through well-publicized disciplinary guidelines;

h. Establishment and implementation of a system with dedicated staff for:

1) routine internal monitoring and auditing of compliance risks;

2) prompt response to compliance problems as identified in the course of self-evaluation and audits;

3) correction of such problems promptly and thoroughly (and, if necessary, coordination with law enforcement agencies) to reduce the potential for recurrence; and

4) ongoing compliance with the requirements under this Contract.

i. Communication of suspected violations of state and federal law to EOHHS, consistent with the requirements of this section.

3. Provider and Covered Individual Fraud and Abuse Prevention, Detection and Reporting

The Contractor shall:

a. Develop and maintain a comprehensive internal fraud and abuse program to detect and prevent fraud and abuse by Network Providers and Covered Individuals. At a minimum, this program shall:

1) Require the reporting of suspected and confirmed fraud, waste, and abuse in accordance with this Contract;

2) Require a risk assessment of the Contractor's various fraud, waste, and abuse and program integrity processes that, among other things, shall identify the Contractor's three most vulnerable areas, and an outline of action plans to mitigate such risks. The Contractor shall submit this risk assessment to EOHHS on a quarterly basis. The Contractor shall also submit this risk assessment at EOHHS's request and immediately after identifying

a program integrity-related issue, including those that are financial-related (such as overpayment, repayment and fines). If submitting a risk assessment in response to a program integrity-related issue, the Contractor shall also describe the issue; describe its methods for educating its employees regarding federal and state laws and regulations related to Medicaid program integrity and the prevention of fraud, abuse, and waste; and provide assurances that all of its officers, directors, managers and employees know and understand the provisions of the Contractor's compliance and fraud, waste, and abuse plans;

3) Outline activities for:

   a) educating Providers regarding federal and state laws and regulations related to Medicaid program integrity and the prevention of fraud, waste, and abuse, and

   b) identifying and educating targeted Providers with patterns of incorrect billing practices or overpayments;

4) Contain procedures designed to prevent and detect fraud, waste, and abuse in the administration and delivery of services under this Contract; and

5) Include a description of the specific controls in place for prevention and detection of potential or suspected fraud, waste, and abuse, such as:

   a) A list of automated pre-payment claims edits;

   b) A list of automated post-payment claims edits;

   c) A description of desk audits performed on post-processing review of claims;

   d) A list of reports of provider profiling and credentialing used to aid program and payment integrity reviews;

   e) A list of surveillance and/or utilization management protocols used to safeguard against unnecessary or inappropriate use of Medicaid services;

   f) A list of provisions in the subcontractor and provider agreements that ensure the integrity of provider credentials;

b. In accordance with all other Contract requirements, report to EOHHS, within two business days, all overpayments identified and/or recovered, specifying those overpayments attributable to potential fraud;

c. Report promptly to EOHHS, in accordance with all other Contract requirements, when it learns or receives information about an Covered Individual's circumstances that may affect the Covered Individual's MassHealth eligibility, including, but not limited to, a change in the Covered Individual's residence or the Covered Individual's death;

d. Report promptly to EOHHS, and in any event within two business days, when it receives information about a Provider's circumstances that may affect the Provider's ability to participate in the Contractor's network or in MassHealth;

e. Verify, on a regular basis and in accordance with other Contract requirements, through sampling, whether services that have been represented to have been delivered by Providers were received by Covered Individuals;

f. Provide employees, subcontractors, and agents detailed information about the False Claims Act and other federal and state laws described in section 1902(a)(68) of the Social Security Act, including whistleblower protections;

g. In accordance with all other Contract requirements, report within two business days to EOHHS, or, in accordance with EOHHS policies, directly to the MFD, any potential or confirmed fraud, waste, or abuse in connection with the services rendered under this Contract;

h. Pursuant to 42 CFR 455.23, and in accordance with all other Contract requirements and EOHHS policies, suspend payments to Providers for which EOHHS determines there is a credible allegation of fraud;

i. In accordance with M.G.L. c. 12, § 5J, not discriminate against an employee for reporting a fraudulent activity or for cooperating in any government or law enforcement authority's investigation or prosecution;

j. Upon a complaint of fraud or abuse from any source or upon identifying any questionable practices, report the matter in writing to EOHHS within two business days;

k. First notify EOHHS and receive its approval prior to initiating contact with a Provider suspected of Fraud about the suspected activity;

l. Make diligent efforts to recover improper payments or funds misspent due to fraudulent or abusive actions by the Contractor, or its parent organization, its Providers, or its subcontractors;

m. Require Network Providers to implement timely corrective actions approved by EOHHS or terminate Provider Agreements, as appropriate;

n. In accordance with **Appendix E-1,** submit, on a quarterly basis, a fraud and abuse report, as well as ad hoc reports as needed or as requested by EOHHS, ;

o. Have the CEO, CFO, or compliance officer certify in writing on an annual basis to EOHHS, using the template in **Appendix E-3**, that after a diligent inquiry, to the best of his/her knowledge and belief, the Contractor is in compliance with **Section 3.7.H** of this Contract and has not been made aware of any instances of fraud and abuse in any program covered by this Contract, other than those that have been reported by the Contractor in writing to EOHHS;

p. Notify EOHHS within two business days after contact by the MFD, the Bureau of Special Investigations (BSI) or any other investigative authorities conducting fraud, waste, and abuse investigations, unless specifically directed by the investigative authorities not to notify EOHHS. The Contractor, and where applicable any subcontractors or Material Subcontractors, shall cooperate fully with the MFD, BSI and other agencies that conduct investigations; full cooperation includes, but is not limited to, timely exchange of information and strategies for addressing fraud, waste, and abuse, as well as allowing prompt direct access to information, free copies of documents, and other available information related to program violations, while maintaining the confidentiality of any investigation. The Contractor shall make knowledgeable employees available at no charge to support any investigation, court, or administrative proceeding.

q. Notify EOHHS within one business day of any voluntary Provider disclosures resulting in receipt of overpayments in excess of $25,000, even if there is no suspicion of fraudulent activity.

r. Report annually to EOHHS, in a form and format specified by EOHHS, on the Contractor's recoveries of overpayments in accordance with 42 CFR 438.608.

4. Employee Education about False Claims Laws

a. The Contractor shall comply with all federal requirements for employee education about false claims laws under 42 U.S.C. § 1396a(a)(68) if the Contractor received or made Medicaid payments in the amount of at least $5 million during the prior federal fiscal year.

b. If the Contractor is subject to such federal requirements, the Contractor must:

1) on or before September 30 of each year, or such other date as specified by EOHHS, provide written certification, in a form

acceptable to EOHHS and signed under the pains and penalties of perjury, of compliance with such federal requirements;

2) make available to EOHHS, upon request, a copy of all written policies implemented in accordance with 42 U.S.C. § 1396a(a)(68), any employee handbook, and such other information as EOHHS may deem necessary to determine compliance; and

3) initiate such corrective action as EOHHS deems appropriate to comply with such federal requirements.

c. Failure to comply with this section may result in intermediate sanctions in accordance with **Section 13.18**.

5. Fraud and Abuse Prevention Coordinator

The Contractor shall designate a fraud and abuse prevention coordinator, who may be the Contractor's compliance officer, and who is responsible for the following:

a. Assessing and strengthening internal controls to ensure Claims are submitted and payments properly made;

b. Developing and implementing an automated reporting protocol within the Claims processing system to identify billing patterns that may suggest Network Provider and/or Covered Individual fraud and shall, at a minimum, monitor for under-utilization or over-utilization of services;

c. Conducting regular reviews and audits of operations to guard against fraud and abuse;

d. Receiving all referrals from employees, Covered Individuals or Network Providers involving cases of suspected fraud and abuse and developing protocols to triage all referrals involving suspected fraud and abuse;

e. Educating employees, Network Providers and Covered Individuals about fraud and how to report it, including informing employees of their protections when reporting fraudulent activities per M.G.L. c. 12, § 5J; and

f. Establishing mechanisms to receive, process, and effectively respond to complaints of suspected fraud and abuse from employees, Providers and Covered Individuals and report such information to EOHHS.

Section 3.8 Reporting

The Contractor shall submit to EOHHS all required reports related to Network Providers and Provider Network management, as described in this **Section 3** or in **Appendix E-1**, in

accordance with specified timetables, definitions, formats and assumptions, as well as any ad hoc reports required by EOHHS in accordance with **Section 11.2.B**.

SECTION 4. CLINICAL SERVICE AND UTILIZATION MANAGEMENT

Section 4.1 Administrative Requirements

A. Overview

The Contractor shall:

1. As of the Service Start Date, perform all clinical and Utilization Management (UM) functions and be responsible for the clinical management of Network Providers as described in this Contract.

2. Develop the Clinical Criteria to govern the authorization of services provided under the Contract. As part of the development process, the Contractor shall consult with experts who are familiar with standards and practices of mental health and substance abuse treatment for adults and children and adolescents in Massachusetts. The Contractor shall:

    a. Submit the proposed Clinical Criteria to EOHHS for review and approval; and

    b. Annually review, and update as necessary, the Clinical Criteria and any other clinical protocols that have been developed, and submit any proposed changes to EOHHS for prior review and approval.

3. Develop and maintain UM policies and procedures, including but not limited to policies and procedures for service authorizations that are consistent with the EOHHS-approved Clinical Criteria the Contractor has developed, and with the requirements set forth in **Section 4.2**. The Contractor shall:

    a. Initially, submit the UM policies and procedures to EOHHS for approval at least one month prior to the Service Start Date.

    b. Annually review, and update as necessary, the UM policies and procedures and submit any proposed changes to EOHHS for prior review and approval. The UM policies and procedures shall be conveyed through staff training and supervision, and shall:

        1) ensure that Covered Individuals receive the care that is Medically Necessary; and

        2) place emphasis on ensuring that BH Covered Services are not over-utilized or provided without a determination of Medical Necessity.

B. Staffing

1. The Contractor shall employ a multidisciplinary clinical staff at staffing levels that ensure an adequate ratio of staff to Covered Individuals to perform the clinical, UM and Care Management Program functions of the Contract, including authorizing and coordinating services.

2. The Contractor shall ensure that the Chief Medical Officer or an Associate Medical Director is available 24 hours per day, seven days a week, for decision-making and consultation with the Contractor's clinical staff and Network Providers.

3. The Contractor shall make best efforts to ensure that the clinical staff described herein have never had any disciplinary or other type of sanction action taken against him or her by the relevant professional licensing or oversight board, or the Medicare or Medicaid program. The Contractor shall require its clinical staff to disclose to the Contractor any such action taken against current Contractor staff, and the Contractor shall inform EOHHS within five days of becoming aware of any such action.

4. Staff must include:

    a. A full-time Chief Medical Officer who is designated as key personnel. The Chief Medical Officer shall be board-certified in psychiatry and/or internal medicine; be in compliance with all professional licensing requirements; and have at least two years of experience in managed BH care, peer review, or both.

    b. At least two full-time equivalent (FTE) Associate Medical Directors, each of whom shall be physicians, and:

        1) One shall be board-certified or board-eligible in child and adolescent psychiatry.

        2) One shall be board-certified or board-eligible in internal medicine, with experience in integration of care across medical and Behavioral Health Providers and shall be responsible for the oversight of the Care Management Program described in **Section 6.2**.

        3) One shall be responsible for the oversight of the Quality Management program described in **Section 8**.

        4) If the full-time Chief Medical Officer is not a board-certified adult psychiatrist, then an additional full-time equivalent Associate Medical Director must be a board-certified adult psychiatrist.

c. Supervisory clinical staff with expertise in medical or Behavioral Health care who represent nursing, social work, psychology, substance abuse, counseling or other BH fields, possess sufficient educational background and experience, have all applicable professional licenses, have experience in managed care, UM, and QM.

d. Supervisory staff that include subject matter experts in Severe and Persistent Mental Illness, Severe Emotional Disturbances in children and adolescents, intellectual disabilities, substance abuse treatment, and treatment of persons with Dual Diagnosis.

e. Staff clinicians at the master's level or bachelor's level. Bachelor's-level staff shall perform tasks not pertaining to Medical Necessity determination.

C. Training and Supervision

The Contractor shall ensure that all staff are appropriately licensed at hiring and during the tenure of employment. In addition, the Contractor shall:

1. Ensure that staff clinicians receive weekly group or individual clinical supervision to ensure standardization and quality.

2. Ensure that clinical staff obtain the training (i.e., CEUs, CMUs) needed to maintain their professional licensing.

3. Ensure that clinical staff are trained on Clinical Criteria, Utilization Management standards and on Member rights for Internal Appeals and Grievances.

Section 4.2 Service Authorization, Utilization Review, Clinical Service Coordination and Clinical Referral

A. Policies and Procedures for Service Authorization

1. Standards for Clinicians

The Contractor shall ensure the following standards for clinicians who authorize services, unless otherwise approved by EOHHS:

a. The clinician(s) coordinating services and making service authorization decisions must have training and experience in the specific area of service for which they are coordinating and authorizing services.

b. The clinician(s) coordinating and authorizing adult mental health services must have experience and training in adult mental health services.

c. The clinician(s) coordinating and authorizing child and adolescent mental health and substance abuse services must have experience and training in child and adolescent mental health and substance abuse services, including

services for Children in the Care and/or Custody of the Commonwealth and children who have experienced trauma.

d. The clinician(s) coordinating and authorizing adult substance abuse services must have experience and training in adult substance abuse services.

e. The clinician(s) coordinating and authorizing services for a PCC Plan Enrollee with a coexisting medical and BH diagnosis must be a registered nurse, psychiatrist, or other licensed clinician with experience and training in services with a coexisting medical and BH diagnosis.

f. In the event a clinician with experience in the specific area of service is unavailable to authorize a service, appropriate clinical consultation must be provided.

2. Service Authorization Procedure

The Contractor shall implement, as of the Service Start Date, its written policies and procedures for processing of requests for initial and continuing authorizations of services which, among other things:

a. Require that any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested be made by a board-certified or board-eligible psychiatrist or health care professional who has appropriate expertise addressing the Covered Individual's behavioral health needs, except as provided in **subsection 2.b**;

b. In cases of denials of services for psychological testing, require that the denials be rendered by a qualified psychologist;

c. Have in effect mechanisms to ensure consistent application of review criteria for authorization decisions;

d. Consult with the requesting Network Provider when appropriate;

e. Make authorization decisions and provide notice as follows and as further specified in **Section 7.6**.

1) For standard authorization decisions, make a decision and provide notice of any denial or decision to authorize services in an amount, duration, or scope that is less than requested as expeditiously as the Covered Individual's health condition requires and within the following timeframes:

a) For Outpatient Services, Outpatient Day Services, and non-24-hour Diversionary Services, the Contractor shall make a

decision no later than 14 calendar days following receipt of the request, and shall mail a written notice to both the Covered Individuals and the Network Provider on the next business day after the decision is made; and

b) For Inpatient Services and 24-hour Diversionary Services, the Contractor shall make a decision within 24 hours of the request, notify the Network Provider orally within 24 hours, and notify both the Covered Individual and the Network Provider in writing within three days;

2) For expedited service authorization decisions, where the Network Provider indicates or the Contractor determines that following the standard timeframe in **subsection 2.e.1)** could seriously jeopardize the Covered Individual's life or health or ability to attain, maintain, or regain maximum function, the Contractor shall make a decision and provide notice as follows:

a) The Contractor shall make a decision as expeditiously as the Covered Individual's health condition requires and within 72 hours after receipt of the request for service, with a possible extension not to exceed an additional 14 calendar days. Such extension shall be allowed only if:

(i) the Covered Individual or the Network Provider requests an extension; or

(ii) the Contractor can justify (to EOHHS upon request) that (a) the extension is in the Covered Individual's interest, and (b) there is a need for additional information where there is a reasonable likelihood that receipt of such information would lead to approval of the request, if received; and such outstanding information is reasonably expected to be received within 14 calendar days.

b) The Contractor shall notify the Network Provider orally and notify both the Covered Individual and the Network Provider in writing of any denial or decision to authorize services in an amount, duration, or scope that is less than requested on the day that the decision is made.

f. In accordance with 42 CFR 438.3(i) and 422.208, ensure that compensation to individuals or entities that conduct Utilization Management activities for the Contractor are not structured so as to provide incentives for the individual or entity to deny, limit, or discontinue Medically Necessary services to any Covered Individual.

g. Require the Contractor to conduct monthly reviews of a random sample of no fewer than 50 Covered Individuals per month to ensure that such Covered Individuals received the services for which Network Providers billed with respect to such Covered Individuals.

h. Specify that prior authorization shall not be required for:

1) Effective October 1, 2015:

a) Inpatient Substance Use Disorder Services (Level IV), as defined in **Appendix A-1**;

b) Acute Treatment Services (ATS) for Substance Use Disorders (Level III.7), as defined in **Appendix A-1**. Medical necessity shall be determined by the treating clinician in consultation with the Enrollee;

c) Clinical Support Services for Substance Use Disorders (Level III.5), as defined in **Appendix A-1**. Medical necessity shall be determined by the treating clinician in consultation with the Enrollee;

d) Outpatient Couples/Family Treatment, Group Treatment, Individual Treatment, and Ambulatory Detoxification (Level II.d), as defined in **Appendix A-1**;

e) Structured Outpatient Addiction Program (SOAP), as defined in **Appendix A-1**;

f) Intensive Outpatient Program (IOP), as defined in **Appendix A-1**; and

g) Partial Hospitalization (PHP) with short-term day mental health programming available seven days per week, as defined in **Appendix A-1**; and

2) Effective November 15, 2015: The initiation or re-initiation of a buprenorphine/naloxone prescription of 32 mg/day or less, for either brand formulations (e.g. Suboxone™, Zubsolv™, Bunavail™) or generic formulations, provided, however, that the Contractor may have a preferred formulation. The Contractor may establish review protocols for continuing prescriptions.

i. Require that Providers providing Clinical Support Services for Substance Use Disorders (Level III.5) and ATS shall provide the Contractor, within 48 hours of an Enrollee's admission, with notification of admission of an Enrollee and an initial treatment plan for such Enrollee. The Contractor may establish the manner and method of such notification but may not require the provider to submit any information other than the name of the

Enrollee, information regarding the Enrollee's coverage with the Contractor, and the provider's initial treatment plan. The Contractor may not use failure to provide such notice as the basis for denying claims for services provided.

j. The Contractor may not impose concurrent review and deny coverage for ATS based on such review. However, the Contractor may contact providers of ATS to discuss coordination of care, treatment plans, and after care.

k. If utilization management review activities are performed for Clinical Support Services for Substance Use Disorders (Level III.5), such activities may be performed no earlier than day 7 of the provision of such services, including but not limited to discussions about coordination of care and discussions of treatment plans. The Contractor may not make any utilization management review decisions that impose any restriction or deny any future Medically Necessary Clinical Support Services for Substance Use Disorders (Level III.5) unless an Enrollee has received at least 14 consecutive days of Clinical Support Services for Substance Use Disorders (Level III.5). Any such decisions must follow the requirements regarding Adverse Action notifications to Enrollees and clinicians, as specified in **Section 4.2.A.2.e**, and processes for Internal and BOH Appeals of the Adverse Action, as specified in **Section 7.6**.

Notwithstanding any other provision of this Contract, the Contractor shall not authorize services or treatment plans for services to be rendered after the termination of this Contract without EOHHS's prior review and approval, or unless otherwise directed by EOHHS.

B. Clinical Referral and Service Authorization Functions

1. Clinical Referrals Function

In order to assist Providers and Covered Individuals in identifying Network Providers who can provide BH Covered Services in accordance with this Contract, the Contractor shall operate and maintain a toll-free Clinical Referral Line that is staffed 24 hours a day, seven days a week by, at a minimum, bachelor's-level staff who are trained and knowledgeable about Contractor referral resources and who can make appropriate referral suggestions.

2. Service Authorization Function

a. In order to authorize delivery of Behavioral Health Covered Services, if appropriate, and to assist Providers and Covered Individuals in identifying Network Providers who can provide Covered Services in accordance with this Contract, the Contractor shall operate and maintain a toll-free Service Authorization Line that is staffed 24 hours a day, seven days a week by, at a minimum, master's-level staff as described in **Section 4.1.B.4.c**. Such

clinical staff shall have access to Covered Individuals' clinical and service authorization information.

b. The Contractor shall ensure that supervisory staff is available to assist staff clinicians with handling calls to the Service Authorization Line.

c. The Contractor shall propose for EOHHS review and approval a plan to adopt an alternative to the Service Authorization Line and/or additional method for Network Providers to request and receive authorization for services.

d. The Contractor shall coordinate service authorization functions with the Care Management Program described in **Section 6.2**, as appropriate.

C. Service Authorization for Specific BH Covered Services

1. Inpatient Service Authorization

The Contractor shall develop Inpatient Service authorization policies and procedures, submit them to EOHHS for review and approval no later than one month prior to the Service Start Date, and implement them on the Service Start Date. Unless the Contractor proposes and EOHHS approves alternative policies and procedures, the policies and procedures shall include, at a minimum, the following:

a. A plan and system in place to direct Covered Individuals to the least intensive clinically appropriate service;

b. A system for ensuring that, to the extent permitted by law, authorizations for inpatient admissions occur after an ESP has conducted a crisis assessment and determined that the admission of the Covered Individual is Medically Necessary;

c. Processes to ensure placement for Covered Individuals who require Behavioral Health Inpatient Services when no inpatient beds are available;

d. A system for authorizing and assigning an initial length of stay for all admissions, and communicating information on the assigned length of stay to the Covered Individual, facility and attending physician, as specified in **Section 4.2.A.2.e**;

e. A system for ensuring that Inpatient Services are authorized for 24 hours for all Covered Individuals ordered hospitalized by a judge pursuant to M.G.L. c. 123 § 12(e); and that Inpatient Services for such individuals are authorized for more than 24 hours only if the Contractor determines that such services are Medically Necessary;

f. A system of concurrent review for Inpatient Services to monitor the Medical Necessity of the need for continued stay and achievement of Behavioral Health Inpatient treatment goals;

g. A system for addressing Discharge Planning during initial authorization and concurrent review;

h. A system for conducting retrospective reviews of the medical records of selected inpatient authorizations, to assess the Medical Necessity, clinical appropriateness, and appropriateness of the Level of Care and duration of the stay; and

i. A system for ensuring that the Inpatient Services Network Provider asks for the Covered Individual's consent to notify the Covered Individual's PCC that the Covered Individual has been hospitalized.

2. 24-Hour Diversionary Service Authorization

The Contractor shall develop Diversionary Service authorization policies and procedures, submit them to EOHHS for review and approval no later than one month prior to the Service Start Date, and implement them on the Service Start Date. Unless the Contractor proposes and EOHHS approves alternative policies and procedures, the policies and procedures shall include, at a minimum, the following:

a. A system that operates 24 hours a day, seven days a week, for authorizing admissions of Covered Individuals to 24-hour Diversionary Services, utilizing the Contractor's Clinical and Medical Necessity Criteria;

b. A system for making clinically appropriate referrals for children and adolescents in need of Community-Based Acute Treatment Services for Children and Adolescents when such Providers have no available beds;

c. A system for authorizing and assigning an initial length of stay for all admissions to 24-hour Diversionary Services, and communicating information on the assigned length of stay to the Covered Individual, facility and attending physician, as specified in **Section 4.2.A.2.e**;

d. A system for authorizing non-24-hour Diversionary Services based on Medical Necessity Criteria;

e. A system of concurrent review for 24-hour Diversionary Services to monitor justification and appropriateness of the length of stay, need for continued stay, and achievement of treatment goals;

f. A system for addressing Discharge Planning during initial authorization and concurrent review;

g. A system for ensuring that Network Providers of 24-hour Diversionary Services ask for the Covered Individual's consent to notify the Covered Individual's PCC that the Covered Individual has been admitted; and

h. A system for conducting retrospective reviews of the medical records of selected Diversionary Services cases, to assess the Medical Necessity, clinical appropriateness, and appropriateness of Level of Care and duration of the stay.

3. Outpatient Service Authorization

The Contractor shall develop Outpatient Service authorization policies and procedures, submit them to EOHHS for review and approval no later than one month prior to the Service Start Date, and implement them on the Service Start Date. Unless the Contractor proposes and EOHHS approves alternative policies and procedures, the policies and procedures shall include, at a minimum, the following:

a. A system that operates 24 hours a day, seven days a week;

b. A policy and system for automatically authorizing at least 12 outpatient sessions per Covered Individual per Contract Year;

c. A policy and system, secure from unauthorized access, for authorizing outpatient sessions beyond 12 sessions;

d. A policy and system for authorizing Outpatient Services and lengths of treatment based on the Contractor's Clinical Criteria;

e. A policy and system for generally informing Network Providers of the Contractor's protocols for approving Outpatient Services, such as including such protocols in the Provider Manual; and

f. A policy and system to ensure that the provision of outpatient BH Services is based on the individual clinical needs of each Covered Individual, and that the BH Covered Service(s) provided are the least intensive clinically appropriate service(s).

Section 4.3 Assessment, Treatment Planning and Discharge Planning

A. Assessments

The Contractor shall:

1. Ensure that all Network Providers prepare an individualized written assessment for any Covered Individual entering treatment, regardless of treatment setting.

2. Ensure that assessments are conducted by Network Providers and include but are not limited to:

a. history of presenting problem;

b. chief complaints and symptoms;

c. past BH history;

d. past medical history, including but not limited to Primary Care, specialty care, treatment for chronic conditions, and use of prescription drugs;

e. the Covered Individual's family history, social history and linguistic and cultural background, with an assessment of the Covered Individual's identified supports in each of these domains;

f. for Children in the Care and/or Custody of the Commonwealth, history of placements outside the home;

g. current substance use;

h. mental status exam including assessment of suicide and violence risk;

i. previous medication trials, current medications and any allergies;

j. diagnosis, clinical formulation, rationale for treatment, and recommendations;

k. level of functioning;

l. the individual's strengths and, for children and adolescents, family strengths; and

m. name of PCC and other key Providers.

3. Ensure that when assessments are completed, a multidisciplinary treatment team has been assigned to each Covered Individual. The multidisciplinary treatment team shall, with consent from the Covered Individual, include the following Providers and community supports, as appropriate for the Covered Individual's clinical needs: the PCC, current community-based BH Network Providers, other specialists, state agency case managers and/or service providers, Peer Supports identified by the Covered Individual, and others recommended by a team member or requested by the Covered Individual. For children under 18, a parent or legal guardian must be an active participant in the team. The treatment team shall meet to review the assessment and initial treatment plan within the following time frames:

   a. For Inpatient Services: within 24 hours of admission;

   b. For Diversionary Services: within 48 hours of admission; and

c. For Outpatient Services, for clinics, group practices and solo practitioners, the timeline specified in DPH regulation 105 CMR 140.540.

4. Make best efforts to ensure that the assessments are conducted by Network Providers who have training and experience that match the Covered Individual's clinical needs based on the Covered Individual's presenting problem(s) and diagnosis.

5. Require the clinicians who provide Behavioral Health services described in **Section 3.5** to use the CANS Tool and the information gathered from its use to inform treatment planning and Discharge Planning when: providing initial Behavioral Health Clinical Assessments; as part of the Discharge Planning process from Inpatient Psychiatric Hospitalizations, and Community-Based Acute Treatment Services; and, at a minimum, every 90 days during treatment provided to Covered Individuals who are under age 21.

B. Treatment Planning

The Contractor shall ensure that its Network Providers:

1. Utilize the individualized written assessment, including the clinical formulation, to develop a treatment plan;

2. Develop initial treatment plans that are in writing, dated and signed, and include, at a minimum:

   a. a description of all services needed during the course of treatment;

   b. goals, expected outcomes and time frames for achieving the goals;

   c. indication of the strengths of the individual and his/her family as identified in the assessment;

   d. links to Primary Care and specialty care, especially when there is an active co-occurring medical condition;

   e. when appropriate, the plan to involve a case manager from a state agency, such as DCF, DMH, DYS or DDS; and

   f. treatment recommendations consistent with the service plan of the relevant state agency for Covered Individuals who are also DMH Clients, Children in the Care and/or Custody of the Commonwealth, or DDS clients.

3. Periodically review initial treatment plans and modify them as necessary;

4. Receive Covered Individual medical and pharmaceutical profiles on a regular basis and use these profiles as part of its periodic review of the Covered Individual's treatment plan;

5. Invite and encourage the following persons to participate in the development and modification of the Covered Individual's treatment plan, the treatment itself, and to attend all treatment plan meetings:

    a. In the case of an individual over age 16 or an emancipated minor, the Covered Individual, the Covered Individual's family members, guardians, the PCC, Network Providers of BH Outpatient Services, key specialists and other identified supports, but only when the consent of the Covered Individual to such involvement(s) has been obtained, unless the individual has a legal guardian, in which case the consent of the legal guardian is required.

    b. In the case of an individual under age 16 who is not an emancipated minor, with the consent of a parent or guardian, the Covered Individual, if appropriate, family members, the PCC, Network Providers of BH Outpatient Services, Family Partners, Care Coordinators, key specialists, and other identified supports.

    c. For Covered Individuals who are also DMH Clients, DDS clients or Children in the Care and/or Custody of the Commonwealth, the designated staff from the relevant state agencies.

    d. For Covered Individuals who are participating in Care Management through the Contract, the Contractor's assigned care manager.

6. Make best efforts to schedule treatment planning meetings concerning children and adolescents at a time when their family members or guardians are available;

7. Encourage Covered Individuals over the age of 18 to consent to the participation of guardians and family members in the treatment and treatment planning;

8. Assign a multidisciplinary treatment team to each Covered Individual within the following time frames:

    a. for Inpatient Services: within 24 hours of admission;

    b. for 24-hour Diversionary Services: within 24 hours of admission.

C. Discharge Planning

The Contractor shall:

1. Ensure that all Network Providers, especially Network Providers of Inpatient and Diversionary Services, upon admission of Covered Individuals:

    a. assign appropriate designated staff who are knowledgeable about the continuum of coordinated BH and medical services, services and supports in the community, and Discharge Planning;

b. provide notice to the Covered Individual's PCC within one business day of the admission, include the PCC in current Discharge Planning efforts and schedule a follow-up appointment with the PCC for care, as appropriate;

c. coordinate and collaborate with the Contractor's care manager if the Covered Individual is participating in Care Management under the Contractor;

d. make best efforts to ensure a smooth transition to the next service, if any, or to the community;

e. document all efforts related to these activities, including the Covered Individual's active participation in his or her individualized Discharge Planning and, in the case of Covered Individuals under 18, their parent or legal guardian; and

f. Identify barriers to aftercare and develop strategies to assist Covered Individuals with aftercare services.

2. Develop, in collaboration with each Covered Individual, prior to the individual's discharge from any Inpatient BH Service or, if appropriate, any other BH Covered Service, a written, individualized person-centered, strength-based discharge plan for the next service or program, anticipating the individual's movement along a continuum of services, including availability of Wraparound services for children under 18 and their families;

3. Include in the discharge plan, at a minimum:

a. Identification of the individual's needs, including but not limited to:

1) housing;

2) finances;

3) medical care;

4) transportation;

5) family, employment, and educational concerns;

6) natural community and social supports; and

7) a Crisis Prevention Plan that follows the principles of recovery and resilience, and which may be a component of a Wellness, Recovery Action Plan (WRAP) model for adults and the Risk, Management, Safety Plan for children and their families.

b. A list of the services and supports that are recommended post-discharge;

c. Identified Providers, PCCs and other community resources available to deliver each recommended service;

d. A list of prescribed medication, dosages and possible side effects; and

e. Treatment recommendations consistent with the service plan of the relevant state agency for Covered Individuals who are also DMH Clients, Children in the Care and/or Custody of the Commonwealth, or DDS clients.

4. Invite and encourage the following persons to participate in Discharge Planning meetings:

a. In the case of an individual over age 16 or an emancipated minor, the Covered Individual, the Covered Individual's family members, guardians, PCC, Network Providers of BH Outpatient Services, key specialists, and other identified supports, but only when the consent of the individual to such involvement(s) has been obtained, unless the individual has a legal guardian, in which case consent of the legal guardian is required;

b. In the case of an individual under age 16 who is not an emancipated minor, with the consent of a parent or guardian, the Covered Individual, if appropriate, family members, PCC, Network Providers of BH Outpatient Services, key specialists and other identified supports;

c. For Covered Individuals who are also DMH Clients, Children in the Care and/or Custody of the Commonwealth, or DDS clients, designated staff from the relevant state agencies; and

d. For Covered Individuals receiving Care Management services through the Contractor, the Contractor's assigned care manager.

5. Schedule Discharge Planning meetings concerning children and adolescents at a time when their family members or guardians are available;

6. Develop linkages and policies that create a smooth, clinically sound transition of a Covered Individual's care from one service setting or BH Covered Service to the next, including transition to services provided by state agencies;

7. Assist Covered Individuals in obtaining post-discharge appointments as follows: within seven calendar days of discharge for aftercare services, which may include Outpatient Services as well as a broader range of BH Covered Services, including Non-24-Hour Diversionary Services such as partial hospital programs, if necessary; and within 14 calendar days of discharge for Medication Monitoring, if necessary;

8. Require the treatment team staff responsible for implementing the individual's discharge plan to document the discharge plan in the medical record;

9. Ensure that Network Providers of 24-hour Levels of Care furnish, with appropriate consent, written discharge instructions to the Covered Individual, parents, guardians, residential providers, PCCs, and relevant state agencies or Contractor care managers at the time of the individual's discharge, to include, without limitation:

    a. A list of prescribed medications and information about any potential medication side effects;

    b. aftercare appointments;

    c. recommended behavior management techniques when applicable; and

    d. a Crisis Prevention Plan, including the toll-free phone number of the Member's local ESP.

10. Ensure that Network Providers of inpatient mental health, ICBAT and CBAT Providers furnish, with appropriate consent, a written discharge summary to the Covered Individual, parents, guardians, PCCs, Contractor care managers, and the Member's current Behavioral Health Providers within two weeks of discharge, to include a summary of:

    a. the course of treatment;

    b. the Member's progress;

    c. the treatment interventions and behavior management techniques that were effective in supporting the Member's progress;

    d. medications prescribed; and

    e. treatment recommendations.

11. Ensure that the discharge plans for Covered Individuals who are DMH Clients are coordinated with the DMH Area or Site Office.

D. Additional Discharge Planning Requirements for Homeless Enrollees

The Contractor shall:

1. Strongly discourage Network Providers from discharging Homeless Enrollees to shelters;

2. Ensure that all Network Providers provide comprehensive Discharge Planning for Homeless Enrollees, and that Network Providers exhaust all potential avenues to secure placement or housing resources, with assistance from the Contractor;

3. Ensure that, within two business days of admission, all Network Providers complete and forward to DMH a DMH Service Authorization packet for

Homeless Enrollees who appear to meet DMH clinical criteria for service eligibility;

4. Identify community resources for the Homeless and ensure that Network Providers are aware of and utilize all such resources to assist with Discharge Planning for Homeless Enrollees;

5. Collaborate with DMH to ensure that Network Providers are aware of and utilize all available DMH resources to assist with Discharge Planning for Homeless Enrollees; and

6. Maintain and periodically update website links to Homeless services resources on the Contractor's website to assist Network Providers with Discharge Planning for Homeless Enrollees.

Section 4.4 Pharmacy Support Services

A. Overview

The MassHealth Pharmacy Program is the Pharmacy Benefit Manager (PBM) for the PCC Plan Enrollees and other Covered Individuals served under this Contract.

The Contractor shall:

1. Support the initiatives of the MassHealth Pharmacy Program, as directed by EOHHS.

2. Establish and maintain the capability to receive and analyze Claims data received from the EOHHS Data Warehouse for all Covered Services, including pharmacy utilization data for all Covered Individuals.

3. Establish a process to ensure that Covered Individuals referred to the Contractor by the MassHealth DUR and Pharmacy Program are referred to either the ICMP or to ECC to determine if they need care management or care coordination. If the Contractor is unable to reach a Covered Individual, or if the Covered Individual who needs ICMP or ECC denies services, the Contractor will follow through with the Covered Individual's PCC or prescriber to ensure coordinated care.

4. Establish and maintain the capacity for the Contractor's pharmacy director to create and submit reports regarding Provider prescribing patterns, and Covered Individuals' pharmacy claims and utilization patterns to Providers and to EOHHS, on a case-by-case ad hoc, non-production basis (i.e., reports manually produced by the Contractor's pharmacy director).

    a. The Contractor's pharmacy staff shall use these reports for care management and reconciliation activities, including but not limited to providing current information on pharmacy utilization to ICMP staff and the Contractor's staff and, upon request, to the Covered Individual's Network Providers.

b. The Contractor's pharmacy director shall report quarterly to MassHealth on the pharmacy-related activities the Contractor has performed in support of this Contract. This report shall include but not be limited to the following categories of activities:

1) A summary showing the frequency of the pharmacists' interactions with care managers to support Covered Individuals in the ICMP and ECC programs that includes the number of Covered Individuals presented, the Pharmacy Program initiative, pharmacy intervention, and outcomes;

2) A summary report of the number of Covered Individuals in each Pharmacy Program initiatives that DUR or OCA have referred to the Contractor's Care Management Program and the results of the referral; and

3) Educational supports to:

a) The ICMP program;

b) Network Providers and PCCs;

c) Pediatric Behavioral Health Medication Initiative (PBHMI); and

d) The controlled substances management program;

5. Ensure that sufficient pharmacist and/or clinical staff with an understanding of medication(s) as it relates to the project are available to fulfill the pharmacy requirements of the Contract.

a. Prior to July 20, 2014, provide to EOHHS for approval a staffing plan that ensures the integrity of pharmacy deliverables.

b. Continually evaluate staffing needs and provide to EOHHS for approval prior to the beginning of each Contract Year a staffing plan that ensures the clinical integrity of the pharmacy deliverables.

c. The Contractor's pharmacy director, as identified to EOHHS, shall have access to pharmacy data through POPS and the POPS data query tool known as "Business Objects" to support these efforts. If the Contractor supplies a level of clinical oversight for the use of the data that is approved by MassHealth, MassHealth may consider granting additional Contractor staff access to this tool on a case-by-case basis

6. Coordinate pharmacy support activities, as directed by EOHHS with DMH, and EOHHS's Drug Utilization Review (DUR) and Pharmacy Online Processing System (POPS) vendors.

7. For the purposes of this section the Contractor shall provide Member-level information described herein only to Providers who have a record of treating the Member, or otherwise as directed by MassHealth and consistent with prevailing laws and regulations.

B. Pharmacy Initiatives

The Contractor shall support and collaborate with MassHealth on pharmacy activities and efforts, including but not limited to:

1. Ensuring that Network Providers have access to the most current MassHealth Drug List, and that Network Providers prescribe pharmaceuticals in accordance with the policies and instructions provided by EOHHS and reflected in the MassHealth Drug List, and other MassHealth publications.

2. Using Covered Individuals' drug utilization data obtained from EOHHS to inform and guide prescribing activity. As part of this effort, the Contractor shall:

    a. Work to improve collaboration by prescribers, thereby reducing conflicting or duplicate prescribing; and

    b. Assist Care Managers in finding and implementing ways to improve Enrollees' compliance with prescribed medication regimens.

3. Providing reports to PCCs, other PCC Plan Providers, and Network Providers on the patterns of prescription utilization by Covered Individuals, in an effort to increase collaboration across providers and reduce inappropriate prescribing patterns.

4. Managing the prescribing of psychoactive medication to Covered Individuals under age 18, including:

    a. Working with the Pediatric Behavioral Health Medication Initiative's Therapeutic Class Management team, the Contractor's Child/Adolescent Psychiatrist must make prescriber/doctor outreach calls if clinically indicated and provide MassHealth a summary of these reviews/consultations. The Contractor and MassHealth shall coordinate prescriber/doctor outreach calls to avoid unnecessary duplication of outreach to the same prescriber for the same member and purpose.

    b. If clinically indicated for those referred to the Contractor by the MassHealth DUR and Pharmacy Program who are not receiving Behavioral Health services, referring such members to ICMP or ECC for care management or care coordination.

    c. Using criteria developed in collaboration with and agreed to by EOHHS, identifying Covered Individuals under the age of 18 on antipsychotic medication who need metabolic monitoring (diabetes and lipid screening

tests) and notify both the Covered Individual's prescribing clinician and the PCC in a form and format and at a frequency to be specified by EOHHS. Six months after mailing the first letters, the Contractor shall evaluate if the covered individuals referenced in those letters have a change in rates of diabetes and lipid screening tests;

5. Collaborating with and assisting EOHHS in the management of the MassHealth Controlled Substance Management Program (CSMP), which was developed to identify potential misuse or abuse of controlled substances. The Contractor's responsibilities shall include the following:

   a. Identify every six months a cohort of Covered Individuals meeting EOHHS criteria for CSMP through the following process:

      1) Analyze the pharmacy data to determine a list of potential Covered Individuals that meet criteria for pharmacy lock-in; and

      2) Ensure that a clinician reviews the list to eliminate those Covered Individuals who appear to have a medically necessary reason(s) for their controlled substance use and produce final list of Covered Individuals to be included in the CSMP program.

   b. Supply information to MassHealth Pharmacy Program and DUR Program as directed by EOHHS to assist in the enrollment into and disenrollment of Covered Individuals from the program.

   c. Send Covered Individuals identified in **Section 4.4.B.6.a** letters as approved by EOHHS.

   d. Inform methadone providers when the Covered Individuals they treat also participate in CSMP.

   e. Inform ICMP of any ICMP Covered Individuals in CSMP.

   f. Send a PCC a letter approved by EOHHS if their patient is enrolled in CSMP and not using behavioral health or ICMP services according to criteria set by EOHHS.

   g. Review MMIS every other month for any CSMP Covered Individual who has changed his or her PCC and notify the new PCC that the Covered Individual is enrolled in CSMP. Such notification shall be by means of an EOHHS approved provider update letter.

   h. Identify Covered Individuals for disenrollment from the CSMP by EOHHS based on not meeting the criteria for enrollment during the past 12-month review of controlled substance utilization.

i. Send the names, addresses, Member ID and PCCs of each Covered Individual to be released from pharmacy lock-in to the DUR.

j. Send out a discharge letter approved by EOHHS to the Covered Individual's PCC upon disenrollment of Covered Individual from CSMP.

k. Evaluate the CSMP for effectiveness and report results to EOHHS in a timeframe agreed to by the parties. The Contractor will track enrolled and dis-enrolled CSMP Covered Individuals' prescription medication utilization to monitor the effectiveness of the program and to determine cost savings according to methodology jointly established by EOHHS and the Contractor, changes in controlled substance prescription patterns, changes in ED use and utilization of behavioral health services.

l. Identify and engage Covered Individuals enrolled in CSMP who might need Behavioral Health services and medical care and help them access such services.

m. Work with MassHealth to determine how to implement a Prescriber Lock-in Program.

n. Produce a quarterly report that lists PCC members locked-into CVS and Walgreens pharmacies.

6. Supporting EOHHS pharmacy initiatives by promoting and communicating the adoption of MassHealth clinical policy recommendations to PCC Plan Providers and BH Network Providers.

7. Proposing additional pharmacy interventions focused on Covered Individuals. Such interventions shall include, at a minimum:

a. Identifying and mitigating duplication of, or conflict with, other pharmacy interventions by EOHHS or its contractors;

b. Educating PCC Plan Providers and Network Providers on pharmaceuticals used for BH conditions, through PCC Plan Management Support Services (MSS) site visits, Network Provider site visits, or other methods, including publications;

c. Educating PCC Plan Providers and Network Providers regarding the need to coordinate and manage prescribed medication use for BH and medical conditions through an alert, brochure and/or newsletter; and

d. Collaborating with DCF, DYS and EOHHS to develop a system to monitor their clients' use of pharmaceuticals for BH conditions.

8. Implementing other pharmacy interventions as approved by EOHHS in accordance with the time frames specified by EOHHS.

C. Work Group Participation

The Contractor shall assign its staff pharmacist to participate in all appropriate pharmacy work groups as determined necessary by the EOHHS, including but not limited to:

1. The Drug Utilization Review (DUR) Board as well as open DUR workgroups and committees;

2. The DMH drug advisory committee (known as the Psychopharmacology Experts Work Group);

3. The Children's psychopharmacology workgroup (known as the Psychoactive Medications in Children Working Group; and

4. Participation in any EOHHS pharmacy strategic planning process as requested or directed by EOHHS.

Section 4.5 Massachusetts Child Psychiatry Access Project

The Massachusetts Child Psychiatry Access Project (MCPAP) consists of two psychiatric consultation programs. The first, MCPAP, consist of children's behavioral health consultation teams throughout the state to help Primary Care Practitioners (PCPs) manage the behavioral health needs of their pediatric patients. The primary goals of MCPAP are to improve access to treatment for children with behavioral health problems and to promote productive relationships between primary care and child psychiatry and rational utilization of scarce resources. The second, MCPAP for Moms, consist of behavioral health consultation teams that provide behavioral health consultation for obstetric, pediatric, adult primary care and psychiatric providers to effectively prevent, identify, and manage depression and other mental health concerns in pregnant and postpartum women up to one year after delivery.

The Contractor shall:

A. Establish a Massachusetts Child Psychiatric Access Project (MCPAP) Unit to manage the Massachusetts Child Psychiatric Access Project, and allocate sufficient medical leadership and program administration resources to assure that the goals of the program are met and quality is maintained.

B. Establish and maintain a network of MCPAP providers to provide consultation to pediatric Primary Care Practitioners (PCPs), including Primary Care Clinicians (PCCs), treating pediatric Members who may need Behavioral Health services and a network of MCPAP for Mom providers to provide consultation to obstetric, pediatric, adult primary care, and psychiatric providers treating pregnant or postpartum women up to one year after delivery with depression and other mental health concerns.

C. Reprocure the network of MCPAP providers in order to reorganize current MCPAP services and functions and implement new MCPAP functions recommended by the MCPAP Strategic Assessment Report and agreed upon in collaboration with DMH. The Contractor shall:

1. Issue a Request for Proposal;

2. Select MCPAP Teams;

3. Negotiate contracts with MCPAP Teams;

4. Implement the redesigned program by January 1, 2017; and

5. As part of the procurement, change the name of program to Massachusetts Child Psychiatric Access Program.

D. Recruit pediatric PCPs and obstetric providers across the state who have not yet signed a MCPAP or MCPAP for Moms enrollment agreement.

E. Ensure that MCPAP and MCPAP for Moms services are available statewide.

F. Maintain a system to collect Encounter data and utilize the Encounter data collected to evaluate and analyze the effectiveness of the MCPAP programs.

G. Contract with a sufficient number of MCPAP Teams to ensure continuous access for PCPs between 9:00 a.m. to 5:00 p.m., Monday through Friday (excluding holidays) including the following:

1. immediate advice within 30 minutes of the contact;

2. referral of patient to the MCPAP Team to assist in arranging and linking to Behavioral Health services and contact family within 48 hours of referral; and

3. referral of the patient to the team psychiatrist for diagnostic or psychopharmacologic assessment (within 10 business days) or, for MCPAP, to the team behavioral health clinician for non-psychopharmacologic assessment (within 5 business days).

H. Perform the following ongoing MCPAP responsibilities, without limitation:

1. Collecting Encounter data pursuant to the Contractor's requirements;

2. Conducting outreach to recruit, enroll, and build relationships with pediatric PCP and obstetric practices;

3. Informing pediatric PCP and obstetric practices in a MCPAP Team's region how to access MCPAP services;

4. Regularly communicating with pediatric PCPs and obstetric providers regarding satisfaction with MCPAP;

5. Regularly communicating with pediatric PCPs and obstetric providers who underutilize MCPAP programs to identify barriers to using the MCPAP service;

6. Maintaining up-to-date and comprehensive information for PCCs on access to Network Behavioral Health Providers;

7. Maintaining program-specific dedicated website about MCPAP programs that provides information about the programs and information about behavioral health topics and resources for PCPs, obstetric providers, and families; and

8. Providing proactive practice-based education and training on managing behavioral health in primary care.

I. Provide quarterly aggregate progress reports to EOHHS and DMH 20 days after the closing of each quarter, which shall include the following data elements at a summary level for each month in the quarter:

1. Number and names of MCPAP program teams for MCPAP and MCPAP for Moms;

2. Number of PCPs and PCP practices enrolled in MCPAP and number of obstetric practices and provider enrolled in MCPAP for Moms;

3. A list of pediatric MassHealth PCCs, noting which PCCs have enrolled in MCPAP and which PCCs have not yet enrolled and noting efforts to enroll each unenrolled PCC;

4. For each MCPAP Team and statewide: number of Encounters by type of Encounter, diagnosis, reason for contact, insurance status of the child, PCP or obstetrics providers and PCP or obstetric practice;

5. For each MCPAP Team and statewide: unduplicated count of members served, by type of Encounter, diagnosis, reason for contact, insurance status of the member, and name of PCP or obstetric provider;

6. Average number of encounters per unduplicated Members, by MCPAP Team and statewide;

7. Report of outcome, diagnosis, and medication per consultation by MCPAP Team;

8. Number of enrolled PCPs, by MCPAP Team and number of enrolled obstetric providers in MCPAP for Moms;

9. Revenue generated by billing insurers, including Mass Health and MassHealth MCOs, for direct face-to-face treatment to children and families by MCPAP Provider and statewide;

10. Other program utilization data elements that may be identified by EOHHS, MCPAP and DMH after the regional MCPAP teams are procured by January 1, 2017; and

11. Additional MCPAP reporting requirements as directed by EOHHS and DMH.

J. Submit annual itemized budgets for each MCPAP Program Provider and MCPAP central administration by July 1st of each calendar year, and whenever there is a change in the budget.

K. Coordinate all MCPAP program activities with DMH, including but not limited to:

1. Attending monthly planning meetings and other meetings as required by DMH;
2. Establishing and regularly convening a MCPAP Advisory Committee to inform and advise MCPAP and DMH on program improvements and direction;
3. Revising program activities as requested by DMH and approved by EOHHS; and
4. Participating in any DMH-initiated program evaluation activities and accompanied recommendations for future direction.

L. As directed by EOHHS, collaborate with DMH to implement financial and programmatic strategies to ensure sustainability of MCPAP within the context of alternative payment and service delivery methodologies associated with healthcare.

M. By the end of Contract Year Five, submit a utilization report with recommendations for increasing appropriate utilization of MCPAP services by practices and providers to EOHHS and DMH for review and approval. The report shall include:

1. An analysis of the current utilization and trends in the utilization of the MCPAP services at the practice and provider level;
2. An analysis of the results of the most recent annual PCP Experience survey;
3. A description of the methodology used to quantify practice and provider utilization of MCPAP and examine utilization trends; and
4. Strategies to increase the appropriate utilization of MCPAP services.

N. In Contract Year Five, complete the implementation strategies to increase pediatricians' capacity to identify, provide brief intervention, and refer for treatment adolescents with substance use disorder needs. The Contractor shall:

1. Oversee MCPAP Teams in training their enrolled pediatric practices in the new S2BI screening tools using the revised SBIRT Toolkit;
2. Re-administer the pediatrician substance use survey to a random sample of pediatric PCPS statewide to assess whether the MCPAP Team training increased PCP use of SBIRT practices; and
3. Submit to EOHHS and DMH quarterly and annual reports, stratified by months and year to date, on aggregate de-identified adolescent substance use encounters by MCPAP Providers statewide, provided that such report will not include identifiable data except to the extent permitted by law and requested by EOHHS.

Section 4.6 Forensic Evaluations

Forensic Evaluations are a clinical assessment of mental status that enables local police departments to obtain psychiatric hospitalizations, when appropriate, for persons who are arrested but not yet arraigned because the court is closed.

The Contractor shall provide a system to access Designated Forensic Professionals (DFPs) for Forensic Evaluations conducted as part of a Pre-Arraignment Protocol (PAP) as described in M.G.L. c. 123, § 18(a) (see **Appendix A-6)**. After the Contractor has conducted an initial clinical evaluation of an individual who has been arrested but not yet arraigned, the Contractor shall determine the need for further evaluation for hospitalization and issue a referral for a Forensic Evaluation. Upon receiving a referral for a Forensic Evaluation, the DFP shall:

A. Evaluate the arrested individual, generally at the hospital Emergency department or in a police lock-up, through an interview and other available clinical data;

B. Determine whether the individual is in need of hospitalization and that no other alternatives are feasible; and

C. Present this finding to an on-call judge who is empowered to issue a temporary commitment to a DMH facility or to Bridgewater State Hospital.

Section 4.7 Money Follows the Person - (MFP) Waivers

The Money Follows the Person (MFP) Demonstration is designed to assist individuals participating in the Demonstration to transition from long-term care facility settings to community-based settings. Individuals participating in the MFP Demonstration that enroll in an MFP HCBS Waiver are MFP Waiver Participants. MFP Waiver Participants who are not otherwise eligible for managed Behavioral Health benefits through either the Contractor or an MCO are Covered Individuals for the purpose of this **Section 4.7**.

The Money Follows the Person Residential Supports Waiver (MFP-RS) and the Money Follows the Person Community Living (MFP-CL) Waiver assist individuals to transition from long-term care facility settings to community-based settings. Individuals who are determined to be eligible for and enroll in an MFP Waiver are MFP Waiver Participants. MFP Waiver Participants who are not otherwise eligible for managed Behavioral Health benefits through either the Contractor or a MassHealth-contracted MCO are Covered Individuals for the purpose of this **Section 4.7**.

A. The Contractor shall:

1. At the request of an MFP Waiver Case Manager/Service Coordinator, provide referral assistance to in-network behavioral health providers, provide case consultation, and accept and review referrals for care management for high risk individuals to determine the MFP Waiver Participant's clinically indicated Behavioral Health needs;

2. Work with the MFP Waiver Case Manager/Service Coordinator to determine care needs, and in collaboration, develop a course of treatment (i.e. individual service

plan), and provide a set of services (recommend and assist with arranging and provide authorization when appropriate), based upon the individual clinical needs of the MFP Waiver Participant;

3. When clinically indicated, refer the MFP Waiver Participant to an in-network Community Support Program to conduct a Behavioral Health Assessment;

4. Provide information regarding the MFP Waivers, including coverage information to contracted providers;

5. Instruct contracted providers, where applicable, to include the MFP Waiver Case Manager/Service Coordinator on the team if a multidisciplinary care team is convened;

6. Monitor the MFP Waiver Participant's Individual service plan and continue collaboration and on-going communications with the MFP Waiver Case Manager/Service Coordinator;

7. Communicate the individual service plan to and coordinate such plan with the appropriate agencies, organizations and providers; and

8. Provide an update of the MFP Tracking Report on a monthly basis.

9. Maintain enrollment as a provider of MFP Transitional Assistance Services.

B. At the request of EOHHS, the Contractor shall train MFP Waiver Case Managers/Service Coordinators, and any other individuals that MassHealth identifies, contracts with or appoints to aid in transitioning MFP Waiver Participants from nursing facilities or hospitals. Such training shall include, at minimum:

1. a description of the purpose and goals of the Behavioral Health program and available services and support;

2. identification of the Network Providers available through the Contract;

3. a description of how to make appropriate referrals;

4. a process for making such referrals; and

5. contact information for dedicated Contractor staff that MFP Waiver Case Managers/Service Coordinators can contact to appropriately and efficiently refer an MFP Waiver Participant.

C. Once MassHealth determines that Covered Individual is eligible for one of the MFP Waivers, the Contractor shall, within 90 days of a planned discharge:

1. Accept referrals from the MFP Waiver Case Manager/Service Coordinator; work with the MFP Waiver Case Manager/Service Coordinator to determine care needs, and identify potential behavioral health services needed, and determine what services are available in the expected community location;

2. As requested by the MFP Waiver Case Manager/Service Coordinator, provide a list of in-network behavioral health providers, provide case consultation, and accept and review referrals for care management for high risk individuals to determine the need for pre-transition referrals to in-network Community Support Program to conduct a Behavioral Health Clinical Assessment and/or referral to in-network behavioral health providers for pre-transition services. Pre-transition referrals shall be made no more than 90 days prior to the planned discharge date.

3. Payment for all in-network behavioral health services provided pre-transition shall be made in accordance with **Section 10.17**.

Section 4.8 Social Innovation Financing for the Chronically Homeless Program (SIF Program)

The Commonwealth is implementing its Social Innovation Financing for Chronic Homelessness Program (SIF Program), a Housing First model, and has procured an entity to facilitate this implementation (SIF Intermediary). The Contractor shall support the SIF Program as described in this section.

A. The Contractor shall enter into good faith negotiations with SIF Program providers identified by EOHHS and, provided such negotiations are successful, execute and maintain Network Provider contracts with SIF Program providers identified by EOHHS to provide Community Support Program (CSP) services as set forth in **Appendix A-1** and below; provided, however, that such Network Providers must meet all applicable Contract, statutory, and regulatory requirements. The Contractor shall pay its contracted SIF Program providers a case rate consistent with the current market rate for the services in **Section 4.8.C** below for each day a Covered Individual is a SIF Program participant.

B. SIF Program participants shall be those Covered Individuals whom the SIF Intermediary refers to the Contractor (a "referral"). The Contractor shall accept from the SIF Intermediary referrals that identify Covered Individuals, including veterans, who are SIF Program participants. Such referrals shall only be for Covered Individuals who either:

1. Meet the definition of "Chronically Homeless" as set forth by the U.S. Department of Housing and Urban Development, i.e., is an unaccompanied homeless individual with a disabling condition who either has been continuously homeless for a year or more, or has had at least four episodes of homelessness in the past three years; or

2. Are identified by SIF Program providers and approved by the SIF Intermediary as an individual who is homeless and a high-cost user of emergency services.

The Contractor may also work with the SIF Intermediary and SIF Program providers to develop a process for the Contractor to refer Covered Individuals to the SIF Intermediary and SIF Program providers who the Contractor believes may qualify to be SIF Program participants.

C. Subject to Medical Necessity requirements, other Contract requirements, and applicable statutory and regulatory requirements, the Contractor shall authorize, arrange, coordinate, and provide to Covered Individuals who are SIF Program participants Community Support Program (CSP) services as set forth in **Appendix A-1** in a manner consistent with the goals of the SIF Program. Such CSP services shall consist of face-to-face, intensive, and individualized support, as described by EOHHS, which shall include:

1. Assisting SIF Program participants in enhancing daily living skills;
2. Providing service coordination and linkages;
3. Assisting SIF Program participants with obtaining benefits, housing and healthcare;
4. Developing a crisis plan;
5. Providing prevention and intervention; and
6. Fostering empowerment and recovery, including linkages to peer support and self-help groups.

D. The Contractor shall work with EOHHS to take all steps and perform all activities necessary to implement the above requirements consistent with SIF Program goals, policies and procedures as communicated by EOHHS, including but not limited to participating in meetings with the SIF Intermediary."

Section 4.9 Mobile Crisis Intervention/Runaway Assistance Program (MCI/RAP)

A. The Contractor (MBHP) shall ensure that its contracted Emergency Services Program Providers (ESPs) establish a "Mobile Crisis Intervention/Runaway Assistance Program" (MCI/RAP). Through this program, as further described in this **Section 4.9**, the ESPs shall provide a temporary and safe place for Youth as defined in **Section 4.9.B** below to stay on a voluntary basis, until such Youth is transferred to an Alternative Lock-up Program or other appropriate level of service in accordance with **Section 4.9.C.4**, below.

B. For the purposes of this **Section 4.9**, the following definitions shall apply:

1. Youth –

   a. Any "Child Requiring Assistance" under Chapter 240 of the Acts of 2012, currently defined as a child between the ages of 6 and 18 who: (i) repeatedly runs away from the home of the child's parent, legal guardian or custodian; (ii) repeatedly fails to obey the lawful and reasonable commands of the child's parent, legal guardian or custodian, thereby interfering with their ability to adequately care for and protect the child; (iii) repeatedly fails to obey the lawful and reasonable regulations of the

child's school; (iv) is habitually truant; or (v) is a sexually exploited child; or

b. Any minor between the ages of 7 and 18 who has been arrested by police for a non-violent offense.

2. MCI/RAP site – the site the ESP maintains to operate the MCI/RAP in accordance with **Section 4.9.C.2** below. Such site may be the same site as the ESP location.

3. Non-Court Hours – Hours during which the courts in the Commonwealth of Massachusetts are not open in accordance with www.mass.gov. Such hours are typically Monday through Friday between 4:30 PM and 8:30 AM, weekends, and holidays.

C. Implementation of MCI/RAP

In implementing the MCI/RAP, the Contractor shall require its contracted ESPs to:

1. Receive and respond to phone calls or other forms of communication related to the MCI/RAP during Non-Court Hours.

2. Maintain a MCI/RAP site where police can bring Youth during Non-Court Hours.

3. Greet police officers and Youth who come to the MCI/RAP site during Non-Court Hours.

4. Supervise Youth brought by a police officer to the MCI/RAP site on at least a one-to-one basis until the Youth:

   a. Is transferred to a hospital level of care;

   b. Is transferred to the care of Alternative Lock-up Program (ALP) staff; or

   c. Voluntarily leaves the site.

5. If a Youth who was brought to the MCI/RAP site chooses to voluntarily leave the site,

   a. Immediately notify the police department of the city or town where the MCI/RAP site is located and the Department of Children and Families (DCF) (if the Youth is known to be in DCF custody), of the youth's departure,

   b. Determine the appropriateness of an application for admission in accordance with M.G.L. c. 123, §12, and, if determined appropriate , apply for hospitalization of such Youth; and

c. Submit a critical incident report form to the Contractor. The Contractor shall submit such report to EOHHS.

6. Designate a manager to oversee the MCI/RAP. The manager shall:

a. Ensure MCI/RAP is staffed by on-call, appropriately trained staff, 365 days per year during Non-Court Hours and be available to MCI/RAP staff for consultation;

b. Provide back-up coverage for on-call MCI/RAP staff;

c. Train program staff regarding MCI/RAP procedures;

d. Outreach to police departments to promote the availability of the MCI/RAP, and answer questions local police may have regarding MCI/RAP; and

e. On the following business day, follow up with the police department that transported the Youth to the MCI//RAP site, and follow-up with any ALP to which the Youth was transferred.

D. Implementation Timeline

1. On November 5, 2014, the Contractor shall ensure that at least two of its contracted ESPs to operate the MCI/RAP in accordance with this **Section 4.9**.

2. From January 1, 2015 through March 31, 2015, the Contractor shall:

a. Allow, but not require, additional contracted ESPs to operate the MCI/RAP.

b. With support from EOHHS, arrange at least one statewide meeting with all contracted ESPs to discuss full implementation of the MCI/RAP.

3. On April 1, 2015, the Contractor shall ensure that all of its contracted ESPs operate the MCI/RAP in accordance with this **Section 4.9.**

E. MCI/RAP Outreach and Training

As directed by EOHHS, the Contractor shall provide additional outreach and training to contracted ESPs and other stakeholders, including:

1. Meeting with the ESPs, police and probation officers, and ALPs to discuss the MCI/RAP;

2. In conjunction with EOHHS and its designees (such as Mass211), hosting statewide trainings or conferences, in addition to requirements outlined in **Section 9** of this Contract; and

3. Training Contractor staff on MCI/RAP.

F. MCI/RAP Outcome and Output Measures

The Contractor shall require its contracted ESPs to provide quarterly and annual reports to the Contractor, who will report to EOHHS, in a form and format agreed upon by the Contractor and EOHHS, on outcomes and outputs related to the MCI/RAP, including but not limited to:

1. The number of Youth who receive a crisis intervention assessment;

2. Demographics related to Youth served including but not limited to age, gender, ethnicity and city/town of residence

3. The number of Youth unable to be maintained safely at the MCI/RAP site and require further assessment in the secure environment of the emergency department;

4. The number of Youth transferred to the care of Alternative Lock-up Program (ALP) staff; and

5. The number of Youth who voluntarily leave the MCI/RAP site.

G. Contractor Payment to ESPs for MCI/RAP

1. Each state fiscal year, the Contractor shall pay each contracted ESP $35,476.00 for its operation of the MCI/RAP.

2. The Contractor shall make the payments in **Section 4.9.G.1**, and shall account for any other costs associated with operation of the MCI/RAP, using only the payments EOHHS provides the Contractor in accordance with **Section 10.12** and the Contractor's own funds. The Contractor shall not use any other payments EOHHS provides the Contractor in accordance with **Section 10** to operate the MCI/RAP. Unless specifically directed to do so by EOHHS, the Contractor shall not include the Contractor's costs and expenditures related to the MCI/RAP in its Encounter Data submitted to EOHHS and such costs and expenditures shall not be considered when calculating any payment pursuant to the risk sharing arrangement in **Section 10.6** and **Appendix H-1**.

Section 4.10 Community Support Program (CSP) Services for Chronically Homeless Individuals

Subject to the Medical Necessity requirements under 130 CMR 450.204, other Contract requirements, and applicable statutory requirements, the Contractor shall provide CSP services as set forth in **Appendix A-1** to chronically homeless individuals as described in this section.

1. The Contractor shall authorize, arrange, coordinate, and provide CSP services as set forth in **Appendix A-1** to Covered Individuals who are Chronically Homeless, which shall include:

    a. Assisting in enhancing daily skills;

b. Providing services coordination and linkages;

c. Assisting with obtaining benefits, housing and healthcare;

d. Developing a crisis plan;

e. Providing prevention and intervention; and

f. Fostering empowerment and recovery, including linkages to peer support and self-help groups.

2. For the purposes of this **Section 4.10**, Chronically Homeless Covered Individuals shall be those Covered Individuals who meet the definition of "Chronically Homeless" as set forth by the U.S. Department of Housing and Urban Development, described as an unaccompanied homeless individual with a disabling condition who either has been continuously homeless for a year or more, or has had at least four episodes of homelessness in the past three years.

Section 4.11 Reduction in Emergency Department Boarding

The Contractor shall make best efforts to minimize boarding of Covered Individuals in emergency departments as follows:

A. The Contractor shall provide timely access to medically necessary, clinically appropriate BH Covered Services for populations determined by EOHHS to be disproportionately boarded in emergency departments, including but limited to individuals with:

1. Autism Spectrum Disorder (ASD);

2. Intellectual or Developmental Disability (IDD);

3. Dual Diagnosis for mental health and substance use disorder;

4. Co-morbid Medical Condition; and

5. Assaultive or combative presentation resulting in the need for special accommodation in an inpatient psychiatric setting; and

B. In a form and format and at a frequency to be determined by EOHHS, the Contractor shall report to EOHHS on any Covered Individuals awaiting placements in a 24-hour level of behavioral health care who remains in an emergency department for 24 hours or longer, as further directed by EOHHS.

Section 4.12 Specialized Inpatient Services for Youth with Autism Spectrum Disorder or Intellectual or Developmental Disability (ASD/IDD)

The Contractor shall provide specialized Inpatient Services for Covered Individuals under the age of 21 with Autism Spectrum Disorder or Intellectual or Developmental Disability (ASD/IDD) in specialized ASD/IDD inpatient treatment settings, as directed by EOHHS.

Section 4.13 Rates For Certain Behavioral Health Covered Services

A. On or after October 1, 2017, for each Behavioral Health Covered Service to be specified by EOHHS in **Appendix L**, the Contractor shall pay Providers no less than the rate to be specified by EOHHS in **Appendix L** for that service.

B. On or after October 1, 2017, the Contractor shall pay non-acute psychiatric hospital Providers for Inpatient Mental Health Services an increased rate to be specified by EOHHS pursuant to performance criteria to be specified by EOHHS.

C. The Contractor shall pay Providers of Program of Assertive Community Treatment (PACT) no less than the rate specified in 101 CMR 430.03.

Section 4.14 Collaboration in Policy Development

The Contractor shall participate in any EOHHS efforts related to the development of policies or programs, as well as measurement, analytics, and reporting relating to such policies and programs, that support access, coordination, and continuity of behavioral health care and which address emergency department boarding and the opioid epidemic. Such policies or programs may include, but are not limited to, the development of:

A. Specialized inpatient services;

B. New diversionary and urgent levels of care;

C. Expanded substance use disorder treatment services; and

D. Services and supports tailored to populations with significant behavioral health needs, including justice involved and homeless populations.

Section 4.15 Reporting

The Contractor shall submit to EOHHS all required reports related to clinical service and utilization management under the Contract, as described in this **Section 4** or in **Appendix E-1**, in accordance with specified timetables, definitions, formats and assumptions, as well as any ad hoc reports required by EOHHS in accordance with **Section 11.2.B**.

SECTION 5. PCC PLAN MANAGEMENT SUPPORT SERVICES

Overview

The Contractor shall assist EOHHS in the management of the PCC Plan by providing certain administrative functions, as described in this section, on behalf of EOHHS.

Section 5.1 PCC Plan Management Support Services (PMSS) Staffing and Staff Training

The Contractor shall:

A. Employ appropriately qualified staff experienced in supporting providers in the areas of transformation, integration and general primary care support functions in sufficient numbers to satisfy all responsibilities. Staff shall include the following positions, unless otherwise approved by EOHHS.

1. **PCC Plan Management Support Services Director** - dedicated solely to the Contract; responsible for all applicable PCC Plan Management Support Services (PMSS) activities as described in **Section 5.**

2. **PCC Plan Support Managers**-dedicated solely to the Contract, with appropriate provider relations, QM, and relevant background and experience; responsible for conducting activities on behalf of EOHHS as described in **Section 5.**

B. Ensure that all Contractor staff providing services under this Contract are informed and knowledgeable about relevant aspects of MassHealth policy changes, including but not limited to EOHHS payment reform and integration initiatives, MassHealth accountable care organizations, community partners, and have other skills associated with this Contract. In consultation with EOHHS, the Contractor shall determine the need for training some or all of the Contractor's staff in relevant aspects of MassHealth policy updates, payment reform and integration initiatives, or in other skills associated with this Contract and, if necessary, develop and provide such training within a timeline agreed upon with EOHHS.

C. Annually, within the first three months of the first day of the Contract Year, develop a plan for training and enhancing staff performance on all functions associated with the PCC Plan Management Support Services (PMSS). Training material must receive prior review and approval from EOHHS.

Section 5.2 PCC Plan Management Support Services (PMSS) Program

A. PCC Plan Management Support Services (PMSS)

The Contractor shall:

1. Establish, implement and maintain a PMSS program for PCCs that measures, monitors and promotes improvements in health care delivery systems, including integration of care, at the PCC practice level;

2. Review, update, and establish any new written standard operating policies and procedures for the Contractor's staff associated with the PMSS program;

3. Provide to EOHHS copies of the standard operating policies and procedures for the PMSS program within six months of the first day of the Contract Year and modify such policies and procedures in support of the PCC Plan as directed by EOHHS;

4. Accept and utilize any data files that EOHHS provides in connection with the PMSS program, in the format determined by EOHHS;

5. Notify EOHHS if, after diligent effort on the part of the Contractor, a PCC refuses to cooperate with the PMSS program or other Contract requirements;

6. Develop and implement written action plans, as needed, related to reports produced for PCC Service Locations. Prior to disseminating such reports, the Contractor shall certify the accuracy of the data to EOHHS regarding these reports as required in **Section 11.l.B;**

7. Provide support to PCCs consistent with integration of Behavioral Health, medical care, long-term support, and social services;

8. Provide support to PCCs as required related to ICMP activities as follows:

    a. Strengthen ICMPs relationships with PCCs, including improving communications, and enhancing and expanding use of ICMP for Enrollees; and

    b. Manage and coordinate PCC inquiries, requests, and concerns regarding interacting with ICMP.

9. Provide support to PCCs as required related to PBCM activities as follows:

    a. Support PCCs with the implementation of new PBCM programs, including evaluating the PCC for readiness to perform care management activities;

    b. Provide on-going support to the PBCM program, including identifying strategies for process improvements for outreaching and engaging Enrollees in the PBCM program, improving workflows, and providing technical assistance related to reporting and other operational issues;

    c. Monitor compliance of PBCM programs with care management activities, and

d. Manage and coordinate PCC inquiries, requests, and concerns regarding interacting with the PBCM program.

10. The Contractor shall support the Pilot ACO program as directed by MassHealth. These areas of support include but are not limited to::

    a. Collaboratively working with Pilot ACOs to avoid duplication of efforts between the Pilot ACOs' activities and MBHP's PCC Plan Management Support Services including, but not limited to, network management and provider support activities such as site visits, training, materials, etc.;

    b. Maintaining and implementing protocols for handling PCC inquiries, requests and concerns received by the Contractor regarding the Pilot ACOs.

11. Represent the PCC Plan and EOHHS with respect to PCC Plan activities, at provider conferences, community agency meetings and other forums that require a PCC Plan presence, if requested or approved by EOHHS;

12. Establish relationships with other EOHHS contractors (e.g., the MassHealth Customer Service Center (CSC) vendor) and refer PCCs to the CSC in order to resolve questions and issues such as eligibility, claims and billing inquiries, and to provide file updates; and

13. In addition to submission of the monthly PMSS report(s) outlined in **Appendix E-1**, submit to EOHHS an annual report on the PMSS activities for the Contract Year.

B. Compliance with PCC Plan Provider Contract with EOHHS

The Contractor shall:

1. Annually submit a report to EOHHS documenting the process used to monitor PCC compliance with the EOHHS PCC Plan Provider Contract in areas such as outreach and appointment times as set forth in **Appendix** C-2.

2. Refer PCCs to the Customer Service Center for enrollment with the MassHealth Provider Online Service Center (POSC) and Job Aids (Enrollment Roster, Referral) to support compliance with the PCC Contract;

3. Reinforce the importance of updating and inform PCCs on how to update PCC information with MassHealth Customer Service Center including but not limited to Provider information and capacity;

4. Assist PCC Plan staff with ensuring that all Providers who wish to remain in the PCC Plan network sign and return to EOHHS new PCC Provider Contracts whenever MassHealth updates such contracts; and

5. Report to EOHHS any PCC who could benefit from outreach by MassHealth's Customer Service Center Provider Outreach and Education Unit to support delivery of services to PCC Plan members.

C. PMSS Site Visits

1. PMSS Introduction Visit

   The Contractor shall:

   a. Conduct an introduction visit with each PCC, regardless of the PCC's enrollment roster/panel size;

   b. Ensure that the PMSS introduction visit includes:

      1) An introduction to the Contractor and a description of the Contractor's role and the PMSS program;

      2) A discussion regarding the PCC's current priorities and engagement with MassHealth members and health plans;

      3) A discussion of the current EOHHS and PCC Plan goals and policies;

      4) A description of available Contractor programs, including but not limited to, ICMP and ESP;

      5) A description of materials that are used in the PMSS program;

      6) Obtaining the PCC's Support Manager's name, telephone number, and e-mail address;

      7) Providing the PCC Hotline number and a list of reasons a PCC might want to call the PCC Hotline; and

      8) A description of any additional reports and/or information as directed by EOHHS.

2. PMSS On-going Site Visits

   After the introduction visit, the Contractor shall conduct PMSS site visits according to an EOHHS-approved schedule. The Contractor shall review the needs of the PCC or PCC Service Location prior to scheduling a site visit, including PCC-specific and/or PCC Service Location-specific data, and shall conduct site visits to PCCs and PCC Service Locations as appropriate, or as requested by the PCC or PCC Service Location.

   a. The Contractor shall develop and propose for EOHHS's approval a detailed plan for PMSS site visits to all PCCs and PCC Service Locations

that meet the site visit criteria agreed to by EOHHS. Such proposal shall include, at a minimum, the following elements:

1) A schedule for PMSS site visits that is specific to each PCC and PCC Service Location, based on the agreed-upon site visit criteria and the PCC's priorities and performance;

2) The criteria by which PCCs and PCC Service Locations will be visited including frequency for visits;

3) The content and subject matter of the site visits or, for those PCCs that may not receive a visit, other communications;

4) A description of how the Contractor will support PCC questions regarding Claims payment or other PCC Plan services not managed by the Contractor;

5) A description of how the Contractor will prioritize and promote integration of Behavioral Health and medical care, and care management efforts for Enrollees as part of each site visit;

6) A method for documenting the site visits and the communications that have taken place with PCCs and PCC Service Locations;

7) A method and timeframe for evaluating the success of PMSS site visits under the Contractor's proposal; and

8) A description of any additional reports and/or information as directed by EOHHS.

b. Subject to EOHHS approval, the Contractor shall implement its PMSS site visit proposal.

c. The Contractor shall work with PCCs and PCC Service Locations to schedule a convenient time for PMSS site visits.

d. The Contractor shall make best efforts to involve the medical director of the PCC in the site visit, and shall advise the PCCs and PCC Service Locations that appropriate clinical and non-clinical staff should attend the site visit.

e. The Support Manager shall discuss other related PCC issues as identified by the PCC or the Support Manager, or as directed by EOHHS.

f. The Support Manager shall conduct the PMSS site visit and other EOHHS or Contractor staff shall attend, at the discretion of EOHHS.

g. At each PMSS site visit, the Support Manager shall review with the PCC any new PCC Plan Management Support Services Materials and inquire of any PCC- developed materials useful for Enrollees including how and where the materials can be accessed.

h. The Contractor shall inform PCCs and PCC Service Locations that they may call the PCC Hotline to request assistance with acquiring PCC Plan Management Support Services materials and shall furnish such materials upon request

i. The Contractor shall maintain and document ongoing communication with PCCs and PCC Service Locations through additional site visits, email, and telephone follow-up, as appropriate or as directed by EOHHS.

j. The Contractor and EOHHS may negotiate a modified schedule and methodology for PMSS site visits and, with EOHHS approval, the Contractor shall perform PMSS site visits in accordance with such alternate schedule and methodology.

k. The Contractor shall prepare, deliver to, and discuss with PCC Plan staff a detailed report of site visits on a monthly basis. The Contractor and EOHHS may negotiate report format, contents, and frequency during the term of the Contract.

3. PMSS Joint Visits with a MBHP Behavioral Health Regional Network Manager and a member of MBHP's ICMP.

The Contractor shall develop and propose for EOHHS's approval a plan for PMSS and BH or ICMP joint site visits. Such proposal shall include, at a minimum:

a. The criteria by which joint visits will be conducted;

b. The content and subject matter of the site visit; and

c. A description of how the Contractor will support integration of Behavioral Health, medical care, and social services.

D. PCC Performance Dashboard

1. PCC Performance Dashboard (PD)

At the request of EOHHS, the Contractor shall:

a. Develop a PCC Performance Dashboard (PD) for each PCC and PCC Service Location(s) that meets the threshold number of Enrollees as agreed to by EOHHS and the Contractor. The PD shall be implemented and updated according to a schedule determined by EOHHS;

b. Produce the PDs as requested by EOHHS;

c. Ensure the PDs are formatted in a user-friendly style approved by EOHHS;

d. One month prior to the dissemination of the PD, prepare for EOHHS's prior approval a written user's guide that explains the purpose of the report and the information it contains;

e. Include in each PD PCC-specific site information and PCC Panel Enrollee demographics;

f. Include in each PD all measures provided by EOHHS. Measures shall be reported by both PCC and PCC Service Location level, when applicable. Such measures are subject to change during the term of the Contract. For each measure, the Contractor shall:

    1) Present PCC-specific data; and

    2) Compare each PCC's performance using appropriate benchmarks and trended indicator rates as directed by EOHHS, such as:

        a) aggregate PCC Plan performance;

        b) available national, state, local or industry benchmarks; and

        c) the PCC's PD trended data;

g. Include in the PD a one-page summary of trended rates for the PCC and by PCC Service Location for all clinical measures, as appropriate; compare the Service Location rates to that of the PCC entity, other PCC Service Locations, the overall PCC Plan rates, and other benchmarks as directed by EOHHS;

h. Maintain a password accessible website that provides each PCC and PCC Service Location access to their current PD report and ensure that the current PD report remains posted until the next cycle's PD is released or, subject to EOHHS's approval, develop an alternative mechanism for dissemination of the PCC PD report.

i. Within one business day of posting the updated PD, notify PCCs and PCC Service Locations via email that the reports are available; and

j. Design and propose for EOHHS approval additional clinical indicators that address medical and Behavioral Health integration as aligned with EOHHS's dashboard.

2. Additional Reports and Reporting Activities

   a. The Contractor shall propose to EOHHS additional reports to support the PMSS program, as appropriate.

   b. The Contractor shall produce additional PMSS reports, including but not limited to analysis of trends identified from PMSS data, data and analytics on population health management, and other supplemental and management reports that support quality and integration activities as negotiated by the parties.

   c. Upon the request of EOHHS, the Contractor shall participate in activities to enhance and align with any existing dashboards designed by EOHHS. EOHHS and the Contractor may negotiate alternate PD measures, report formats, methods and timeframe for these activities including design and propose for EOHHS approval additional clinical indicators that address medical and Behavioral Health integration.

   d. EOHHS may at its discretion instruct the Contractor to replace the production of certain existing reports with reports generated for PCCs and PCC Service Locations as part of other EOHHS programs and/or initiatives (e.g., ACO).

E. PCC Plan Management Support Materials

During Contract Year Five, the Contractor shall:

1. Continue to develop and update the Health Literacy Library as directed by EOHHS. Topics shall clearly and concisely describe relevant health education, including medical, Behavioral Health, substance use, chronic disease management, and wellness/prevention topic areas. The Contractor shall submit new or updated materials to EOHHS for prior approval.

2. Establish a plan to review with EOHHS the current PCC Plan Management Support Materials, at EOHHS's request, to determine the need for revised, additional, or replacement Support Material necessary to support improved Member experience and integration of physical and Behavioral Health care, including materials developed by the PCC Plan and the Contractor upon request by EOHHS related to ACOs serving Enrollees. The Contractor shall deliver materials for EOHHS approval within required timeframes, as determined by EOHHS.

3. Provide storage to accommodate all of the PCC Plan Management Support Materials necessary to meet the needs of the BH and PCC Providers.

4. Maintain a sample original package of all PCC Plan Management Support Materials and an inventory including:

a. A list of topics for which PCC Plan Management Support Materials are available; and

b. The number of each item in the Contractor's inventory.

F. Education and Training

PMSS will be responsible for the coordination of educational and training opportunities for PCCs and PBCMs that serve Enrollees. PMSS shall collaborate with stakeholders and subject matter experts both internally and externally to identify relevant training topics that will support current and future EOHHS initiatives. These shall include educational opportunities, such as learning collaboratives, regional learning sessions, or other educational modes that support PCCs and PBCMs that serve Enrollees to engage in group learning and identified topics.

G. Health Care Reform

The Contractor shall work with EOHHS on matters related to MassHealth's delivery system reform as it impacts Enrollees and Providers. The Contractor shall support the improvement of integrated care delivery for Enrollees and preparations for the implementation of the MassHealth ACO program as directed by EOHHS.

Section 5.3 Reporting

The Contractor shall submit to EOHHS all required reports related to clinical service and utilization management under the Contract, as described in this **Section 5** or in **Appendix E-1,** in accordance with specified timetables, definitions, formats and assumptions, as well as any ad hoc reports required by EOHHS in accordance with **Appendix E-1.**

SECTION 6. INTEGRATION OF CARE

Overview

The Contractor shall conduct and appropriately staff the activities described in this **Section 6** with a combination of clinicians, professionals and paraprofessionals.

Section 6.1 Integration of Medical and Behavioral Health Care

A. Goal of Integration

The Contractor shall make best efforts to ensure the integration of medical and Behavioral Health care provided to Covered Individuals, and to ensure that such care is:

1. patient-centered, strength-based and recovery-oriented (if appropriate);
2. accessible (e.g., hours, communication methods);
3. driven by clinical and care issues and functions, and not practice and administrative issues;
4. integrated within practices or facilities as well as across practices and care settings;
5. integrated across both physical and Behavioral Health settings; and
6. focused on information sharing (process, clinical, and health outcomes) across physical and Behavioral Health systems at the state level.

B. Integration of Care Activities

The Contractor shall conduct the following activities, at a minimum, to promote coordination and collaboration among PCCs and Network Providers in the care they provide to Covered Individuals:

1. Educate Contractor staff on all MassHealth Covered Services provided to Covered Individuals;
2. Design, with input from Network Providers and PCCs and other Primary Care Practitioners, develop and implement policies that promote communication, coordination and collaboration across medical and Behavioral Health Providers; including a process for Providers to obtain consent, if required, from Covered Individuals to release information to other Providers involved in the Covered Individual's care.
3. Contact Covered Individuals to:

a. Discuss the importance of information sharing among Providers in order to best integrate the Covered Individuals' medical and Behavioral Health care; and

b. obtain verbal consent to participate in Care Management and Care Coordination Programs.

4. Facilitate specific communication and coordination of a Covered Individual's Behavioral Health and Primary Care with the Network Provider, the PCC or other Primary Care Practitioners, and the Covered Individual;

5. Coordinate BH Covered Services with other MassHealth services, any other non-MassHealth services, and programs delivered to Covered Individuals, in concert with the natural community supports identified by the Covered Individual, as necessary and appropriate;

6. At the direction of EOHHS, measure the rate at which PCCs receive timely information about their patients' use of Emergency Departments (ED) and inpatient admissions, and participate in MassHealth-identified strategies to improve timely information transfer.

7. On a quarterly basis, evaluate the frequency and quality of interactions of Network Providers and PCCs and other Primary Care Practitioners regarding Covered Individuals, and develop and implement policy and process improvements based on these evaluations;

8. Educate PCCs and Network Providers on pharmaceuticals used for BH, in coordination with and support of the MassHealth Pharmacy Program (see **Section 4.4**);

9. Educate PCCs and Network Providers regarding the need to coordinate and manage prescribed medication use for BH and medical conditions, in coordination with and support of the MassHealth Pharmacy Program;

10. Monitor PCCs and BH Network Providers and conduct support activities to assist Providers in implementing best practices for integration of care through, at a minimum:

a. Regular screenings by PCCs to identify Behavioral Health risk factors;

b. Sharing of information through BH Network reports**;**

c. Outcome measurement; and

d. Information, education and training in evidence-based practices, wellness programs, and chronic care management.

11. Utilize the Contractor's website, as described in **Section 7.1.G**, to:

a. Provide PCCs and other non-Behavioral Health Providers with easy access to BH referral sources, treatment options and crisis intervention protocols;

b. Provide BH Network Providers with information on how to access the MassHealth Customer Service vendor for Primary Care referral sources, community resources and acute and Urgent Care Services facilities; and

c. Provide Covered Individuals with user-friendly access to at least the following sections of the Contractor's website: the Member Engagement Center, Member medical and Behavioral Health Covered Services, Nurse Advice Line, community supports, and self-referral to the CMP.

12. Educate Primary Care Practitioners serving children on the availability of psychiatric consultation through the MCPAP and MCPAP for Moms, described in **Section 4.5**.

13. Ensure that PCCs have access to Behavioral Health Network Providers, e.g., current Behavioral Health Provider Directory, PCC Hotline, Massachusetts Child Psychiatry Access Project.

14. Develop an annual statewide training for all PCC and Behavioral Health Providers, approved by EOHHS, that focuses on medical and Behavioral Health integration, utilizing training modules based on collaborative team building and multidisciplinary treatment approaches. The Contractor shall invite all PCCs, PCC Service Locations, and individual primary care practitioners and shall encourage them to attend the training. The Contractor shall submit a plan for training and content to EOHHS for approval two months in advance of the training date.

15. Ensure that meeting content and goals for Behavioral Health Network Providers and joint meetings with PCCs sites support service delivery reform, integration and system advancement activities, quality initiatives, lessons learned, and opportunities to resolve challenges and barriers faced by Providers. The Contractor shall utilize one or more of the meetings for content requested by EOHHS, as directed.

16. Attend and participate in all EOHHS meetings and workgroups as directed by EOHHS with a particular focus on workgroups targeting medical and Behavioral Health integration.

17. Prior to any disclosure of information identifying or concerning an Covered Individual made during the provision of services under this **Section 6.1**, obtain written consent, if required by law, and maintain a copy of it in each individual Covered Individual's files at the Contractor's principal place of business.

Section 6.2 Care Management Program (CMP)

A. Integrated Care Management Program (ICMP) Overview

1. Practice Based Care Management

   The Contractor shall:

   a. Continue the expansion of the Practice Based Care Management Program (PBCM) in all regions to PCCs and BH Providers who are not currently participating in a Pilot ACO or planning to participate in a MassHealth ACO or as a Community Partner. Expansion of PBCM includes providing technical assistance on such topics as approaches to population health management for the high risk/complex member and strategies to engage members into care management, as well as support for the provision of care management as needed by the participating practice;

   b. Coordinate with Pilot ACOs whose networks include PCCs with established PBCM programs to define areas of responsibility that:

      1) Avoid duplication or fracturing of care management activities and prevents disruption in a Member's care;

      2) Avoid duplication in practice monitoring; and

      3) Avoid duplication in reporting; and

   c. Monitor each practice's compliance with the PBCM contract.

2. Plan Based Care Management

   The Contractor shall continue to actively promote and provide plan based care management for identified high risk Enrollees not associated with a PBCM or Pilot ACO. The Contractor may provide care management support for enrollees served by PBCM or Pilot ACO program, when requested by the PBCM or Pilot ACO.

3. The Contractor's ICMP services shall include, but are not limited to, the identification of Enrollees for outreach and engagement in the ICMP through predictive modeling, acceptance of referrals from PCCs, Enrollees or other providers for participation in the ICMP, communication with Enrollees and Providers about ICMP, and implementing and evaluating the care plan with the Enrollee.

B. Integrated Care Management Support

1. The Contractor shall provide:

   a. Direct-to-Provider practice transformation support services for established and expanded PBCMs, including but not limited to, Behavioral Health consultation, Enrollee engagement strategies and supports, population health management strategies, state agency resources, and care management tools; and

b. Care management (which are clinical care related services rendered to the member directly either in person or via telephone as per the individual care plan) and Care Coordination (which are care activities rendered by the Contractor on behalf of the Enrollee) to identified Enrollees who have complex medical or Behavioral Health needs and whose overall health care may benefit from the assistance of a Care Manager.

2. The ICMP shall identify Enrollees with health risks for both PBCM and the ICMP. Care management services and Care Coordination for Enrollees shall provide holistic coordinated health care, social supports, and wellness and recovery tools, and shall assist Enrollees with identifying and using their medical home for treatment of Behavioral Health and medical conditions.

C. Integrated Design for Care Management

1. The Contractor shall submit to EOHHS a work plan for the Contract Year, including timelines, for providing ongoing support for PBCM programs and providing integrated care management for Enrollees served in ICMP. The work plan shall include:

   a. the supports offered by the Contractor's care management staff related to care management activities provided by PBCMs not participating in a Pilot ACO; and

   b. a timeline and plan for working with Pilot ACOs that outlines areas of responsibility for care management activities with Enrollees.

2. The work plan shall be submitted, for review and approval, within two months of the first day of the current Contract Year. This work plan shall:

   a. Prioritize direct real-time referrals to ICMP for high risk Enrollees not served by PBCM programs;

   b. Describe the process of referring Enrollees referred to ICMP to PBCMs;

   c. Include a description and process for Care Coordination activities within ICMP for those Enrollees in need of primary complex Care Coordination;

   d. Address care management services for those Enrollees transitioning to the community from long term support services;

   e. Address the expansion of PBCM and plan-based programs throughout the Commonwealth to provide care management for Enrollees identified by the Contractor as high risk and eligible for care management, including ICMP among members for whom PBCM is not available;

   f. Include the supports and services offered by ICMP to Providers who request support from the Contractor for their care management program;

g. Include an ICMP staffing plan with both professional licensed staff and para- professional staff (peer support/recovery staff and community health workers), including the functions to be performed by para-professional staff under the clinical supervision of licensed clinical staff. Licensed staff includes Behavioral Health clinicians and nurses. All ICMP para-professional staff shall be employed directly by the Contractor; and

h. Include the functions of the PCC Support Managers as an ICMP team member.

3. Until EOHHS's approval of the work plan for the Contract Year, the Contractor shall implement the existing Care Management Program under the leadership of a multidisciplinary medical and Behavioral Health team that include a diverse staff with the appropriate skills to deliver clinical and non-clinical components of the program, including the Enrollment of Enrollees into the ICMP.

4. Within three months of the first day of the current Contract Year, the Contractor shall submit to EOHHS any updates in the policies and procedures for daily operation of the Care Management Program.

5. The Contractor shall specifically tailor the care management provided to improve the health outcomes of each Participant, including such items as the frequency and intensity of interventions, and ensuring that the staff assigned to the Participant is appropriate based on each Participant particular needs.

   a. The Contractor shall include in each Participant's plan a range of care management activities that may vary in frequency or intensity depending on the Participant's clinical needs.

   b. The Contractor shall assign a registered nurse, or a Behavioral Health licensed care manager who shall oversee their assigned caseload, perform direct clinical activities and oversee all Care Coordination or support activities performed by para-professional staff.

6. The Contractor shall educate all Participants in self-care strategies, illness prevention and Wellness Program activities, and ensure that staff assigned to the Participant have knowledge of community-based services and supports.

7. Within six (6) months of the beginning of each Contract Year, the Contractor shall evaluate the current ICMP electronic system for tracking, profiling and managing Participants, including but not limited to face-to-face, telephonic, home visits, e-mail, texts, and mail encounter(s) between the care manager and the Participant and submit to EOHHS the results of the evaluation including a proposal, if applicable, to utilize a new electronic system.

D. Identification and Engagement of Enrollees for Care Management

1. The Contractor shall use a predictive modeling tool that incorporates health claims data in its algorithm to stratify high risk Enrollees for Enrollment into a PBCM or ICMP. EOHHS may in its sole discretion instruct the Contractor to use EOHHS's risk stratification of the PCC Plan for the Care Management Program. EOHHS may also request from the Contractor its risk stratification data on Enrollees. The Contractor shall work with the PBCMs to determine sites in need of population based stratification of high-risk members.

2. The Contractor shall use the Health Needs Assessment (HNA) tool to identify Enrollees who may want to participate in Care Management.

3. ICMP shall accept referrals of Enrollees who might be appropriate for Care Management or who may want to participate in care management from EOHHS, the Contractor's staff, PCCs, state agencies, Enrollees, other Providers, hospital discharge planners, Network Providers, or other knowledgeable sources.

4. The Contractor shall provide the PBCM program a monthly list of Enrollees affiliated with the PBCM eligible for care management.

5. The Contractor shall serve high-risk complex and specialty populations of Enrollees referred to CMP and not associated with PBCM, unless otherwise requested.

6. The Contractor shall document CMP Engagement activities in-person or telephonic encounters with or on behalf of an Enrollee for the purposes of completing a comprehensive health assessment, creating an Individual Care Plan (ICP), and /or implementing the Participant's ICP. These care management activities including in-person or telephonic voice-to-voice contact with the Participant must occur no less than once each month while the Participant is enrolled in the Care Management Program. When the Contractor's documented attempts to contact the Participant within thirty (30) days are unsuccessful, the Contractor shall ensure that face-to-face or telephonic voice-to-voice contact with the Participant is made within sixty (60) days.

7. The Contractor shall ensure that Enrollees, PCCs, and Behavioral Health Network Providers are informed about the plan-based Care Management Program in sufficient detail so that Enrollees, PCCs, and Behavioral Health Network Providers understand the program and how to participate.

8. The Contractor shall submit to EOHHS for approval within three (3) months of the beginning of each Contract Year a work plan for informing Enrollees, PCC's and Behavioral Health Network Providers of the plan-based Care Management program. The work plan shall include a plan for outreach to and Engagement of identified or referred Enrollees.

9. The Contractor shall document the Participant's verbal consent to participate in the Care Management Program, noting the date consent was given, the care

management staff to whom the consent was given, and, to the extent that the person giving consent is not the Participant, document the name of the person giving consent and the authority of that person to do so (e.g., "parent" or "guardian"). Additionally, the Contractor shall send a letter to the Participant explaining the Care Management Program in sufficient detail so that the Participant understands the program for which the verbal consent was given and provide sufficient information so that the Participant may opt out.

10. The Contractor shall make available to EOHHS the Contractor's contract with the PBCMs and the outreach, Enrollment and reporting processes expected of PBCMs.

E. Assessment of an Enrollee for Care Management

1. Prior to an assessment for the ICMP, the Contractor shall ensure that Enrollees eligible for participation in PBCM will not be assessed by ICMP.

2. The Contractor shall ensure that an assessment by appropriate health care professionals is conducted for Enrollees in need of care management. The care management assessment shall include the following components:

    a. Assessment of an Enrollee's physical and Behavioral Health status including cognitive functioning and condition-specific issues, including the Enrollee's understanding of their condition-specific issues;

    b. Enrollee's history, needs, and preferences with regard to race, ethnicity, language, culture, literacy, gender identity, sexual orientation, income, housing status, recent incarceration, food insecurity and other social characteristics;

    c. Assessment of the Enrollee's health care utilization patterns, including ED visits, types and variety of Providers who have treated the Enrollee and the Enrollee's diagnoses, if any;

    d. Documentation of clinical history, including medications;

    e. Assessment of activities of daily living;

    f. Assessment of life planning activities; and

    g. Evaluation of caregiver resources and natural community supports.

3. A licensed Behavioral Health clinician or a nurse supervisor will determine if an Enrollee is in need of ICMP intensive Care Coordination activities with limited or no care management. All Care Coordination activities will be documented in an electronic system.

F. Development, Implementation and Monitoring of an Individual Care Plan (ICP) for Care Management

The Contractor shall:

1. Develop required ICPs for, and with, Participants receiving ICMP care management and ensure that an ICP is developed by PBCMs for their Participants.

2. Ensure that the ICMP care manager coordinates a Participant's care across the Contractor's staff, including BH service authorization and BH Utilization Management, and utilizes a multidisciplinary Care Team that includes the Participant, the PCC, and others who are stakeholders in the Participant's care (e.g., family members, Peer Support, BH Providers or other specialists, state agency case managers and/or service providers, and other community supports), as agreed to by the Participant;

3. Ensure that the ICP addresses the Participant's specific medical and BH care needs and includes the following components:

    a. Long- and short-term goals identified by the Participant and care management team that seek to reduce the risk and help manage the complexity of the Participant's health conditions;

    b. Identification of barriers to meeting goals and consideration of the Participant's ability to adhere to treatment plans;

    c. Development of a schedule for follow-up and ongoing Participant assessment and communication;

    d. Development and communication of self-management, health promotion, and Wellness Programs for Participant;

    e. Assessment of progress toward meeting goals established in the ICP; and

    f. Behavioral Health Crisis Prevention Plans as appropriate.

4. Initiate activities, as indicated in the ICP, related to care management to ensure:

    a. Medication review and reconciliation;

    b. Communication with other treating Providers and other supports identified by the Enrollee;

    c. Comprehensive care transition planning;

    d. Education on self-management of chronic conditions; and

e. Education and empowerment of Participants and their family support system.

5. Initiate activities, as indicated in the ICP, to ensure Participants' timely and coordinated access to Primary, medical specialty and BH care, such as:

   a. Reinforcement of PCC, specialists or other Network Provider instructions;

   b. Guidance and assistance with obtaining a PCC/medical home for Enrollees when needed;

   c. Assistance in scheduling appointments;

   d. Well-visit and preventive care self-management reminders;

   e. Medical and BH appointments reminders and confirmation with the Participant that appointments have been kept;

   f. Wellness activities (e.g., smoking cessation, weight loss);

   g. Confirming with Participants that they are adhering to medication recommendations; and

   h. Facilitating communities of social supports available for Participants.

6. Provide the Participant with the opportunity to sign off on and/or verbally agree to the ICP goals and treatment plan prior to the implementation of such plan;

7. On at least a monthly basis, assess and monitor each Participant's ICP to ensure that the goals set forth in the ICP are met, the Participant's compliance is monitored, and recommendations for follow-up and all ICP activities are documented in the Participant's ICP.

G. Care Management Activities

The Contractor shall:

1. Assist Providers and Participants in the development of an appropriate ICMP discharge plan when the Enrollee changes treatment settings or is admitted to an in-patient treatment program. The development of a discharge plan shall occur prior to a Participant's hospital or long term care setting discharge or change in treatment setting, in coordination with appropriate staff, including but not limited to discharge planners, care managers, staff, the Participant's PCC, and other Network Providers. Where possible, the care manager should be present at Discharge Planning meetings;

2. Ensure that PBCM providers develop appropriate discharge plans for their Participants transitioning between treatment settings. Complete discharge plans

for continuity of care for Participants who transition from ICMP to PBCM and/or Pilot ACO care management programs;

3. Provide on-going ICMP clinical updates and Care Coordination activities to PCCs and BH Providers for ICMP Participants with complex conditions. The Contractor shall document any clinical information received from the PCC or BH Provider in the ICMP record. Clinical updates to PCCs may be made telephonically, through face-to-face contacts, by mailings or fax, or as otherwise agreed upon with the PCC. The Contractor shall ensure PBCM providers provide and document clinical updates and Care Coordination activities for their Participants;

4. As necessary for successful Participant Enrollment and tenure, ensure face-to-face contact occurs in home visits, community, inpatient, or emergency department settings, as necessary and appropriate;

5. Facilitate communication among the ICMP Participant, the PCC, the Network Provider and other specialty Providers, and the Participant's support network, as identified by the Participant, who are involved in the Participant's health care, to promote service delivery coordination and improved outcomes;

6. Ensure PBCM programs facilitate communication and service delivery coordination to improve outcomes for their Participants;

7. Monitor medical and pharmacy utilization for ICMP Participants through claims data obtained from EOHHS and appropriately update the ICP and coordinate follow-up care as indicated through data received;

8. Educate and provide to the ICMP Participant and Provider, as appropriate, EOHHS-approved informational materials created by the Contractor or obtained from external sources, about the ICMP Participant's medical or BH condition;

9. Document activities related to the provision of Care Management to ICMP Enrollees and share progress reports with care team members, with written consent from the Enrollees, if required by law; and

10. Prior to any disclosures regarding an Participant made during the provision of care management services, obtain written consent if required by law, and maintain a copy of it in each individual Participant’s files at the Contractor's principal place of business, to the extent required by law.

H. ICMP and Transition to Practice-Based care management programs

The Contractor shall continue to provide either a transition or discharge summary from the ICMP or a face-to-face or telephonic clinical meeting based on an agreed upon transition plan when a Participant transitions to a PBCM from ICMP to encourage a seamless transition and continuity of care.

I. ACO and Community Partner (CP) Transition Preparations

During the current Contract Year, the Contractor shall partner with EOHHS to develop and execute a transition plan for ICMP and PBCM Members who are identified by EOHHS for future enrollment in an ACO or CP. This plan shall include but not be limited to, Member-specific transitional "handoff" meetings between ICMP/PBCM and ACOs or CPs.

Section 6.3 Coordination for Covered Individuals not enrolled in the PCC Plan, including children in DCF and DYS and Covered Individuals enrolled in the MFP Waivers.

A. The Contractor shall establish clinical protocols for providing Care Coordination to a Covered Individual who is not an Enrollee when:

1. The Covered Individual presents with a pattern or history of:

    a. high inpatient utilization;

    b. ongoing active involvement with other state agency services and programs;

    c. frequent ESP utilization;

    d. utilization of both psychiatric inpatient and detoxification services; or

    e. co-existing medical and Behavioral Health problems; or

2. The Covered Individual presents to a Network Provider with complex child custody and placement issues that are adversely affecting the provision of Behavioral Health and medical services.

B. The Contractor shall accept referrals from EOHHS, PCPs, state agencies, Network Providers, MFP Case Management entity, or other knowledgeable sources identifying Covered Individuals who may be appropriate for Care Coordination as described in this **Section 6.3.A**.

C. Within thirty days of the first day of the Contract Year, the Contractor shall submit to EOHHS a work plan for Contract Year 6A, for the Clinical Service Coordination programs as described in **Section 6.3.A**, for EOHHS review and approval.

D. The Contractor shall provide Care Coordination for Covered Individuals as follows by:

1. Ensuring that each Covered Individual has a specifically assigned Care Coordinator:

    a. With the authority to authorize Covered Services pursuant to the Covered Individual's plan;

b. Who shall convene an interdisciplinary team for service planning meetings; and

c. Who shall work directly with state agency representatives in coordinating care to expedite a timely community placement as part of the Discharge Planning activities described in **Section 4.3.C**.

2. Ensuring that each Covered Individual has a service plan that addresses the Covered Individual's specific BH care needs, including short-term and long-term service needs and, as applicable, medical services the Covered Individual may require and that coordinates BH services with services provided by other state agencies involved with the Covered Individual;

3. Ensuring that the service plan is sent to the Covered Individual's Primary Care Practitioner after receiving consent, if such consent is required;

4. Facilitating a schedule of home visits and face-to-face contacts with the Covered Individual, if appropriate;

5. Facilitating communication among the Covered Individual, Primary Care Practitioner, Network Providers and other specialty providers involved in the Covered Individual's health care, to promote service delivery coordination and improved outcomes;

6. Providing linkages with staff in other state agencies and community service organizations that may be able to provide services the Covered Individual needs;

7. Assisting the Covered Individual to access Primary Care and medical specialty care;

8. Ensuring that each Covered Individual receives his or her Care Coordinator's contact information;

9. Implementing procedures to coordinate the services that the Contractor furnishes to the Covered Individual:

a. between settings of care, including appropriate discharge planning for short- and long-term hospital and institutional stays;

b. with the services the Covered Individual receives in fee-for-service Medicaid; and

c. with the services the Covered Individual receives from community and social support providers.

Section 6.4 Demonstration Programs

The Contractor, in collaboration with EOHHS, shall propose a demonstration program to improve integration across Behavioral and medical health care for Covered Individuals which it

shall implement upon approval by EOHHS. The program must have a goal of improving medical and behavioral health integration for Children in the Care and/or Custody of the Commonwealth.

Section 6.5 Reporting

The Contractor shall submit to EOHHS all required reports related to integration of care and the Care Management Program, as described in this **Section 6** or in **Appendix E-1**, in accordance with specified timetables, definitions, formats and assumptions, as well as any ad hoc reports required by EOHHS in accordance with **Section 11.2.B**.

SECTION 7. MEMBER AND PROVIDER SERVICES

Section 7.1 General Requirements

The Contractor shall establish and operate as of the Service Start Date a discrete Member (Covered Individual) and Provider Services Department dedicated to the Contract, responsible for assisting Covered Individuals, Network Providers, PCCs and other PCC Plan providers. The Member and Provider Services Department shall maintain coverage for a minimum of nine hours per day during normal business hours and shall answer 90 percent of all calls within 30 seconds.

A. Staffing

The Contractor shall:

1. Employ service representatives with appropriate education and work experience to successfully perform the responsibilities of the position as described in **Section 7.1.B**, and in sufficient numbers to respond to all incoming calls to the Member and Provider Services Department and to handle any written correspondence received;

2. Train and supervise the service representatives, consistent with **Section 2.2.G** and as follows. The Contractor shall:

    a. Prior to the Service Start Date and thereafter on an ongoing basis, orient and train service representatives regarding their job responsibilities and all applicable Contract matters.

    b. Ensure that all service representatives are cross-trained to handle non-clinical calls from Covered Individuals, Network Providers, PCCs and other PCC Plan providers, including calls related to MassHealth Covered Services, BH Network Provider access, and BH Claims payment.

    c. Immediately refer clinical calls received in the Member and Provider Services Department to clinical staff with the appropriate clinical expertise for response and resolution.

    d. Adequately supervise service representatives to ensure quality and consistency in the performance of their responsibilities.

    e. Establish a schedule of intensive training for newly hired and current service representatives about:

        1) when, where and how Covered Individuals may obtain EPSDT/PPHSD screenings and diagnosis and treatment services;

        2) the Children's Behavioral Health Initiative; and

3) the Contract's focus on integration of medical and Behavioral Health care and how the customer service representatives should incorporate integration into their contact with Covered Individuals, Network Providers, PCCs and other PCC Plan providers.

f. Develop a written curriculum for each training, which shall be reviewed and approved by EOHHS before use by the Contractor.

3. Adjust the number of service representatives to accommodate significant changes in phone call volume;

4. Empower service representatives to assist all callers as completely as possible and to handle all calls appropriately;

5. Develop a process with the MassHealth Customer Service vendor to assist in the resolution of calls that initiate with Member and Provider Services Department;

6. Ensure that all calls from all providers are resolved, to the maximum extent possible, by the same service representative who handled the initial call;

7. Have the capacity to respond to callers who speak languages other than English; and

8. Ensure that service representatives have online access to the following BH Network Provider database elements:

   a. Network Provider name;

   b. website;

   c. e-mail address;

   d. contracted services;

   e. site addresses (street address, town, ZIP code);

   f. site telephone numbers;

   g. site hours of operation;

   h. Emergency/after-hours provisions;

   i. professional qualifications and licensing;

   j. areas of specialty;

   k. handicapped accessibility; and

   l. cultural and linguistic capacity.

9. Ensure that service representatives have online access to MassHealth and PCC Plan provider database elements:

    a. Provider name;

    b. website;

    c. e-mail address;

    d. contracted services;

    e. site addresses (street address, town, ZIP code);

    f. site telephone numbers;

    g. site hours of operation;

    h. Emergency/after-hours provisions;

    i. professional qualifications and licensing;

    j. areas of specialty;

    k. handicapped accessibility;

    l. cultural and linguistic capacity;

    m. PCCs with open and closed panels, where "open panel" refers to those accepting any new patient, and "closed panel" refers to those that are limited to the current patients only.

10. Ensure that service representatives have online access to the following database elements for pharmacies:

    a. Alphabetical listing of pharmacies included in MassHealth's network, with their addresses and phone numbers, as provided by EOHHS; and

    b. Instructions for the Enrollee to select the Member Services menu option from the Contractor's toll-free telephone line (as described in **Section 9.7**) for assistance in finding a convenient pharmacy.

B. Orientation, Outreach, and Education to PCC Plan Enrollees

The Contractor shall:

1. For each new Enrollee who enrolls in the PCC Plan after the Service Start Date, but who has not been enrolled in the PCC Plan in the past six months, offer and make best efforts to provide to the Enrollee an orientation, by telephone or in person, within 30 days of the Enrollee's Effective Date of Enrollment in the PCC

Plan. The Contractor shall submit to EOHHS for review and approval its orientation and outreach materials and phone scripts. Such orientation shall include, at a minimum:

a. How the PCC Plan operates, including the role of the PCC;

b. A description of MassHealth Covered Services and service limitations;

c. Information on participating PCC Plan Providers and how to access the provider directory either via the internet or in writing;

d. The value of screening and preventive care; and

e. How to obtain MassHealth Covered Services.

2. The Contractor shall also provide the orientation described in **subsection 1**, above to parents or guardians of newborns that are enrolled in the PCC Plan, to the extent applicable. As part of such orientation, the Contractor shall confirm the selection or assignment to a pediatrician within the newborn's geographic area as an appropriate PCC.

3. The Contractor must provide a range of health promotion and Wellness information and activities for Enrollees in formats that meet the needs of all Enrollees. The Contractor shall:

a. Work with EOHHS to implement innovative Enrollee education strategies for Wellness care and immunizations, as well as general health promotion and prevention, and Behavioral Health rehabilitation and recovery;

b. Work with PCCs and specialists, as appropriate, to integrate health education, Wellness and prevention training into the care of each Enrollee;

c. Participate in any EOHHS-led joint planning activities with MassHealth-contracted MCOs to develop and implement statewide or regional approaches to Enrollee health and Wellness education;

d. Provide condition- and disease-specific information and educational materials to Enrollees, including information on its Care Management Program described in **Section 6.2**; and

e. Provide condition- and disease-specific information and educational materials to Covered Individuals.

4. Ensure, in accordance with 42 U.S.C. § 1396u-2(a)(5), that all written information for use by Enrollees and potential Enrollees is prepared in a format and manner that is easily readable, comprehensible to its intended audience, well designed, and includes a card or other notice instructing the Enrollee in multiple languages

that the information affects their health benefit, and to contact EOHHS for assistance with translation.

5. Make best efforts to obtain updated contact information whenever the Contractor has been unable to contact an Enrollee as a result of undeliverable mail or an incorrect telephone number. On a monthly basis, notify EOHHS of all Enrollees whom the Contractor has been unable to contact. Such notification shall be in the format and process specified by EOHHS in consultation with the Contractor.

C. Health Needs Assessment

The Contractor shall:

1. Develop, implement, and maintain procedures for completing an initial Health Needs Assessment (HNA), within 90 days after an Enrollee's Effective Date of Enrollment in the PCC Plan, for each new Enrollee whose enrollment occurs after the Service Start Date but who has not been enrolled in the PCC Plan in the past six months. The Contractor shall make subsequent attempts to conduct an initial HNA if the initial attempt to contact the Enrollee is unsuccessful.

2. Develop, and administer to the Enrollees described in **subsection 1**, a template for HNAs, which shall include but not be limited to questions that assess Enrollee demographic characteristics, personal and family health history, including Behavioral Health and self-perceived health status, to predict an Enrollee's likelihood of experiencing certain conditions. The template shall advise the Enrollee regarding how the information obtained from the HNA may be used and to whom it will be disclosed, including to EOHHS. The Contractor shall submit the HNA template to EOHHS for prior review and approval.

3. Make best efforts to ensure that the Contractor's information systems, and other records as appropriate, are updated whenever the Contractor and/or a Provider or PCC becomes aware that the Enrollee's health status has changed significantly from that indicated in the initial HNA;

4. Use the findings from the HNA to identify Enrollees who may benefit from Care Management as described in **Section 6.2**;

5. Ensure that Enrollees who are identified as requiring a particular type of service are offered assistance in accessing those services, including Behavioral Health Covered Services; and

6. Share with EOHHS, or any other MassHealth Managed Care entity serving the Covered Individual, the results of the HNA to prevent duplication of activities and services.

D. Virtual Gateway My Account Page Application

With Enrollee consent, the Contractor shall assist Enrollees in providing MassHealth with their current address (residential and mailing), phone numbers and other demographic

information including pregnancy, ethnicity, and race, by entering the updated demographic information into the change form via the My Account Page Application on the Virtual Gateway, as follows:

1. If the Contractor learns from an Enrollee or an authorized representative, orally or in writing, that the Enrollee's address or phone number has changed, or if the Contractor obtains demographic information from the Enrollee or authorized representative, the Contractor shall provide such information to EOHHS by entering it into the change form via the My Account Page Application on the Virtual Gateway, after obtaining the Enrollee's permission to do so, and in accordance with any further guidance from EOHHS.

2. Prior to entering such demographic information, the Contractor shall advise the Enrollee as follows:

   "Thank you for this change of address/phone information. You are required to provide updated address [phone] information to MassHealth. We would like to help you to do that so, with your oral permission, we will forward this information to MassHealth. You may also provide MassHealth with information about your race or ethnicity. This is not required, but it will help MassHealth to improve Member services. You have provided us with this information. If you do not object, we will pass that information on to MassHealth for you."

3. If the Contractor receives updated demographic information from a third party, such as a provider, a vendor hired to obtain demographic information, or through the post office, the Contractor must confirm the new demographic information with the Enrollee and obtain the Enrollee's permission prior to submitting the information to EOHHS on the change form.

4. The Contractor shall ensure that all appropriate staff entering this information have submitted the documentation necessary to complete this function on the Virtual Gateway and completed any necessary Virtual Gateway training requirements.

E. Responsibilities of Service Representatives

Service representatives shall:

1. Determine the nature of all inquiries and respond appropriately;

2. Exhibit sensitivity to the cultural differences and needs of EOHHS's diverse populations;

3. Appropriately utilize the reference guide described in **Section 7.1.F**;

4. Work with Covered Individuals, Network Providers, PCCs, other PCC Plan providers and other individuals as necessary to resolve Complaints or questions where appropriate;

5. Enter pertinent call information accurately into the Contractor's call tracking system described in **Section 9.7.A.5**, and be able to access relevant information from previous calls;

6. Arrange for the mailing of Network Provider policies, procedures, billing instructions and other related materials to Network Providers who request them, within two business days of the request;

7. Arrange for the mailing of Covered Individual educational/informational materials, as appropriate;

8. Arrange for the mailing of MSS materials to PCCs and other PCC Plan providers that request them, within two business days of the request; and

9. Perform other related activities as directed by EOHHS.

F. Member and Provider Services Reference Guide

The Contractor shall:

1. Develop, and submit to EOHHS for review and approval no later than two weeks after the Service Start Date, a Member and Provider Services reference guide that includes protocols for promptly and accurately:

    a. responding to and resolving Covered Individuals' questions and inquiries;

    b. resolving Providers' questions and concerns;

    c. responding to PCCs' questions and concerns related to the PCC Plan; and

    d. providing seamless collaboration with the PCC Plan staff for resolution of issues raised by Providers and Enrollees.

2. The Member and Provider Services reference guide shall include detailed information on the Contractor's role in promoting the integration of medical and Behavioral Health care, and how the Contractor can support the Covered Individual, Network Providers, PCCs and other PCC Plan providers in achieving integrated care.

3. Maintain the Member and Provider Services reference guide, reviewing it annually, and updating it as necessary or upon EOHHS request.

G. Website

The Contractor shall:

1. No later than two months prior to the Service Start Date, develop and submit for EOHHS's approval a plan for a website containing information specifically related to the Contract.

2. Launch the website as of the Service Start Date, and maintain it subject to EOHHS's approval.

3. Provide a link from the website to EOHHS's website, including, as further specified by EOHHS, a direct link to MassHealth supported provider directory.

4. Include, at a minimum, the following on its website:

    a. Culturally and linguistically competent information for Covered Individuals regarding services available through the PCC Plan's BHP;

    b. A searchable BH Provider Network Directory that is updated at least monthly and as needed;

    c. As directed by EOHHS, a searchable PCC Plan Provider Directory for non-BH providers that is updated at least monthly and more frequently as needed;

    d. The BH Network Provider manual;

    e. The PCC Plan Provider handbook;

    f. The PCC Plan Member handbook;

    g. BHP-only handbook for Covered Individuals that are not enrolled in the PCC Plan;

    h. Educational materials and links to evidence-based practices;

    i. Information and materials to support integration between Network Providers and PCCs; and

    j. Community resources.

5. Develop and propose to EOHHS within six months following the Contract Start Date a secure Provider and Covered Individual portal as part of the website.

6. Not provide any link to the Contractor's corporate website on any part of the website, unless agreed to by EOHHS.

7. Not provide any link to any type of corporate promotion on any part of the website.

8. Verify and, consistent with **Section 11.1.B**, certify to EOHHS on a quarterly basis the accuracy of all information contained on the website.

9. Data Gathering and Reporting Capacity in the Massachusetts Behavioral Health Access (MABHA) Website.

a. Subject to further direction and specification by EOHHS, the Contractor shall collect and report data regarding any MassHealth Member waiting over 24 hours for a 24 Hour Level of Care Placement or on Administratively Necessary Days (AND) status in a 24 Hour Level of Care, as follows:

1) The Contractor shall build and maintain a platform on the Massachusetts Behavioral Health Access (MABHA) website (the "MABHA Platform") to collect and manage the data;

2) The Contractor shall report to EOHHS on Members awaiting placement within a 24-hour level of care or who are on Administratively Necessary Days (AND) status within a 24 hour level of care, respectively, as follows:

a) Member-level reporting on a daily, weekly, and monthly basis;

b) Aggregate reporting on a quarterly and annual basis; and

c) Additional reporting in a form and frequency as requested by EOHHS on an ad hoc basis;

3) The Contractor shall establish a process for the ESP/MCI programs set forth in **Appendix A-3** to input data on Members who receive services on a fee-for-service basis or who have Third-Party Liability who are waiting over 24 hours for a 24 hour level of care into the MABHA Platform;

4) The Contractor shall establish a process for MassHealth managed care entities and others specified by EOHHS to input data on Members awaiting placement within a 24-hour level of care or who are on Administratively Necessary Days (AND) status within a 24 hour level of care into the MABHA Platform;

5) As directed by EOHHS, the Contractor shall create capacity for MassHealth managed care entities and others specified by EOHHS to view and print reports from the MABHA Platform in a manner allowable under federal and state privacy laws; and

6) The Contractor shall manage access of MassHealth managed care entities and others specified by EOHHS to the MABHA Platform at appropriate security levels.

b. The Contractor acknowledges and agrees that the data to be collected, managed, maintained, reported and otherwise used by the Contractor in completing the activities set forth in this **Section 7.1.G.9** will include Protected Health information (PHI), as defined in 45 CFR §160.103, and

other types of Personal Information (PI), as defined in **Section 14** of this Contract. The Contractor further acknowledges and agrees that in collecting, managing, maintaining, transmitting, disclosing and/or using such data for purposes of performing the activities described in this **Section 7.1.G.9** it is doing so in the capacity of EOHHS' Business Associate, as defined in 45 CFR §160.103, and is subject to, and shall comply with, all applicable terms, conditions and requirements set forth in **Section 14** hereof, including those relating to the Contractor's compliance with the Privacy and Security Rules as the Business Associate of EOHHS. Without limiting the generality of the foregoing, the Contractor agrees that the collection, management, maintenance and use of PI in and using the MABHA Platform shall comply with all applicable security requirements to which MBHP is subject, including those applicable under **Section 14** hereof.

10. Pursuant to Chapter 52 of the Acts of 2016 of the Massachusetts General Laws, Section 61, the Contractor shall post contact information for all insurance payers, including a phone number which is accessible 24 hours per day, for the purpose of enhancing communication between payers and providers.

Section 7.2 Member Services for Covered Individuals

A. General Requirements

As of the Service Start Date, the Contractor shall:

1. Inform Covered Individuals of the Member Services menu option from the Contractor's toll-free telephone number, and that such number can be used by Covered Individuals to obtain general information about the PCC Plan's BHP;

2. Handle calls from Covered Individuals, family members, guardians, and other interested parties regarding BH Covered Services, Network Providers, and QM initiatives;

3. Monitor the quality and accuracy of information through a representative sample of 10 percent of all English-speaking and 10 percent of all Spanish-speaking Member Services calls received, or such other percentage agreed to by EOHHS;

4. Handle calls and questions from Enrollees regarding the Contractor's Care Management Program as described in **Section 6.2**;

5. Inform Covered Individuals of their legal rights when receiving BH treatment;

6. Develop and distribute to Covered Individuals materials, such as BH-related fact sheets, quarterly newsletters and Network Provider directories, and mail materials requested by Covered Individuals within one business day of the request;

7. As appropriate, refer Covered Individuals to other relevant resources, such as the MassHealth Customer Services line, for resolution of their issues or inquiries;

8. Have the ability to answer inquiries in the Covered Individual's primary language through an alternative language device or interpreter, and notify Covered Individuals of this capacity;

9. Have in place mechanisms to help Covered Individuals and potential Enrollees understand the requirements and benefits of the BHP;

10. Make interpretation services, including oral interpretation, and auxiliary aids and services, such as TTY/TDY and American Sign Language (ASL), available upon request of each Covered Individual or Potential Enrollee at no cost;

11. Develop, using a model to be provided by EOHHS to the Contractor, a Covered Individual handbook, which serves as a summary of benefits and coverage.

    a. At a minimum, this handbook shall contain all of the information required by 42 CFR 438.10(g), including:

        1) The benefits provided by the Contractor;

        2) How to access BH Covered Services, including the amount, duration and scope of BH Covered Services, in sufficient detail to ensure that Covered Individual understand the benefits to which they are entitled and the procedures for obtaining such benefits, including the Contractor's toll-free telephone line(s), authorization requirements, information regarding applicable access and availability standards, any cost sharing, self-referral, and referral by family members or guardians, a Provider, PCP or community agency;

        3) Inform Covered Individuals of the availability of assistance through the MassHealth Customer Service Center for help with determining where and how to access non-BH Covered Services. In the case of a counseling or referral service that the Contractor does not cover because of moral or religious objections, the handbook must inform Covered Individuals that the service is not covered by the Contractor;

        4) The name and customer services telephone number for all Material Subcontractors that provide BH Covered Services to Covered Individuals unless the Contractor retains all customer service functions for such BH Covered Services;

        5) The BH Covered Services that do not require authorization or a referral from the Covered Individual's PCP;

        6) The extent to which, and how, Covered Individuals may obtain benefits, including Emergency Services, from out-of-network providers;

7) The role of the PCP, and the policies on referrals for specialty care and for other benefits not furnished by the Covered Individual's PCP;

8) How to obtain information about Network Providers;

9) The extent to which, and how, after-hours and Emergency Services and Poststablization Care Services are covered, including:

   a) What constitutes an Emergency Medical Condition, Emergency Services, and Poststabilization Care Services;

   b) The fact that prior authorization is not required for Emergency Services;

   c) How to access the Contractor's 24-hour Clinical Advice and Support Line,

   d) The process and procedures for obtaining Emergency Services, including the use of the 911-telephone system;

   e) The services provided by Emergency Services Programs (ESPs) and how to access them;

   f) The locations of any emergency settings and other locations at which Providers and hospitals furnish Emergency Services; and

   g) The fact that the Covered Individual has a right to use any hospital or other setting for Emergency Services;

10) Covered Individual cost sharing;

11) Any restrictions on freedom of choice among Network Providers;

12) The availability of free oral interpretation services at the Plan in all non-English languages spoken by Covered Individuals and how to obtain such oral interpretation services;

13) The availability of all written materials that are produced by the Contractor for Covered Individuals in Prevalent Languages and how to obtain translated materials;

14) The availability of all written materials that are produced by the Contractor for Covered Individual in Alternative Formats and how to access written materials in those formats and the availability of auxiliary aids and services;

15) The toll-free Covered Individual services telephone number and hours of operation, and the telephone number for any other unit providing services directly to Covered Individuals;

16) The rights and responsibilities of Covered Individuals;

17) Information on Grievance, Internal Appeal, and Board of Hearing (BOH) procedures and timeframes, including:

a) The right to file Grievances and Internal Appeals;

b) The requirements and timeframes for filing a Grievance or Internal Appeal;

c) The availability of assistance in the filing process;

d) The toll-free numbers that the Covered Individual can use to file a Grievance or an Internal Appeal by phone;

e) The fact that, when requested by the Covered Individual, BH Covered Services will continue to be provided if the Covered Individual files an Internal Appeal or a request for a BOH hearing within the timeframes specified for filing, and that the Covered Individual may be required by EOHHS to pay the cost of services furnished while a BOH Appeal is pending, if the final decision is adverse to the Covered Individual;

f) The right to obtain a BOH hearing;

g) The method for obtaining a BOH hearing;

h) The rules that govern representation at the BOH hearing; and

i) The right to file a grievance directly with EOHHS, how to do so, and EOHHS contact information;

18) Information on advance directives in accordance with **Section 13.34**;

19) Information on the access standards specified in **Section 3.1.G**; and

20) Information on how to report suspected fraud or abuse.

b. The Contractor shall distribute this handbook to each Covered Individual as follows:

1) For each existing Covered Individual, the Contractor shall:

a) Mail a printed copy of the handbook to the Covered Individual at his or her mailing address;

b) Provide an electronic copy of the handbook by electronic mail after obtaining the Covered Individual's agreement to receive the information by electronic mail;

c) Post the handbook on its website and advise the Covered Individual, in both paper and electronic form, that the handbook is available on the internet, including the appropriate URL, provided that Covered Individuals with disabilities who cannot access the handbook online are provided auxiliary aids and services upon request at no cost; or

d) Provide the handbook by any other method that can reasonably be expected to result in the Covered Individual receiving the information contained in the handbook.

2) For new Covered Individuals, the Contractor shall, within a reasonable time after receiving notice of the Member's enrollment with the Contractor, distribute the handbook in accordance with 7.2.A.11.b.1.

12. Develop Covered Individual notices using models to be provided by EOHHS to the Contractor.

B. Resource Materials

1. General Requirements

The Contractor shall:

a. Subject to EOHHS approval, develop, produce and distribute to Covered Individuals written materials focusing on issues that reinforce Contract priorities and positive health outcomes for Covered Individuals, including educational materials relating to self-care, Behavioral Health conditions, integration of medical and Behavioral Health services, and other topics;

b. Submit a draft of the above materials to EOHHS for approval no later than six weeks before the planned production date, or as otherwise agreed to by EOHHS;

c. Produce and distribute the approved materials to PCC Plan Providers and Network Providers for sharing with Covered Individuals;

d. Accept materials from EOHHS and distribute them as directed by EOHHS;

e. Make all materials available to service representatives for distribution, and when community-based presentations are conducted;

f. Establish and maintain an inventory system to ensure the availability of all resource materials, including those identified in this **subsection B** and in **subsection D**. At a minimum, the system must monitor the types of materials in stock, quantities in stock, quantities of materials mailed, and to whom;

g. Share educational/informational materials electronically;

h. Work collaboratively with EOHHS to encourage paperless communication; and

i. Provide EOHHS with any Covered Individual education materials that are provided to individuals under age 21 and update and distribute such materials to describe EPSDT/PPHSD services as further directed by EOHHS.

2. Behavioral Health Network Provider Directory

The Contractor shall:

a. As of the Service Start Date, develop and make available a Network Provider directory that identifies the Contractor's Network Providers. The directory shall include each Network Provider's:

1) Name, as well as any group affiliation;

2) Street address(es);

3) Telephone number(s);

4) Web site URL (if applicable);

5) Specialty(ies) (if applicable);

6) Ability to accept new enrollees;

7) Cultural and linguistic capabilities, including languages (including American Sign Language) offered by the provider or a skilled medical interpreter at the provider's office, and whether the provider has completed cultural competence training;

8) Office's/facility's accommodations for people with physical disabilities, including offices, exam room(s), and equipment;

9) Office hours;

10) Network Provider licensing information;

11) Accessibility by public transportation;

12) Special experience, skills, training, and/or expertise in treating:

a) children and adolescents;

b) persons with physical disabilities, chronic illness, HIV/AIDS, and/or persons with Serious Mental Illness;

c) Homeless persons;

d) persons with Dual Diagnosis; and

e) other specialties.

b. Maintain the Network Provider directory required by this section in both electronic and paper form as follows:

1) Paper Version – The Contractor shall update its paper provider directory at least monthly.

2) Electronic Version – The Contractor shall maintain an up-to-date version of the Network Provider Directory on the Contractor's website that is available to the general public. The Contractor shall update this electronic directory no later than 30 calendar days after the Contractor receives updated provider information. The Contractor shall maintain this electronic directory in a machine-readable file and format. At a minimum, the Contractor shall maintain this electronic directory in such a fashion that enables users of the Contractor's website to search by:

a) Provider name;

b) town;

c) ZIP code;

d) Provider specialty;

e) Provider languages spoken; and

f) Provider licensing information.

c. Within a reasonable time after EOHHS enrolls a new Covered Individual pursuant to **Section 12.3A**, provide each such individual with notification

that a copy of the Network Provider Directory can be accessed online at the Contractor's website, and is available in writing upon request by calling the Member and Provider Services Department;

d. At EOHHS's discretion, provide written notice to Covered Individuals of any changes in the Network Provider Directory at least 30 days before the intended effective date of the change or as soon as the Contractor becomes aware of such change;

e. In the event of the termination of a Network Provider, provide written notice within 15 days after receipt or issuance of the termination notice to each Covered Individual who received his or her primary care from, was seen on a regular basis by, or was seen within the previous 90 days by, the terminated Provider, and ensure that care is transferred to another Network Provider in a timely manner to minimize any disruptions to treatment;

f. Provide annual notification to Providers, PCCs, Covered Individuals and other interested parties that the most current version of the Network Provider Directory is available on the Contractor's website and that hard copies are available on request.

3. Physician Incentive Plans

Upon the request of any Covered Individual, the Contractor shall make available, in electronic and paper form, any physician incentive plans that it operates pursuant to **Section 3.3A** of this Contract.

C. Community Events

The Contractor may conduct or participate in community events (i.e., forums sponsored by the Contractor or other entities that are not organized for the primary purpose of promoting the Contractor's services) at which the Contractor may present information about EOHHS's PCC Plan or BH services or distribute EOHHS-approved materials, only when the following requirements are met:

1. For Contractor-sponsored community events, the Contractor shall:

   a. At least 20 business days in advance, submit to EOHHS for review and approval any proposed community event and a description of the event, including the time, date, location and expected attendance; and

   b. Invite EOHHS staff and representatives from EOHHS's Customer Services program to attend at no cost.

2. For community events not sponsored by the Contractor, the Contractor shall:

   a. At least 20 business days before the event, submit to EOHHS a request for approval to participate in the scheduled community event or, if the

Contractor is made aware of the event less than 20 business days in advance, as soon as the Contractor determines that it plans to attend; and

b. Provide a description of the event, including the time, date, location and expected attendance, with the name and phone number for the person or organization responsible for organizing it.

D. Marketing Activity Requirements

1. General Requirements

The Contractor's Marketing activities, if any, must comply with the provisions of 42 CFR 438.104. In conducting any Marketing activities described herein, the Contractor shall:

a. Ensure that all Marketing Materials regarding the Contractor's services under this Contract clearly state that information regarding all MassHealth Managed Care enrollment options including, but not limited to, this Contractor, are available from the MassHealth Customer Service Center. The Contractor shall ensure that all written Marketing Materials prominently display the telephone number and hours of operation of the MassHealth Customer Service Center in the same font size as the same information for the Contractor. EOHHS, in its sole discretion, may exempt, in writing, promotional materials or activities from this requirement upon written request by the Contractor;

b. Submit all Marketing Materials to EOHHS for approval 60 days prior to distribution or as early as possible;

c. Distribute and/or publish Marketing Materials statewide, unless the Contractor submits a written request which is approved by EOHHS to implement a targeted Marketing campaign. A targeted Marketing campaign involves distributing and/or publishing materials to a region or part of a region of the state, or, where the campaign relates to a local event (such as a health fair) or to a single Provider (such as a hospital or clinic), to a certain ZIP code or ZIP codes.

d. Provide EOHHS with a copy of all press releases pertaining to the Contractor's MassHealth line of business for prior review and approval.

2. Permissible Marketing Activities

The Contractor may engage in only the following Marketing activities, in accordance with the requirements stated in **subsection D.1**, above.

a. The Contractor may participate in a health fair or community activity sponsored by the Contractor, provided that the Contractor shall notify all MassHealth-contracted MCOs within the geographic region of their ability to participate. Such notification shall be in writing and shall be made as

soon as reasonably possible prior to the date of the event. If other MassHealth-contracted MCOs choose to participate in a Contractor's sponsored event, they shall contribute to the costs of such event as a condition of participation, provided costs are reasonably apportioned among the MassHealth-contracted MCOs. The Contractor may conduct or participate in Marketing at Contractor- or non-Contractor-sponsored health fairs and other community activities only if:

1) Any Marketing Materials the Contractor distributes have been pre-approved by EOHHS; and

2) Any free samples and gifts offered by the Contractor are only of a nominal value and are available to all attendees of the health fair or other community activity regardless of their intent to enroll in the PCC Plan.

b. The Contractor shall participate in health benefit fairs sponsored by EOHHS.

c. The Contractor may market to Covered Individuals, in accordance with **subsection D.1**, above, by distributing and/or publishing Marketing Materials or implementing a targeted Marketing campaign that is pre-approved by EOHHS. The methods for distributing and/or publishing Marketing Materials may include:

1) Posting written Marketing Materials that have been pre-approved by EOHHS at Network or PCC Provider sites and other locations; and posting written promotional Marketing Materials throughout the state;

2) Initiating mailing campaigns that have been pre-approved by EOHHS, where the Contractor distributes Marketing Materials by mail; and

3) Television, radio, newspaper, website postings, and other audio or visual advertising.

3. Prohibitions on Marketing and Enrollment Activities

The Contractor shall <u>not</u>:

a. Distribute any Marketing Material that has not been pre-approved by EOHHS;

b. Distribute any Marketing Material that is inaccurate or false or that misleads, confuses, or defrauds the recipient of the Marketing Material, including but not limited to any assertion or statement, whether written or oral, that:

1) The recipient of the Marketing Material must enroll in the PCC Plan in order to obtain benefits or in order to not lose benefits; or

2) The Contractor is endorsed by CMS, the federal or state government or similar entity.

c. Seek to influence a Member's enrollment in the PCC Plan in conjunction with the sale or offering of any private insurance products (e.g., life insurance);

d. Seek to influence a Member's enrollment into the PCC Plan in conjunction with the sale or offering of cash, cash equivalents or in-kind gifts;

e. Directly or indirectly, engage in door-to-door, telephonic, e-mail, texting, or any other cold-call marketing activities ("cold-call marketing" includes any unsolicited personal contact by the Contractor with a Covered Individual who is not enrolled with the BHP that can reasonably be interpreted as intended to influence the individual to enroll in the PCC Plan or the BHP, or to not enroll in or to disenroll from a MassHealth MCO or the BHP);

f. Engage in any Marketing activities that could mislead, confuse or defraud Members or Covered Individuals, or misrepresent MassHealth, EOHHS, the Contractor or CMS;

g. Conduct any provider site Marketing, except as otherwise provided in **Section 7.2.D**;

h. Incorporate any costs associated with Marketing or Marketing incentives, or non-medical programs or services in the Contractor's cost reports;

i. Engage in Marketing activities that target Members on the basis of health status or future need for health care or Behavioral Health services, or which otherwise may discriminate against individuals eligible for health care services.

4. Marketing Plan and Schedules

a. The Contractor shall make available to EOHHS, for review and approval upon request, a comprehensive Marketing plan, including proposed Marketing approaches, current schedules of all Marketing activities, and the methods, modes, and media through which Marketing Materials will be distributed.

b. Annually, the Contractor shall present its Marketing plan in person to EOHHS for review and approval.

c. The Contractor shall annually submit to EOHHS a written statement including an executive summary of its MassHealth Marketing plans and a statement that all of its Marketing plans and Marketing Materials are accurate and do not mislead, confuse, or defraud Members or misrepresent the state, and are otherwise in accordance with the requirements of 42 CFR 438.104.

5. Information to Covered Individuals

Nothing herein shall be deemed to prohibit the Contractor from providing non-Marketing information to Covered Individuals consistent with this Contract regarding existing or new services, personnel, Covered Individual education materials, Care Management programs and Provider sites.

6. MassHealth Benefit Request and Eligibility Redetermination Assistance

The Contractor or Provider staff may help MassHealth applicants apply for MassHealth eligibility in the following ways. Such staff may:

a. Explain the MassHealth Benefit Request (MBR) and Eligibility Redetermination Verification (ERV) forms to applicants;

b. Assist MassHealth applicants in completing and submitting MBRs;

c. Offer to assist Enrollees with completion of the annual ERV form; and

d. Refer MassHealth applicants to the MassHealth Customer Service Center.

E. Enrollment and Disenrollment

1. The Contractor shall:

a. Accept for enrollment all Members identified by EOHHS in the order in which they are referred without restriction;

b. Accept for enrollment all Members identified by EOHHS at any time without regard to income status, physical or mental condition (such as cognitive, intellectual, mobility, psychiatric, and sensory disabilities as further defined by EOHHS), age, gender, sexual orientation, religion, creed, race, color, physical or mental disability, national origin, ancestry, status as a Member, pre-existing conditions, expected health status, or need for health care services;

c. Not request the disenrollment of any Covered Individual due to an adverse change in the Covered Individual's health status or because of the Covered Individual's utilization of medical services, diminished mental capacity, or uncooperative or disruptive behavior resulting from his or her special needs. The Contractor, however, may submit a written request,

accompanied by supporting documentation, to EOHHS to disenroll a Covered Individual, for cause, for the following reason:

1) After reasonable efforts, the Contractor has attempted to provide Medically Necessary BH Covered Services to the particular Covered Individual through at least three Network Providers that:

   a) Meet the access requirements specified in **Section 3.1.G**. for the relevant provider type; and

   b) Are critical for providing ongoing or acute BH Covered Services to meet the Covered Individual's needs;

2) Where reasonable efforts include attempting to provide all resources routinely used by the Contractor to meet Covered Individuals' needs, including but not limited to, Behavioral Health Services and Care Management; and

3) Despite such efforts, the continued enrollment of the Covered Individual with the Contractor seriously impairs the Contractor's ability to furnish services to either this particular Covered Individual or other Covered Individuals.

2. EOHHS reserves the right, at its sole discretion, to determine when and if the Contractor's request to terminate the enrollment of a Covered Individual will be granted based on the criteria in **Section 7.2.E.1.c** above. In addition, if EOHHS determines that the Contractor too frequently requests termination of enrollment for Covered Individuals, EOHHS reserves the right to deny such requests and require the Contractor to initiate corrective action to improve the Contractor's ability to serve such Covered Individuals.

F. Notices and Written Materials

The Contractor shall:

1. Notify Covered Individuals of the availability of written materials in Alternative Formats – i.e., in a format that takes into consideration the special needs of those Members who, for example, are visually limited, have limited reading proficiency (e.g., Braille, large font, audiotape, videotape, or information read aloud), or are of limited English proficiency – and provide them in such formats upon request, and at no cost. At a minimum, such notices must explain that:

   a. Oral interpretation services are available for any language at no cost, which notice shall explain how to access those services;

   b. Written translation services are available for any Prevalent Language at no cost, which notice shall explain how to access those services; and

c. Auxiliary aids and services are available upon request at no cost, which notice shall explain how to access those services.

2. Include a notice with all written materials which explains that the enclosed materials are important and should be translated immediately, and provides information on how the Covered Individual may obtain help with getting written translation or oral interpretation services at no cost. This message shall be written in large print in all Prevalent Languages, as well as Cambodian, Chinese, Haitian Creole, Laotian, Portuguese, Russian and Vietnamese, and other languages as directed by EOHHS;

3. Include a notice with all written materials which explains the availability of no-cost auxiliary aids and services and includes the Contractor's toll-free TTY/TDY telephone number. This message shall be written in large print in all Prevalent Languages, as well as Cambodian, Chinese, Haitian Creole, Laotian, Portuguese, Russian and Vietnamese, and other languages as directed by EOHHS;

4. Include a notice with all written materials which explains the availability of the written materials in alternative formats, such as audio or video;

5. Unless otherwise provided in this Contract, ensure that all written materials provided by the Contractor to Covered Individuals and potential Enrollees:

   a. Are Culturally and Linguistically Appropriate, reflecting the diversity of the Contractor's membership;

   b. Are produced in a manner, format, and language that may be easily understood and are readily accessible by Covered Individuals and potential Enrollees with limited English proficiency;

   c. Are translated into Prevalent Languages of the Contractor's membership. If EOHHS notifies the Contractor that Prevalent Languages shall include additional languages, the Contractor shall submit a work plan to EOHHS within 60 days of the notice and shall comply with the work plan, as approved by EOHHS;

   d. Are made available in Alternative Formats (including audio and video), and through auxiliary aids and services, in an appropriate manner that takes into consideration the special needs of Covered Individuals or potential Enrollees with disabilities or limited English proficiency;

   e. Use a font size no smaller than 12 point;

   f. Include a large print tagline (i.e., no smaller than 18 point font size);

6. Not provide Covered Individual Information required by this Contract electronically unless all of the following are met:

a. The format is readily accessible;

b. The information is placed in a location on the Contractor's web site that is prominent and readily accessible;

c. The information is provided in an electronic form which can be electronically retained and printed;

d. The information is consistent with the content and language requirements of this Contract; and

e. The Covered Individual is informed that the information is available in paper form without charge upon request and the Contractor provides it upon request within 5 business days.

Section 7.3 Network Provider Relations

A. General Requirements

As of the Service Start Date, the Contractor shall:

1. Ensure that the Contractor's toll-free telephone number has a menu option for Network Provider Relations, and that such number can be used by Network Providers who need general assistance with the Contractor's policies or with Claims and billing inquiries and issues;

2. Utilize EOHHS's Eligibility Verification System (EVS) to facilitate the resolution of Network Providers' questions regarding eligibility and enrollment matters for Covered Individuals. The Contractor and Network Providers shall not require such verification prior to providing Emergency Services; and

3. Monitor a representative sample of a minimum of 10 calls per agent per month of all Provider calls received, or other sample size as directed by EOHHS, for consistency and accuracy of the information being provided.

B. Network Provider Concerns

The Contractor shall:

1. Maintain written policies and procedures for handling all Network Provider concerns appropriate to the Contract and make available to EOHHS upon request;

2. Notify Network Providers of the Contractor's toll-free number and that it can be used by Network Providers who need general assistance regarding Contractor policies and procedures;

3. Review the policies and procedures for handling Network Provider concerns at least annually, submitting the results of this review to EOHHS, and making improvements as appropriate;

4. Acknowledge, orally or in writing as the Contractor determines is appropriate, within 24 hours, the receipt of a Provider concern;

5. Create and maintain a log to document the type and nature of each concern, date of receipt, date of resolution, how each was addressed, whether orally or in writing, and what corrective action, if any, was taken;

6. Provide resolution summary, orally or in writing as the Contractor determines is appropriate, to Network Provider concerns within 15 days;

7. Designate a staff person(s) to be responsible for coordination, receipt and handling of Provider concerns; and

8. Provide a summary report to EOHHS of Provider concerns on a quarterly basis, or other schedule determined by EOHHS.

Section 7.4 PCC Plan Provider Services

A. General Requirements

As of the Service Start Date, the Contractor shall:

1. Establish and maintain the PCC Plan Hotline for PCCs and other PCC Plan providers to use for information related to the Contractor's responsibilities related to the PCC Plan, including reporting, Quality Management, operations, PCCs participating in PCMHI, and the PCC Plan Provider Contract (see **Appendix C-2**) and other topics as directed by EOHHS.

2. Ensure that the Contractor's toll-free telephone number (see **Section 2.1.A.2**) has a menu option for the PCC Hotline so that such number can be used by PCCs and other PCC Plan providers who need general assistance regarding PCC Plan operations and PCC QM issues as outlined in **Sections 5** and **8**;

3. Refer callers to the PCC Hotline to other resources, such as EOHHS or EOHHS's other contractors, as appropriate and in accordance with **Appendix C-9**;

4. Monitor a representative sample of a minimum of 10 calls per agent per month of all PCC Plan Hotline calls received, or other sample size as directed by EOHHS, for consistency and accuracy of the information being provided. The results shall be made available to EOHHS upon request.

B. PCC Plan Provider Concerns

The Contractor shall:

1. Handle PCCs' and other PCC Plan providers' concerns only as they relate to the responsibilities under MSS, Care Management, the PCC Hotline, the PCC Plan Quarterly newsletter and any other PCC Provider Contract issue, directing other PCC issues such as inquiries related to Claims payment or Grievances to EOHHS's Customer Services vendor in accordance with **Appendix C-9**.

2. Maintain written policies and procedures for handling all appropriate PCC and other PCC Plan provider concerns, and make them available to EOHHS upon request.

3. Review the policies and procedures for handling PCC and other PCC Plan provider concerns at least annually, submitting the results of this review to EOHHS PCC Plan staff. Propose improvements as appropriate and submit any proposed amendments to EOHHS for approval at least one month before the enactment date of the amendment, unless otherwise specified by EOHHS.

4. Acknowledge, orally or in writing as the Contractor determines is appropriate, within 24 hours, the receipt of a PCC or other PCC Plan provider concern.

5. Create and maintain a log to document the type and nature of each concern, date of receipt, date and method of acknowledgment, date of resolution, how each was addressed, whether orally or in writing, what corrective action, if any was taken, and a copy of any correspondence with the PCC or other PCC Plan providers.

6. Provide resolution summary, orally or in writing, as the Contractor determines is appropriate, to PCC and other PCC Plan provider concerns within 15 days.

7. Designate a staff person(s) to be responsible for coordination, receipt and handling of PCC and other PCC Plan provider concerns.

8. Document PCCs' and other PCC Plan providers' concerns in a PCC Plan MSS monthly report, report them to MassHealth's PCC Plan staff, and, when appropriate, propose solutions to MassHealth.

9. Work with EOHHS to determine which PCCs' and other PCC Plan providers concerns need to be elevated to the PCC Plan staff immediately for assistance in triage and resolution.

Section 7.5 Provider and PCC Publications

A. PCC Plan Quarterly Newsletter

The Contractor shall:

1. On a quarterly basis, create, produce and electronically transmit or mail to each Network Provider and PCC a PCC Plan newsletter to be entitled "PCC Plan Quarterly," similar to the sample in **Appendix C-6**. Each issue shall include relevant information on Contractor efforts to enhance the integration between medical and Behavioral Health care and the opportunities for support of PCCs and other Providers in the care of Enrollees who have complex medical and/or Behavioral Health care needs through the Care Management Program. EOHHS reserves the right to modify the name, format or content of this newsletter at any time.

2. At least one time per year, meet with MassHealth staff regarding the mission and themes for the upcoming year's newsletters.

3. Submit a written plan to EOHHS for approval regarding the formatting, production and distribution of the newsletter prior to each scheduled publication of "PCC Plan Quarterly" in a timeframe agreed to by EOHHS.

4. Prepare newsletter content as follows:

    a. Collect potential article ideas consistent with the approved newsletter theme from appropriate sources.

    b. Present all the potential article ideas to EOHHS for review and approval to be included in the upcoming newsletter.

    c. Solicit authors for approved article ideas. (If an appropriate author cannot be identified, the Contractor may author the article.)

    d. Edit articles submitted and review draft with appropriate stakeholders, including a medical professional, before submitting a final draft to EOHHS.

5. Format and design the layout of the newsletter such that it is visually appealing, using graphics and illustrations in the production of each issue, unless otherwise approved by EOHHS.

6. Print and distribute the "PCC Plan Quarterly" newsletter with EOHHS approval.

B. PCC Plan Member Newsletter

The Contractor shall

1. Two times a year, create, produce and mail to each PCC Plan Member case head a newsletter entitled "Health Highlights," similar to the sample in **Appendix C-7**. The "Health Highlights" newsletter shall focus on promoting and supporting EOHHS or PCC Plan initiatives, its quality improvement activities, the integration of medical and Behavioral Health care, and include information on MassHealth Covered Services as appropriate. EOHHS reserves the right to modify the name, format or content of this newsletter at any time.

2. At least one time per year, meet with EOHHS staff regarding the mission and themes for the upcoming year's newsletters.

3. Submit a written plan to EOHHS for approval regarding the formatting, production and distribution of the newsletter prior to each scheduled publication of "Health Highlights" in a timeframe agreed to by EOHHS.

4. Prepare newsletter content as follows:

a. Collect potential article ideas consistent with the approved newsletter theme from appropriate stakeholders.

b. Present all the potential article ideas to EOHHS for review and approval to be included in the upcoming newsletter.

c. Solicit authors for approved article ideas. (If an appropriate author cannot be identified, the Contractor may author the article.)

d. Edit articles submitted and review draft with appropriate stakeholders, including a medical professional, before submitting a final draft to EOHHS.

5. Format and design the layout of the newsletter such that it is visually appealing, using graphics and illustrations, unless otherwise approved by EOHHS.

6. Submit to EOHHS a proposal for review and approval if the Contractor would like to distribute "Health Highlights" electronically. Such a proposal must maintain the capability to mail "Health Highlights" to Enrollees who have not chosen to receive "Health Highlights" electronically.

7. Print and distribute "Health Highlights" with EOHHS approval.

C. PCC Plan Support Materials Catalog

On a semiannual basis, the Contractor shall develop, publish and distribute PCC Plan Support Materials Catalog in collaboration with EOHHS. (See also **Appendix C-9** and **Section 5.3**.)

Section 7.6 Inquiries, Grievances, Internal Appeals, and BOH Appeals

A. General Requirements

The Contractor shall

1. Maintain written policies and procedures for:

a. The receipt and timely resolution of Grievances and Internal Appeals, as further described in **Section 7.6.B**, below. Such policies and procedures shall be approved by EOHHS; and

b. The receipt and timely resolution of inquiries, where timely resolution means responding to the Inquiry at the time it is raised to the extent possible or, if not possible, acknowledging the inquiry within one business day and making best efforts to resolve the inquiry within one business day of the initial inquiry. Such policies and procedures shall be approved by EOHHS.

2. Review the inquiry, Grievance and Internal Appeals policies and procedures established pursuant to **subsection 1**, above, at least annually, to amend and improve those policies and procedures. The Contractor shall provide copies of any such amendments to EOHHS, for review and approval, 30 calendar days prior to the date of the amendment, unless otherwise specified by EOHHS;

3. Create and maintain records of inquiries, Grievances, Internal Appeals, and BOH Appeals, using the health information system(s) specified in **Section 9.1.B.11**, to document:

    a. The type and nature of each inquiry, Grievance, Internal Appeal, and BOH Appeal;

    b. How the Contractor disposed of or resolved each Grievance, Internal Appeal, or BOH Appeal; and

    c. What, if any, corrective action the Contractor took.

4. Report to EOHHS annually regarding inquiries, Grievances, Internal Appeals and BOH Appeals, as described in **Appendix E-1**;

5. Assure that individuals with authority, such as senior and executive level staff, participate in any corrective action that the Contractor determines is necessary following the resolution of any inquiry, Grievance, Internal Appeal, or BOH Appeal;

6. Provide Covered Individuals with information about Grievance, Internal Appeal, and BOH Appeal procedures and timeframes, as specified in **Section 7.6.B.2**; and

7. Pursuant to 42 CFR 438.414, provide the information specified in **Section 7.2A.11.a.17)** to all Providers and Material Subcontractors at the time they enter into a contract with the Contractor.

B. Grievances and Internal Appeals

The Contractor shall maintain written policies and procedures for the filing by Covered Individuals or Appeals representatives and the receipt, timely resolution, and documentation by the Contractor of any and all Grievances and Internal Appeals which shall include, at a minimum, the following, in accordance with 42 CFR Part 438, Subpart F. (For purposes of this section, in cases where a minor is able, under law, to consent to a medical procedure, that minor can request an appeal of the denial of such treatment, or may appoint an Appeal Representative to represent them, without parental/guardian consent.)

1. General Requirements

    a. The Contractor shall put in place a standardized process that includes:

1) A means for assessing and categorizing the nature and seriousness of a Grievance or Internal Appeal;

2) A means for tracking how long the Contractor takes to dispose of or resolve Grievances and Internal Appeals and to provide notice of such disposition or resolution, as specified in **Sections 7.6.B.2.a.3)** and **7.6.B.4,** below; and

3) A means for expedited resolution of Internal Appeals, as further specified in **Section 7.6.B.4.d**, when the Contractor determines (for a request from the Covered Individual) or a Provider indicates (in making the request on the Covered Individual's behalf or supporting the Covered Individual's request) that taking the time for a standard resolution, in accordance with **Section 7.6.B.4.a**, could seriously jeopardize the Covered Individual's life or health or ability to attain, maintain, or regain maximum function.

b. The Contractor shall put in a place a mechanism to:

1) Accept Grievances filed either orally or in writing; and

2) Accept Internal Appeals filed either orally or in writing within 60 calendar days from the notice of Adverse Action, provided that if an Internal Appeal is filed orally, the Contractor must require the Covered Individual to submit a written, signed Internal Appeal form following the oral filing unless an expedited resolution is requested as specified in **Section 7.6.B.4.d**. Internal Appeals filed later than 60 calendar days from the notice of Adverse Action may be rejected as untimely.

c. The Contractor shall send a written acknowledgement of the receipt of any Grievance or Internal Appeal to Covered Individuals and, if an Appeals representative filed the Grievance or Internal Appeal, to the Appeals representative and the Covered Individual within one business day of receipt by the Contractor.

d. The Contractor shall track whether an Internal Appeal was filed orally or in writing within 60 calendar days from the notice of Adverse Action specified in **Section 7.6.B.2**.

2. Notice of Adverse Action

a. The Contractor shall put in place a mechanism for providing written notice to Covered Individuals of any Adverse Action in a form approved by EOHHS as follows:

1) The notice must meet the language and format requirements specified in **Sections 7.1.B.4** and **7.2.A.9-11**.

2) The notice must explain the following:

a) The Adverse Action the Contractor has taken or intends to take;

b) The reason(s) for the Adverse Action, including the right of the Covered Individual to be provided, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the Adverse Action, such as medical necessity criteria and processes, strategies, and standards related to the Adverse Action;

c) The Covered Individual's right to file an Internal Appeal or to designate an Appeal Representative to file an Internal Appeal on behalf of the Covered Individual, including exhausting the appeal process and right to file an appeal with the Board of Hearings;

d) The procedures for a Covered Individual to exercise his/her right to file an Internal Appeal;

e) The circumstances under which expedited resolution of an Internal Appeal is available and how to request it;

f) That the Contractor will provide the Covered Individual Continuing Services, if applicable, pending resolution of the review of an Internal Appeal if the Covered Individual submits the request for review within 10 days of the Adverse Action; and

g) That the Contractor will provide the Covered Individual Continuing Services, if applicable, pending resolution of a BOH Appeal if the Covered Individual submits the request for the BOH Appeal within 10 days of receipt of notice of the Final Internal Appeal decision, unless the Covered Individual specifically indicates that he or she does not want to receive Continuing Services.

3) The notice must be mailed within the following timeframes:

a) For termination, suspension, or reduction of a previous authorization for a requested service, at least 10 calendar days prior to the Date of Action in accordance with 42 CFR 431.211, except as provided in 42 CFR 431.213. In accordance with 42 CFR 431.214, the period of advance notice may be shortened to five calendar days before the Date of Action if the Contractor has facts indicating that

action should be taken because of probable fraud by the Covered Individual and the facts have been verified, if possible through secondary sources.

b) For denial of payment where coverage of the requested service is at issue, on the day of the payment denial, except that no notice is necessary for procedural denials of payment where coverage of the requested service is not at issue, which include, but are not limited to, denials for the following reasons:

(i) Failure to follow prior authorization procedures;

(ii) Failure to follow referral rules; and

(iii) Failure to file a timely claim.

c) For standard service authorization decisions that deny or provide limited authorization for requested services, as specified in **Section 4.2A.2.e.1)**, as expeditiously as the Covered Individual's health condition requires but no later than 14 calendar days following receipt of the service request, unless the timeframe is extended up to 14 additional calendar days. Such extension shall be implemented as follows:

(i) The extension shall only be allowed if:

(a) The Provider, Covered Individual or Appeal Representative requests the extension, or

(b) The Contractor can justify (to EOHHS, upon request) that:

(1) The extension is in the Covered Individual's interest; and

(2) There is a need for additional information where:

- There is a reasonable likelihood that receipt of such information would lead to approval of the request, if received; and
- Such outstanding information is reasonably expected to be received within 14 calendar days.

(ii) If the Contractor extends the timeframe, it must:

(a) Give the Covered Individual written notice of the reason for the extension and inform the Covered Individual of the right to file a Grievance if the Covered Individual disagrees with that decision; and

(b) Issue and carry out its determination as expeditiously as the Covered Individual's health condition requires and no later than the date the extension expires.

d) For expedited service authorization decisions that deny or provide limited authorization for requested services, as specified in **Section 4.2.A.1.e.2)**, as expeditiously as the Covered Individual's health requires but no later than 72 hours after the receipt of the expedited request for service, unless the timeframe is extended up to 14 additional calendar days. Such extension shall be implemented as follows:

(i) The extension shall only be allowed if:

(a) The Provider, Covered Individual or Appeal Representative requests the extension, or

(b) The Contractor can justify (to EOHHS, upon request):

(1) The extension is in the Covered Individual's interest; and

(2) There is a need for additional information where:

- There is a reasonable likelihood that receipt of such information would lead to approval of the request, if received; and
- Such outstanding information is reasonably expected to be received within 14 calendar days.

(ii) If the Contractor extends the timeframe, it must do the following:

(a) Give the Covered Individual written notice of the reason for the extension and inform the Covered Individual of the right to file a Grievance if the Covered Individual disagrees with that decision; and

(b) Issue and carry out its determination as expeditiously as the Covered Individual's health condition requires and no later than the date the extension expires.

e) For standard or expedited service authorization decisions not reached within the timeframes specified in **Sections 4.2.A.1.e.1)** and **2),** whichever is applicable, on the day that such timeframes expire.

f) When the Contractor fails to provide services in a timely manner in accordance with the access standards in **Section 3.1.G**, within one business day upon notification by the Covered Individual or Provider that one of the access standards in **Section 3.1.G** was not met.

3. Handling of Grievances and Internal Appeals

In handling Grievances and Internal Appeals, the Contractor shall:

a. Inform Covered Individuals of the Grievance, Internal Appeal, and BOH Appeal procedures.

b. Give reasonable assistance to Covered Individuals in completing forms and following procedures applicable to Grievances and Internal Appeals, including, but not limited to, providing interpreter services and toll-free numbers with TTY/TTD and interpreter capability;

c. Provide notice of Adverse Actions as specified in **Section 7.6.B.2**;

d. Accept Grievances and Internal Appeals filed in accordance with **Section 7.6.B.3**;

e. Send written acknowledgement of the receipt of each Grievance or Internal Appeal to the Covered Individual and Appeal Representative within one business day of receipt by the Contractor;

f. Ensure that the individuals who make decisions on Grievances and Internal Appeals:

1) are individuals who were not involved in any previous level of review or decision-making, and are not the subordinates of any such individuals; and

2) Take into account all comments, documents, records, and other information submitted by the Covered Individual or the Appeal Representative without regard to whether such information was submitted or considered in the Adverse Action determination;

g. Ensure that the following types of Grievances are decided by health care professionals who have the appropriate clinical expertise in treating the Covered Individual's medical condition, performing the procedure, or providing the treatment that is the subject of the Grievance:

1) Grievances regarding the denial of a Covered Individual's request that an Internal Appeal be expedited, as specified in **Section 7.6.B.4.a.3.d**; and

2) Grievances regarding clinical issues;

h. Ensure that the following special requirements are applied to Internal Appeals:

1) The Contractor shall offer one level of review of an Adverse Action for Internal Appeals;

2) All reviews of Internal Appeals shall be conducted by health care professionals who have the appropriate clinical expertise in treating the medical condition, performing the procedure, or providing the treatment that is the subject of the Adverse Action;

3) The Contractor shall treat an oral request seeking to appeal an Adverse Action as an Internal Appeal in order to establish the earliest possible filing date for Internal Appeals and may require the Covered Individual or an Appeal Representative to confirm such oral requests in writing as specified in **Section 7.6.B.3.e**;

4) The Contractor shall provide a reasonable opportunity for the Covered Individual or an Appeal Representative to present evidence and allegations of fact or law, in person as well as in writing, and shall inform the Covered Individual or an Appeal Representative about the limited time available for this opportunity in the case of an expedited Internal Appeal;

5) The Contractor shall provide the Covered Individual and Appeal Representative, before and during the Internal Appeal process, the Covered Individual's case file, including medical records, and any other documentation and records considered, relied upon, or generated during the Internal Appeal process. This information shall be provided free of charge and sufficiently in advance of the applicable resolution timeframe;; and

6) The Contractor shall include, as parties to the Internal Appeal, the Covered Individual and Appeal Representative or the legal representative of a deceased Covered Individual's estate.

4. Resolution and Notification of Grievances and Internal Appeals

a. The Contractor shall:

1) Dispose of each Grievance, resolve each Internal Appeal, and provide notice of each disposition and resolution, as expeditiously as the Covered Individual's health condition requires, within the following timeframes:

2) For the standard resolution of Grievances and notice to affected parties, no more than 30 calendar days from the date the Contractor received the Grievance, either orally or in writing, from a valid party, e.g., the Covered Individual or the Covered Individual's authorized Appeal Representative;

3) For standard resolution of Internal Appeals and notice to the affected parties, no more than 30 calendar days from the date the Contractor received either in writing or orally, whichever comes first, the Covered Individual request for an Internal Appeal unless this timeframe is extended under **subsection 4.b**, below;

4) For expedited resolution of Internal Appeals and notice to affected parties, no more than 72 hours after the Contractor received the expedited Internal Appeal unless this timeframe is extended under **subsection 4.b**, below. The Contractor shall process the expedited Internal Appeal even if a Provider is allegedly serving as the Covered Individual's Appeal Representative, but the Contractor has still not received in writing the Authorized Appeal Representative form. The Contractor must require that the Provider submit a signed Authorized Appeal Representative form to the Contractor as documentation that the Covered Individual did in fact authorize the Provider to file the expedited Internal Appeal on the Covered Individual's behalf, as long as the expedited Internal Appeal is not delayed waiting for the Authorized Appeal Representative form;

b. Extend the timeframes specified in **Sections 7.6.B.4.a.2)** and **3)** as follows:

1) Extend the timeframe in **Section 7.6.B.4.a.2)** by up to five calendar days if:

a) The Covered Individual or Appeal Representative requests the extension, or

b) The Contractor can justify (to EOHHS upon request) that:

(i) The extension is in the Covered Individual's interest; and

(ii) There is a need for additional information where:

(a) There is a reasonable likelihood that receipt of such information would lead to approval of the request, if received; and

(b) Such outstanding information is reasonably expected to be received within five calendar days;

2) Extend the timeframes in **Section 7.6.B.4.a.3)** and **Section 7.6.B.4.a.4** for up to 14 calendar days if:

a) The Covered Individual or Appeal Representative requests the extension, or

b) The Contractor can justify (to EOHHS upon request) that:

(i) The extension is in the Covered Individual's interest; and

(ii) There is a need for additional information where:

(a) There is a reasonable likelihood that receipt of such information would lead to approval of the request, if received; and

(b) Such outstanding information is reasonably expected to be received within 14 calendar days;

3) For any extension not requested by the Covered Individual, the Contractor shall:

a) Make reasonable efforts to give the Covered Individual and Appeal Representative prompt oral notice of the delay;

b) Provide the Covered Individual and Appeal Representative written notice of the reason for the delay within 2 calendar days. Such notice shall include the reason for the extend the timeframe and the Covered Individual's right to file a grievance; and

c) Resolve the appeal as expeditiously as the Covered Individual's health condition requires and no later than the date the extension expires.

c. Provide notice in accordance with **subsection 4.a**, above, regarding the disposition of a Grievance or the resolution of a standard or expedited Internal Appeal as follows:

1) All such notices shall be in writing in a form approved by EOHHS, and satisfy the language and format standards set forth in 42 CFR 438.10. For notice of an expedited Internal Appeal resolution, the Contractor must also make reasonable efforts to provide oral notice to the Covered Individual; and

2) The notice shall contain, at a minimum, the following:

a) The results of the resolution process and the effective date of the Internal Appeal decision;

b) For Internal Appeals not resolved wholly in favor of the Covered Individual:

(i) The right to file a BOH Appeal and how to do so, and include the Request for a Fair Hearing form; and

(ii) That the Covered Individual will receive Continuing Services, if applicable, while the BOH Appeal is pending if the Covered Individual submits the appeal request to the BOH within 10 days of the Adverse Action, unless the Covered Individual specifically indicates that he or she does not want to receive Continuing Services.

d. Resolve expedited Internal Appeals as follows:

1) The Contractor shall resolve Internal Appeals expeditiously in accordance with the timeframe specified in **subsection 4.a**, above, when the Contractor determines (with respect to a Covered Individual's request for expedited resolution) or a Provider indicates (in making the request for expedited resolution on the Covered Individual's behalf or supporting the Covered Individual's request) that taking the time for a standard resolution could seriously jeopardize the Covered Individual's life or health or ability to attain, maintain, or regain maximum function. The Contractor shall process the expedited Internal Appeal even if the Provider is allegedly serving as the Covered Individual's Appeal Representative, but the Contractor has still not received in writing the Authorized Appeal Representative form.

2) The Contractor shall not take punitive action against Providers who request an expedited resolution, or who support a Covered Individual's Internal Appeal.

3) If the Contractor denies a Covered Individual's request for an expedited resolution of an Internal Appeal, the Contractor shall:

a) Transfer the Internal Appeal to the timeframe for standard resolution in **subsection 4.a**, above; and

b) Make reasonable efforts to give the Covered Individual and Appeal Representative prompt oral notice of the denial, and follow up within two calendar days with a written notice. Such notice shall include the Covered Individual's right to file a Grievance.

c) Resolve the appeal as expeditiously as the Covered Individual's health condition requires, and no later than the applicable deadlines set forth in this Contract.

4) The Contractor shall not deny a Provider's request (on a Covered Individual's behalf) that an Internal Appeal be expedited unless the Contractor determines that the Provider's request is unrelated to the Covered Individual's health condition.

C. Board of Hearings

The Contractor shall:

1. Require Covered Individuals and their Appeal Representatives to exhaust the Contractor's Internal Appeals process before filing an appeal with the Board of Hearings (BOH). The exhaustion requirement is satisfied if either of the following conditions is met:

   a. The Contractor has issued a decision following its review of the Adverse Action; or

   b. The Contractor fails to act within the timeframes for reviewing Internal Appeals or fails to satisfy applicable notice requirements;

2. Include with any notice following the resolution of an Internal Appeal any and all instructive materials and forms provided to the Contractor by EOHHS that are required for the Covered Individual to request a BOH Appeal; and

3. Notify Covered Individuals that:

   a. Any Continuing Services being provided by the Contractor that are the subject of a BOH Appeal will continue, unless the Covered Individual specifically indicates that he or she does not want to receive Continuing

Services and that the Covered Individual may be required by EOHHS to pay the cost of services furnished while a BOH Appeal is pending, if the final decision is adverse to the Covered Individual; and

b. It is the Covered Individual's or the Appeal Representative's responsibility to submit any request for a BOH Appeal to the BOH and to ensure that the BOH receives the request within the following time limits, as specified in 130 CMR 610.015(B)(7):

1) For BOH Appeals of a standard Internal Appeal resolved by the Contractor within the timeframes specified in **subsection 4.a**, 30 calendar days after the notice following the Final Internal Appeal, as specified in **Section 7.6.B.h**;

2) For BOH Appeals of a standard Internal Appeal resolved by the Contractor within the timeframes specified in **subsection 4.a**, in which the Covered Individual wants to continue receiving the services that are the subject of the BOH Appeal, 10 calendar days after the notice following the Final Internal Appeal, as specified in **Section 7.6.B.h**;

3) For BOH Appeals of an expedited Internal Appeal resolved by the Contractor within the timeframe specified in **subsection 4.d**, 20 calendar days after the notice following the Final Internal Appeal, as specified in **Section 7.6.4.h** or within 30 calendar days in which case the BOH Appeal will be treated as a non-expedited (i.e., standard) BOH Appeal Request;

4) For BOH Appeals of a standard Internal Appeal not resolved by the Contractor within the timeframe specified in **subsection 4.a**, 30 calendar days from the date on which that timeframe expired; and

5) For BOH Appeals of an expedited Internal Appeal not resolved by the Contractor within the timeframe specified in **subsection 4.d**, 20 calendar days from the date on which that timeframe expired.

4. Be a party to the BOH Appeal, along with the Covered Individual and his or her representative or the representative of a deceased Covered Individual's estate.

D. Additional Requirements

The Contractor shall:

1. For all Internal Appeal decisions upholding an Adverse Action, in whole or in part, provide EOHHS a copy of the decision sent to the Covered Individual and Appeal Representative within one business day of issuing the decision. This shall include letters that are sent when the Contractor fails to act within the time frames for reviewing Internal Appeals, and letters sent issuing a decision. The Contractor

shall provide EOHHS with all necessary information to assist EOHHS's review of the Contractor's determination. For decisions involving Behavioral Health Services, EOHHS will consult with the Deputy Commissioner of the Department of Mental Health in its review of the Contractor's decision;

2. Upon learning of a hearing scheduled on a BOH Appeal concerning such an Internal Appeal, notify EOHHS immediately and include the names of the Contractor's clinical and other staff who will be attending the BOH hearing;

3. Comply with any EOHHS directive to reevaluate the basis for its decision in a manner that is consistent with EOHHS's interpretation of any statute, regulation, and contractual provisions that relates to the decision;

4. Submit all applicable documentation to the BOH, EOHHS, the Covered Individual and the designated Appeal Representative, if any, within five business days prior to the date of the hearing, or if the BOH Appeal is expedited, within one business day of being notified by the BOH of the date of the hearing. Applicable documentation shall include, but not be limited to, a copy of the notice of Adverse Action, any documents relied upon by the Contractor in rendering the decision resolving the Internal Appeal, and any and all documents that will be relied upon at hearing;

5. Make best efforts to ensure that a Provider, acting as an Appeal Representative, submits all applicable documentation to the BOH, the Covered Individual and the Contractor within five business days prior to the date of the hearing, or if the BOH Appeal is expedited, within one business day of being notified by the BOH of the date of the hearing. Applicable documentation shall include, but not be limited to, any and all documents that will be relied upon at the hearing;

6. Comply with and implement the decisions of the BOH;

7. In the event that the Covered Individual appeals a decision of the BOH, comply with and implement the decisions of any court of competent jurisdiction; and

8. Designate an Appeals Coordinator to act as a liaison between EOHHS and the BOH to:

    a. Determine whether each Covered Individual who requests a BOH Appeal has exhausted the Contractor's Internal Appeals process, in accordance with **Section 7.6.C.1**;

    b. If requested by the Covered Individual, assist the Covered Individual with completing a request for a BOH Appeal;

    c. Receive notice from the BOH that an Covered Individual has requested a BOH Appeal, immediately notify EOHHS, and track the status of all pending BOH Appeals;

d. Ensure that Continuing Services are provided when informed by the BOH that a request for a BOH Appeal was timely received, unless the Covered Individual specifically indicates that he or she does not want to receive Continuing Service;

e. Instruct Covered Individuals for whom an Adjustment has been made about the process of informing the BOH in writing of all Adjustments and, upon request, assist the Covered Individual with this requirement, as needed;

f. Ensure that the case folder and/or pertinent data screens are physically present at each hearing;

g. Ensure that appropriate Contractor staff attend BOH hearings;

h. Coordinate with BOH requests to reschedule hearings and ensure that the Contractor only requests that hearings be rescheduled for good cause;

i. Upon notification by BOH of a decision, notify EOHHS immediately;

j. Ensure that the Contractor implements BOH decisions upon receipt;

k. Report to EOHHS within 30 calendar days of receipt of the BOH decision that such decision was implemented;

l. Coordinate with the BOH, as directed by EOHHS; and

m. Ensure that appropriate Contractor staff attend BOH Appeals training sessions organized by EOHHS.

9. Provide information about the Contractor's Grievances and Appeals policies to all Providers and Material Subcontractors at the time the Contractor and these entities enter into a contract; and

10. Maintain records of Grievances and Appeals in a manner accessible to EOHHS, available to CMS upon request, and that contain, at a minimum, the following information:

a. A general description of the reason for the Appeal or Grievance;

b. The date received, the date of each review, and, if applicable, the date of each review meeting;

c. Resolution of the Appeal or Grievance, and date of resolution; and

d. Name of the Covered Individual for whom the Appeal or Grievance was filed.

E. Continuing Services

1. The Contractor shall comply with the provisions of 42 CFR 438.420 and, in addition, provide Continuing Services while an Internal Appeal is pending and while a BOH Appeal is pending, unless the Covered Individual specifically indicates that he or she does not want to receive Continuing Services, when the appeal involves the reduction, suspension, or termination of a previously authorized service;

2. The Contractor shall provide Continuing Services until one of the following occurs:

    a. The Covered Individual withdraws the Internal Appeal or BOH Appeal; and

    b. The BOH issues a decision adverse to the Covered Individual;

3. If the Contractor or BOH reverses an Adverse Action to deny, limit, or delay services that were not furnished while the Internal Appeal or BOH Appeal were pending, the Contractor shall authorize or provide the disputed services promptly, and as expeditiously as the Covered Individual's health condition requires, but no later than 72 hours from the date it receives notice reversing the determination; and

4. If the Contractor or BOH reverses an Adverse Action to deny, limit, or delay services and the Covered Individual received Continuing Services while the Internal Appeal or BOH Appeal were pending, the Contractor shall pay for such services.

Section 7.7 Reporting

The Contractor shall submit to EOHHS all required reports related to Covered Individual, Provider and PCC services, as described in this **Section 7** or in **Appendix E-1**, in accordance with specified timetables, definitions, formats and assumptions, as well as any ad hoc reports required by EOHHS in accordance with **Section 11.2.B**.

SECTION 8. QUALITY MANAGEMENT (QM)

Overview

The Contractor shall implement a comprehensive Quality Management (QM) program that includes ongoing quality assessment and performance improvement of all areas of the Contractor's responsibility under this Contract.

The QM program shall:

- Assess the quality and appropriateness of care and services furnished to all Covered Individuals, including Covered Individuals with special health care needs;
- focus on improving the Covered Individual's health status through the delivery of high-quality and cost-effective care, and by the provision of programmatic supports that foster a high level of communication and cooperation among medical and Behavioral Health care providers, with regard to the Enrollees they are both serving;
- incorporate the principles of continuous quality improvement into all aspects of the operation of the Contract;
- be based upon robust data collection, accurate measurement, and data analysis that enhance Behavioral Health service delivery; the integration of care delivered by medical and Behavioral Health care providers; and Covered Individual health outcomes;
- include effective assessment of healthcare disparities and strategies to identify and address variations related to health care access and health outcomes; and
- include activities, resources and strategies that support Covered Individuals through Wellness and preventive health programs.

Section 8.1 QM Program, Philosophy and Structure

The Contractor shall implement by the Service Start Date and maintain throughout the Contract a comprehensive QM program based on a written QM philosophy that is consistent with EOHHS priorities and goals**.**

A. Organizational Structure

The QM program shall be supported by an organizational structure that:

1. Is organization-wide, disseminated to, and understood by all Contractor employees;

2. Delineates clear lines of accountability for Quality Management within the organization;

3. Corresponds and complies with National Committee on Quality Assurance (NCQA) accreditation requirements;

4. Provides for an organizational Quality Council that is responsible for overseeing the QM activities throughout the organization and invites participation by EOHHS and DMH;

5. Includes written standard operating policies and procedures;

6. Includes a set of clearly defined qualifications, functions, roles and responsibilities for QM staff, including physicians, other clinicians and non-clinicians; and

7. Provisions for inclusion of Covered Individuals and their families in Quality Improvement (QI) activities.

B. Data Management

The Contractor's QM program shall be informed by consistent utilization and analysis of data, incorporating at least the following elements:

1. A process for collecting, analyzing and managing with data to improve Covered Individuals' health outcomes;

2. A process for collecting and submitting performance measurement data in accordance with 42 CFR 438.330;

3. A process for tracking to resolution areas targeted for QI as identified by the Contractor, EOHHS or CMS;

4. Using multiple data sources and drawing conclusions based on data to drive system improvement through evidence-based practices, Practice Guidelines, and other data-driven clinical initiatives.

C. NCQA Accreditation

The Contractor shall:

1. Either:

    a. Be NCQA-accredited as an Health Plan/MCO or as a MBHO; or

    b. Apply and be accredited by NCQA as an Health Plan/MCO or a MBHO within the first year of the Contract;

2. Annually inform EOHHS if it is nationally accredited or if it has sought and been denied such accreditation, and submit to EOHHS, at the direction of EOHHS, a summary of its accreditation status and the results of any quality-related external audits; and

3. Authorize NCQA to provide EOHHS a copy of its most recent accreditation review, including but not limited to, as applicable, accreditation status, survey type, level, accreditation results, recommended actions, recommended

improvements, corrective action plans, summaries of findings; and expiration date of accreditation.

Once accredited, the Contractor shall maintain accreditation pursuant to the requirements of NCQA.

Section 8.2 QM Plan for Behavioral Health Management

The Contractor shall create on an annual basis, submit for EOHHS review and approval by January 31st of each Contract Year, and implement a single, comprehensive Quality Management plan that defines the QM program, details the Contractor's quality activities and provides for self-assessment of the Contractor's responsibilities under the Contract.

A. The QM plan for the first year of the Contract shall focus on the establishment of baselines and benchmarks for use in setting and assessing health improvement targets and quality improvement goals in subsequent years of the Contract.

B. The QM plan shall include activities, measures and performance improvement projects that are specifically relevant to each of the core activities designated within the Interdepartmental Service Agreement between DMH and EOHHS (ESP programs, MCPAP, and Forensic Evaluation program).

C. The QM plan shall describe planned improvement activities related to:

1. The Contractor's management of the BH services provided to Covered Individuals;
2. The Contractor's Management Support Services for the PCC Plan;
3. The Contractor's efforts to improve care integration across medical and Behavioral Health care services; and
4. The Contractor's Care Management Program.

D. Each year's proposed QM plan shall be informed by an assessment of prior years' activities and results through an annual retrospective report, which the Contractor shall prepare and submit to EOHHS for approval within the first month of each Calendar Year, beginning with January 2013. The annual QM plan shall include but not be limited to:

1. Monitoring of the following performance indicators, at a minimum, and others as directed by EOHHS. If the results of the performance indicator(s) meet or exceed the benchmark, the Contractor shall continue to monitor the indicator(s); if the results of the performance indicator(s) fall below the benchmark, the Contractor shall implement a Quality Improvement Program (QIP) as directed by EOHHS. Performance Indicators shall, at a minimum:

a. Assess whether qualified and clinically appropriate Network Providers are available to provide BH Covered Services, and the degree to which the Provider Network met the needs of Covered Individuals for:

1) access within the access standards required by the Contract;

2) access within different geographic areas across the Commonwealth;

3) access to individuals with physical disabilities;

4) ability to communicate, either directly or through a skilled interpreter, with Covered Individual in his/her primary language; and

5) ability to address Covered Individuals' health disparity needs.

b. Assess Network Providers' success at communicating with Primary Care Practitioners, when appropriate.

c. Assess the development of the Behavioral Health service delivery system, including overuse, underuse and misuse of services; special measures shall be developed and implemented to highlight Provider best practices.

d. Assess and measure of utilization reviewers' consistency in applying Medical Necessity criteria in UM activities and in the medical record (chart) review process.

e. Assess and summarize critical incidents reported by Network and non-Network Providers, including actions taken in response.

f. Assess the subjects and outcomes of Appeals, Grievances and complaints, including timeframes required to reach resolution, and opportunities for improvement.

g. Assess Covered Individual, Network Provider and PCC satisfaction through administration of satisfaction surveys.

2. Timelines, objectives and goals for improvement projects and activities, including clinical and non-clinical activities as well as those BH improvement projects generated by the quality improvement (QI) goals as required by EOHHS. The projects shall be designed to achieve, through ongoing measurements and intervention, significant improvement, sustained over time, in clinical care and non-clinical care areas that are expected to have a favorable effect on health outcomes and Covered Individual, Network Provider and PCC satisfaction. The performance improvement projects must involve the following:

a. measurement of performance using objective indicators of quality;

b. implementation of system interventions to achieve improvement in quality;

c. evaluation of the effectiveness of the interventions; and

d. planning and initiation of activities for increasing or sustaining improvement.

The Contractor must complete each project in a reasonable time period so as to generally allow information on the success of performance improvement projects in the aggregate to produce new information on quality of care every year. The Contractor must report and present the status and results of each project to EOHHS at least twice a year, and as requested.

3. Analysis of the effectiveness of treatment services, employing standard measures of symptom reduction/management as well as measures of functional status and recovery. The Contractor shall recommend to EOHHS an approach to meet this requirement, including the assessment instrument, or scale, to be used and the methodology for its application. EOHHS reserves the right to approve or specify the instrument(s) and analysis methodology to be used.

4. Administration no less often than biennially of satisfaction surveys to Covered Individuals (see **Section 8.4.C**).

5. Administration no less often than biennially of Network Provider satisfaction surveys, with results stratified by provider type and specialty.

6. Administration biennially of PCC satisfaction surveys with results stratified by provider type and specialty.

Section 8.3 Quality Management Plan for PCC Plan Management Support Services

The Contractor shall create and implement a single, comprehensive Quality Management plan, containing the same elements as described in **Section 8.2**, that reflects the Contractor's organizational QM philosophy and structure and includes PCC Plan Management Support Services-related activities. Such QM plan shall be submitted to EOHHS for review and approval by January 31st of each Contract Year. This component of the QM plan shall describe planned improvement projects and activities, including but not limited to:

A. Timelines, objectives and goals for the planned improvement projects and activities, including clinical and non-clinical initiatives;

B. A process for monitoring data for, and tracking to resolution, areas targeted for quality improvement (QI) as identified by the Contractor or EOHHS;

C. A process for comparing QI project results against established goals;

D. Plans for coordinating medical and Behavioral Health care services;

E. A process for monitoring PCCs' ability to manage the health care needs of culturally diverse PCC Plan Enrollees;

F. A process to evaluate annually the effectiveness of QM plan activities and, based on the results, to identify and implement improvement activities;

G. An annual retrospective QM activities report based on the previous year's QM plan, which the Contractor shall prepare and submit to EOHHS for approval within the first month of each Calendar Year, beginning with January 2013.

Section 8.4 Satisfaction Measurements

Consistent with NCQA accreditation requirements, the Contractor shall conduct assessments of Network Provider, PCC and Covered Individual satisfaction.

A. Network Provider Satisfaction

The Contractor shall survey Network Providers biennially, starting with Contract Year Two, using a written survey instrument approved by EOHHS, to assess Network Provider satisfaction with the Contractor's administration and management of the BHP and the Care Management Program. The Contractor shall analyze the results of the survey and provide EOHHS with results stratified by Provider type and specialty, by separate program components, and in aggregate.

B. PCC Provider Satisfaction

The Contractor shall survey PCCs biennially, starting with Contract Year Two, using a written survey instrument approved by EOHHS, to assess PCC satisfaction with the Contractor's administration and management of the BHP, PCC Plan Management Support Services, and the Care Management Program. The Contractor shall analyze the results of the survey and provide EOHHS with results stratified by Provider type and specialty.

C. Covered Individual Satisfaction

At the direction of EOHHS, and using one or more external organizations with appropriate experience, the Contractor shall conduct satisfaction surveys of Covered Individuals regarding the requirements of this Contract, as follows. The Contractor shall:

1. Propose to EOHHS an approach to meet this requirement, including the experience of care survey to be used, and the methodology for its application. EOHHS reserves the right to approve or specify the instrument(s) and analysis methodology to be used;

2. Ensure that the surveying organization has appropriate experience, conducts surveys by mail or by telephonic and/or site-based interviewing, and includes a valid sample of Covered Individuals; and

3. Share survey results and analysis with Providers and EOHHS, in accordance with timelines as directed by EOHHS, and utilize the survey results as part of Network

Management, Quality Management and program development. The Contractor shall provide such reports to EOHHS upon request.

4. Upon request by the Member, share the results of the Member's Enrollee survey.

Section 8.5 Quality Improvement Projects

The Contractor shall annually develop and propose to EOHHS quality improvement projects (QIPs) to be incorporated into the Contract each year.

A. Development of QIPs

1. In conjunction with the development of the annual Quality Management plan each Contract Year, the Contractor shall identify and propose for EOHHS's review and approval a minimum of five annual contractual quality improvement projects. The Contractor shall design Quality Improvement Projects (QIPs) to achieve significant improvement in clinical care and non-clinical care areas that have a favorable effect on health outcomes and Covered Individual satisfaction. The Contractor shall design QIPs as ongoing interventions, sustained over time. The Contractor shall target QIPS to areas that present significant opportunities for performance improvement and meet the following description:

    a. The QIPs shall be based on the Contractor's actual experience serving Covered Individuals, the findings of the assessments required in **Section 8.2.D**, and the performance indicators required in **Section 8.6**. The Contractor also may identify other areas, such as those internal to the Contractor's operation, for inclusion in quality improvement projects.

    b. Data sources for the design of the QIP may include without limitation:

        1) critical incident (Reportable Adverse Incident) reports;

        2) continuing care after discharge from one Level of Care to another, community tenure, and recidivism rates;

        3) Grievances and Internal Appeals and other feedback from Covered Individuals;

        4) Provider concerns;

        5) medical record reviews;

        6) Provider waiting lists;

        7) Covered Individual and Provider satisfaction/experience surveys;

        8) direction from EOHHS and DMH related to agencies' goals;

        9) data related to PCC Plan Management Support Services activities;

10) the Care Management program; and

11) data relative to the Contractor operations, such as Claims processing time frames and telephone response time.

c. The proposed QIPs may include administrative service, quality, and program development goals, although no more than two projects may address administrative services.

2. Each proposed QIP shall incorporate a project statement that includes highly specified and measurable goals and objectives, methodology, as well as detailed metric calculation specifications.

3. For each QIP, the Contractor shall develop a work plan for completion of the project including time frames by which the Contractor must demonstrate that the goals of the project have been achieved.

At least two of the five QIPs the Contractor proposes shall be as described in **Section 8.2.D.2** that satisfy the requirements of 42 CFR 438.240(b) and (d). EOHHS's External Quality Review (EQR) vendor shall validate the Contractor's performance of these quality improvement projects. Current listing of BH priority area standard goals including performance measures and quality improvement project initiatives are in **Appendix G**.

Should EOHHS and Contractor be unable to reach agreement on the improvement projects and/or the measures, EOHHS shall establish the improvement projects and/or measures.

B. Management of the QIPs

1. The Contractor shall designate relevant QM staff to meet with EOHHS twice a year to review operational issues, milestones and initiatives, as well as progress toward the QIPs, in Contract status meetings.

2. The Contractor shall evaluate the outcome of the QIPs and present its findings to EOHHS in the forms and time frames agreed to by EOHHS.

3. If EOHHS determines that the Contractor is not in compliance with the requirements for proposed annual QIPs, the Contractor shall prepare and submit a corrective action plan to EOHHS for review and approval.

Section 8.6 Pay for Performance (P4P)

A. Development of Behavioral Health Pay for Performance Measures

The Contractor shall be eligible for P4P based on exceptional performance based on Contractor results on a select subset of measures that are reliable indicators of quality improvement.

1. Measures shall be standardized and nationally accepted, except as described in **subsection B.2** below.

2. EOHHS may consider including non-nationally-accepted measures where such measures are not available to assess Contractor performance on a matter of particular importance to EOHHS.

3. Measures may change in each Contract Year, at the discretion of EOHHS. The current Contract Year measures are set forth in **Appendix G**.

B. Behavioral Health Pay for Performance Methodology

1. Incentive Structure

The P4P incentive structure shall:

a. Allow for a maximum incentive value for each P4P measure to be designated by EOHHS that corresponds proportionally to the size of the population identified for each P4P measure as detailed above.

b. Allow for partial P4P to the Contractor for demonstrating incremental improvements in performance, where those improvements exceed certain standards set by EOHHS.

c. Provide full payment to the Contractor for attaining the highest designated standard of performance as established by EOHHS.

2. Performance Targets and Tiers of Measurement

The Contractor shall work with EOHHS to develop performance targets and Tiers of measurement when appropriate for measures selected as eligible for P4P. Performance targets shall be based on either incremental improvement over performance in the prior period or comparative performance relative to benchmarks, as appropriate to the measure and as agreed upon by the Contractor and EOHHS. Tiers of measurement shall be structured as follows:

a. Tier 2: represents a minimum level of acceptable performance based on current PCC Plan performance or national Medicaid averages, whichever is higher, that must be met in order for any P4P payment to be made; and

b. Tier 1: representing excellent performance and full payment for performance.

3. Data and Measurement Integrity

The Contractor shall be responsible for the integrity of the performance measurement data sets for all required measures, including any subsets of select measures included in P4P.

a. Contractor shall be responsible for the accuracy of the calculations and measurement.

b. Contractor shall make available to EOHHS and its designees, including auditors and the EQRO, all performance measurement data sets, including any subsets of select measures included in pay for performance, and associated programming, calculation methodologies and related materials.

C. Care Management Performance Incentives

1. Care Management Performance Incentive Arrangements shall be based on Contractor performance in engaging Providers and program Participants and improving outcomes for such Participants.

2. Each Contract Year the Contractor shall propose, subject to EOHHS approval, the minimum Engagement Targets and the PPPM rate.

3. The remaining Care Management Performance Incentive Arrangements may be earned based on Contractor performance on a designated set of outcomes measures to be proposed by the Contractor for EOHHS review and approval. There shall be no fewer than four outcome measures in Contract Year One.

4. The Care Management performance measurement areas for Year One are included in **Appendix G**.

Section 8.7 Other Measures of Quality

A. Overview

In addition to the Performance Incentive measures described in **Section 8.6**, the Contractor shall conduct ongoing measurement based on a set of quality indicators established by EOHHS or proposed by the Contractor and approved by EOHHS. Other measurement categories include:

1. Quality indicators that are to be monitored relative to established contract standards and for which the Contractor may incur sanctions or penalties, as determined by EOHHS, if the Contractor's performance is below the standard;

2. Quality indicators that may be applicable, to Enrollees and to Covered Individuals, and for which the measurement design and measurement specifications may be proposed by the Contractor and approved by EOHHS; and

3. Quality indicators assessed through standard reporting requirements.

Measures of quality shall be reassessed annually and may be prioritized, modified, substituted or deleted throughout the Contract term.

B. Development of Measures

Measures will be developed based on the following criteria:

1. Measures should be relevant, and should assess:

a. Processes known to be linked to improved health outcomes; and

b. Health outcomes or proxies for improved health outcomes.

2. Measures should be, to the extent possible, based upon industry standards for the measure specifications; and

3. Measures should be based on data that is feasible to collect; and shall include clear, detailed specifications.

Section 8.8 QM Staffing and Staff Training

The Contractor shall:

A. Employ appropriately qualified staff experienced in QM in sufficient numbers to satisfy all QM responsibilities. Staff shall include the following positions, unless otherwise approved by EOHHS:

1. **QM Director** – a senior manager designated as key personnel; responsible for overseeing all QM activities related to the Contract, and accountable to the Contractor's appropriate clinical leadership, such as an Associate Medical Director with Quality Management experience, for the successful performance and execution of such activities; and

2. The Contractor's **Director of Quality** shall be dedicated solely to the Contract, with demonstrated expertise in quality improvement processes, and shall develop and coordinate all quality improvement program-related activities, including but not limited to staff training in quality improvement processes. Quality improvement objectives shall meet the health care needs of Enrollees, and address integration of care.

3. **QM Analyst(s)** – dedicated solely to the Contract and its QM activities, responsible for MIS-related functions such as report production, analysis, and methodological problem solving and data interpretation.

B. Each Contract Year, determine the need for training staff in relevant aspects of Quality Management, practice management, or other related skills, and develop and provide such training as necessary.

C. Ensure that Contractor QM staff collaborate with all applicable units within the Contractor's organization to provide Contract services in a consistent, coordinated manner.

Section 8.9 Quality Management – Network Providers

A. Quality Management Activities

The Contractor shall:

1. Develop and implement by a date agreed to by EOHHS a work plan for QM activities with Network Providers that measures, among other things, Covered Individuals' functional status and recovery from mental illness and substance use disorders and ensures that:

    a. community-based Network Providers utilize standardized assessment tools approved by the Contractor to assess treatment outcomes, and that data is being utilized in those settings as needed for practice improvement activities;

    b. acute services Network Providers utilize standardized assessment tools approved by the Contractor to inform discharge planning; and

    c. the results of the assessment and discharge plans are forwarded whenever a Covered Individual proceeds to another Level of Care, and to PCCs, as applicable.

2. Develop and implement a medical record (chart) review process for:

    a. Monitoring provider compliance with written policies and procedures, program specifications, Medical Necessity criteria and billing practices,

    b. Monitoring the quality of services provided, including adherence/fidelity to any evidence-based practices; and

    c. Documenting remedial steps undertaken pursuant to QI corrective action plans for Network Providers.

3. Ensure that Network Providers adopt continuous quality improvement practices.

4. Develop and implement:

    a. A process for monitoring Network Providers' compliance with the Contractor's written policies and procedures, program specifications, and appropriateness of care;

    b. A quality assurance process to monitor variation in Provider Network practice patterns, and the identification of outliers and promote care consistent with evidence-based clinical Practice Guidelines;

    c. A process to monitor Providers' safe and appropriate use of restraint and seclusion techniques and its implementation of plans to reduce the use of such techniques; and

    d. A process to use issues identified through the Reportable Adverse Incident reporting process to guide quality and Network management strategies.

5. In collaboration with and as directed by EOHHS, the Contractor shall:

a. Develop a process to monitor the quality of services and evaluate the adequacy of medical record keeping for Outpatient services provided to Covered Individuals under the age of 21;

b. Utilize a quality assessment tool approved by EOHHS to conduct this review; and

c. Annually evaluate at least 10% of the Covered Individuals under the age of 21 who have received Outpatient services during each Contract Year, consisting of a mix of Outpatient providers, provided however that the Contractor shall not be required to review more than 25 Covered Individual's medical files per region per Contract Year.

Section 8.10 Coordination of Network Provider and PCC Profiling and Reporting

The Contractor shall coordinate its profiling activities for Network Provider and PCC Plan MSS programs as described in **Section 5** to ensure optimal integration of delivery of BH Covered Services to Covered Individuals and Enrollees. Findings from each program shall inform the other program over the course of the Contract. Specifically, the Contractor shall:

A. Develop and submit to EOHHS for approval a plan to ensure that both medical and BH issues are addressed in both the PCC Plan MSS and the Network Provider profiling. The plan must include:

1. the measures, specifications and data sources the Contractor will use; and

2. timelines for development and implementation of coordinated measures.

B. Work collaboratively with EOHHS to continually enhance the Network Provider and PCC Plan MSS profiling programs to improve health outcomes for Covered Individuals and Enrollees.

Section 8.11 Forums and Councils

A. Provider and PCC Quality Forums

The Contractor shall:

1. Annually organize and conduct at least two quality forums, as follows:

   a. The quality forums shall be held through a webinar at a variety of times convenient to PCCs, Network Providers and other providers as directed by EOHHS. Some or all of the forums may also be held at locations throughout the state, in comfortable environments that encourage PCCs, Network Providers and other providers as appropriate to attend, and including refreshments (food and non-alcoholic beverages) as part of the event.

b. The quality forums shall be offered on topics that primarily focus on EOHHS goals, quality improvement, increased coordination and collaboration of medical and Behavioral Health care services, or improved service delivery and health outcomes for Covered Individuals.

c. By September 1 of each year, the Contractor shall submit to EOHHS for review and approval a proposal for the quality forum topics for the year. EOHHS may also require the Contractor to conduct forums on topics of EOHHS's choosing.

d. The Contractor shall develop the content of each quality forum in collaboration with EOHHS and key stakeholders.

2. Ensure that only those individuals on the Contractor's staff who are necessary to ensure an effective quality forum attend each forum.

3. Implement a mechanism for attendees and the Contractor to evaluate the quality forums and identify areas for improvement and, with EOHHS's approval, incorporate such improvements into future quality forums.

4. Obtain the required approval to offer and grant continuing medical education, risk management, and continuing education units to participants.

5. Provide a summary report on each series of quality forums described in this **Section 8.11**. The report shall include, at a minimum, information on the number and type of attendees (profession and practice name), the location, the presentation topic and responses from attendees regarding the quality of the program presented. The report shall be submitted within 30 days after the last session of a forum series.

B. Advisory Committees and Councils

The Contractor shall establish the following advisory councils for the exchange of stakeholder ideas related to this Contract, discussion of relevant topics, and the solicitation of advice, recommendations or concerns. The structure and purpose of the committees and councils must be consistent with NCQA protocols. The goal of these committees and councils shall be to foster improved quality, integrated care and Covered Individual, Provider and PCC satisfaction. The committees and councils shall follow standard rules of order and maintain a written record or minutes of each meeting. All committees and councils must meet at least once during the first six months of Contract Year One, and on a regular schedule thereafter.

The advisory committees and councils described in this section shall not be the only venue for soliciting input from stakeholders.

1. PCC Clinical Advisory Committee

The Contractor shall establish and facilitate a PCC Clinical Advisory Committee whose main objective is to support and promote improvement in the quality of clinical services provided to Enrollees.

a. The meetings shall be held at least three times a year and shall include refreshments (food and non-alcoholic beverages) as part of the event.

b. The membership of the PCC Clinical Advisory Committee shall be subject to EOHHS's approval, and shall consist of:

1) from eight to 14 PCCs who represent different types of PCC practices, different PCC specialty types, and diverse geographic areas of the Commonwealth;

2) at least one BH Network Provider; and

3) other MassHealth providers acting as specialists, if directed or approved by EOHHS.

c. The activities of the PCC Clinical Advisory Committee shall include:

1) meeting jointly with the BH Clinical Advisory Committee (see **Section 8.11.B.2**, below), at least one time per Contract Year; and

2) developing agendas with the PCC Plan Director and Medical Director and that promote and support the improvement in quality of clinical services provided to Enrollees.

2. BH Clinical Advisory Committee

The Contractor shall establish and facilitate a BH Clinical Advisory Committee whose main objective is to support and promote improvement in the quality of BH Covered Services provided to Covered Individuals, including the integration of medical and Behavioral Health services to the benefit of the Covered Individual.

a. The meetings shall be held at least three times a year and shall include refreshments (food and non-alcoholic beverages) as part of the event.

b. The membership of the BH Clinical Advisory Committee shall be subject to EOHHS's approval, and shall consist of:

1) from eight to 14 Network Providers who represent different types of Network Providers (e.g., mental health clinics, hospitals, individual practitioners) and different BH specialties from diverse geographic areas of the Commonwealth; and

2) at least one PCC.

EOHHS may also recommend to the Contractor Network Providers to be invited to serve on the committee. EOHHS, DMH, and other state agencies and major stakeholders identified by EOHHS shall be invited to participate in the committee's meetings.

c. The activities of the BH Clinical Advisory Committee shall include:

1) establishing bylaws that include designating a term of duty for committee members;

2) meeting jointly with the PCC Clinical Advisory Committee (see **Section 8.11.B.1**, above), at least one time per Contract Year; and

3) developing agendas that promote and support the QM activities of the BHP, including the integration of medical and Behavioral Health care services to the benefit of Covered Individuals and Enrollees.

3. Enrollee and Family Advisory Councils

The Contractor must include Enrollees and their families in QM activities and document their participation in Enrollee and family advisory councils.

4. Other Advisory Committees

As directed by EOHHS during the term of the Contract, the Contractor shall facilitate and convene additional advisory committees, which EOHHS shall chair.

Section 8.12 HEDIS and Other QM Data Activity

A. QM Data Collection

The Contractor shall collect and provide to EOHHS:

1. Data identified by EOHHS in a format specified by EOHHS in order that EOHHS can complete the Behavioral Health-related Healthcare Effectiveness Data and Information Set (HEDIS) measures, which are selected annually by EOHHS and validated by its EQR Contractor pursuant to 42 CFR 438.358(b)(1);

2. Encounter data; and

3. Other QM data sets, including data from medical record reviews, as directed by EOHHS during the term of the Contract.

B. Calculation of HEDIS Measures

The Contractor shall calculate selected BH and non-BH HEDIS measures as directed by EOHHS. The Contractor shall ensure the accuracy of all HEDIS measurement calculations.

Section 8.13 Practice Guidelines

A. Practice Guidelines Endorsed by EOHHS and its Agencies

The Contractor shall:

1. Adopt any practice guidelines established or endorsed by EOHHS and its agencies, including DMH; and

2. Disseminate such guidelines to all affected Network Providers, PCCs, and other providers as appropriate, as well as to Covered Individuals upon request. Such dissemination may include posting the guidelines on the Contractor's website.

3. Disseminate evidence-based clinical practice guidelines and process improvement methodologies to Network Providers and PCCs, as appropriate.

B. Practice Guidelines Established by the Contractor

1. The Contractor may propose Practice Guidelines to EOHHS for prior approval, as the Contractor deems appropriate. Such guidelines must:

    a. be based on valid and reliable clinical evidence or a consensus of health care professionals in the particular field;

    b. consider the unique Behavioral Health and medical needs of Covered Individuals; and

    c. be developed in conjunction with Covered Individuals, their families, Network Providers, PCCs, and clinical subject-matter experts within EOHHS agencies.

2. The Contractor shall not adopt such Practice Guidelines unless EOHHS approves them. If EOHHS approves the guidelines, the Contractor shall:

    a. review and update the Practice Guidelines periodically, as appropriate, and submit any modifications to EOHHS for approval;

    b. disseminate the Practice Guidelines to all affected Network Providers, PCCs, and other providers as appropriate, as well as to Covered Individuals upon request. Such dissemination may include posting the guidelines on the Contractor's website;

    c. provide training, education, and support for their implementation; and

    d. ensure that decisions regarding Utilization Management, Covered Individual education, coverage of services, and other areas to which such Practice Guidelines apply are consistent with the guidelines.

Section 8.14 External Quality Review (EQR) Activities

The Contractor shall take all measures necessary to support the External Quality Review Organization (EQRO) contracted by EOHHS (EQR Contractor) to conduct External Quality Review Activities in accordance with 42 CFR 438.350 through 42 CFR 438.370, as described below.

A. EQR activities shall include, but are not necessarily limited to:

1. Annually validating performance improvement projects required by EOHHS;

2. Annually validating performance measures calculated by the Contractor as a prepaid inpatient health plan, as directed or calculated by EOHHS; and

3. At least once every three years, reviewing compliance with activities mandated by 42 CFR Part 438, Subpart D, and at the direction of EOHHS, regarding access, structure and operations, and quality of care and services furnished to Covered Individuals.

B. EQR measures to support the EQR Contractor in conducting EQR Activities shall include, but are not necessarily limited to:

1. Designating a qualified individual to serve as Project Director for each EQR Activity who shall, at a minimum:

    a. Oversee and be accountable for compliance with all aspects of the EQR Activity;

    b. Coordinate with staff responsible for the EQR Activity and ensure that staff respond to requests by the EQR Contractor in a timely manner;

    c. Serve as liaison to the EQR Contractor and EOHHS staff and answer questions or coordinate responses to questions from the EQR Contractor and EOHHS staff; and

    d. Ensure timely access to information systems, data and other resources, as necessary for the EQR Contractor to perform the EQR Activity and as requested by the EQR Contractor or EOHHS.

2. Maintaining data and other documentation necessary to validate performance of EQR Activities. The Contractor shall maintain such documentation for a minimum of seven years.

3. Reviewing the EQR Contractor's draft EQR Activities report and offering comments and documentation to support the correction of any factual errors or omissions, in a timely manner, to the EQR Contractor or EOHHS.

4. Implementing actions, as directed by EOHHS, to address recommendations for quality improvement made by the EQR Contractor and sharing outcomes and

results of such activities with the EQR Contractor and EOHHS in subsequent years.

Section 8.15 Reporting

The Contractor shall submit to EOHHS all required reports related to Quality Management, as described in this **Section 8** or **Appendix E-1**, in accordance with specified timetables, definitions, formats and assumptions, as well as any ad hoc reports required by EOHHS in accordance with **Section 11.2.B**.

SECTION 9. INFORMATION SYSTEMS AND TECHNICAL SPECIFICATIONS

Section 9.1 General Information Systems Requirements

A. General

The Contractor shall:

1. Maintain information systems (Information Systems) that will enable the Contractor to meet all of the EOHHS's requirements as outlined in this Contract. The Contractor's Information Systems shall be able to support current EOHHS requirements, and any future IT architecture or program changes.

2. Accept all Contract-related files and data delivered by EOHHS, in the format specified by EOHHS.

3. Ensure a secure, HIPAA-compliant exchange of information on Covered Individuals and Uninsured Individuals and persons with Medicare only, as applicable, between the Contractor and EOHHS and any other entity EOHHS deems appropriate. Such files shall be transmitted to EOHHS through secure FTP, HTS, or a similar secure data exchange as determined by EOHHS.

4. Develop and maintain a website that is accurate, up-to-date, and designed in a way that enables Covered Individuals and Providers to quickly and easily locate all relevant information (see **Section 7.1.G**). The Contractor's website must be ADA-compliant and compliant with the online security protocols of the Public Company Accounting Reform and Investor Protection Act of 2002 (the so-called "Sarbanes-Oxley" law), as appropriate. If directed by EOHHS, establish appropriate links on the Contractor's website that direct users back to the EOHHS website(s).

5. Cooperate with EOHHS in its efforts to verify the accuracy of all Contractor data submissions to EOHHS.

6. Actively participate in any EOHHS Systems Workgroup or other workgroups, as directed by EOHHS. The workgroup shall meet in the location and on a schedule determined by EOHHS.

7. Retain online access to all EOHHS information systems as required by the Contract or directed by EOHHS, and ensure that such access is maintained for the duration of the Contract, unless otherwise directed by EOHHS.

8. Establish and maintain an Internet or future interchange connection with the Massachusetts Information Technology Division (ITD) and/or EOHHS to permit file transfers (e.g., eligibility updates) and interactive access by EOHHS to the Contractor's Information System, and ensure that such connection is maintained for the duration of the Contract, unless otherwise directed by EOHHS.

9. Provide all other automated tracking and processing systems needed to carry out the responsibilities of the Contract.

10. Provide and maintain all necessary functionality, hardware and software to meet industry standards, to include at least the following:

    a. Standard office software (word processing, spreadsheets, databases, e-mail communication, etc.) and operating systems on desktop, compatible with EOHHS's systems and licensed for all staff users;

    b. Internet connectivity and the appropriate internet capacity to support the Contract; and

    c. Business Intelligence reporting capability that is compatible with EOHHS's systems.

11. Implement any changes, enhancements and updates to its Information System to allow the Contractor to perform its responsibilities under the Contract, including collaborating with EOHHS on any changes to EOHHS's systems that affect the Contractor's ability to perform its responsibilities under the Contract.

12. Work with EOHHS to test or evaluate new or enhanced system changes pertaining to the exchange of any electronic information, to ensure that such changes meet Contract specifications and are compatible with other operating processes.

13. Take all steps necessary to ensure that the Contractor's Information Systems will be able to interface with and accommodate any new EOHHS IT projects that affect the Contractor.

14. Immediately report to EOHHS any telephone system, fax website, related software application or Information System problem(s) identified in the course of daily operations that prevent or impair the Contractor's performance of its Contract responsibilities.

B. Design Requirements

The Contractor shall:

1. Comply with EOHHS requirements, policies and standards in the design and maintenance of its Information Systems in order to successfully meet the requirements of this Contract.

2. Ensure that its Information Systems interface with and are compliant with EOHHS's MMIS, the EOHHS Virtual Gateway, and other EOHHS IT architecture that EOHHS identifies.

3. Have adequate resources to support the MMIS interfaces. The Contractor shall demonstrate the capability to successfully send and receive interface files

including HIPAA transaction files, as specified on the 820 Companion Guide, 834 Outbound Companion Guide available at: http://www.mass.gov/eohhs/gov/newsroom/masshealth/providers/mmis-posc/hipaa-version-5010.html.

4. Interface files in the Contract include but are not limited to:

   a. HIPAA 834 History Request File

   b. HIPAA 834 Outbound Daily File

   c. HIPAA 834 Outbound Full File

   d. HIPAA 834 History Response

   e. HIPAA 820

5. Have the ability to receive and analyze data from the EOHHS Data Warehouse regarding medical and pharmacy Claims, as provided by EOHHS.

6. Conform to HIPAA-compliant standards for data management and information exchange.

7. Implement controls to maintain information security and integrity.

8. Maintain appropriate internal processes to determine the validity and completeness of data submitted to EOHHS. These processes may be reviewed by EOHHS upon request.

9. Collaborate with EOHHS to verify its compliance with Version 5010 standards during the readiness review period prior to the Service Start Date.

10. Use the Version 5010 standards for HIPAA electronic health care transactions, including claims, remittance advice, eligibility inquiries, referral authorization, and other administrative transactions.

11. Implement Version 5010 standards and framework for the revised medical data code sets (ICD-10-CM and ICD-10-PCS), by October 1, 2014.

12. Ensure that an automated health information system (HIS) to support all of the Contractor's responsibilities under the Contract is operative as of the Service Start Date and remains operative for the duration of the Contract, unless otherwise directed or agreed to by EOHHS. The HIS must achieve the objectives of 42 CFR Part 438, Subpart D and shall collect, analyze, integrate and report data, including but not limited to information regarding:

    a. Service authorizations;

    b. Utilization;

c. Inquiries, Grievances, Internal Appeals, and BOH Appeals;

d. Disenrollments for reasons other than for loss of MassHealth eligibility;

e. Claims;

f. Provider information;

g. Services furnished to Covered Individuals through an Encounter data system, as specified in **Section 9.5**;

h. Covered Individual characteristics, including but not limited to race, ethnicity, spoken language, hearing loss and use of ASL Interpreter or CART services by deaf, hard-of-hearing and deaf blind persons, blindness and wheelchair dependence, and characteristics gathered through Contractor contact with Covered Individuals, e.g., through the Care Management Program, Behavioral Health Clinical Assessments, or other reliable means;

i. Enrollee participation in the Care Management Program; and

j. Identification of Covered Individuals as belonging to any of the special populations or subgroups identified through provision of clinical services.

13. Ensure that data received from Providers is 99 percent complete and 95 percent accurate by:

a. Verifying the accuracy and timeliness of reported data;

b. Screening the data for completeness, logic and consistency;

c. Establishing a remediation process for data that is deemed inaccurate during verification and screening; and

d. Collecting service information from Providers, in standardized formats to the extent feasible and appropriate or as directed by EOHHS, including secure information exchanges and technologies utilized for State Medicaid quality improvement and care coordination efforts.

14. Make all collected data available to EOHHS and, upon request, to CMS, as required by 42 CFR 438.242(b)(3).

15. Utilize its HIS to pay Network Providers for BH Covered Services and ESP Services rendered to Covered Individuals and Uninsured Individuals, including persons covered by Medicare only, in accordance with the Contractor's service authorization, Claims processing, enrollment and disenrollment procedures, and data handling and administrative billing requirements.

16. As set forth in 42 CFR 438.242(b)(1), the Contractor shall comply with Section 6504(a) of the Affordable Care Act.

C. System Access Management and Information Accessibility Requirements

1. The Contractor shall make all Information Systems and system information available to authorized EOHHS and other agency staff as determined by EOHHS to evaluate the quality and effectiveness of the Contractor's data and Information Systems.

2. The Contractor is prohibited from sharing or publishing EOHHS data and information without prior written consent from EOHHS.

D. System Availability and Performance Requirements

1. The Contractor shall ensure that its Covered Individual and Provider web functions and phone-based functions are available to Covered Individuals and Providers 24 hours a day, seven days a week.

2. The Contractor shall draft an alternative plan that describes access to Covered Individual and Provider information in the event of Information System failure. Such plan shall be contained in the Contractor's Continuity of Operations Plan (COOP) (see **Section 13.36**) and shall be updated annually and submitted to EOHHS upon request. In the event of Information System failure or unavailability, the Contractor shall notify EOHHS upon discovery, and implement the COOP immediately.

3. The Contractor shall preserve the integrity of Covered Individual-sensitive data whether active or archived.

E. Virtual Gateway

If EOHHS directs the Contractor during the term of this Contract to access certain services through the Virtual Gateway, the Contractor shall:

1. Submit all specified information, including but not limited to invoices, Contract or other information to EOHHS through these web-based applications;

2. Comply with all applicable EOHHS policies and procedures related to such services;

3. Use all business services through the EOHHS Virtual Gateway, as required by EOHHS;

4. Take necessary steps to ensure that the Contractor and its subcontractors or affiliates have the ability to access and utilize all required web-based services; and

5. Execute and submit all required agreements, including subcontracts, agreements, memorandums of understanding, confidentiality and/or end user agreements in

connection with obtaining necessary end user accounts for any Virtual Gateway business service.

Section 9.2 Automated Service Authorization

The Contractor shall employ an automated service authorization system that supports the service authorization requirements and procedures in **Section 4.2** and provides for the documentation of at least the following information for each Covered Individual:

A. Identifying demographic information;

B. Identification of Provider delivering service, including his/her national provider identifier (NPI);

C. Diagnosis code(s);

D. Authorized service units.

Section 9.3 Claims Processing

The Contractor shall ensure that its Claims processing system performs, at a minimum the following functions:

A. Maintains a unique Provider identification number for each Provider and utilizes the NPI for purposes of billing.

B. Accepts Claims submitted by Network Providers or their designated representative(s). The Contractor shall:

1. Accept national UB-04 and national CMS 1500 electronic formats;

2. Accept paper-based Claims using standardized forms.

C. Adjudicates Claims and issues payment for approved Claims once a week, at a minimum.

D. Adjudicates and issues payment for all Clean Claims within 30 days of receipt of the Clean Claim.

E. Provides policies and procedures that track all Claims from point of receipt to final disposition, in order to ensure that all invoices and electronic media Claims are processed to completion and have not been previously paid.

F. Creates payment and HIPAA 835 remittance advices for each Provider for Claims activities during a current cycle. The system specifications and file layout must:

1. Identify each Claim in a cycle and its status, including a description of all errors and denial reasons; and

2. Generate the remittance advices in electronic or paper format, as appropriate for each Provider.

G. Collects and maintains Network Provider financial data and issues state and federal income tax documents in accordance with state and federal law. This shall include, at a minimum, TIN/FEIN and NPI.

H. Maintains all Claims files and records in accordance with all applicable laws, and submits them to EOHHS, the Commonwealth or federal agencies, as needed and upon request.

I. Ensures that security controls are in accordance with current industry standards and relevant CMS policy.

J. Ensures confidentiality of all data in accordance with state and federal laws and regulations, including 42 CFR 431, Subpart F, implementing procedures to properly safeguard and dispose of data. (See also **Section 14.B.5**.)

Section 9.4 Member Eligibility System Requirements

The Contractor shall create policies and procedures to ensure that its enrollment system performs, at a minimum, the following functions:

A. On each business day, obtains from EOHHS by electronic communications link and immediately updates its database with all information pertaining to all Covered Individual enrollments.

B. Uniquely identifies each Covered Individual, and includes in the Contractor's data system information provided by the EOHHS eligibility feed regarding the Covered Individual's state agency affiliations, PCC enrollment, PCC, and TPL status. This information must also be incorporated into the Contractor's clinical Information Systems. The Contractor must use the EOHHS-assigned MID as the Covered Individual identifying number.

C. On each business day receives and processes an electronic file of EOHHS's MID merges.

D. On each business day, receives from EOHHS by electronic communications link and processes information pertaining to all disenrollments.

E. Once a month receives and processes a copy of EOHHS's carrier file, including carrier codes, and uses this file to reconcile the Contractor's cost avoidance and recovery activities.

F. Once a month receives a list of EOHHS's PCCs and track the accuracy of information on PCCs if directed to do so by EOHHS.

G. Receives and processes on a quarterly basis, or as otherwise agreed to by EOHHS, a file containing a list of all Covered Individuals, by MID, Plan Type and effective dates, and uses this file to reconcile the Contractor's Covered Individual enrollment file with EOHHS data.

Section 9.5 Encounter Data

The Contractor shall collect, manage, and report Encounter Data as described in this section and as further specified by EOHHS. The Contractor shall:

1. Collect and maintain 100% Encounter Data for all Behavioral Health Covered Services provided to Covered Individuals and Uninsured Individuals, including from any subcapitated sources. Such data must be able to be linked to MassHealth eligibility data;

2. Participate in site visits and other reviews and assessments by EOHHS, or its designee, for the purpose of evaluating the Contractor's collection and maintenance of Encounter Data;

3. Upon request by EOHHS, or its designee, provide medical records of Covered Individuals and a report from administrative databases of the Encounters of such Covered Individuals in order to conduct validation assessments. Such validation assessments may be conducted annually;

4. Produce Encounter Data according to the specifications, format, and mode of transfer reasonably established by EOHHS, or its designee, in consultation with the Contractor. Such Encounter Data shall include, but is not limited to, the data elements described in **Appendix D**, the delivering physician, and elements and level of detail determined necessary by EOHHS. As directed by EOHHS, such Encounter Data shall also include the National Provider Identifier (NPI) of the Servicing/Rendering, Referring, Prescribing and Primary Care Provider, and any National Drug Code (NDC) information on drug claims. As directed by EOHHS, such Encounter Data shall also include information related to denied claims and 340B Drug Rebate indicators;

5. Provide Encounter Data to EOHHS on a monthly basis or within time frames specified by EOHHS in consultation with the Contractor, including at a frequency determined necessary by EOHHS to comply with any and all applicable statutes, rules, regulations and guidance. The Contractor shall submit Encounter Data by the last calendar day of the month following the month of the claim payment. Such submission shall be consistent with all Encounter Data specifications set forth in **Appendix D**;

6. Submit Encounter Data that is at a minimum compliant with the standards specified in **Appendix D**, including but not limited to the standards for completeness and accuracy. To meet the completeness standard, all critical fields in the data must, at a minimum, contain valid values. To meet the accuracy standard, the Contractor must, at a minimum, have systems in place to monitor

and audit claims. The Contractor must also correct and resubmit denied encounters as necessary;

7. Ensure that all EPSDT screens, including behavioral health screenings, are explicitly identified in the Encounter Data in accordance with this **Section 9.5;**

8. Ensure that all initial Behavioral Health Clinical Assessments are explicitly identified in the Encounter Data submitted in accordance with this **Section 9.5;**

9. If EOHHS, or the Contractor, determines at any time that the Contractor's Encounter Data is not compliant with the benchmarks described in **Appendix D** the Contractor shall:

    a. Notify EOHHS, prior to Encounter Data submission, that the data is not complete or accurate, and provide an action plan and timeline for resolution;

    b. Submit for EOHHS approval, within a time frame established by EOHHS which shall in no event exceed 30 days from the day the Contractor identifies or is notified that it is not in compliance with the Encounter Data requirements, a corrective action plan to implement improvements or enhancements to bring the accuracy and/or completeness to an acceptable level;

    c. Implement the EOHHS-approved corrective action plan within a time frame approved by EOHHS which shall in no event exceed 30 days from the date that the Contractor submits the corrective action plan to EOHHS for approval; and

    d. Participate in a validation study to be performed by EOHHS, or its designee, following the end of a twelve-month period after the implementation of the corrective action plan to assess whether the Encounter Data is compliant with the standards described in **Appendix D**. The Contractor may be financially liable for such validation study;

10. Submit any correction/manual override file within 10 business days from the date EOHHS places the error report on the Contractor's server. Such submission shall be consistent with all Encounter Data specifications set forth in **Appendix D;**

11. Report as a voided claim in the monthly Encounter Data submission any claims that the Contractor pays, and then later determines should not have paid;

12. EOHHS may, at any time, modify the specifications required for submission of Encounter Data, including but not limited to requiring the Contractor to submit additional data fields to support the identification of Covered Individuals' affiliation with their Primary Care Provider;

13. At EOHHS' request, the Contractor shall submit denied claims, as further specified by EOHHS;

14. EOHHS may impose an intermediate sanction in accordance with **Section 13.18** in the event that Contractor's submitted Encounter Data does not meet the completeness, accuracy, timeliness, form, format, and other standards described in this section;

15. At a time specified by EOHHS, the Contractor shall comply with all Encounter Data submission requirements related to HIPAA and the ASCX12N 837 format. This may include submitting Encounter Data to include professional, institutional and dental claims and submitting pharmacy claims using NCPDP standards. This submission may require the Contractor to re-submit Encounter Data previously supplied to EOHHS in alternative formats.

Section 9.6 Eligibility Verification System (EVS)

The Contractor shall maintain access to EOHHS's computer network for online inquiry access to the Eligibility Verification System (EVS) and the Medicaid Management Information System (MMIS) databases for confirmation of provider information, identification of Covered Individuals, their MassHealth eligibility, Managed Care enrollment status, and service restrictions.

Section 9.7 Telephone System

A. Specifications

As of the Service Start Date, the Contractor shall:

1. Maintain the telephone number (800-495-0086), with telecommunications device for the deaf (TDD) and teletypewriter (TTY) transmission and reception capability for the deaf and hearing-impaired, as the Contractor's toll-free number, unless otherwise agreed to by EOHHS.

2. Provide access through the toll-free number to Member and Provider Customer Service representatives via dedicated menu option(s).

3. Maintain a telephone system that performs the following functions:

    a. Assigns priority status to Covered Individuals in crisis to ensure immediate response from a clinician staffing the Clinical Referral and Service Authorization line;

    b. Provides a sufficient number of telephone lines and trunks to handle all incoming calls so that no caller receives a busy signal;

    c. Provides a means for callers to leave messages for the Contractor after business hours, and ensures that such calls are handled by the next business day; and

    d. Allows the Contractor to directly connect the caller to other agencies or contractors, as specified by EOHHS.

4. Submit to EOHHS for approval 30 days prior to the Service Start Date:

    a. A description of its working automated telephone system with menu options that include:

        1) the Clinical Referral and Service Authorization line;

        2) Member Services, Provider Relations, and PCC Hotline; and

        3) a diagram for direct call distribution to the Contractor's telephone queues;

    b. The proposed script for the telephone system's greeting; and

    c. A description of the messages and prompts that ate part of the automated telephone system.

5. Develop, implement, maintain and enhance, as necessary, a call management system for Clinical Authorization and Referral and Member and Provider Customer Service calls that:

    a. Records and tracks all calls handled, to include the following information:

        1) name of caller and Covered Individual, Provider or PCC identification number, where applicable;

        2) call date and time;

        3) reason for the call;

        4) disposition of the call, including whether the matter was resolved at the time of first contact if a complaint, was resolved by the end of the next business day, or if the call is pending resolution; and

        5) if the call is pending resolution, additional information to assist in the escalation and resolution of outstanding issues.

    b. Tracks Covered Individual call volume by PCC, DYS, DCF, TPL, etc.; and

    c. Provides service representatives with online access to relevant information from previous calls.

6. Arrange for appropriate telephone book listings of the Contractor, as approved by EOHHS, to be submitted for publication at least one month prior to the Service Start Date.

7. Periodically, and as directed by EOHHS, evaluate the effectiveness of the Provider and Member Customer Services telephone system, and submit proposals for improvement to EOHHS.

B. Telephone Response Requirements

The Contractor shall ensure that:

1. Calls from Covered Individuals in crisis are handled immediately by a staff clinician;

2. For each line, including Clinical Referral and Service Authorizations, Member and Provider Customer Service and PCC Hotlines, staff make best efforts to answer all calls from Covered Individuals and Providers and PCCs within 30 seconds of when callers selects the menu option for the line they are trying to reach; but in no case shall fewer than 90 percent of these calls be answered within 30 seconds;

3. Calls to all lines have an abandoned call rate of less than 5 percent; and

4. Calls to each specific line are answered within the specified time frames by the appropriate staff:

    a. Calls to clinical lines are answered by a clinician;

    b. Calls to Customer Service are answered by customer service staff; and

    c. Calls to the PCC Hotline are answered by trained and dedicated Provider service representatives.

Section 9.8 Other Contractor-Managed Data Systems for Specific Requirements of the Contract

The Contractor shall maintain data systems, which may be standalone, web-based, or integrated into its larger Information System, that are required to manage and report on specific program requirements of the Contract. These data systems include but are not limited to:

A. ESP Encounter database as described in **Section 3.4.C.6.c**.

B. Behavioral Health Service Access System database for use by providers to locate available capacity for inpatient, and certain Diversionary and CBHI services, as described in **Section 3.4.A.12**.

C. CSA referral and enrollment data tracking system as described in **Section 3.5.E.8**.

Section 9.9 Reporting

The Contractor shall submit to EOHHS all required reports related to MIS, telephone or other technical systems, as described in this **Section 9** or in **Appendix E-1**, in accordance with

specified timetables, definitions, formats and assumptions, as well as any ad hoc reports required by EOHHS in accordance with **Section 11.2.B**.

SECTION 10. PAYMENT AND FINANCIAL PROVISIONS

Section 10.1 General Financial Provisions

A. Payment for Provision of Covered Services to Covered Individuals

EOHHS shall make payments to the Contractor in accordance with the payment provisions in this **Section 10.1**. Payments to the Contractor for Covered Individuals, including the Behavioral Health Covered Services Capitation Rates, the Administrative Component of the BH Covered Services Capitation Rates, payments made for Risk Sharing, and payments made for Performance Incentive Arrangements including Pay for Performance and Care Management Incentive Payments shall be made in accordance with 42 CFR 438.4-438.8. Except as expressly set forth herein, the Contractor shall accept the payments set forth below as payment in full for the provision of Behavioral Health Covered Services and all other activities described in this Contract.

All payments under this Contract are subject to state appropriation and all necessary federal approvals.

1. Behavioral Health Covered Services Capitation Rates

EOHHS shall pay the Contractor Behavioral Health Covered Services Capitation Rates for all BH Covered Services provided under this Contract except as set forth in **Section 10.1.A.2** below. All Behavioral Health Covered Services Capitation Rates shall be as set forth in **Appendix H-1**.

2. Exclusions from the Behavioral Health Covered Services Capitation Rates

EOHHS shall pay the Contractor for services provided by ESPs to Uninsured Individuals and persons with Medicare only according to the methodology set forth in **Section 10.10**.

3. Risk-Sharing Arrangements

The Contractor and EOHHS may share financial risk for Behavioral Health Covered Services. Risk sharing arrangements shall be as set forth in **Appendix H-1**.

4. Administrative Component of the Behavioral Health Covered Services Capitation Rate and up to 20% of Care Management Program.

   a. EOHHS shall pay the Contractor an Administrative Component of the Behavioral Health Covered Services and up to 20% of Care Management Program Capitation Rate for each Contract Year as set forth in **Appendix H-1**.

   b. The Administrative Component of the Behavioral Health Covered Services Capitation Rate shall be based on a Per Member (Covered Individual) Per Day (PMPD) rate that is determined using the Covered Individuals served under the Contractor's BHP.

   c. Payment shall be for services as set forth in **Appendices G** and **H-1**.

5. Performance Incentive Arrangements

EOHHS and the Contractor may establish Performance Incentive Arrangements. If such Performance Incentive Arrangements are established, EOHHS shall pay the Contractor Performance Incentive Arrangement payments based on EOHHS's assessment of the Contractor's achievement of such Performance Incentives and all terms and conditions for payment as set forth in this Contract and **Appendices G** and **H-1**. Any such incentive payment shall not result in payments in excess of 105 percent of the approved Capitation Payments.

B. PCC Plan Management Support Services

EOHHS shall pay the Contractor for the PCC Plan Management Support Services activities described in **Section 5** and other sections of the Contract as identified by the parties each Contract Year, as set forth in **Appendix H-1**.

The PCC Plan Management Support payments shall be based on a Per Member (Enrollee) Per Day (PMPD) rate that is determined using the Enrollees in the PCC Plan.

C. Payment for Provision for DMH Specialty Programs Services

EOHHS shall pay the Contractor to provide DMH Specialty Programs services. Such payments shall include a DMH Specialty Programs Administrative Compensation Rate and a DMH Specialty Programs Service Compensation Rate as set forth in **Appendix H-1**.

D. Contractor's Use of Earnings for Compliance with Financial Stability Requirements

In no event shall any portion of the any payments made under this Contract, other than earnings, be used to pay the Contractor's cost for compliance with financial stability provisions (**Section 10.12.C**).

E. Modification of Covered Services

If, at any time during the term of the Contract, EOHHS directs the Contractor to eliminate or modify a BH Covered Services or DMH Specialty Program, the Contractor shall accept a modification in Behavioral Health Covered Services Capitation Rates or in the DMH Specialty Programs Payments, which shall be calculated by EOHHS in consultation with the Contractor.

F. Periodic Rate Review

In its discretion, at any time, EOHHS may review with the Contractor BH Covered Services Capitation Rates and the other financial provisions of this Contract to determine if such provisions should be adjusted due to changes in enrollment, case mix, or other factors. To the extent required by applicable federal law, such payment adjustments shall comply with the principles of actuarial soundness as determined by EOHHS in accordance with 42 CFR 438.6. In the event that EOHHS performs such a Periodic Rate Review and proposes modifications to any financial provisions as a result, the Contractor shall have 60 days to

accept such modifications. In the event that the Contractor does not accept the financial provisions within 60 days, EOHHS may terminate the Contract and the provisions of **Section 13.16.B** shall apply.

G. Annual Negotiation of Financial Terms

In determining the financial terms of the Contract, the Contractor shall meet with EOHHS annually to renegotiate the financial terms for each Contract Year. Such meetings shall begin no later than three months before the end of each Contract Year. EOHHS shall incorporate annual financial terms into the Contract into the Contract as **Appendix H-1**.

H. Failure to Accept Financial Provisions

1. In the event that the Contractor does not accept financial provisions for the next Contract Year by the first day of the new Contract Year, EOHHS shall continue to pay the Contractor under the current year's financial provisions and the Contractor shall accept such payment as payment in full under the Contract subject to **subsections a** and **b** below. In the event that any component of the current year's financial provisions are outside the actuarially sound range for the new Contract Year, as determined by EOHHS' actuaries, then EOHHS shall pay the Contractor within the actuarially sound range for the new Contract Year, and the Contractor shall accept such payments as payment in full under the Contract subject to **subsections a** and **b** below. EOHHS may halt all new Enrollee assignments into the PCC Plan until the Contractor accepts the financial provisions offered by EOHHS.

    a. In the event that the interim payments made under **Section 10.H.1.** are higher than the financial provisions for the new Contract Year that the Contractor ultimately accepts, EOHHS may recoup the higher payments made during the interim period.

    b. In the event that the interim payments made under **Section 10.H.1.** are lower than the financial provisions for the new Contract Year that the Contractor ultimately accepts, EOHHS will not retroactively adjust the lower payments made during the interim period.

    c. In the event that the Contractor does not accept the financial provisions within 60 days of EOHHS's offer, EOHHS may terminate the Contract in accordance with **Section 13.16.B**.

2. If the Contractor does not accept the financial terms within 60 days of EOHHS's offer, EOHHS may terminate the Contract and the Contractor shall be obligated to continue to perform all obligations under the Contract as described in **Section 13.16.E**, until such time as all Covered Individuals are disenrolled from the Contractor's BHP. The Contractor shall accept the lower of the prior year's financial provisions or the EOHHS financial provision offer as payment in full during this time period.

I. Responsibilities of Chief Financial Officer

The Contractor shall employ a Chief Financial Officer who shall be responsible for overseeing all financial provisions and requirements of this Contract, including but not limited to the following:

1. Serving as the Contractor's liaison to EOHHS's financial representatives on all financial matters, including payments, reconciliations, and financial forecasting.

2. Validating the accuracy and completeness of all financial reports required under this Contract.

J. Payment for Provision of Services by Indian Health Care Providers to Indian Enrollees

All payments to the Contractor are conditioned on compliance with the provisions below, 42 CFR 438.14, and all other applicable provisions of the American Recovery and Reinvestment Act of 2009. The Contractor shall:

1. offer Indian Enrollees the option to choose an Indian Health Care Provider as a Primary Care Provider if the Contractor has an Indian Primary Care Provider in its network that has capacity to provide such services. The Contractor shall permit Indian Enrollees to obtain BH Covered Services from out-of-network Indian Health Care Providers from whom the Enrollee is otherwise eligible to receive such services. The Contractor shall also permit an out-of-network Indian Health Care Provider to refer an Indian Enrollee to a Network Provider;

2. demonstrate that it has sufficient access to Indian Health Care Providers to ensure that Indian Enrollees have timely access to BH Covered Services from such providers;

3. pay both network and non-network Indian Health Care Providers who provide BH Covered Services to Indian Enrollees a negotiated rate which shall be no lower than the MassHealth fee for service rate for the same service or the applicable encounter rate published annually in the Federal Register by the Indian Health Service, whichever is greater, or, in the absence of a negotiated rate, an amount not less than the amount that the Contractor would pay for the BH Covered Service provided by a non-Indian Health Care Provider or the MassHealth fee for service rate for the same service, whichever is greater;

4. make prompt payment to Indian Health Care Providers; and

5. pay non-network Indian Health Care Providers that are FQHCs for the provision of services to an Indian Enrollee at a rate equal to the rate that the Contractor would pay to a network FQHC that is not an Indian Health Care Provider, including any supplemental payment described in 42 CFR 438.14(c)(1).

Section 10.2 Rating Categories (RC) for Covered Individuals

A. RC I (Families) excluding Children under 21 with TPL

RC I includes MassHealth Members under age 65 who are enrolled in MassHealth Standard, including individuals receiving Transitional Aid to Families with Dependent Children (TAFDC) benefits; MassHealth Members who are categorically related to the TAFDC program, (excluding spend-down cases); MassHealth Members under age 65 under the Refugee Resettlement Program, MassHealth Members in MassHealth (Family Assistance); RC I excludes individuals who have Third-Party Liability coverage.

B. RC I Children under 21 with TPL Only

RC I Children under 21 with TPL Only includes MassHealth Members in MassHealth Standard under age 21 with Third- Party Liability coverage, including Medicare, coverage from any other public payer, or commercial insurance.

C. RC II (Disabled) excluding Children under 21 with TPL

RC II includes: MassHealth Members under age 65 who are disabled and receiving Supplemental Security Income (SSI), excluding those individuals who receive either Medicare Part A or Medicare Part B benefits; MassHealth Members who are disabled, excluding those individuals who receive either Medicare Part A or Medicare Part B benefits; MassHealth Members receiving SSI and Massachusetts Commission for the Blind benefits, excluding those individuals who receive either Medicare Part A or Medicare Part B benefits; MassHealth Members of the Massachusetts Commission for the Blind excluding those individuals who receive either Medicare Part A or Medicare Part B benefits; MassHealth Standard (Disabled) Members; and Members of MassHealth CommonHealth who have no Third-Party Liability coverage.

D. RC II Children under 21 with TPL Only

RC II Children under 21 with TPL Only includes MassHealth Members in MassHealth Standard (Disabled) and CommonHealth under age 21 with Third-Party Liability coverage, including Medicare, coverage from any other public payer, or commercial insurance.

E. RC V (Basic)

RC V includes MassHealth Members over the age of 18 and under the age of 65 who qualify under EOHHS's MassHealth Basic eligibility criteria, which includes persons who have been identified by DMH as getting services or as being on a waiting list to get services from the DMH, are "long-term unemployed," and have income at or below 100 percent of the federal poverty level

F. RC VII (Essential)

RC VII includes MassHealth Members over the age of 18 and under the age of 65, who qualify under MassHealth Essential eligibility criteria which includes (1) persons not

currently working; (2) persons that have not worked in more than one year or, if a person has worked, that person has not earned enough to collect unemployment; (3) persons not eligible to collect unemployment benefits; (4) persons who have an immigration status that prevents them from getting MassHealth Standard, are long-term unemployed and meet MassHealth disability rules; and (5) persons who are not eligible for MassHealth Basic.

G. RC VIII (MFP)

RC VIII includes MassHealth Members enrolled in one of the two HCBS waivers called the MFP Community Living (MFP-CL) (HCBSG Benefit Plan) Waiver and MFP Residential Supports (MFP-RS) (HCBSH Benefit Plan) Waiver.

H. RC IX (CarePlus)

RC IX includes Covered Individuals over the age of 20 and under the age of 65 with incomes up to 133 percent of the Federal Poverty Level (FPL), who are not pregnant, disabled, or a parent or a caretaker relative of a child under age 19, or eligible for other MassHealth coverage. Also excluded from RC IX are individuals who are dually-eligible for Medicaid and Medicare.

I. RC X (CarePlus)

RC X includes Covered Individuals over the age 20 and under the age of 65 with incomes up to 133 percent of the FPL, who are receiving Emergency Aid to the Elderly, Disabled and Children (EAEDC) through the Massachusetts Department of Transitional Assistance. Excluded from RC X are individuals who are pregnant, disabled, or a parent or caretaker relative of a child under age 19, or eligible for other MassHealth coverage. Also excluded from RC X are individuals who are dually-eligible for Medicaid and Medicare.

Section 10.3 Payment Methodology for BH Covered Services Capitation Rates

A. Monthly Estimated BH Covered Services Capitation Rate Payment Process

Each month EOHHS shall pay the Contractor an Estimated Capitation Payment, which will include the BH Covered Services Capitation Payment, in accordance with the following methodology. EOHHS shall:

1. Convert the BH Covered Services Capitation Rates into a Per-Covered Individual Per-Day (PMPD) amount for each RC by multiplying the Per-Member Per-Month (PMPM) payment rate by 12, then dividing by 365; for Contract Year One, such calculation shall be made by multiplying the PMPM payment rate by 9 then dividing by 273.

2. Multiply the estimated number of Eligible Days for the month, as determined by EOHHS in each RC, by the PMPD amount for the RC.

3. Sum the calculations described in **subsection 2** for each RC; this is the Estimated Monthly BH Covered Services Capitation Amount.

B. Estimated Monthly BH Covered Services Capitation Amount Reconciliation Process

1. EOHHS shall perform a monthly reconciliation of the Estimated Monthly BH Covered Services Capitation Payment Amount calculated according to **Sections 10.3.A.1-2** against the actual number of Eligible Days by RC, as determined by EOHHS, in accordance with the following methodology. EOHHS shall:

    a. Multiply the actual number of Eligible Days, as determined by EOHHS for each RC for the previous month, by the PMPD amount for each RC.

    b. Sum the calculations for each RC described in **subsection a**; this is the Actual Monthly BH Covered Services Capitation Amount.

    c. Compare the sum of the Estimated Monthly BH Covered Services Capitation Payment paid for the month against the Actual Monthly BH Covered Services Capitation Amount. This reconciliation shall occur monthly.

The Contractor shall provide any information necessary to complete such reconciliation in the time frame and format specified by EOHHS.

2. Based on the comparison described in **subsection 1.c** above, EOHHS shall determine each month whether overpayments or underpayments were made to the Contractor.

    a. EOHHS shall remit to the Contractor the full amount of any underpayments made for the month. Such payments shall be made through an adjustment to future Estimated Monthly BH Covered Services Capitation Payments or by another mechanism, as determined by EOHHS.

    b. The Contractor shall remit to EOHHS the full amount of any overpayments made for the month. Such payments shall be made through an adjustment to a future Estimated Monthly BH Covered Services Capitation Payments or by another mechanism, as determined by EOHHS.

C. Monthly CarePlus Estimated Capitation Payment Process

EOHHS shall make capitation payments for Covered Individuals in Rating Categories IX and X, as follows:

1. Monthly, EOHHS shall pay the Contractor an Estimated Capitation Payment equal to the sum of the products of:

    a. The number of Covered Individuals in Rating Categories IX and X in the Contractor's Plan as determined by EOHHS on the first day of the Payment Month, multiplied by

b. The Behavioral Health Covered Services Capitation Rates for each applicable Rating Category.

2. EOHHS shall include Covered Individuals in Rating Categories IX and X in the capitation calculation described in **subsection 10.3.C.1**. above as follows:

a. For Covered Individuals in Rating Categories IX and X who have an Effective Date of Enrollment with the Contractor's Plan as of the first day of the Payment Month, EOHHS shall include such Covered Individuals in Rating Categories IX and X in the capitation calculation for that Payment Month.

b. For Covered Individuals in Rating Categories IX and X who have an Effective Date of Enrollment with the Contractor's Plan after the first day of the Payment Month, EOHHS shall include such Covered Individuals in Rating Categories IX and X in the capitation calculation starting with the following Payment Month.

3. For Covered Individuals in Rating Categories IX and X for whom EOHHS has assigned a specific disenrollment date due to a qualifying event such as a member attaining age 65 within the Payment Month, EOHHS shall make a pro-rated Estimated Capitation Payment to the Contractor. The pro-rated Estimated Capitation Payment will equal:

a. The Behavioral Health Covered Services Capitation Rate,

b. Multiplied by the number of Enrollee Days during the Payment Month

c. Divided by the total number of days in the Payment Month.

Section 10.4 Payment Methodology for the Administrative Component of the BH Covered Services Capitation Rates

A. Estimated Monthly Administrative Payments

Each month EOHHS shall pay the Contractor an Estimated Administrative Payment, which will include the care management administrative rate, in accordance with the following methodology:

1. EOHHS shall convert the PMPM Rates into a Per-Member (Covered Individual) Per-Day (PMPD) amount by multiplying the Per-Member Per-Month (PMPM) payment rate by 12, then dividing by 365; for Contract Year One, such calculation shall be made by multiplying the PMPM payment rate by 9, then dividing by 273; and

2. Multiply the estimated number of Eligible Days for the month, as determined by EOHHS, by the PMPD; this is the Estimated Monthly Administrative Component of the BH Covered Services Capitation Rate amount.

B. Estimated Monthly Administrative Reconciliation Process

1. EOHHS shall perform a monthly reconciliation of the Estimated Monthly Payment for Administrative Component of the BH Covered Services Capitation Rate calculated according to **Sections 10.4.B.1-2** against the actual number of Eligible Days by Covered Individual and Enrollees in the Care Management portion of the administrative payment as determined by EOHHS, in accordance with the following methodology. EOHHS shall:

    a. Multiply the actual number of Eligible Days, as determined by EOHHS for Covered Individual and Enrollees for the previous month, by the PMPD BH Administrative rate and the Care Management administrative rate amount; this is the Actual Monthly Administrative Component of the BH Covered Services Capitation Rate.

    b. Compare the Estimated Monthly Administrative Component of the BH Covered Services paid for the month against the Actual Monthly Administrative Component of the BH Covered Services Capitation Rate.

    The Contractor shall provide any information necessary to complete such reconciliation in the time frame and format specified by EOHHS.

2. Based on the comparison described in **subsection 1.b** above, EOHHS shall determine each month whether overpayments or underpayments were made to the Contractor.

    a. EOHHS shall remit to the Contractor the full amount of any underpayments made for the month. Such payments shall be made through an adjustment to future Estimated Monthly Administrative Component of the BH Covered Services Capitation Rates payment or by another mechanism, as determined by EOHHS.

    b. The Contractor shall remit to EOHHS the full amount of any overpayments made for the month. Such payments shall be made through an adjustment to future Estimated Monthly Administrative Component of the BH Covered Services Capitation Rates payment or by another mechanism, as determined by EOHHS.

Section 10.5 Payment Methodology for PCC Plan Management Support Services

A. Estimated PCC Plan Management Support Services Payment

Each month EOHHS shall pay the Contractor an Estimated PCC Plan Management Support Services Payment, in accordance with the following methodology. EOHHS shall:

1. Convert the PMPM Rates into a per-Enrollee per-day (PMPD) amount by multiplying the Per-Member Per-Month (PMPM) payment rate by 12, then

dividing by 365; for Contract Year One, such calculation shall be made by multiplying the PMPM payment rate by 9, then dividing by 273.

2. Multiply the estimated number of Eligible Days for the month, as determined by EOHHS, by the PMPD; this is the Estimated Monthly PCC Plan Management Support Services Payment Amount.

B. Estimated PCC Plan Management Support Services Payment Reconciliation Process

1. EOHHS shall perform a monthly reconciliation of the Estimated Monthly Payment for the PCC Plan Management Support Services calculated according to **Sections 10.5.B.1-2** against the actual number of Eligible Days by Enrollee, as determined by EOHHS, in accordance with the following methodology. EOHHS shall:

    a. Multiply the actual number of Eligible Days, as determined by EOHHS for Enrollees for the previous month, by the PMPD amount; this is the Actual Monthly PCC Plan Management Support Services Payment.

    b. Compare the Estimated PCC Plan Management Support Services Payment paid for the month against the Actual Monthly PCC Plan Management Support Services Amount.

The Contractor shall provide any information necessary to complete such reconciliation in the time frame and format specified by EOHHS.

2. Based on the comparison described in **subsection 1.b** above, EOHHS shall determine each month whether overpayments or underpayments were made to the Contractor.

    a. EOHHS shall remit to the Contractor the full amount of any underpayments made for the month. Such payments shall be made through an adjustment to future Estimated PCC Plan Management Support Services Payments or by another mechanism, as determined by EOHHS.

    b. The Contractor shall remit to EOHHS the full amount of any overpayments made for the month. Such payments shall be made through an adjustment to future Estimated PCC Plan Management Support Services Payments or by another mechanism, as determined by EOHHS.

Section 10.6 Risk-Sharing Arrangements

A. General Provisions

1. There may be distinct financial risk-sharing arrangements for the Behavioral Health Covered Services Component of the Capitation Rates paid for under the Rates for RC I excluding Children under 21 with TPL; RC I Children under 21 with TPL only; RC II excluding Children under 21 with TPL; RC II Children

under 21 with TPL only; and RC IX and RC X, as applicable, as set forth in **Appendix H-1**.

2. The arrangement described in this **Section 10.6** may result in payment by the Contractor to EOHHS or by EOHHS to the Contractor.

3. All payments to be made by the Contractor to EOHHS or by EOHHS to the Contractor shall be calculated and determined by EOHHS based on the Contractor's expenditures related to Covered Individuals, as determined by EOHHS.

4. The Contractor's Behavioral Health Covered Services Capitation Rate revenue shall mean the sum of the applicable 12 Actual Monthly Behavioral Health Covered Services Capitation Rate payments for the Contract Year, as determined in accordance with **Section 10.3.B.1.b**. This calculation shall be used to determine the Contractor's revenue for the Behavioral Health Covered Services Capitation Rate.

5. By 210 days after the end of each Contract Year, the Contractor shall provide EOHHS with a report of actual expenditures for all of the services included in the Behavioral Health Covered Services Capitation Rate, subtracting any TPL recoveries retained by the Contractor pursuant to **Section 2.3.C.2**. The report of expenditures shall be based on all Claims paid through no fewer than 180 days, including the Contractor's best estimate of Claims incurred but not reported (IBNR) and any applicable IBNR completion factor reported to EOHHS with the IBNR methodology report (see **Appendix E-1**). In the event that the above final report of actual expenditures includes an IBNR completion factor greater than 1 percent for total BH Covered Services, EOHHS reserves the right to conduct an audit of the Contractor's IBNR methodology.

6. EOHHS shall in its sole discretion make the final determination of IBNR, using the Contractor's report of actual expenditures to inform that determination.

7. EOHHS shall compare the actual PMPD Behavioral Health Covered Services Capitation Rate payments for the Contract Year to the Contractor's actual expenditures. Based on such comparison, and calculating any difference, EOHHS shall determine in accordance with **Section 10.3.B.2** whether overpayments or underpayments were made to the Contractor.

    a. EOHHS shall pay the Contractor a final payment for the preceding Contract Year in accordance with the same methodology as described in **Section 10.3.B.2.a**.

    b. The Contractor shall pay EOHHS a final payment for the preceding Contract Year in accordance with the same methodology as described in **Section 10.3.B.2.b**.

8. Notwithstanding the generality of the foregoing, if EOHHS determines that risk sharing arrangements result in payments that exceed the approved capitation rates

and the excess payments exceed that total amount MassHealth would have paid on a fee for service basis for the BH Covered Services actually furnished to Covered Individuals, EOHHS shall re-price any or all of the Contractor's paid Claims so that the total final payments to the Contractor based on risk sharing arrangements do not exceed the amount MassHealth would have paid for the actual services provided to Covered Individuals on a Fee-For-Service basis.

Section 10.7 Performance Incentive Arrangements

A. Overview

1. The Contractor may be eligible for three types of Performance Incentive Arrangements under this Contract: Pay for Performance (P4P), Care Management Performance Incentives and an ABA Incentive.

2. In no case shall total payments to the Contractor for Performance Incentive Arrangements exceed 105% of the approved Capitation Payments.

3. All Performance Incentive arrangements shall meet the following requirements:

    a. Performance Incentives shall be for a fixed period of time, which shall be described in the specific Performance Incentive and will be measured during the Contract Year in which the Performance Inventive Arrangement is applied;

    b. No Performance Incentive shall be renewed automatically;

    c. All Performance Incentives shall be made available to both public and private contractors;

    d. No Performance Incentive shall be conditioned on intergovernmental transfer agreements; and

All Performance Incentives shall be necessary for the specified activities, targets, performance measures, or quality-based outcomes that support program initiatives, as specified in the state's quality strategy.

B. Pay for Performance

1. Each Contract Year during Contract negotiations, the Contractor shall propose to EOHHS a minimum of five P4P measures as described in **Section 8.6**, including the measure methodology and proposed improvement targets which the Contractor must meet in order to receive any P4P payments.

2. Each Contract Year, EOHHS may in its sole discretion approve, modify or disapprove any or all proposed P4P measures or supporting methodologies.

3. EOHHS shall make payments to the Contractor based on its performance on selected P4P measures, if agreed to by EOHHS. Partial payments may be made based on demonstration of incremental improvement.

4. Except as otherwise expressly stated, for any P4P and supporting methodology for which performance is determined by reference to a baseline, EOHHS shall in its sole discretion establish such baseline.

5. EOHHS shall have the sole authority for determining whether the Contractor has met, exceeded or fallen below any P4P measure. EOHHS shall make its determination as to whether the Contractor has achieved any P4P measure or incremental target, except if EOHHS has not received sufficient material information from the Contractor to make such a determination.

6. The Contractor shall receive annual payment for performance, where earned, based on actual performance improvement no earlier than six months following the end of the Contract Year of the measurement.

C. Care Management Performance Incentives

The Contractor may receive payment for Care Management based on a combination of its Administrative Component of the BH Covered Services Capitation Rates and earned Performance Incentives. The total Care Management Performance Incentives amount the Contractor may earn depends on how much of its Care Management Program (up to 20 percent of total costs) is paid through its Administrative Component of the BH Covered Services Capitation Rate, and the Contractor's success in engaging program Participants and improving health outcomes.

1. Engagement Performance Incentives

    a. The Contractor may earn Per Participant Per Month payments based on Engagement of Participants in the Care Management Program.

    b. The Contractor shall propose, subject to EOHHS approval, the minimum Engagement Targets and the PPPM rate.

    c. The Contractor shall calculate and report on the number of Participants in Practice Based Care Management on a monthly basis and shall be paid an Engagement PPPM, upon EOHHS review and approval, on a quarterly basis.

    d. The Contractor shall be subject to reconciliation on an annual basis to ensure that the Contractor has met its Annual Projected Engagement Target of unduplicated Participants. Beginning in Contract Year Two, if the Contractor has not engaged the Annual Projected Engagement Targets by close of Contract Year Two, EOHHS will assess a penalty against the Contractor, using the following formula: EOHHS shall calculate the difference between the Annual Projected Engagement Target number of

unduplicated Participants and the actual number of unduplicated Participants served in all Tiers. The penalty shall equal the difference multiplied by the weighted average of the Engagement PPPM for the Contract Year.

e. Engagement Performance Incentives will be calculated on a monthly basis and paid on a quarterly basis to the Contractor for all Participants who meet the Engagement definition for that month. The remainder of the Care Management outcomes Performance Incentives will be made on an annual and retrospective basis. Payments shall follow the schedule described in **Section 10.7.B**. Performance Incentive calculations shall be performed by EOHHS.

2. Care Management Outcome Performance Incentives

a. The Contractor may earn Care Management Outcome Performance Incentive payments based on its performance on designated outcomes measures as described in **Section 8.6.C** and **Appendix G**.

b. Each Contract Year during Contract negotiations, the Contractor shall propose to EOHHS a minimum of four outcome measures, including the measure methodology and proposed improvement targets which the Contractor must meet in order to receive any Care Management Outcome Performance Incentives.

c. EOHHS may in its sole discretion approve, modify or disapprove any proposed measure or supporting methodology.

d. The Contractor may receive partial payment for performance meeting set outcome measures targets, if agreed to by EOHHS.

e. Care Management Outcome Performance Incentive payments will be made on an annual and retrospective basis, no earlier than six months following the end of the calendar year.

D. ABA Reconciliation

The Contractor shall employ sufficient staff to provide ABA related technical assistance, ABA related network management activities, and ABA related utilization management activities. In addition, the Contractor shall employ at least one individual with extensive knowledge of ABA such as a Board Certified Behavioral Analyst (BCBA).

After the end of Contract Year 6A and each Contract Year thereafter, EOHHS will reconcile the payments made to the Contractor for ABA services against the amount paid to Providers for such services. If the amount paid to the Providers exceeds the amount paid to the Contractor, EOHHS will reimburse the Contractor for the difference.

Section 10.8 BH Covered Services Continuing Services Reconciliation

EOHHS shall perform a year-end Continuing Services reconciliation as follows:

A. The Contractor shall process and pay its Providers' Claims for all Continuing Services provided in accordance with **Section 7.6.E** at the Contractor's contracted rate with its Providers.

B. EOHHS shall perform a reconciliation by September 30 following the end of the Contract Year to determine those Continuing Service claims paid by the Contractor for which the Contractor's Adverse Action was upheld by BOH and which were provided following the conclusion of the Internal Appeal ("approved Continuing Service claims"); provided that the Contractor submits to EOHHS by 210 days following the end of the Contract Year all data regarding such services, as required in **Appendix E-1**.

C. EOHHS shall pay the Contractor no later than 60 days following the reconciliation set forth in **subsection B** the total value of the approved Continuing Service claims referenced in **subsection B** that were provided in the applicable Contract Year; provided that the Contractor timely submitted all data required by EOHHS pursuant to **Appendix E-1**.

D. Approved Continuing Service claims shall include, at a minimum, the following information:

1. Covered Individuals information, by RID, including date of birth, sex, dates of enrollment, the dates on which the Continuing Services were provided, and current enrollment status;

2. Costs incurred, by RID, including dates of service; and

3. Such other information as may be required pursuant to any EOHHS request for information.

E. The reconciliation payment procedures may include an audit, to be performed by EOHHS or its authorized agent, to verify all claims for the Covered Individuals by the Contractor. The findings of such audit shall determine the amount, if any, that the Contractor shall be reimbursed by EOHHS. If an audit is not conducted, EOHHS shall reimburse the Contractor as otherwise provided herein.

Section 10.9 Payment Methodology for DMH Specialty Programs and MCPAP

A. DMH Specialty Programs Payments

1. EOHHS shall pay the Contractor for DMH Specialty Programs, which include two components: a Service Component and an Administrative Component. The DMH Specialty Program Administrative Compensation Rate and DMH Specialty Program Services Compensation Rate shall be used to provide ESP Services for

Uninsured Individuals and persons with Medicare only, as described in **Section 3.4** and Forensic Services as described in **Section 4.6** and **Appendix A-6.**

2. In no event shall any payment, other than the DMH Specialty Program Administrative Compensation Rate or the DMH Specialty Program Services Compensation Rate payments, be utilized by the Contractor as payment for DMH Specialty Program services provided to any Uninsured Individual and persons with Medicare only, or for the cost of administering DMH Specialty Program services.

3. The DMH Specialty Programs Service Compensation Rate shall be paid each month in an amount equal to one-twelfth of the annual budget for the Contract Year, as set forth in **Appendix H-1**.

4. EOHHS shall establish a DMH Specialty Program Administrative Compensation Rate payment for the administration of the DMH Specialty Program that is equal to the sum of: Direct Costs; Indirect Costs; and earnings, and such sum shall not exceed an agreed-upon amount, as set forth in **Appendix H-1**.

5. Earnings shall be an agreed-upon amount, as set forth in **Appendix H-1**.

6. Each month EOHHS shall pay the Contractor an amount equal to one-twelfth of the DMH Specialty Program Administrative Compensation Rate amount for the Contract Year set forth in **Appendix H-1**.

B. Reconciliation Process for Forensic Evaluation Services

EOHHS shall perform an annual reconciliation of Forensic Evaluation Services.

1. EOHHS shall determine annually whether overpayments or underpayments were made to the Contractor.

   a. EOHHS shall remit to the Contractor the full amount of any underpayments made for the month. Such payments shall be made through an adjustment to future Forensic Evaluation Services or by another mechanism, as determined by EOHHS.

   b. The Contractor shall remit to EOHHS the full amount of any overpayments. Such payments shall be made through an adjustment to a future Forensic Evaluation Services or by another mechanism, as determined by EOHHS.

2. Notwithstanding any other provision of this Contract, EOHHS shall not be required to make any payments for Forensic Evaluation Services funded by the DMH Specialty Program Service Component Rate described in this section until it has received funding from DMH in the amounts necessary to make any such payments.

C. DMH MCPAP Payments

1. EOHHS shall pay the Contractor for DMH MCPAP Program, which includes two components: a Service Component and an Administrative Component. The DMH MCPAP Program Administrative Compensation Rate and DMH MCPAP Program Services Compensation Rate shall be used to provide behavioral health consultation services to pediatric providers for children and adolescents, as well as adult behavioral health consultation to obstetric providers, as described in **Section 4.5.**

2. EOHHS shall establish a DMH MCPAP Program Administrative Compensation Rate payment for the administration of the DMH MCPAP Program that is equal to the sum of: Direct Costs; Indirect Costs; and earnings, and such sum shall not exceed an agreed-upon amount, as set forth in **Appendix H-1**.

3. Earnings shall be an agreed-upon amount, as set forth in **Appendix H-1**.

4. Each month EOHHS shall pay the Contractor an amount equal to one-twelfth of the DMH MCPAP Program Administrative Compensation Rate amount for the Contract Year set forth in **Appendix H-1**.

Section 10.10 Particular Payment Provisions for ESP Services for Uninsured Individuals and Persons with Medicare Only

A. General Provisions

The Contractor shall:

1. For ESP services for Uninsured Individuals and persons with Medicare only, require ESP Providers to bill other insurances (TPL), where available, and the Health Safety Net in accordance with applicable law (see also **Section 2.3.D**).

2. Pay ESPs the rate for ESP Services established by the Massachusetts Division of Healthcare Finance and Policy and, as further directed by EOHHS, implement all policies and procedures with regard to payments and payment methodologies to ESPs for ESP Services for Uninsured Individuals and persons with Medicare only delivered under the Contract.

3. Not utilize the ESP Amount except to pay for ESP Services delivered to Uninsured Individuals and persons with Medicare only.

B. Payment Methodology

1. By May 1 of each year, EOHHS shall provide the Contractor with an estimated amount it expects to pay each ESP for ESP Services delivered on a Fee-for-Service basis by EOHHS.

2. Each year by May 31, the Contractor shall provide EOHHS with a report (see **Appendix E-1**) of the Contractor's estimate of the total amount it expects to pay

for ESP Services, including both BH Covered Services and DMH Specialty Program delivered under the Contract.

3. Based on the Contractor's estimate of the amount it expects to pay for such ESP Services, EOHHS shall establish an ESP Amount for Uninsured Individuals and persons with Medicare only.

4. The ESP Amount shall be in accordance with **Appendix H-1**. The Contractor shall develop a plan to monitor and report on, throughout each Contract year, ESP expenditures for Uninsured Individuals and persons with Medicare only compared to the amount in **Appendix H-1**. Such report shall also include monitoring of ESP expenditures for Covered Individuals.

5. Notwithstanding any other provision of this Contract, EOHHS shall not be required to make any payments for ESP Services funded by the DMH Specialty Program Service Component Rate described in this section until it has received funding from DMH in the amounts necessary to make any such payments.

C. Reconciliation Process for ESP Services Provided to Uninsured Individuals and Persons with Medicare Only

1. By 210 days after the end of each Contract Year, the Contractor shall provide EOHHS with a report (see **Appendix E-1**) of the Contractor's actual expenditures for ESP Services provided to Uninsured Individuals and persons with Medicare only, based on Claims paid through no later than 180 days, including its best estimate of IBNR Claims and any applicable IBNR completion factor reported to EOHHS.

2. EOHHS shall conduct a year-end reconciliation of the Contractor's estimated expenditures on ESP Services provided to Uninsured Individuals and persons with Medicare only delivered under the Contract against actual expenditures, including IBNR.

3. If actual expenditures are less than the Contractor's estimates, EOHHS shall recoup the difference from the Contractor.

4. If actual expenditures are greater than the Contractor's estimate, EOHHS shall pay the difference to the Contractor.

Section 10.11 Payment Methodology for Comprehensive Primary Care Payment Covered Services

A. BH Rate

Each month the Contractor shall pay Tier 2 and 3 PCPR Providers the BH Rate associated with each Participating Site, for PCC Panel Enrollees, for the provision of Tier 2 or Tier 3 CPCP Covered Services identified in **Appendix J-5**.

The Contractor shall not pay the PCPR Provider for the Tier 1 portion of CPCP Rate, nor for any portion of the Medical Home Load. EOHHS pays Tier 1 CPCP Covered Services and Medical Home Load directly to the PCPR Provider.

EOHHS shall calculate the BH Rate according to the following formula:

The BH Rate = CPCP Rate – EOHHS share of CPCP, where the EOHHS share of CPCP is equal to Tier 1 Services Rate + Tier 2 or 3 Medical Home Load (MHL)

1. Tier 1 Services Rate = Tier 1 Billable Services Rate x Tier 1 PCAL x Tier 1 EESPA

2. Tier 2 or 3 MHL = 12.50 x Tier 2 or 3 PCAL x Tier 2 or 3 EESPA

B. Quarterly Receipt of CPCP Rate

Beginning with the second quarter of calendar year 2014, EOHHS shall provide the Contractor with the BH Rate for each Tier 2 or Tier 3 PCPR Provider's Participating Site on a quarterly basis, on or about the first Friday of the month prior to the start of each quarter year (e.g., June, September, December, March).

C. Monthly Receipt of the List of Attributed PCC Plan Enrollees

No later than the third Monday of each month, EOHHS shall make available to the Contractor a list of PCC Panel Enrollees assigned to Tier 2 and Tier 3 Participating Sites, as determined by EOHHS, for which EOHHS shall pay the PCPR Participant EOHHS' portion of the CPCP Rate.

D. Comparison of Enrollment Data

Each month, the Contractor shall produce a list of all PCC Plan Enrollees attributed to each Participating Site as of the first of that month, based on the Contractor's enrollment records, and shall send these reports to EOHHS as early as reasonably possible but not later than the 20th of every month.

The above-referenced list will include the following information for each identified PCC Plan Enrollee: name, MassHealth ID, attributed Participating Site, enrollment start date, and enrollment end date.

E. Timing of Payment to Tier 2 and Tier 3 PCPR Providers

The Contractor shall pay Participant within seven business days of Contractor's receipt from EOHHS of (a) the portion of the CPCP Rate that is based on Behavioral Health Services provided to Panel Enrollees (the "BH Rate") and (b) the monthly report of total Panel Enrollees, unless a different payment day is mutually agreed upon by EOHHS and the Contractor at least 30 days prior to the following month's scheduled payment to PCPR Providers.

F. Claims Adjudication for Tier 2 and Tier 3 PCPR Providers

The Contractor shall ensure that Tier 2 or Tier 3 PCPR Providers continue to submit claims to the Contractor for all CPCP Covered Services to ensure the accurate collection of Encounter data.

1. The Contractor shall provide no payment to Tier 2 or Tier 3 PCPR Providers for claims submitted that meet the following criteria (such claims shall be considered "zero-paid") with the exception of any Hold Harmless payment owed to PCPR Providers as describe in **subsection G**:

    a. The claim is for care provided to a PCC Panel Enrollee who is attributed to a PCPR Participating Site on the date of service based on Contractor's enrollment data;

    b. The claim is for a Tier 2 or Tier 3 CPCP Covered Service in **Appendix J-2**; and

    c. The billing entity is either the PCPR Provider to which the PCC Panel Enrollee is attributed on the date of service; or a Voluntary Pooled Provider that is also a Tier 2 or Tier 3 PCPR Provider.

2. The Contractor shall include PCPR Encounter data reflecting zero-paid claims in the monthly Encounter data feed sent to EOHHS, as required by **Section 9.5.B**. Such claims shall include the FFS value of the claim (i.e., the Contractor shall not set the dollar value to zero as a result of zero-paid claims as described above.)

G. PCPR Provider Hold Harmless Payments

1. EOHHS shall calculate a Hold Harmless Payment for each PCPR Provider, and, for each Tier 2 or 3 PCPR Provider, shall calculate a Contractor portion of such payment, which Contractor shall be responsible for paying to each such Provider.

2. EOHHS shall calculate each PCPR Provider's Hold Harmless Payment in accordance with Section 4.1 of the Primary Care Payment Reform Initiative Contract Addendum to the Fourth Amended and Restated Primary Care Clinician Plan Provider Contract (**Appendix J-1**).

3. EOHHS shall calculate the Contractor portion of each Tier 2 or Tier 3 PCPR Provider's Hold Harmless Payment as a percentage of that PCPR Provider's Hold Harmless Payment. That percentage shall be equal to

    a. The difference between:

        1) The total FFS value of claims that were submitted to Contractor by the PCPR Provider with dates of service during the Hold Harmless period and were zero-paid by Contractor, and

2) The total amount of BH Rate payments made by Contractor to the PCPR Provider during the Hold Harmless period;

b. Divided by the following difference:

1) The total FFS value of all claims that were submitted by the PCPR Provider to Contractor and to EOHHS with dates of service during the Hold Harmless period and were zero-paid by Contractor or by EOHHS, minus

2) The total amount of CPCP payments made by Contractor and EOHHS to the PCPR Provider during the Hold Harmless period.

4. EOHHS shall notify the Contractor of the amount of the Contractor portion of each Tier 2 or 3 PCPR Provider's Hold Harmless Payment for each Hold Harmless period. The Contractor may review the amount calculated by EOHHS as the Contractor portion for accuracy and compliance with the calculation methods stated herein. The Contractor shall pay the Contractor portion to each such Provider by the next monthly PCPR payment.

H. EOHHS and Contractor Reconciliation for PCPR

1. EOHHS shall pay the Contractor for PCPR payments to PCPR Providers that exceed the FFS amount of payments the Contractor provides to Tier 2 or Tier 3 PCPR Providers for CPCP Covered Services.

2. EOHHS shall calculate the following for each period a Hold Harmless Payment is made. The Contractor may review the amount calculated by EOHHS for accuracy and compliance with the calculation methods stated herein.

a. EOHHS's payment to the Contractor for Tier 2 or 3 CPCP Covered Services for PCC Panel Enrollees attributed to Tier 2 or Tier 3 PCPR Provider shall equal the product of:

1) the portion of the Contractor's BH Covered Services Capitation Rate described in **Sections 10.3.A** and **Section 10.3.B** that corresponds to Tier 2 or 3 CPCP Covered Services in **Appendix J-2**; and

2) The total number of PCC Plan Enrollees attributed to PCPR Providers as of the first of the month utilizing the EOHHS lists described in **Section 10.11.C.**

b. Contractor's payment to Tier 2 or Tier 3 PCPR Providers for Tier 2 or Tier 3 CPCP Covered Services shall equal the sum of:

1) the BH Rate paid by Contractor; plus

2) the Hold Harmless Payments made by the Contractor; plus

3) all FFS reimbursement for Tier 2 or 3 CPCP Covered Services in **Appendix J-2** rendered by providers to PCC Panel Enrollees attributed to another PCPR Provider.

If the product of the calculation set forth in subparagraph b. above exceeds the product of the calculation set forth in subparagraph a. above, EOHHS shall pay the Contractor 100% of the difference.

c. Such payment shall allow for a six months of claims run out as well as additional lag for MassHealth to receive and process the data and make the requisite calculations.

I. EOHHS Payment to Contractor for PCPR

1. Any payment paid by EOHHS in accordance with the EOHHS –Contractor Reconciliation described in **subsection H** will be included in the calculation described in **Section 10.6.A.4**.

2. Any payment owed to EOHHS in accordance with the EOHHS Contractor Reconciliation described in **subsection H** will be included in the calculation described in **Section 10.6.A.7.**

Section 10.12 Mobile Crisis Intervention/Runaway Assistance Program (MCI/RAP)

EOHHS shall pay the Contractor for its payments to ESPs for the MCI/RAP in accordance with **Appendix H-1, Section 4**. No additional payment will be provided by EOHHS to the Contractor for the operation of MCI/RAP.

Section 10.13 Health Insurer Provider Fee Adjustment

Each year, to account for the portion of the Contractor's Health Insurer Provider Fee under Section 9010 of the ACA (the HIPF) that is allocable to capitation payments made by EOHHS to the Contractor under this Contract (sometimes referred to as "MassHealth premiums", a type of premium under Section 9010):

A. Each year, Contractor shall provide EOHHS with information about the Contractor's HIPF, as requested by EOHHS, including but not limited to the bill the Contractor receives from the U.S. Internal Revenue Service.

B. EOHHS shall calculate and perform an adjustment set forth in **Appendix H-1**, **Exhibit 1** to the Contractor's Capitation Rates to account for the portion of the Contractor's HIPF that is allocable to capitation payments made by EOHHS to the Contractor under this Contract and, subject to federal financial participation for the tax liability related to the HIPF.

C. For Calendar Year 2013, such adjustment shall be a retroactive one-time adjustment made as a single payment on or after October 1, 2014.

D. For calendar year 2014, such adjustment shall be a retroactive one-time adjustment made as a single payment on or after November 1, 2015.

Section 10.14 Financial Requirements

A. Direct Service Reserve Account

The Contractor shall establish a Direct Service Reserve Account (DSRA) into which all payments received from EOHHS must be deposited.

1. The DSRA shall be:

    a. An interest-bearing trust account in a banking institution located in Massachusetts and approved by EOHHS. The Commonwealth of Massachusetts shall have the right and title to any and all interest earned in the DSRA.

    b. Maintained, to the extent legally permissible, in a manner that prevents creditors of the Contractor from in any way encumbering or acquiring any funds in the DSRA.

2. In no event shall funds in the DSRA be used by the Contractor or any other agent or third party to satisfy, temporarily or otherwise, any Contractor liability, or for any other purpose except as provided under the Contract.

3. EOHHS may require at any time that the Contractor confer upon an authorized representative of EOHHS or a third party approved by EOHHS the obligation to approve all withdrawals and countersign all checks drawn on the DSRA.

4. The Contractor shall obtain approval of all aspects of the DSRA from EOHHS before establishing or making any changes to the account, and shall make changes to the DSRA at the direction of EOHHS, as necessary.

5. The Contractor shall transfer all deposits other than deposits for the BH Covered Services Capitation Rate and the DMH Specialty Programs Services Compensation Rate out of the DSRA within seven business days of receiving them.

6. The Contractor shall transmit all interest income from the DSRA, net of bank charges, to EOHHS in the form of a check payable to the Commonwealth of Massachusetts, twice a year on dates to be specified by EOHHS.

    a. In no case shall the Contractor use interest income as any Earnings or bonus payment.

    b. The Contractor shall exclude interest income from reconciliations of administrative and service expenditures.

7. EOHHS may, at any time and at its discretion, audit the Contractor's administration and use of the DSRA funds consistent with the Contract requirements.

8. The Contractor shall comply with the following requirements relative to the management of the DSRA:

    a. Separately tracking the following types of deposits from EOHHS into the DSRA:

        1) BH Covered Services Capitation Rate payments, which includes the Administrative Component of the BH Covered Services Capitation Rate payments;

        2) Care Management Engagement payment;

        3) All Performance Incentive Arrangement payments;

        4) PCC Plan Management Support Services payments;

        5) DMH Specialty Services payments; and

        6) DMH Administrative payments.

    b. Establishing an audit trail that evidences that all payments and transfers from the DSRA are made from deposits received from EOHHS for that express purpose; specifically, that:

        1) All payments from the DSRA for BH Covered Services are made from deposits received from EOHHS for Covered Services for Covered Individuals, and the administration and arrangement of BH Covered Services are made from deposits from EOHHS for that purpose (the Administrative Component of the BH Covered Services Capitation Rate);

        2) All transfers from the DSRA for the Care Management Program-Engagement are made from deposits received from EOHHS for the Care Management Program;

        3) All transfers from the DSRA for PCC Plan Management Support Services are made from deposits received from EOHHS for the PCC Plan Management Support Services; and

        4) All payments from the DSRA for DMH Specialty Programs are made from deposits received from EOHHS for DMH Specialty Programs.

    c. Tracking the interest earned on all deposits into the DSRA.

9. Except as specifically set forth in this **Section 10.12.A**, the Contractor shall not withdraw funds from the DSRA except to pay Claims properly submitted by Providers for Covered Services authorized by the Contractor pursuant to the Contract.

10. The Contractor and EOHHS shall reconcile deposits into and transfers from the DSRA within 120 days of the end of each state fiscal year for the preceding fiscal year.

B. Financial Solvency Requirements

Throughout the term of the Contract, the Contractor shall meet the solvency standards established by the Massachusetts Division of Insurance for private health maintenance organizations, or be licensed or certified by the Massachusetts Division of Insurance as a risk-bearing entity.

C. Financial Stability

1. Throughout the term of this Contract, the Contractor shall:

    a. Remain financially stable.

    b. Maintain adequate protection against insolvency in an amount determined by EOHHS to be adequate to both:

        1) Provide to Covered Individuals all Covered Services required by this Contract for a period of 45 days following the date of insolvency; and

        2) Continue to provide all such services to Covered Individuals who are receiving Inpatient Services at the date of insolvency until the date of their discharge.

2. The Contractor shall maintain liability protection sufficient to protect itself against any losses arising from any claims against it, including, at a minimum, workers' compensation insurance, comprehensive liability insurance, and property damage insurance (see also **Section 13.35**).

D. Performance Guarantees and Additional Security

1. Insolvency Reserve

The Insolvency Reserve shall be defined as the funding resources necessary to meet the costs of providing services to Covered Individuals for a period of 45 days in the event that the Contractor is determined insolvent. Please note that for CY1 the Contractor shall provide at minimum fifty-percent of the Insolvency Reserve, consistent with the risk corridor calculation.

a. EOHHS shall calculate the amount of the Insolvency Reserve annually and provide this calculation to the Contractor within 45 days of the start of the Contract Year.

b. The Insolvency Reserve calculation shall be an amount equal to 45 days of the Contractor's capitation payment revenue.

c. Within 30 calendar days of receipt of the Insolvency Reserve calculation, the Contractor shall submit to EOHHS written documentation of its ability to satisfy the Insolvency Reserve requirement. The documentation shall be signed and certified by the Contractor's chief financial officer.

d. Submit to EOHHS for approval, documentation that the Contractor has satisfied the Insolvency Reserve Requirement through:

1) Restricted cash reserves of $10,000,000 or 16.7%; and

2) any combination equaling 83.3% of the following:

a) Net worth of the Contractor (exclusive of any restricted cash reserves);

b) Performance bond or guarantee;

c) Insolvency insurance;

d) An irrevocable letter of credit; and

e) A written guarantee from the Contractor's parent organization.

2. Prior to the Service Start Date, the Contractor shall provide EOHHS with:

a. Performance Guarantees as specified in **Appendix H-2**, the form of which shall be subject to EOHHS's prior review and approval.

b. A promissory note from the Contractor's parent(s) to guarantee performance of the Contractor's obligation to provide Covered Services in the event of the Contractor's insolvency, the form and amount of which shall be subject to EOHHS's prior review and approval.

c. A promissory note from the Contractor's parent(s) to guarantee performance of the Contractor's obligations to perform activities related to the administration of the Contract in the event of the Contractor's insolvency, the form and amount of which shall be subject to EOHHS's prior review and approval.

E. Medical Loss Ratio (MLR) Requirements

1. Annually, and upon any retroactive change to the Capitation Rates by EOHHS, the Contractor shall calculate a Medical Loss Ratio (MLR) in accordance with 42 CFR 438.8. The Contractor shall perform such MLR calculation in the aggregate for the Contractor's Covered Individual population and individually for each Rating Category. Within 212 days following the end of the Contract Year, the Contractor shall report such MLR calculations to EOHHS in a form and format specified by EOHHS and as set forth in **Appendix E**. Such report shall include at least the following, pursuant to 42 CFR 438.8(k):

    a. Total incurred claims

    b. Expenditures on quality improving activities;

    c. Expenditures related to activities compliant with 42 CFR 438.608(a)(1)-(5),(7),(8), and (b);

    d. Non-claims costs;

    e. Premium revenue;

    f. Taxes, licensing, and regulatory fees;

    g. Methodology(ies) for allocation of expenses;

    h. Any credibility adjustment applied;

    i. The calculated MLR, which shall be the ratio of the numerator (as set forth in **Section 10.14.E.2.a**) to the denominator (as set forth in **Section 10.14.E.2.b**);

    j. A comparison of the information reported in this section with the audited financial report required under this **Section 10.14.F**;

    k. A description of the aggregation method used in calculating MLR;

    l. The number of member months;

    m. An attestation that the calculation of the MLR is accurate and in accordance with 42 CFR 438.8; and

    n. Any other information required by EOHHS.

2. As further specified by EOHHS, the Contractor shall calculate its MLR in accordance with 42 CFR 438.8, as follows:

    a. The numerator of the Contractor's MLR for each year is the sum of the Contractor's incurred claims; expenses for activities that improve health

care quality, including medical sub-capitation arrangements; and fraud reduction activities, all of which must be calculated in accordance with 42 CFR 438.8.

b. The denominator of the Contractor's MLR for each year is the difference between the total capitation payment received by the Contractor and the Contractor's federal, state, and local taxes and licensing and regulatory fees, all of which must be calculated in accordance with 42 CFR 438.8.

3. As further directed by EOHHS, the Contractor shall maintain a minimum MLR of 85 percent in the aggregate for the Contractor's Covered Individual population. If the Contractor does not maintain such minimum, the Contractor shall, pursuant to 42 CFR 438.8(j), remit an amount equal to the difference between actual medical expenditures and the amount of medical expenditures that would have resulted in a MLR of 85%.

F. Other Financial Requirements

The Contractor shall:

1. Ensure that an independent financial audit of the Contractor, and any parent or subsidiary, is performed annually. These audits must comply with the following requirements and must be accurate, prepared using an accrual basis of accounting, verifiable by qualified auditors, and conducted in accordance with generally accepted accounting principles and generally accepted auditing standards:

   a. No later than 120 days after the Contractor's fiscal year end, the Contractor shall submit to EOHHS its most recent year-end audited financial statements (balance sheet, statement of revenues and expenses, source and use of funds statement and statement of cash flows that include appropriate footnotes).

   b. The Contractor shall demonstrate to its independent auditors that its internal controls are effective and operational as part of its annual audit engagement. The Contractor shall provide to EOHHS an attestation report from its independent auditor on the effectiveness of the internal controls over operations of the Contractor related to this Contract in accordance with statements and standards for attestation engagements as promulgated by the American Institute of Certified Public Accountants. The Contractor shall provide such report annually and within 30 days of when the independent auditor issues such report; provided, however, if the Contractor is Service Organization Control (SOC) compliant, the Contractor shall annually submit a copy of the SOC report in lieu of the attestation report described above within 30 days of the Contractor's independent auditors issuing its SOC report.

   c. The Contractor shall submit, on an annual basis after each annual audit, the final audit report together with all supporting documentation, a

representation letter signed by the Contractor's chief financial officer and its independent auditor certifying that its organization is in sound financial condition and that all issues have been fully disclosed.

2. Submit annually, by September 30th, a Financial Ratio Analysis that describes the Contractor's performance for financial ratios required by EOHHS in accordance with the definitions in **Appendix E**, **Exhibit 3A** and the format in **Appendix E**, **Exhibit 3B.** The report shall be generated from the Contractor's audited financial statements.

3. Maintain separate records of all Direct and Indirect administrative Costs, in accordance with generally accepted accounting principles, and make these financial records available to EOHHS on a quarterly basis, for audit purposes.

4. Obtain EOHHS's approval of and utilize a methodology to estimate IBNR claims adjustments.

5. Immediately notify EOHHS of any material negative change in the Contractor's financial status that could render the Contractor unable to comply with any requirement of this Contract, or that is significant enough for the Chief Executive Officer or Chief Financial Officer to notify its Board of the potential for insolvency.

6. Notify EOHHS in writing of any default of its obligations under this Contract, or any default by a parent corporation on any financial obligation to a third party that could in any way affect the Contractor's ability to satisfy its payment or performance obligations under this Contract.

7. Advise EOHHS no later than 30 days prior to execution of any significant organizational changes, new contracts or business ventures being contemplated by the Contractor that may negatively impact the Contractor's ability to perform under this Contract.

G. Provider Preventable Conditions

In accordance with 42 CFR 438.6(g)(2), the Contractor shall:

1. As a condition of payment, comply with the requirements mandating Provider identification of Provider Preventable Conditions, as well as the prohibition against payment for Provider Preventable Conditions as set forth in 42 CFR 434.6(a)(12) and 447.26;

2. Report all identified Provider Preventable Conditions in a form and format and frequency specified by EOHHS, including but not limited to any reporting requirements specified in accordance with **Section 2.3.F** or **Appendix E**.

Section 10.15 Reporting

The Contractor shall submit to EOHHS all required financial reports, as described in this **Section 10** or in **Appendix E**, in accordance with specified timetables, definitions, formats and assumptions, as well as any ad hoc financial reports required by EOHHS in accordance with **Section 11.2.B**.

Section 10.16 Alternative Payment Methodology for CBHI Intensive Care Coordination Services

Under the direction and with the approval of EOHHS, the Contractor shall develop and implement an alternative payment methodology for CBHI Intensive Care Coordination services.

Section 10.17 MFP Claim Information Submission

The Contractor shall submit claim information to EOHHS or its agent for all in-network behavioral health services provided for all MFP Waiver Participants pre-transition. Such claim information shall not be submitted until after the date of discharge, i.e. once the member has transitioned to the community. EOHHS or its agent shall review the information submitted by the Contractor prior to submitting claims information to MMIS for processing and payment to the Contractor. The rate for in-network behavioral health services provided pre-transition shall be in accordance with the Contractor's regular fee schedule for the specific behavioral health service provided to the member.

SECTION 11. REPORTING AND DATA SUBMISSIONS

Section 11.1 Data Requirements for Data

A. General Requirements

The Contractor shall provide and require its subcontractors to:

1. provide any and all information EOHHS requires under the Contract related to the performance of the Contractor's responsibilities;

2. provide any and all information EOHHS requires in order to comply with the Balanced Budget Act of 1997 or any other federal or state laws and regulations, including, but not limited to, data required pursuant to 42 CFR 438.604; and

3. provide EOHHS and DMH with any and all data to meet all applicable federal and state reporting requirements within the legally required time frames.

B. Data Certification Requirements

In accordance with 42 CFR 438.600 et seq., the Contractor's Chief Executive or Chief Financial Officer, or a person who has delegated authority to sign for and who reports directly to the Contractor's Chief Executive or Chief Financial Officer, shall, at the time of submission of the types of information, data, reports and other documentation listed below, sign and submit to EOHHS certification checklists in the form and format provided in **Appendix E-2,** certifying that the information, data, and documentation being submitted by the Contractor is true, accurate, and complete to the best of his or her knowledge, information and belief, after reasonable inquiry:

1. Data on which payments to the Contractor are based;

2. All enrollment information, Encounter data, and measurement data;

3. Data related to medical loss ratio requirements;

4. Data or information related to protection against the risk of insolvency;

5. Documentation related to requirements around availability and accessibility of services, including adequacy of the Contractor's Provider Network;

6. Information on ownership and control, such as that pursuant to **Section 13.2**;

7. Reports related to overpayments; and

8. Data and other information required by EOHHS, including, but not limited to, reports and data described in this Contract.

The Contractor shall submit the certification concurrently with the certified data.

C. Additional Clinical Data

Upon request of EOHHS, the Contractor shall participate in the development of specifications for a data set consisting of clinical data in the Contractor's Information Systems that include Covered Individual identifier, and data on participation in the Children's Behavioral Health Initiative, Care Management Program, and special populations, which the Contractor shall produce and submit to EOHHS in the frequency and format to be determined by EOHHS.

D. Corrective Action for Inadequate Data

If EOHHS determines that the Contractor's Encounter data are complete and accurate for less than 90 percent of the data elements contained in the CMS-approved minimum data set (MDS), the Contractor shall implement a corrective action approved by EOHHS to bring the accuracy to the acceptable level. EOHHS may impose daily financial penalties until the Contractor's deficiencies are corrected.

Section 11.2 Requirements for Reporting

A. General Requirements

The Contractor shall:

1. Be responsible for all administrative costs associated with the development, production, mailing and delivery of all reports required under the Contract.

2. Submit to EOHHS all required reports in accordance with the specifications, templates and time frames described in this Contract and its Appendices, specifically including but not limited to the reports described in **Appendix E-1**, unless otherwise directed or agreed to by EOHHS. Any modifications, revisions or enhancements the Contractor proposes to make to any reports must be submitted to EOHHS for its approval prior to making such changes. EOHHS may update or replace **Appendix E-1** without the need for a Contract amendment

3. Work with EOHHS to correct or modify any reports as directed by EOHHS and resubmit them to EOHHS for final acceptance and approval within agreed-upon time frames.

4. At the written request of EOHHS's Director of Behavioral Health Programs or designee, or at the written or oral request of the State Office of the Inspector General or Office of the Attorney General, provide additional ad hoc or periodic reports, including any reports EOHHS asks the Contractor to produce as a result of an investigation into the performance of a provider, or analyses of data related to the Contract, according to a schedule and format specified or agreed to by EOHHS. Ad hoc reports shall be requested for one-time or non-routine submission to EOHHS or other agency designated by EOHHS.

5. Have the capacity to display data graphically, in tables, and in charts, as directed by EOHHS.

6. Ensure that all reports are identified with a cover page that includes at least the following information:

    a. title of the report;

    b. due date of the report;

    c. production date of the report;

    d. contact person for questions regarding the report;

    e. data sources for the report;

    f. reporting interval;

    g. date range covered by the report; and

    h. methodology employed to develop the information for the report.

7. Provide with each report a narrative summary of the key findings contained in the report, unless otherwise agreed to by EOHHS, actions taken or planned next steps related to those findings.

8. Deliver all reports to EOHHS electronically. The Contractor and EOHHS shall work with the MassHealth end users and IT to develop the best method for electronic report delivery in a format and media compatible with EOHHS' software and hardware requirements. The electronic submission must be organized with clearly labeled electronic files with the documented named with the report name and date, as well as an electronic table of contents.

9. Provide EOHHS and DMH with reports to meet all applicable federal and state reporting requirements within the legally required time frames.

B. Reporting Timetables

The Contractor shall provide reports to EOHHS according to the timetables in **Appendix E-1**.

C. Corrective Action for Late or Incomplete Reports

If EOHHS determines that the Contractor's reports are incomplete or late, the Contractor shall implement a corrective action approved by EOHHS to correct the deficiencies. EOHHS may impose daily financial penalties until the Contractor's deficiencies are corrected.

SECTION 12. EOHHS RESPONSIBILITIES

Section 12.1 Administrative Responsibilities

EOHHS shall:

A. Designate a Contract Manager for the PCC Plan's BHP, who shall act as liaison, coordinate all requests and activities between the Contractor and EOHHS, and between the Contractor and the other state agencies involved with or affected by the Contract, for the duration of the Contract. EOHHS may change its designation of Contract Manager at any time during the Contract, and shall provide the Contractor with notification of any such change. The Contract Manager shall represent EOHHS in all programmatic and operational aspects of the Contract.

B. Provide the Contractor with available information and data in its possession necessary for successful performance of the Contract.

C. Furnish the Contractor with copies of EOHHS regulations, policies and procedures that may materially affect the Contractor's performance of its contractual obligations.

D. Notify the Contractor of any changes to the PCC Plan and other EOHHS programs, regulations, policies and procedures, operations or systems that may materially affect the Contractor's performance of its contractual obligations.

E. At least three months in advance, notify the Contractor of the Contract requirements on which EOHHS will base its annual review of the Contractor's performance.

F. Review and approve all materials, policies and procedures developed by the Contractor when such review and approval is required by the Contract.

G. Review the Contractor's submitted reports and reserve the right to request additional reports.

H. Meet with the Contractor's representative(s) on a routine basis, as either party deems necessary.

I. At its discretion, attend meetings or other activities conducted by the Contractor.

J. At any time during the term of the Contract, as appropriate, initiate negotiations with the Contractor to revise the scope of the Contract to meet EOHHS's needs.

K. Review any Contractor-proposed revisions to the scope of the Contract and approve, reject or modify the Contractor's proposal.

L. Pay the Contractor in accordance with **Section 10** of the Contract.

M. At its discretion, attend Provider site visits conducted by the Contractor.

N. Inform the Contractor of new PCCs to be included in MSS activities.

Section 12.2 Contract Readiness Review

Prior to the Service Start Date, EOHHS will conduct a Readiness Review of the Contractor.

A. EOHHS will conduct a Readiness Review of the Contactor that may include on-site review. This review shall include, but is not limited to the elements described in **Section 2.1.D**, and shall be conducted no later than 60 days prior to enrollment of Covered Individuals into the Contractor's Plan, and at other times during the Contract period at the discretion of EOHHS.

B. EOHHS will conduct the Readiness Review to verify the Contractor's assurances that the Contractor is ready and able to meet its obligations under the Contract. EOHHS reserves the right to conduct an additional Readiness Review in the event that additional populations become managed care eligible.

C. EOHHS will identify to the Contractor all areas where the Contractor is not ready and able to meet its obligations under the Contract and may, in its discretion, allow the Contractor to propose a plan to remedy all deficiencies prior to the Service Start Date. Alternatively, EOHHS may, in its discretion, postpone the Service Start Date if the Contractor fails to satisfy all Readiness Review requirements

D. If, for any reason, the Contractor does not fully satisfy EOHHS that it is ready and able to perform its obligations under the Contract prior to the Service Start Date, and EOHHS does not agree to postpone the Contract Operational Start Date, or extend the date for full compliance with the applicable Contract requirement, then EOHHS may terminate the Contract and shall be entitled to recover damages from the Contractor.

Section 12.3 Enrollment and Disenrollment

A. EOHHS shall, as appropriate, enroll, disenroll and re-enroll Covered Individuals in the BHP. EOHHS shall:

1. Inform the Contractor of the enrollment disenrollment, or re-enrollment through nightly transmissions of data from MMIS. The Contractor shall accept all Covered Individuals enrolled or re-enrolled by EOHHS.

2. At its discretion, and as appropriate, instruct the Contractor to resolve enrollment discrepancies through a manual system approved by EOHHS.

B. EOHHS shall:

1. Maintain the sole responsibility for the enrollment of Covered Individuals into the PCC Plan's BH Program, as described in this **Section 12.3**. The Contractor shall accept all Covered Individuals enrolled or re-enrolled by EOHHS.

2. On each business day of the Contract Year, make available to the Contractor, via the HIPAA 834 Outbound Daily Enrollment file, information pertaining to all

enrollments, including the Effective Date of Enrollment, which will be updated on a daily (business day) basis.

3. At its discretion, and as appropriate, instruct the Contractor to resolve enrollment discrepancies through a manual system approved by EOHHS.

4. At its discretion, automatically re-enroll on a prospective basis into the PCC Plan's BH Program any Covered Individuals who were disenrolled due to loss of eligibility and whose eligibility was re-established by EOHHS.

5. EOHHS shall disenroll a Covered Individual from the Contractor's program and he or she shall no longer be eligible for services following:

   a. Loss of MassHealth eligibility;

   b. Completion of the Enrollee's voluntary disenrollment request; or

   c. Loss of eligibility for MassHealth Managed Care.

6. Except as otherwise provided under federal law or waiver, an Enrollee may disenroll voluntarily at any time. Such voluntary disenrollments shall take effect one business day after such request.

7. Make best efforts to provide the Contractor with the most current demographic information available to EOHHS. Such demographics shall include, when available to EOHHS, the Covered Individual's name address, MassHealth identification number, date of birth, telephone number, race, gender, ethnicity and primary language.

8. Review and respond to written complaints from the Contractor about EOHHS's Customer Services vendor or such vendor's subcontractors, or EOHHS's contracted Enrollment Broker within a reasonable time. EOHHS may request additional information from the Contractor in order to perform such review.

C. EOHHS may at its discretion develop and implement in consultation with the Contractor necessary processes and procedures required to implement enrollment of additional groups with the Contractor. If it does so, EOHHS shall:

1. Develop a benefit package for any such new group.

2. Inform the Contractor regarding demographic characteristics and utilization experience of any new group prior to initiation of enrollment, to the extent that such information is available.

3. Develop a Base PMPM Capitation Rate(s) for such group(s) consistent with 42 CFR 447.361 or other applicable federal statute and regulations, including with respect to UPL limitations, and in consultation with the Contractor.

4. Develop in cooperation with the Contractor an implementation strategy for providing services to new groups.

Section 12.4 Information Systems

EOHHS shall:

A. Cooperate with the Contractor on any system implementation or enhancement necessary to meet the requirements of the Contract that affects either EOHHS's MMIS or the Contractor's MIS through the term of the Contract.

B. Provide technical assistance as necessary for the Contractor to gain access to specified EOHHS systems where such access is required by the Contract.

C. Provide and maintain a list of access codes for all Contractor staff requiring access to EOHHS systems.

D. Assist the Contractor, as necessary, to verify a Covered Individual's eligibility status in the BHP.

Section 12.5 Performance Evaluation

EOHHS shall:

A. On a semiannual basis, conduct a "lessons learned" exercise with the Contractor. The results shall be used by EOHHS and the Contractor to improve and refine performance as it relates to the responsibilities of this Contract.

B. At its discretion, perform periodic programmatic and financial reviews. These may include on-site inspections and audits, by EOHHS or its agent, of the records of the Contractor and Network Providers.

C. Provide reasonable notice to the Contractor prior to any on-site visit to conduct an audit, and further notify the Contractor of any records EOHHS wishes to review.

D. On a semiannual basis and at its discretion, evaluate and score the Contractor's performance of all contractual obligations and its compliance with the terms of the Contract using an evaluation form such as the Performance Management Evaluation Form found in **Appendix I**.

E. Inform the Contractor of the results of any performance evaluations and of any dissatisfaction with the Contractor's performance, and reserve the right to demand a corrective action plan as set forth in **Section 13.17**, or to apply one or more of the sanctions provided in **Section 13.18**, including termination of the Contract in accordance with **Section 13.16**.

SECTION 13. ADDITIONAL TERMS AND CONDITIONS

Section 13.1 Prohibited Affiliations and Exclusion of Entities

A. In accordance with 42 U.S.C. § 1396u-2(d)(1) and 42 CFR 438.610, the Contractor shall not knowingly have an employment, consulting, provider, subcontractor, or other agreement for the provision of items and services that are significant and material to the Contractor's obligations under the Contract with any person, or affiliate of such person, who is debarred, suspended or otherwise excluded from certain procurement and non-procurement activities, under federal or state law, regulation, executive order or guidelines. Further, no such person may have beneficial ownership of more than five percent of the Contractor's equity nor be permitted to serve as a director, officer, or partner of the Contractor. The Contractor shall provide written disclosure to EOHHS of any prohibited affiliations identified by the Contractor.

B. The Contractor shall be excluded from participating in MassHealth if it meets any of the conditions set forth in 42 CFR 438.808(b).

Section 13.2 Disclosure Requirements

A. The Contractor shall within one business day disclose to EOHHS any non-compliance by the Contractor with any provision of this Contract, or any state or federal law or regulation governing this Contract.

B. The Contractor shall make the following federally required disclosures in accordance with 42. CFR § 455.100-106, 42 CFR 455.436, 42 CFR 1002.3. and 42 U.S.C. § 1396b(m)(4) in the form and format specified by EOHHS, at any time upon a written request by EOHHS, and as follows:

1. Ownership and Control

Upon execution, renewal or extension of this Contract and within 35 days of any change in ownership, the Contractor shall furnish full and complete information to EOHHS as required by 42 CFR 455.104 regarding ownership and control, with respect to both the Contractor and Material Subcontractors.

2. Business Transactions

Pursuant to 42 CFR 455.105, within 35 days of a written request by EOHHS and/or the U.S. Department of Health and Human Services, the Contractor shall furnish full and complete information to the requester regarding business transactions.

3. Criminal Convictions

Pursuant to 42 CFR 455.106, upon any renewal or extension of this Contract and at any time upon a written request by EOHHS, the Contractor shall furnish full and complete information to EOHHS regarding persons convicted of crimes.

4. Other Disclosures

The Contractor shall comply with all reporting and disclosure requirements of 42 USC § 1396b(m)(4)(A) if the Contractor is not a federally qualified health maintenance organization under the Public Health Service Act. Pursuant to 42 U.S.C. § 1396b(m)(4)(B), the Contractor shall make any information reported pursuant to 42 U.S.C. § 1396b(m)(4)(A) available to Covered Individuals upon reasonable request.

C. The Contractor shall ensure that its Network Provider enrollment forms require Provider applicants to disclose complete ownership, control, and relationship information, and that Network Applicants and Network Providers fully and accurately complete the required portions of the EOHHS form developed for such purpose. Further, the Contractor shall require persons with an ownership or control interest, or persons who are agents or managing employees of Network Providers, to utilize the EOHHS form developed for such purpose to fully and accurately disclose health care-related criminal convictions, and to notify EOHHS of such disclosures within 20 working days.

D. Unless otherwise instructed by EOHHS, for the purposes of making the disclosures to EOHHS set forth in **Sections 13.2.B.1-3** and **13.2.C**, the Contractor shall fully and accurately complete the EOHHS form developed for such purpose, the current version of which is attached hereto as **Appendix B-4**. EOHHS may update or replace this Appendix without the need for a Contract amendment.

E. The Contractor shall search the federal HHS-OIG's List of Excluded Individuals/Entities (LEIE) and the System Award Management website for the names of Network providers upon enrollment, reenrollment, credentialing or re-credentialing, as further described in **Section 3.1.I**. In addition, the Contractor shall conduct such searches for the names of Network providers, persons with ownership or control interest in the Contractor, and agents or managing employees of the Contractor at least monthly to ensure that EOHHS does not pay for services provided by excluded persons or entities.

F. EOHHS may immediately terminate this Contract in whole or in part if the Contractor fails to comply with this **Section 13.2** or in response to the information contained in the Contractor's disclosures under this **Section 13.2**. In addition, the Contractor shall not be entitled to payment for any MassHealth services for which EOHHS determines federal reimbursement is not available. Any such payments shall constitute an overpayment as defined in 130 CMR 450.235. Under such circumstances, EOHHS may also exercise its authority under 130 CMR 450.238, et seq. to impose sanctions.

Section 13.3 EOHHS's Option to Amend or Modify Scope of Work

A. EOHHS shall have the option at its sole discretion to modify, reduce or terminate any activity related to the Contract whenever, in the judgment of EOHHS, the goals of the project have been modified or altered in any way that necessitates such changes. In the event of the reduction of the scope of work for any tasks or portions thereof, EOHHS will provide written notice to the Contractor. In the event of a change in the

scope of work of any tasks or portions thereof, EOHHS will initiate negotiations with the Contractor.

Notwithstanding the generality of the foregoing, EOHHS reserves the right to amend the Contract to implement new initiatives or to modify initiatives related to:

1. new MassHealth programs;

2. expansion of or changes to existing MassHealth programs;

3. other programs as specified by EOHHS;

4. programs resulting from state or federal legislation, including but not limited to the Patient Protection and Affordable Care Act (ACA) of 2010 (Public Law 111–148 March 23, 2010), regulations, initiatives, or judicial decisions that may affect in whole or in part any components of the PCC Plan or the BHP;

5. requiring or allowing individuals age 65 and over, with or without Medicare and individuals age 21 or over with Medicare to enroll in the PCC Plan or the BHP; and

6. changes the managed care options available to any or all MassHealth Coverage Types, in whole or in part, including, but limited to, requiring MassHealth Coverage Type(s) to choose among Managed Care Organizations (MCOs), requiring MassHealth Coverage Types to enroll in the PCC Plan and excluding any or all MassHealth Coverage Types from either mandatory or voluntary Managed Care.

7. The parties shall negotiate in good faith to implement any such initiatives proposed by EOHHS. The Contractor's responsibilities, including staffing, space, and all other budgetary requirements, are subject to change due to implementation of such initiatives. EOHHS reserves the right to modify the Contract, including the budget and reimbursements, due to program modifications. In addition, the Contractor may request an opportunity to enter into negotiations with EOHHS over amendments to the Contract related to new initiatives or modified initiatives as described in this section. EOHHS may grant such a request in its sole discretion.

B. EOHHS reserves the right to enroll additional MassHealth Members over the term of the Contract, or to reduce current enrollment levels. Possible EOHHS initiatives that could change enrollment include but are not limited to:

1. Increased or decreased MassHealth membership pursuant to any MassHealth waiver;

2. Expanded eligibility coverage for children under age 19 or adults over 65;

3. Any other state or federal changes that result in an increase or decrease in MassHealth-eligible individuals, including changes to comply with the ACA,

such as an adjustment to the minimum federal poverty eligibility level, or a change in the MassHealth Managed Care enrollment policy or criteria for participation; and

4. Changes in EOHHS's methodology by which assignments are made to MassHealth Managed Care plans.

C. The Contractor shall propose to EOHHS for approval during the term of the Contract new initiatives and reimbursement mechanisms designed to further integrate PCC Plan administrative functions with BH management and performance. Such proposals shall include, upon EOHHS request, detailed work plans and timelines. EOHHS may at its sole discretion accept, reject or modify any proposed initiative.

Section 13.4 Contract Compliance

The Contractor shall immediately notify EOHHS of any occurrence that affects the Contractor's ability to operate and comply with all or any material part of its responsibilities under the Contract, along with an assessment of the time and effort necessary to recover.

Section 13.5 Compliance with Laws

A. The Contractor shall comply with all applicable statutes, orders, and regulations promulgated by any federal, state, municipal, or other governmental authority relating to the performance of this Contract as they become effective. Without limiting the generality of the foregoing, the Contractor shall comply with Title VI of the Civil Rights Act of 1964, as implemented by regulations at 45 CFR Part 80; Title IX of the Education Amendments of 1972; the Age Discrimination Act of 1975, as implemented by regulations at 45 CFR Part 91; the Rehabilitation Act of 1973; the Americans with Disabilities Act; Titles XIX and XXI of the Social Security Act and waivers thereof; Chapter 141 of the Acts of 2000 and applicable regulations; Chapter 58 of the Acts of 2006 and applicable regulations; 42 CFR Part 438; The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (commonly referred to as the Mental Health Parity Law) and applicable regulations; and relevant provisions of the Patient Protection and Affordable Care Act and Health Care and Education Reconciliation Act of 2010, including, but not limited to, section 1557 of that act, and other laws regarding privacy and confidentiality.

B. The Contractor shall promptly execute and comply with any amendment to this Contract that EOHHS determines is necessary to ensure compliance with all applicable federal and state statutes and regulations and any federal waivers including, without limitation, those provisions cited in this Contract, and the terms and conditions of EOHHS's Research and Development Waiver under Section 1115 of the Social Security Act, including any revisions to such waiver.

C. The Contractor shall be liable for any and all loss of Federal Financial Participation (FFP) incurred by the Commonwealth that results from the Contractor's failure to comply with any requirement of federal law or regulation.

Section 13.6 Internal Quality Controls

The Contractor shall:

A. Comply with Office of State Comptroller (OSC) and the Committee of Sponsoring Organization (COSO) Internal Control Standards.

B. Have in place a process for investigating and resolving any EOHHS dissatisfaction with the Contractor's performance and for improvements in its internal systems.

C. Maintain internal quality standards, indicators and written procedures to ensure accurate, timely, and consistent Contract activities to promote:

1. Adherence to Contract deadlines for the submission of accurate and timely reports and other materials;

2. Accurate and consistent dissemination of oral and written information by Contractor staff;

3. Accurate, clear documentation of the Contractor's activities (programmatic and financial) required by EOHHS;

4. Data integrity and confidentially of the Contractor's MIS, including maintenance of history files; and

5. Any other EOHHS-specified operational and reporting performance criteria.

D. Monitor internal quality control measures, standards, and procedures on a continuous basis and update them as needed to keep them current with standards.

E. Report to EOHHS in writing all internal quality control issues and findings when and if they arise.

Section 13.7 Loss of Licensure

The Contractor shall report to EOHHS if at any time during the Contract the Contractor or any material subcontractor loses, or is at risk of losing, any applicable license, state approval or accreditation. Such loss may be grounds for termination of the Contract under the provisions of **Section 13.16**.

Section 13.8 Leases and Licensing of Software

The Contractor shall:

A. Incorporate into all software license agreements a provision that the Contractor is permitted to assign the license to EOHHS or to EOHHS's designee at no cost to EOHHS. However, in the event that the Contractor is unable to obtain such assignment provision, the Contractor shall obtain the written authorization of EOHHS prior to entering into the agreement. This requirement does not extend to

commercially available software for which EOHHS may readily obtain its own license. All payments to maintain the lease, rental agreement, or license that become due after the termination of the agreement become the responsibility of EOHHS or EOHHS's designee. Upon termination of the Contract for any reason, the Contractor hereby agrees to assign or otherwise transfer any such lease, rental agreement or software license agreement to EOHHS or its designee, at no cost to EOHHS, upon EOHHS's request.

B. The Contractor agrees that, except with respect to commercial off-the-shelf software (COTS), EOHHS shall be granted a royalty-free, non-exclusive, perpetual and irrevocable license to the use of all software used by the Contractor in the performance of its obligations under the Contract.

C. Transfer to EOHHS or EOHHS's designee all applications designed or operated under the Contract at no cost to EOHHS, and to provide user and system documentation for any software developed by the Contractor for EOHHS. Upon EOHHS's written request, within 30 calendar days, the Contractor shall deliver to EOHHS, or its designee(s), all software to which the Commonwealth has sole, joint, or several proprietary ownership rights including, without limitation, all code and all documentation of software, as generated by the Contractor and utilized by the Contractor to fulfill its responsibilities in this Contract.

Section 13.9 Other Contracts

Upon EOHHS request, the Contractor shall provide a complete list of any managed behavioral health care contracts it or its corporate parent or subsidiary holds within Massachusetts in addition to this Contract. EOHHS shall not disclose non-public information that the Contractor may consider proprietary, except as required by law.

Section 13.10 Counterparts

The Contract may be executed simultaneously in two or more counterparts, each of which will be deemed an original and all of which together will constitute one and the same instrument.

Section 13.11 Entire Contract

The Contract constitutes the entire agreement of the parties with respect to the subject matter hereof, including all Attachments and Appendices hereto, and supersedes all prior agreements, representations, negotiations and undertakings not set forth or incorporated herein. The terms of the Contract shall prevail notwithstanding any variances with the terms and conditions of any verbal communication subsequently occurring, except as otherwise provided herein.

Section 13.12 Correction of Omissions, Ambiguities, and Manifest Errors

The Contractor shall negotiate in good faith with EOHHS to cure any omissions, ambiguities, or manifest errors in the Contract. By mutual agreement, the Contractor and EOHHS may amend the Contract where such amendment does not violate state or federal statutory, regulatory, or

waiver provisions, provided that such amendment is in writing, signed by both parties, and attached to the Contract.

Section 13.13 No Third-Party Enforcement

This Contract is entered into by and between the parties hereto and for their sole benefit. There is no intent by either party to create or establish a third-party beneficiary status, or to create any rights in or confer any benefits upon any person or entity not a party to this Contract (except for such rights as are expressly created and set forth in this Contract). Except for the foregoing, no third party shall have any right to enforce or to enjoy any benefit or obligation created or established under this Contract.

Section 13.14 Responsibility of the Contractor

The Contractor shall:

A. Ensure the professional quality, technical accuracy and timely completion and delivery of all services furnished by the Contractor under the Contract.

B. Without additional compensation, correct or revise any errors, omissions or other deficiencies in its deliverables and other services.

The approval of services furnished hereunder shall not in any way relieve the Contractor of responsibility for the technical adequacy of its work. The review, approval, acceptance of or payment for any of the services rendered shall not be construed as a waiver of any of EOHHS's rights under the Contract or of any cause of action arising out of the performance of the Contract.

Section 13.15 Contract Term

The Contract is effective upon execution, through December 31, 2017, unless otherwise terminated or extended in accordance with this section or at such other time that EOHHS may implement changes that render the performance of the Contract unnecessary. At EOHHS's option, the Contract may be extended for up to five additional years from June 30, 2017, at the discretion of EOHHS, and in increments and upon terms to be negotiated by the parties.

Section 13.16 Termination

A. Termination without Prior Notice

EOHHS may terminate the Contract immediately and without prior written notice, upon any of the following events:

1. The Contractor's application for or consent to the appointment of a receiver, trustee, or liquidator for itself or any of its property.

2. The Contractor's admission in writing that it is unable to pay its debts as they mature.

3. The Contractor's assignment for the benefit of creditors.

4. Commencement of a proceeding under any bankruptcy, reorganization, insolvency, or readjustment of debt provision of federal or state law or answer admitting the material allegations of a petition filed against the Contractor in any such proceeding.

5. Commencement of an involuntary proceeding against the Contractor or Material Subcontractor under any bankruptcy, reorganization, insolvency, or readjustment of debt provision of federal or state law, which is not dismissed within 60 days.

6. The Contractor loses any applicable state approval.

7. Cessation in whole or in part of state or federal funding for or approval of the Contract.

8. EOHHS determines in its sole discretion that the health, safety or welfare of its Covered Individuals requires immediate termination of the Contract.

9. The Contractor is non-compliant with **Section 13.1**, and the Secretary of Health and Human Services, in accordance with 42 CFR 438.610(c), directs EOHHS to terminate, or does not permit EOHHS to extend, renew or otherwise continue this Contract.

10. The Contractor is non-compliant with **Section 13.2**.

B. Termination with Prior Notice

1. Either party may terminate the Contract upon breach by a party of any duty or obligation hereunder, which breach continues unremedied for 30 days after written notice thereof by the other party.

2. EOHHS may terminate the Contract after written notice thereof to the Contractor in the event the Contractor fails to accept EOHHS's proposed offer of payment for any financial provision identified in **Section 10** of this Contract.

3. EOHHS may terminate the Contract if the EOHHS determines that state or federal health care reform initiatives or state or federal health care cost containment initiative makes termination of the Contract necessary or advisable as determined by EOHHS

C. Termination with Prior Notice for Violation of Section 14 of the Contract

1. Notwithstanding any other provision in the Contract, EOHHS may terminate this Contract immediately, upon written notice, if EOHHS determines, in its sole discretion, that the Contractor has materially breached any of its obligations set forth in **Section 14**, or any other provision of the Contract pertaining to the security and privacy of any Protected Health Information (PHI) or any data provided to the Contractor under this Contract.

2. In the event that termination of this Contract for a material breach of any obligation regarding PHI is not feasible, or if a cure is not feasible, EOHHS shall

report such breach or violation to the U.S. Secretary of Health and Human Services.

D. Effect of Termination for Violation of Section 14

1. Upon termination of the Contract for any reason whatsoever, the Contractor shall return or destroy all PHI and any other Personal Data obtained or created in any form under the Contract, and the Contractor shall not retain any copies of such data in any form. This provision shall apply to all PHI and data in the possession of the Contractor's subcontractors or agents, and the Contractor shall ensure that all such data in the possession of its subcontractors or agents has been returned or destroyed and that no subcontractor or agent retains any copies of such data in any form.

2. Notwithstanding any other provision concerning the term of this Contract, all protections pertaining to any PHI or other data covered by the Contract shall continue to apply until such time as all such data is returned to EOHHS or destroyed.

E. Continued Obligations

1. In the event of termination, expiration or non-renewal of the Contract, the obligations of the parties hereunder with regard to each Covered Individual at the time of termination, expiration, or non-renewal shall continue until the Covered Individual has been disenrolled; provided, however, that EOHHS shall exercise best efforts to complete all disenrollment activities within six months from the date of termination, expiration or non-renewal.

2. In the event that the Contract is terminated, expires, or is not renewed for any reason:

    a. EOHHS shall be responsible for notifying all Covered Individuals covered by this Contract of the date of termination and the process by which they will continue to receive medical care;

    b. The Contractor shall promptly return to EOHHS all payments advanced to the Contractor for coverage of Covered Individuals for periods after the effective date of their disenrollment; and

    c. The Contractor shall supply to EOHHS all information necessary for the reimbursement of any outstanding claims determined by EOHHS to be due to the Contractor, and any such claims shall be paid to the Contractor accordingly.

3. For expiration or non-renewal of the Contract following a reprocurement of the PCC Plan's BH Program, the financial terms in effect for the current Contract Year shall remain in effect until all Covered Individuals have been disenrolled, except that there shall be no Performance Incentives in EOHHS's sole discretion.

Section 13.17 Corrective Action Plan

If, at any time, EOHHS determines that the Contractor is deficient in the performance of its obligations under the Contract, EOHHS may require the Contractor to develop and submit a corrective action plan to correct such deficiency. EOHHS shall approve, disapprove, or require modifications to the corrective action plan based on its reasonable judgment as to whether the corrective action plan will correct the deficiency. The Contractor shall, upon approval of EOHHS, immediately implement the corrective action plan, as approved or modified by EOHHS. The Contractor's failure to implement any corrective action plan may, in the sole discretion of EOHHS, be considered breach of Contract, subject to any and all contractual remedies including: those under the Contractor's Performance Guarantees in accordance with **Appendix H-2**; termination of the Contract with or without notice; or other intermediate sanctions as described in **Section 13.18**.

Section 13.18 Intermediate Sanctions

A. In addition to termination under **Section 13.16**, EOHHS may, in its sole discretion, impose any or all of the sanctions in **subsection B** below, for any of the circumstances described in this **subsection A**. EOHHS shall only impose those sanctions it determines to be reasonable and appropriate for the specific violation(s) identified. Sanctions may be imposed if the Contractor:

1. Fails to provide Medically Necessary Covered Services required under the Contract to Covered Individuals and Uninsured Individuals including persons covered by Medicare only;

2. Imposes premiums or other charges on Covered Individuals and Uninsured Individuals including persons covered by Medicare only in excess of any permitted under the Contract;

3. Discriminates against Covered Individuals on the basis of race, color, gender, or national origin;

4. Misrepresents or falsifies information provided to EOHHS, the U.S. Department of Health and Human Services, Covered Individuals, Providers or PCCs;

5. Fails to comply with applicable federal requirements regarding Provider incentive plans;

6. Fails to comply with federal or state statutory or regulatory requirements related to the Contract;

7. Violates restrictions or other requirements regarding marketing;

8. Fails to comply with any corrective action plan required by EOHHS

9. Fails to meet deliverable timelines which deliverables shall include those reports, analyses, workplans, surveys, evaluations, metrics and other documents with

submission dates explicitly defined in the Contract or, if a date is not specified, with explicit timelines or bases of specified duration provided therein'

10. Fails to meet satisfactory performance based upon EOHHS' Performance Management Evaluation, in accordance with the provisions of **Section 12.5.D**;

11. Fails to comply with financial solvency requirements;

12. Fails to comply, as determined by EOHHS from audit findings, with any provision of this Contract related to DSRAs;

13. Fails to comply with any other requirement of Section 1932 of the Social Security Act, and any implementing regulations; or

14. Fails to comply with any other requirements of this Contract.

B. Such sanctions may include without limitation, any or all of the following:

1. financial penalties, including without limitation asserting EOHHS's rights under its Performance Guarantee, in accordance with the provisions of **Appendix H-2**;

2. withholding of administrative payments;

3. withholding Performance Incentive bonuses;

4. the appointment of temporary management to oversee the operation of the Contractor in those circumstances set forth in 42 U.S.C. § 1396u-2(e)(2)(B);

5. suspension of payment to the Contractor; adjusting or withholding Estimated Base Capitation Rate Payments or other Base PMPM Capitation Rate payments;

6. adjusting or withholding of Service Compensation Payments;

7. adjusting or withholding the DMH Administrative Compensation Rate or Administrative Component of the MassHealth Capitation Payments; and

8. withholding gain from any risk-sharing arrangement.

C. For any Contract responsibilities for which the Contractor utilizes a Material Subcontractor, if EOHHS identifies any deficiency attributable to the Material Subcontractor in the Contractor's performance for which the Contractor has not successfully implemented an approved corrective action plan in accordance with this **Section 13.17**, EOHHS may require the Contractor to terminate its agreement with the Material Subcontractor and subcontract with a Material Subcontractor deemed satisfactory by EOHHS, or to otherwise alter the manner or method in which the Contractor performs those responsibilities.

D. The intermediate sanctions provisions contained in this Contract are pursuant to state authority, unless otherwise specifically provided.

Section 13.19 Authorizations

This Contract is subject to all necessary federal and state approvals.

Section 13.20 Medical Records

The Contractor shall:

A. Comply with, and require Network Providers to comply with, all state and federal statutory and regulatory requirements applicable to medical records, including the requirements set forth in 130 CMR 130 CMR 433.409, 130 CMR 450.205, 42 CFR 456.111 and 42 CFR 456.21 (if applicable), and any amendments thereto. In addition, the Contractor shall require that all medical records maintained by it or its Network Providers shall, at a minimum:

1. Be maintained in a manner that is current, detailed, and organized and that permits effective patient care and quality review;

2. Be maintained and shared in accordance with professional standards;

3. Include sufficient information to identify the Covered Individual, date of encounter and pertinent information that documents the Covered Individual's diagnosis;

4. Describe the appropriateness of the treatment and services, the course and results of the treatment and services; and

5. Accurately document the following:

    a. Covered Individual identifying information;

    b. clinical information;

    c. Behavioral Health Clinical Assessments;

    d. treatment plans;

    e. treatment or services provided;

    f. contacts with Covered Individuals' family, guardians, or significant others; and

    g. treatment outcomes.

B. Comply with, and require Network Providers to comply with, all state and federal statutory and regulatory requirements applicable to confidentiality of medical records, including but not limited to M.G.L. c. 66A and, if applicable, M.G.L. c. 123 § 36, 104 CMR 27.17, and 104 CMR 28.09.

C. Provide EOHHS with a copy of any Covered Individual's medical records, in general within 10 days of EOHHS's request; except that EOHHS may allow the Contractor up to one month from the date of EOHHS's initial request to produce such records if the Contractor has made best efforts to produce them in the specified time and EOHHS reasonably determines that the need for such record(s) is not urgent.

D. Conduct medical record audits periodically and at the request of EOHHS. Such audits may be subject to validation by EOHHS or its agent.

Section 13.21 Record Retention

The Contractor is responsible for maintaining all Contract financial and programmatic records specified by EOHHS in accordance with the requirements of 45 CFR 74.53 and Section 7 of the Commonwealth's Standard Terms and Conditions. Specifically, the Contractor shall:

A. Maintain all pertinent records in a cost-effective and easily retrievable format.

B. Maintain an off-site storage facility for EOHHS-specified records that is outside the disaster range of the Contractor's principal place of business as described in **Section 2.2.B** and that meets recognized industry standards for physical and environmental security.

C. Take all reasonable and necessary steps to protect the physical security of any personal data or other EOHHS data and materials used by the Contractor. The protection of physical security shall mean prevention of unauthorized access, dissemination, misuse, reproduction, removal or damage to data or materials used by or in the possession of the Contractor.

D. Immediately notify EOHHS, both orally and in writing and before releasing any relevant data or materials, if:

1. Access to or copies of personal or EOHHS data are requested through public records law request or subpoena; or

2. The Contractor has reason at any time to believe that any data applicable to the Contract have been improperly accessed, disseminated, misused, copied or removed.

Section 13.22 Research Data

The Contractor shall obtain written authorization from EOHHS for the use of any data pertaining to the Contract, for research or any other purposes, prior to releasing any information.

Section 13.23 Information Sharing

The Contractor shall arrange for the transfer, at no cost to EOHHS or the Covered Individual, of BH and medical information regarding such Covered Individual or Uninsured Individual to any subsequent provider of BH and/or medical services, subject to all applicable federal and state

laws, as may be requested by the Covered Individual, Provider, or directed by EOHHS, regulatory agencies of the Commonwealth or the United States government. With respect to Covered Individuals who are Children in the Care and/or Custody of the Commonwealth, the Contractor shall provide in a timely manner, upon reasonable request of the state agency with custody of the Covered Individuals, a copy of any BH or medical records in the Contractor's possession.

Section 13.24 Protection of Covered Individual-Provider Communications

A. In accordance with 42 U.S.C. § 1396u-2(b)(3) and 42 CFR 438.102, the Contractor may not prohibit, or otherwise restrict, a health care professional acting within the lawful scope of practice from advising or advocating on behalf of a Covered Individual who is his or her patient, for the following:

1. The Covered Individual's health status, medical care, or treatment options, including any alternative treatment that may be self-administered;

2. Any information the Covered Individual needs in order to decide among all relevant treatment options;

3. The risks, benefits, and consequences of treatment or non-treatment; and

4. The Covered Individual's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions.

B. Notwithstanding the provisions of **subsection A**, and subject to the requirements set forth in **subsections B** and **C**, the Contractor is not required to provide, reimburse for, or provide coverage of a counseling or referral service if the Contractor objects to the service on moral or religious grounds. The Contractor must furnish information about any service the Contractor does not cover due to moral or religious grounds as follows:

1. To EOHHS: at least 60 days prior to adopting the policy during the term of the Contract; and

2. To Covered Individuals: at least 30 days prior to adopting the policy during the term of the Contract.

C. The Contractor shall accept a reduction in the Base PMPM Capitation Rate for any service it does not provide, reimburse for, or provide coverage of due to moral or religious grounds.

Section 13.25 Recordkeeping, Audit and Inspection of Records

A. The Contractor shall maintain all records and documents relating to activities or work under this Contract for a period of no less than 10 years.

B. EOHHS, the Governor, the Secretary of Administration and Finance, the Comptroller, the State Auditor, the Attorney General and CMS, or any of their duly authorized representatives or designees shall have the right, at any time, to inspect and audit any records or documents of the Contractor or its subcontractors, and, at any time, to inspect the premises, physical facilities, and equipment where activities or work related to this Contract is conducted. The right to audit under this section exists for 10 years from the last day of this Contract or from the date of completion of any audit, whichever is later.

C. EOHHS, the Governor, the Secretary of Administration and Finance, the Comptroller, the State Auditor, the Attorney General, the U.S. Department of Health and Human Services, and CMS, or any of their duly authorized representatives or designees shall have the right to inspect and audit the financial records of the Contractor and its subcontractors.

Section 13.26 Assignment

The Contractor shall not assign or transfer any right or interest in the Contract to any successor entity or other entity without the prior written consent of EOHHS.

Section 13.27 Subcontractors, Employees, and Agents

The Contractor shall ensure that its employees, subcontractors, and any other of its agents in the performance of the Contract act in an independent capacity, and not as officers or employees of EOHHS or the Commonwealth of Massachusetts.

Section 13.28 Use and Ownership of Data and Software

A. EOHHS Rights

All data developed or acquired by the Contractor from EOHHS or from others in the performance of the Contract (including personal data) remain the property of EOHHS. EOHHS shall be given free and full access at all reasonable times to all such data. All finished or unfinished studies, analyses, flow charts, magnetic tapes, design documents, program specifications, programs, computer source codings and listings, test data, test results, schedules and planning documents, training materials and user manuals, forms, reports, and any other documentation and software, including modifications thereto, prepared, acquired, designed, improved or developed by the Contractor for delivery to EOHHS under the Contract shall be and remain the property of EOHHS. Federal agencies providing full or partial funding for documentation and software pursuant to this Contract shall have royalty-free, non-exclusive and irrevocable license to reproduce, publish or otherwise use and authorize others to use all such documentation and software.

B. Contractor Limitations

The Contractor shall:

1. Not disseminate, reproduce, display or publish any report, map, information, data or other materials or documents produced in whole or in part pursuant to the Contract without the prior written consent of EOHHS, nor shall any such report, map, information, data or other materials or documents be the subject of an application for patent or copyright by or on behalf of the Contractor without the prior written consent of EOHHS.

2. Use EOHHS-owned data, materials and documents, before or after termination or expiration of the Contract, only as required for the performance of the Contract.

3. Return to EOHHS promptly, but in any event no later than one week after EOHHS's request, EOHHS-owned or Commonwealth-owned data, materials and documents, in whatever form they are maintained by the Contractor.

Section 13.29 Ownership of Furnishings and Equipment

Unless EOHHS instructs otherwise, the Contractor shall provide and retain all furnishings and equipment used in the completion of its performance under this Contract.

Section 13.30 Indemnification

The Contractor shall indemnify and hold harmless EOHHS and the Commonwealth from and against any and all liability, loss, damage, costs, or expenses which EOHHS or the Commonwealth may sustain, incur, or be required to pay, arising out of or in connection with the Contractor's violation of any federal or state law or regulation or any negligent action or inaction or willful misconduct of the Contractor, or any person employed by the Contractor, provided that:

A. The Contractor is notified of any claims made directly to EOHHS within a reasonable time from when EOHHS becomes aware of the claim; and

B. The Contractor is afforded an opportunity to participate in the defense of such claims.

Section 13.31 Prohibition against Discrimination

A. In accordance with 42 U.S.C. § 1396u-2(b)(7) and 42 CFR 438.12, the Contractor shall not discriminate with respect to participation, reimbursement, or indemnification as to any Network Provider who is acting within the scope of the Network Provider's license or certification under applicable state law, solely on the basis of such license or certification. If the Contractor declines to include individual or groups of Providers in its network, it must give the affected Providers written notice of the reasons for its decision. This section shall not be construed to prohibit the Contractor from including Network Providers only to the extent necessary to meet the needs of Covered Individuals or from using different reimbursement for different Network Providers, or from establishing any measure designed to maintain quality and control costs consistent with the responsibilities of the Contractor.

B. In accordance with 42 U.S.C. § 1396u-2 and 42 CFR 438.3(d), M.G.L. c. 151B, § 4(10), and all other applicable state or federal laws and regulations, the Contractor shall not discriminate and will not use any policy or practice that has the effect of discriminating against any individual receiving service through this Contract, on the basis of health status, need for health care, race, color, national origin, sex, sexual orientation, gender identity, or disability.

C. If a complaint or claim against the Contractor is presented to the MCAD, the Contractor shall cooperate with MCAD in the investigation and disposition of such complaint or claim.

Section 13.32 Anti-Boycott Covenant

The Contractor shall ensure that during the time the Contract is in effect, neither the Contractor nor any affiliated company, as hereafter defined, participate in or cooperate with an international boycott as defined in Section 999(b)(3) and (4) of the Internal Revenue Code of 1954, as amended, or engage in conduct declared to be unlawful by M.G.L. c. 151E § 2. Without limiting such other rights as it may have, EOHHS shall be entitled to rescind the Contract in the event of noncompliance with this section. As used herein, an affiliated company shall be any business entity directly or indirectly owning at least 51 percent of the ownership interests of the Contractor.

Section 13.33 Public Communications Protocol

The Contractor shall obtain prior approval from EOHHS before the Contractor or any of its officers, agents, employees or subcontractors respond to any media inquiry, make any public comment or issue other public communication regarding any aspect of the Contract.

Section 13.34 Advance Directives

If applicable, the Contractor shall comply with (1) the requirements of 42 CFR Part 489, Subpart I and 42 CFR 422.128, relating to the maintenance of written policies and procedures regarding advance directives; and (2) the requirements of 130 CMR 450.112 and 42 CFR 438.3(j). If applicable, the Contractor shall provide adult Enrollees with written information on advance directives policies, including a description of applicable state law. The information must reflect changes in State law as soon as possible, but no later than 90 days after the effective date of the change.

Section 13.35 Cultural Competence

As directed by EOHHS, the Contractor shall participate in any efforts to promote the delivery of services in a culturally and linguistically appropriate manner to all Covered Individuals, including those with limited English proficiency and diverse cultural and ethnic backgrounds, physical or mental disabilities, and regardless of gender, sexual orientation, or gender identity.

Section 13.36 Insurance for Contractor's Employees

The Contractor shall maintain at its expense all insurance required by law for its employees, including but not limited to worker's compensation unemployment compensation, and health insurance, as applicable, and shall provide EOHHS with certification of same prior to the Service Start Date and by September 30 of each subsequent year.

Section 13.37 Disaster Recovery and Continuity of Operations Plan

The Contractor shall:

A. Develop, submit to EOHHS for approval no later than four months following the Service Start Date, and maintain a disaster recovery plan that meets recognized industry standards and federal requirements for security, disaster range, and disaster recovery requirements.

B. Ensure that the Contractor's responsibilities under the Contract are never interrupted for the delivery of BH Covered Services, and are not interrupted for more than five business days for all other functions.

C. Maintain a continuity of operations plan (COOP) that addresses how the Contractor's, Material Subcontractors', and other subcontractors' operations shall be maintained in the event of a natural disaster, terrorist attack, pandemic or other event which leads to a significant disruption in operations due to staff absence and/or loss of utilities. The Contractor shall provide copies of such plan to EOHHS upon request and shall inform EOHHS whenever such plan must be implemented.

D. Use reasonable care to minimize the likelihood of all damage, loss of data, delays, and errors resulting from an uncontrollable event.

E. Store a copy of the disaster recovery plan.

F. Prepare a summary of the disaster recovery plan to communicate the procedures under the plan to EOHHS and all Contractor employees.

G. Review and, if necessary, update the disaster recovery plan on an annual basis and whenever the Contractor or EOHHS makes changes to systems and/or business operations that warrant updating the plan; resubmit any such updated plan to EOHHS for approval.

H. Test the disaster recovery plan on an annual basis or whenever there have been substantial changes to the plan.

I. Participate in disaster recovery tests conducted by EOHHS or the Massachusetts Information Technology Department to test connections from the Contractor's facilities to the backup data center facility identified in **Section 2.2.B**.

Section 13.38 License of Software

The Contractor agrees that, except with respect to commercial off-the-shelf software (COTS), EOHHS shall be granted a royalty-free, non-exclusive, perpetual and irrevocable license to the use of all software used by the Contractor in the performance of its obligations under the Contract.

Section 13.39 Order of Precedence

The Contractor's response to EOHHS's Request for Responses (RFR) that served as the basis for this Contract is incorporated by reference into the Contract. Any ambiguity or inconsistency between these documents shall be resolved by applying the following order of precedence:

A. this First Amended and Restated Contract, including any amendments thereto;

B. the Contractor's response to the RFR identified below submitted on August 9, 2011; and

C. EOHHS's Request for Responses (RFR) for a Vendor to Provide for the MassHealth Primary Care Clinician Plan a Comprehensive Behavioral Health Program and Management Support Services, as well as Behavioral Health Specialty Programs, issued on May 18, 2011, including any amendments thereto.

Section 13.40 Section Headings

The headings of the sections of the Contract are for convenience only and do not affect the construction hereof.

Section 13.41 Waiver

EOHHS's acceptance or approval of any materials, including those materials submitted in relation to the Contract, shall not constitute waiver of any requirements of the Contract.

Section 13.42 Administrative Procedures Not Covered

EOHHS may from time to time issue memoranda clarifying, elaborating upon, explaining, or otherwise relating to Contract administration and other management matters.

Section 13.43 Effect of Invalidity of Clauses

If any clause or provision of the Contract is in conflict with any state or federal law or regulation, that clause or provision shall be null and void; any such invalidity shall not affect the validity of the remainder of the Contract.

Section 13.44 Survival

The obligations of the Contractor under **Section 14** of this Contract shall survive the termination of the Contract.

Section 13.45 Remedies

Nothing in this Contract shall be construed to waive or limit any of EOHHS's legal rights or remedies which may arise from Contractor's unauthorized use or disclosure of any data received by it under the Contract.

Section 13.46 Interpretation

Any ambiguity in this Contract shall be resolved to permit EOHHS to comply with the Privacy Rule, HIPAA, and any other applicable law pertaining to the privacy, confidentiality, or security of PHI or Personal Data.

Section 13.47 Written Notices

Notices to the parties as to any Contract matter will be sufficient if given in writing and sent by certified mail, postage prepaid, or delivered in hand as follows:

To EOHHS:

Stephanie J. Brown
Director of the Office of Behavioral Health
Executive Office of Health and Human Services
1 Ashburton Place, 11th floor
Boston, MA 02108

With copies to:

General Counsel
Executive Office of Health and Human Services
1 Ashburton Place, 11th floor
Boston, MA 02108

Rashiem Grant, Contract Manager
Executive Office of Health and Human Services
Accounting Unit, 7th floor
600 Washington Street
Boston, MA 02111-1712

And, in addition, for notices required by the provisions of **Section 14**, a copy to:

EOHHS Privacy Office
One Ashburton Place, 11th Floor
Boston, MA 02111

To the Contractor:

Carol Kress
Vice President, Client Partnerships
Massachusetts Behavioral Health Partnership
1000 Washington St., Suite 310
Boston, MA 02118

SECTION 14. PRIVACY AND CONFIDENTIALITY

A. Definitions

All terms used but not otherwise defined in this section shall be construed in a manner consistent with the Privacy and Security Rules and all other applicable state or federal privacy or security laws.

1. Commonwealth Security Information. "Commonwealth Security Information" shall mean all data that pertains to the security of the Commonwealth's information technology, specifically, information pertaining to the manner in which the Commonwealth protects its information technology systems against unauthorized access to or modification of information, whether in storage, processing or transit, and against the denial of service to authorized users, or the provision of service to authorized users, including those measures necessary to detect, document and counter such threats.

2. EOHHS-CE. "EOHHS-CE" shall mean any component of EOHHS and its constituent Agencies that constitutes a Covered Entity under the Privacy and Security Rules (including: the Office of Medicaid; the Department of Developmental Services; the Department of Mental Health; the Soldiers' Home in Massachusetts; the Soldiers' Home in Holyoke; the covered components of the Department of Public Health, a hybrid agency, having designated its covered components as: the Childhood Lead Screening Laboratory and the MDPH Public Health Hospitals (Lemuel Shattuck Hospital; Massachusetts Hospital School; Tewksbury Hospital; Western Massachusetts Hospital; and State Office of Pharmacy Services)) whose data is covered by this Contract.

3. Individual. "Individual" shall mean the person to whom the PI refers and shall include a person who qualifies as a personal representative in accord with 45 CFR § 164.502 (g).

4. Privacy Rule. "Privacy Rule" shall mean the Standards of Privacy of Individually Identifiable Health Information, at 45 CFR Parts 160 and 164.

5. Protected Information (PI). "Protected Information" shall mean any "Personal Data" as defined in Mass. Gen. Laws c. 66A and any "Protected Health Information" as defined in the Privacy Rule; any "Patient Identifying Information" as defined in 42 CFR Part 2; and any other confidential individually identifiable information under any federal or state law (including for example any state and federal tax return information) that the Contractor uses, maintains, discloses, receives, creates or otherwise obtains under this Contract. Information, including aggregate information, is considered PI if it is not fully de-identified in accord with 45 CFR 164.514 (a), (b), and (c).

6. Required By Law. "Required By Law" shall have the same meaning as used in the Privacy Rule.

7. Secretary. "Secretary" shall mean the Secretary of the US Department of Health and Human Services or the Secretary's designee.

8. Security Incident. "Security Incident" shall have the same meaning as used in the Security Rule.

9. Security Rule. "Security Rule" shall mean the Security Standards for the Protection of Electronic Protected Health Information, at 45 CFR Parts 160 and 164.

B. Contractor's Obligations

1. Mass. Gen. Laws c. 66A and other Privacy and Security Obligations

The Contractor acknowledges that in the performance of this Contract it will create, receive, use, disclose, maintain, or otherwise obtain "Personal Data," and that in so doing, it becomes a "Holder" of Personal Data, as such terms are used within Mass. Gen. Laws c. 66A. The Contractor agrees that, in a manner consistent with the Privacy and Security Rules, it shall comply with Mass. Gen. Laws c. 66A, and any other applicable privacy or security law (state or federal) governing Contractor's use, disclosure, and maintenance of any PI under this Contract, including but not limited to, 42 CFR Part 431, Subpart F; Mass. Gen. Laws c. 93H; 801 CMR § 3.00; 201 CMR 17; and Executive Order 504.

The Contractor further agrees that it shall comply with any other privacy and security obligation that is applicable to any PI under this Contract as the result of EOHHS having entered into an agreement with a third party (such as the Social Security Administration) to obtain the data, including by way of illustration and not limitation, signing any written compliance acknowledgment or confidentiality agreement or complying with any other privacy and security obligation required by the third party for access to data that EOHHS receives from the third party.

2. Business Associate

The Contractor acknowledges that in the performance of this Contract, it is the Business Associate of EOHHS, as that term is used in the Privacy and Security Rules for providing services pursuant to **Sections 4.4, 4.5, 5, 6, 7.1, 7.2, 7.3, 7.4**, and **Section 8** to the extent that **Section 8** activities involve functions performed by the Contractor on EOHHS' behalf, and such additional sections as EOHHS shall identify in the Contract or shall identify in either written amendments to the Contract or written work plans or instructions during the course of the Contract. The Contractor further acknowledges that Title XIII (the HITECH Act) of the American Recovery and Reinvestment Act of 2009 and related modifications to the Privacy and Security Rules issued by the federal Department of Health and Human Services on January 25, 2013 at 78 FR 5566 through 5702, with an effective date of March 26, 2013, increases the privacy and security obligations of, and imposes certain civil and criminal penalties upon, a Business Associate under the Health Insurance Portability and Accountability Act and the Privacy and Security Rules. Further, the HITECH Act imposes direct responsibility upon the Business Associate as if the Business Associate were a Covered Entity, as that term is

used in the Privacy and Security Rules, for certain obligations, including but not limited to the requirement to implement administrative, physical, and technical safeguards to protect PI and other requirements set forth in 45 CFR §§ 164.308, 164.310, 164.312, and 164.316. The HITECH Act also imposes certain breach notification obligations upon a Business Associate, and permits a Business Associate to use and disclose Protected Health Information, as that term is used in the Privacy and Security Rules, only if such use or disclosure, respectively, is in compliance with each applicable requirement of 45 CFR 164.504(e). The Contractor agrees to comply with all Business Associate requirements implemented by the HITECH Act and related modifications to the Privacy and Security Rules in accord with any applicable compliance dates.

3. EOHHS Data

The Contractor acknowledges that its access to, receipt, creation, use, disclosure, and maintenance of any PI covered by this Contract, and any data derived or extracted from such PI, arises from and is defined by the Contractor's obligations under this Contract, and that the Contractor does not possess any independent rights of ownership to such data.

4. Agents and Subcontractors

The Contractor shall not engage any agent or subcontractor to perform any activity under this Contract involving PI, unless such engagement is otherwise explicitly permitted under this Contract or unless the Contractor first seeks EOHHS's written permission to engage an agent or subcontractor by submitting a written description of the work to be performed by the proposed agent or subcontractor together with such other information as EOHHS may request. If engaging an agent or subcontractor is permitted, the Contractor shall ensure that the agent or subcontractor agrees in writing to the same restrictions and conditions that apply to Contractor under this Contract with respect to PI, including but not limited to, implementing reasonable safeguards to protect such information and conformance to applicable laws including but not limited to: 45 CFR 160.103; 45 CFR 164.502(e)(l)(ii) and (2); and 45 CFR 164.504(e).

The Contractor shall ensure that its agents or subcontractors who (i) have access to personal information as defined in Mass. Gen. Law c. 93H, and personal data, as defined in Mass. Gen. Laws c. 66A, that the Contractor uses, maintains, receives, creates or otherwise obtains under this Contract, or (ii) have access to Contractor systems containing such information or data, sign an Executive Order 504 Contractor Certification Form or other written agreement containing all applicable data security obligations as required by such certification form. Upon EOHHS' request, Contractor shall provide EOHHS with a listing of its agents or subcontractors who have such access and copies of these certifications.

Contractor is solely responsible for its agents' and subcontractors' compliance with this provision and all requirements in this **Section 14**, and shall not be relieved of any obligation under this **Section 14** because the data was in the hands of its agents or subcontractors.

5. Data Security

a. Administrative, Physical, and Technical Safeguards

The Contractor shall implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of PI and that prevent use or disclosure of such data other than as provided for by this Contract. All such safeguards must meet, at a minimum, all standards set forth in the Privacy and Security Rules, as applicable to a business associate; all applicable standards set forth in **Section 9** of this Contract; and must comply with all security mechanisms and processes established for access to any of EOHHS's databases, as well as all Commonwealth security and information technology resource policies, processes, and mechanisms established for access to PI, including any applicable data security policies and procedures established by Executive Order 504 (for which the Contractor agrees to separately sign all required compliance certifications) and by the Information Technology Division. As one of its safeguards, the Contractor shall not transmit PI in non-secure transmissions over the Internet or any wireless communication device. The Contractor shall protect from inappropriate use or disclosure any password, user ID, or other mechanism or code permitting access to any database containing PI, and shall give EOHHS prior notice of any change in personnel whenever the change requires a termination or modification of any password, user ID, or other security mechanism or code that EOHHS may give to the Contractor for access to EOHHS databases to maintain the integrity of the database.

The Contractor agrees to allow representatives of EOHHS access to its premises where PI is kept for the purpose of inspecting privacy and physical security arrangements implemented by the Contractor to protect such data.

Upon request, the Contractor shall provide EOHHS with copies of all written policies, procedure, standards and guidelines related to the protection, security, use and disclosure of PI, Commonwealth Security Information, or other confidential information and the security and integrity of its technology resources.

b. Commonwealth Security Information

If through this Contract the Contractor obtains access to any Commonwealth Security Information, the Contractor is prohibited from making any disclosures of or about such information, unless in accord with EOHHS's express written instructions. If the Contractor is granted access to such information in order to perform its obligations under this Contract, the Contractor may only use such information for the purposes for which it obtained access. In using the information for such permitted purposes, the Contractor shall limit access to the information only to staff or agents necessary to perform the permitted purposes. While in possession of such information, the Contractor shall apply all privacy and

security requirements set forth in this Contract, as applicable to maintain the confidentiality, security, integrity, and availability of such information. Notwithstanding any other provision in this Contract, the Contractor shall report any non-permitted use or disclosure of such information to EOHHS (both the EOHHS contact specified in the Contract and the EOHHS Privacy Office) immediately within twenty-four hours. the Contractor shall immediately take all reasonable and legal actions to retrieve such information if disclosed to any non-permitted individual or entity; shall include a summary of such retrieval actions in its required report of the non-permitted disclosure; and shall take such further retrieval action as EOHHS shall require. Notwithstanding any other provision in this Contract regarding termination, the Contractor may not retain any Commonwealth Security Information upon termination of this Contract unless such information is expressly identified in any retention permission granted in accordance with **subsection F** (Effect of Termination). If retention is expressly permitted, all data protections stated herein survive termination of this Contract and shall apply for as long as the Contractor retains the information.

6. Non-Permitted Use or Disclosure Report and Mitigation Activities

As used in this subsection, the term Event refers to the following, either individually or collectively: 1) any use or disclosure of PI by the Contractor, its subcontractors or agents, not permitted under this Contract, 2) any Security Incident by the same, or 3) any event that would trigger consumer or oversight agency notification obligations under the Privacy Rule, Mass. Gen. Laws 93H, or other similar federal or state data privacy or security laws.

Immediately upon becoming aware of an Event, the Contractor shall take all appropriate lawful action necessary to: (1) retrieve, to the extent practicable, any PI involved in the Event; (2) mitigate, to the extent practicable, any known harmful effect of the Event; and (3) take such further action as may be required by any applicable state or federal law concerning the privacy and security of any PI involved in the Event. As soon as possible, but in any event no later than two business days following the date upon which the Contractor becomes aware of the Event, the Contractor shall verbally report the Event to EOHHS with as much of the details listed below as possible, and shall follow such verbal report within five business days with a written report outlining the Event with the following details:

a. The date of the Event, if known or if not known, the estimated date;

b. The date of the discovery of the Event;

c. The nature of the Event, including as much specific detail as possible describing the Event (for example, cause, contributing factors, chronology of events) and the nature of the PI involved (for example, types of identifiers involved such as name, address, age, social security numbers or account numbers, or medical or financial or other types of information).

Include any sample forms or documents that were involved in the Event to illustrate the type of PI involved (with personal identifiers removed or redacted), and include any policies and procedures, standards, guidelines, and staff training relevant to the event or to the types of PI involved in the Event;

d. The exact number of individuals whose PI was involved in the Event, if known, or if not known, a reasonable estimate based on the known facts, together with a description of how the exact or estimated number of individuals was determined (If different types of PI was involved for different individuals, please categorize the exact or estimated numbers of individuals involved according to type of PI);

e. A summary of the nature and scope of the Contractor investigation of the Event;

f. The harmful effects of the Event known to the Contractor, all actions the Contractor has taken or plans to take to mitigate such effects, and the results of all mitigating actions already taken; and

g. A review of and any plans to implement changes to the Contractor's policies and procedures, including staff training, to prevent such Event in the future. Include copies of all written policies and procedures reviewed, developed or amended in connection with the Event.

If within the timeframes specified, the Contractor is unable to gather and confirm all details surrounding the Event, the Contractor shall explain the factors delaying its investigation, provide as much detail as possible, and outline actions it intends to take to further gather and confirm facts surrounding the Event. Upon EOHHS's request, the Contractor shall take such further actions as directed by EOHHS to provide further information and clarify any issues or questions that EOHHS may have regarding the Event.

Upon EOHHS's request, the Contractor shall take such further actions as identified by EOHHS or shall take such additional action to assist EOHHS to further mitigate, to the extent practicable, any harmful effect of the Event. Any actions to mitigate harmful effects of such privacy or security violations undertaken by the Contractor on its own initiative or pursuant to EOHHS's request under this paragraph shall not relieve the Contractor of its obligations to report such violations under this paragraph or any other provisions of this Agreement.

7. Consumer Notification

In the event the consumer notification provisions of Mass. Gen. Laws c. 93H or similar notification requirements in other state or federal laws, are triggered by a data breach involving the Contractor, its employees, agents, or subcontractors, the Contractor shall promptly comply with its obligations under such laws. If EOHHS determines, in its sole discretion, that it is required to give such notifications, the Contractor shall, at EOHHS'

request, assist EOHHS in undertaking all actions necessary to meet consumer notification requirements and in drafting the consumer notices and any related required notices to state or federal agencies for EOHHS review and approval, but in no event shall the Contractor have the authority to give these notifications on EOHHS behalf. The Contractor shall reimburse EOHHS for reasonable costs incurred by EOHHS associated with such notification, but only to the extent that such costs are due to: (i) the Contractor's failure to meet its responsibilities under, or in violation of, any provision of this Contract, (ii) the Contractor's violation of law, (iii) the Contractor's negligence, (iv) the Contractor's failure to protect data under its control with encryption or other security measures that constitute an explicit safe-harbor or exception to any requirement to give notice under such laws, or (v) any activity or omission of its employees, agents, or subcontractors resulting in or contributing to a breach triggering such laws.

8. Response to Legal Process

The Contractor shall report to the EOHHS (both the EOHHS contact specified in the Contract and the EOHHS Privacy Office), both verbally and in writing, any instance where PI, Commonwealth Security Information, or any other data obtained under this Contract is subpoenaed or becomes the subject of a court or administrative order or other legal process. If EOHHS directs the Contractor to respond, the Contractor shall take all necessary legal steps, including objecting to the request when appropriate, to comply with Mass. Gen. Laws c. 66A, 42 CFR 431.306 (f), and any other applicable federal and state law. If EOHHS determines that it shall respond directly, the Contractor shall fully cooperate and assist EOHHS in its response. In no event shall the Contractor's reporting obligations under this paragraph be delayed beyond two business days preceding the return date in the subpoena or legal process, or two business days from obtaining such request for data, whichever is shorter.

9. Individual's Request for Access to PI

The Contractor shall take such action as may be requested by EOHHS for any EOHHS-CE to meet obligations under 45 CFR §§ 164.524, 164.526, and 164.528 with respect to any such EOHHS-CE's PI in Contractor 's possession in sufficient time and manner for EOHHS or the EOHHS-CE to meet its obligations under such Privacy Rule provisions. If an Individual contacts the Contractor with respect to exercising any rights the Individual may have under 45 CFR §§ 164.524, 164.526, and 164.528 with respect to PI in the Contractor's possession, the Contractor shall notify EOHHS within two business days of the Individual's request and cooperate with EOHHS or the applicable EOHHS-CE to meet any EOHHS-CE's obligations with respect to such request.

With respect to an Individual's right to an accounting under 45 CFR § 164.528, the Contractor shall document all disclosures of PI and other data access activities as would be necessary for EOHHS to respond to a request by an Individual for an accounting in accord with 45 CFR § 164.528. Within ten business days of the execution of the 4th Amendment to this Contract, the Contractor shall provide EOHHS with a written description of its tracking system to meet accounting obligations under 45 CFR § 164.528.

10. Individual's Direct Authorization to Disclose PI to Third Party

In the event the Contractor receives a request from the Individual or from a third party to release PI to a third party pursuant to a consent, authorization, or other written document, the Contractor shall, within three business days of receipt of such consent, authorization, or other written document, notify EOHHS Privacy Office of receipt of the document, shall cooperate with the Privacy Office in confirming the validity and sufficiency of such document before releasing any PI to the third party, and shall release PI only in accordance with the Privacy Office's instructions.

If an Individual or a third party directly submits to the Contractor a consent, authorization or other written document to disclose PI to a specified third party, the Contractor shall disclose the specified PI to the specified third person only after confirming that the written consent, authorization, or document complies with all requirements under the Privacy Rule, and any other applicable state or federal law. the Contractor may release PI upon receipt of a EOHHS Permission to Share form, provided required elements of the form are completed and the form is signed by the Individual, and no other additional information is required to be included on the form under other applicable state or federal law. If additional information is required under other applicable state or federal law, the data may not be released unless the Contractor obtains a compliant release under such law. If the authorization involves PI not in its possession, the Contractor shall, within three business days of receipt of such authorization, notify EOHHS of the authorization in writing and provide a copy of any written authorization.

11. Individual's Request for PI Amendment

Within five business days of receipt of EOHHS's written request, the Contractor shall make any amendment(s) to PI that EOHHS requests in order for EOHHS to meet its obligations under 45 CFR § 164.526. Such amendments shall be made in a manner specified in, and in accord with any time requirement under, 45 CFR § 164.526. the Contractor shall notify EOHHS in writing of any request under 54 CFR § 164.526 for an amendment to PI maintained under this Contract that an Individual makes directly to the Contractor, within three days of receiving such request, and shall proceed in accord with EOHHS's instructions.

12. Accountable Disclosures

The Contractor shall document all disclosures of PI, and required information related to such disclosures, as would be necessary for EOHHS to respond to a request by an Individual for an accounting of disclosures of PI and related information in accord with 45 CFR § 164.528. Within five business days of EOHHS's written request, the Contractor shall make a listing of such disclosures and related information available to EOHHS, or upon EOHHS's direction to the Individual. In the event an Individual makes a request for an accounting, under 45 CFR § 164.528, directly to the Contractor, the Contractor shall, within three business days of receipt of such request, notify EOHHS (both the EOHHS contact specified in the Contract and the EOHHS Privacy Office) of the request, and cooperate in responding to such request with respect to PI maintained under this Contract. Within ten business days of the execution of this Contract, the Contractor shall provide EOHHS Privacy Office with a written description of its tracking

system for accountable disclosures. The Contractor shall work with EOHHS Privacy Office in developing a process whereby the Contractor reports accountable disclosures to EOHHS on a routine basis.

13. Compliance Access for Secretary

The Contractor shall make its internal practices, books, and records, including policies and procedures and PI, relating to the use and disclosure of PI received from, or created or received by it on behalf of, EOHHS, available to EOHHS or upon EOHHS's written request, to the Secretary, in a time and manner designated by either EOHHS or the Secretary for purposes of the Secretary determining EOHHS's compliance with the Privacy and Security Rules.

Under the modifications to the Privacy and Security Rules referenced in this **Section 14**, the Contractor must comply with any direct obligation that it may have under such modifications to comply with any request from the Secretary.

14. Electronic and Paper Databases Updates

Within 30 days of execution of this Contract, the Contractor shall provide EOHHS (both the EOHHS contact specified in the Contract and the EOHHS Privacy Office), an accurate list of electronic and paper databases containing PI, together with a description of the various uses of the databases. The Contractor shall update such lists as necessary in accord with the addition or termination of such databases.

15. Data Privacy and Security Custodian

Within five days of this Contract's effective date, the Contractor shall provide EOHHS (both the EOHHS contact specified in the Contract and the EOHHS Privacy Office) in writing with the name of an individual(s), who shall act as the Contractor's Privacy and Security Officer(s) and be responsible for compliance with this **Section 14**. The Contractor shall also notify EOHHS (both the EOHHS contact specified in the Contract and the EOHHS Privacy Office) in writing within five business days of any transfer of such duties to other persons within its organization.

C. Permitted Uses and Disclosures by the Contractor

Except as otherwise limited in this Contract, the Contractor may use or disclose PI only as follows:

1. Contract Functions and Services

Except as otherwise limited in this Contract, the Contractor may use or disclose PI to perform functions, activities, or services for, or on behalf of, EOHHS as specified in this Contract, amendments thereto, or any written work plan or instructions during the course of the Contract, provided such use or disclosure would not: (1) violate the Privacy Rule or other applicable laws such as 42 CFR Subpart F and Mass. Gen. Laws c. 66A if done by EOHHS; (2) violate the minimum necessary policies and procedures of EOHHS; or (3) conflict with statements in EOHHS's Notice of Privacy Practices. In performing functions, activities, or services under this Contract, the Contractor represents that it shall seek from EOHHS only the amount of PI that is minimally necessary to perform the

particular function, activity, or service. To the extent this Contract permits the Contractor to request, on EOHHS's behalf, PI from other covered entities under the Privacy Rule, the Contractor shall only request an amount of PI that is reasonably limited to the minimal necessary to perform the intended function, activity, or service.

2. Required By Law

The Contractor may use or disclose PI as Required by Law, consistent with the restrictions of 42 CFR 431.306 (f), Mass. Gen. Laws c. 66A, and the restrictions in any other applicable privacy or security law (state or federal) governing the Contractor's use, disclosure, and maintenance of any PI under this Contract.

3. Restriction on Contacting the Individual

The Contractor may not use PI to attempt to contact the Individual, unless such contact is otherwise specified in the Contract as necessary to perform functions, activities, or services for EOHHS under this Contract, or unless EOHHS otherwise instructs the Contractor to do so in writing.

4. Publication Restriction

The Contractor shall not use PI for any of its own publication, statistical tabulation, research, or similar purpose, even if PI has been transformed into de-identified data in accord with the standards set forth in 45 CFR 164.514(a), (b), and (c)), unless the Contractor obtains EOHHS's prior written permission and complies with any conditions set forth in such permission.

5. Contractor's Activities as a managed care entity subject to HIPAA

a. Contractor may use or disclose PI obtained in it role as a business associate for its own activities as a managed care entity in the following circumstances:

1) its receipt of PI from EOHHS in its role as a covered entity would meet the requirements of 45 CFR 506(c)(4) if EOHHS had made the disclosure of PI to the Contractor as a Covered Entity, and not a business associate;

2) as agreed to by EOHHS in writing during the course of this Contract; and

3) for its proper management and administration, provided:

a) it first determines whether it can reasonably use de-identified data for such management and administrative activities, and if it can, de-identifies PI in accord with standards set forth in the Privacy Rule for such activities;

b) it only uses PI for management and administrative activities that are directly related to its performance under this Contract;

c) the use and disclosure of PI for such management and administrative activities is necessary and complies with minimally necessary principles;

d) one of the following two conditions is met for disclosures:

(i) the disclosure is Required by Law; or

(ii) it (a) obtains reasonable assurances from the person to whom the PI is disclosed that the PI will remain confidential and will be used or further disclosed only as Required by Law or for the purpose for which it was disclosed to the person; and (b) the person to whom the PI is disclosed notifies Contractor of any instances of which it is aware in which the confidentiality of the PI has been breached.

b. Nothing set forth in this **subsection C.5** is intended to circumvent any legal or other requirement to obtain the written consent of the individual to whom the PI applies if such consent is required for the transfer of PI to the Contractor in a role other than as EOHHS' business associate, including, for example, the requirements of 45 CFR Part 2 or the requirements and procedures established by EOHHS for use of the electronic CANS system. In such circumstances, Contractor must obtain the required written consent and maintain documentation of such consent.

6. Notwithstanding any language in this **subsection C** or the "Contract", Contractor may not use or disclose any PI without consent, if such use and disclosure requires written consent under applicable law (including for example 45 CFR Part 2) or any EOHHS policy and procedure (including for example, use of EOHHS CANs electronic exchange system.).

D. EOHHS Obligations

1. Changes in Notice of Privacy Practices

EOHHS shall notify the Contractor in writing of any changes in its notice of privacy practices issued in accordance with 45 CFR § 164.520, to the extent that such change may affect the Contractor's use or disclosure of PI. EOHHS shall provide the Contractor with a new copy of its notice of privacy practices each time such notice is modified or amended.

2. Notification of Changes in Authorizations to Disclose

EOHHS shall notify the Contractor in writing of any changes in, or revocation of, permission by an Individual to use or disclose PI, to the extent that such changes may affect the Contractor's use or disclosure of PI.

3. Notification of Restrictions

EOHHS shall notify the Contractor in writing of any restriction to the use of disclosure of PI that it has agreed to in accordance with 45 CFR § 164.522, to the extent that such restriction may affect the Contractor's use or disclosure of PI.

E. Termination for Privacy or Security Violation

1. Termination for Violation

Notwithstanding any other provision in this Contract, EOHHS may terminate this Contract, immediately upon written notice, if EOHHS determines, in its sole discretion, that the Contractor has materially breached any of its obligations set forth in this **Section 14** or any other provision of this Contract pertaining to the security and privacy of any PI provided to the Contractor under this Contract.

2. Cure

Prior to terminating this Contract as permitted above, EOHHS, in its sole discretion, may provide an opportunity for the Contractor to cure the breach or end the violation. If such an opportunity is provided, but cure is not feasible, or the Contractor fails to cure the breach or end the violation within a time period set by EOHHS, EOHHS may terminate the Contract immediately upon written notice.

3. HHS Report

In the event that termination of this Contract for a material breach of any obligation regarding PI is not feasible, or if cure is not feasible, EOHHS shall report such breach or violation to the Secretary if such material breach and termination pertains to work performed for an EOHHS-CE, under this Contract.

F. Effect of Termination

1. Return or Destroy Data

Except as provided immediately below, upon termination of this Contract for any reason whatsoever, the Contractor shall, at EOHHS's option, either return or destroy all PI obtained or created in any form under this Contract, and the Contractor shall not retain any copies of such data in any form. In no event shall the Contractor destroy any PI without first obtaining EOHHS's approval. In the event destruction is permitted, the Contractor shall destroy PI in accord with standards set forth in NIST Special Publication 800-98, Guidelines for Media Sanitization, all applicable state retention laws, all applicable state and federal security laws (including the HITECH Act), and all state data security policies including policies issued by EOHHS and the Information Technology Division. Within five days of any permitted destruction, the Contractor shall provide

EOHHS with a written certification that destruction has been completed in accord with the required standards and that the Contractor and its subcontractors and agents no longer retain such data or copies of such data. This provision shall apply to all PI in the possession of Contractor's subcontractors or agents, and the Contractor shall ensure that all such data in the possession of its subcontractors or agents has been returned or destroyed and that no subcontractor or agent retains any copies of such data in any form, in accord with EOHHS's instructions

2. Retain Data

If the Contractor determines that returning or destroying PI is not feasible, the Contractor shall provide EOHHS with written notification of the conditions that make return or destruction not feasible. If based on Contractor's representations, EOHHS concurs that return or destruction is not feasible, the Contractor shall extend all protections set forth in this **Section 14** to all such PI and shall limit further uses and disclosures of such data to those purposes that make the return or destruction of such data not feasible, for as long as the Contractor maintains the data.

3. Survival

Notwithstanding any other provision concerning the term of this Contract, all protections pertaining to any PI covered by this Contract shall continue to apply until such time as all such data is returned to EOHHS or destroyed, or until any period of storage following the termination of this Contract is ended, or if return or destruction is not feasible, protections are applied to such data in accord with **subsection 2**, immediately above.

G. Miscellaneous Provisions

1. Regulatory References

Any reference in this Contract to a section in the Privacy or Security Rules or other regulation or law refers to that section as in effect or as amended.

2. Amendment

The Contractor agrees to take such action as is necessary to amend this Contract in order for EOHHS to comply with any requirements of the Privacy and Security Rules, the Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191 (HIPAA), and any other applicable state or federal law pertaining to the privacy, confidentiality, or security of PI. Upon EOHHS's written request, the Contractor agrees to enter promptly into negotiations for any amendment as EOHHS, in its sole discretion, deems necessary for EOHHS's compliance with any such laws. The Contractor agrees that, notwithstanding any other provision in this Contract, EOHHS may terminate this Contract immediately upon written notice, in the event the Contractor fails to enter into negotiations for, and to execute, any such amendment.

3. Survival

The obligations of the Contractor under **subsection F** (Effect of Termination) of this **Section 14** or any provision allowing for continued possession of PI shall survive the termination of this Agreement.

4. Waiver

EOHHS's exercise or non-exercise of any authority under this Contract, or the exercise or non-exercise of inspection or approval of privacy or security practices or approval of subcontractors, shall not relieve the Contractor of any obligations set forth herein, nor be construed as a waiver of any of the Contractor's obligations or as an acceptance of any unsatisfactory practices or privacy or security failures or breaches by the Contractor.

5. Interpretation

Any ambiguity in this Contract shall be resolved to permit EOHHS to comply with the Privacy and Security Rules, HIPAA, M.G.L c. 66A, M.G.L. c. 93H, and any other relevant state or federal requirement.