COMMONWEALTH OF MASSACHUSETTS ~ STANDARD CONTRACT FORM

This form is jointly issued and published by the Office of the Comptroller (CTR), the Executive Office for Administration and Finance (ANF), and the Operational Services Division (OSD) as the default contract for all Commonwealth Departments when another form is not prescribed by regulation or policy. The Commonwealth deems void any changes made on or by attachment (in the form of addendum, engagement letters, contract forms or invoice terms) to the terms in this published form or to the **Standard Contract Form Instructions and Contractor Certifications,** the **Commonwealth Terms and Conditions for Human and Social Services** or the **Commonwealth IT Terms and Conditions** which are incorporated by reference herein. Additional non-conflicting terms may be added by Attachment. Contractors are required to access published forms at CTR Forms: https://www.macomptroller.org/forms. Forms are also posted at OSD Forms: https://www.mass.gov/lists/osd-forms.

CONTRACTOR LEGAL NAME: Community Care Cooperative, Inc. **(and d/b/a):**		**COMMONWEALTH DEPARTMENT NAME: Executive Office of Health and Human Services** **MMARS Department Code:** EHS	
Legal Address: (W-9, W-4): 75 Federal St., 7th Floor, Boston, MA 02110		**Business Mailing Address:** One Ashburton Place, 11th Fl., Boston, MA 02108	
Contract Manager: Christina Severin	**Phone:** 617-852-4709	**Billing Address (if different):**	
E-Mail: cseverin@c3aco.org	**Fax:**	**Contract Manager:** Alejandro Garcia Davalos	**Phone:** 617-838-3344
Contractor Vendor Code: VC0000854728		**E-Mail:** Alejandro.E.GarciaDavalos@mass.gov	**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:** BD-22-1039-EHS01-ASHWA-71410	

☐ 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 all Grants - 815 CMR 2.00) (Solicitation Notice or RFR, and Response or other procurement supporting documentation)
- ☐ **Emergency Contract** (Attach justification for emergency, scope, budget)
- ☐ **Contract Employee** (Attach Employment Status Form, scope, budget)
- ☐ **Other Procurement Exception** (Attach authorizing language, legislation with specific exemption or earmark, and exception justification, scope and budget)

☒ CONTRACT AMENDMENT

Enter **Current Contract End Date *Prior*** to Amendment: **December 31, 2027.**

Enter **Amendment Amount**: $ no change. (or "no change")

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

- ☐ **Amendment to Date, 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)
- ☐ **Other Procurement Exception** (Attach authorizing language/justification and updated scope and budget)

The Standard Contract Form Instructions and Contractor Certifications and the following Commonwealth Terms and Conditions document are incorporated by reference into this Contract and are legally binding: (Check ONE option): ☒ Commonwealth Terms and Conditions ☐ Commonwealth Terms and Conditions For Human and Social Services ☐ Commonwealth IT Terms and Conditions

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.
☒ **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 (M.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. Attach all supporting documentation and justifications.)

This **First Amended and Restated Contract** with Community Care Cooperative, Inc. for its Primary Care ACO incorporates changes made by CY2023 amendments, as well as makes updates to the Contract and appendices effective January 1, 2024.

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

☐ 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 **January 1, 2024**, 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 **December 31, 2027,** 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 certifies that they have accessed and reviewed all documents incorporated by reference as electronically published and the Contractor makes all certifications required under the Standard Contract Form Instructions and Contractor Certifications under the pains and penalties of perjury, and further 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, the Standard Contract Form Instructions and Contractor Certifications, the Request for Response (RFR) or other solicitation, the Contractor's Response (excluding any language stricken by a Department as unacceptable, 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:

DocuSigned by:

X: [signature] . Date: 12/14/2023 .

6C6A4457E3F41C...

(Signature and Date Must Be Captured At Time of Signature)

Print Name: Christina Severin .

Print Title: President & CEO .

AUTHORIZING SIGNATURE FOR THE COMMONWEALTH:

X: [signature] . **Date:** 12/19/2023 .

(Signature and Date Must Be Captured At Time of Signature)

Print Name: **Mike Levine** .

Print Title: **Assistant Secretary for MassHealth** .

PRIMARY CARE ACCOUNTABLE CARE ORGANIZATION CONTRACT

FOR THE

MASSHEALTH ACCOUNTABLE CARE ORGANIZATION PROGRAM

This Contract is by and between the Massachusetts Executive Office of Health and Human Services ("EOHHS") and the Contractor identified in **Appendix K** ("Contractor").

WHEREAS, EOHHS oversees 16 state agencies and is the single state agency responsible for the administration of the Medicaid program and the State Children's Health Insurance Program within Massachusetts (collectively, MassHealth) and other health and human services programs designed to pay for medical services for eligible individuals pursuant to M.G.L. c. 118E, Title XIX of the Social Security Act (42 U.S.C. sec. 1396 et seq.), Title XXI of the Social Security Act (42 U.S.C. sec. 1397aa et seq.), and other applicable laws and waivers; and

WHEREAS, EOHHS issued a Request for Responses (RFR) for Accountable Care Organizations on April 13, 2022, to solicit responses from Accountable Care Organizations (ACOs), to provide comprehensive health care coverage to MassHealth Members; and

WHEREAS, EOHHS has selected the Contractor, based on the Contractor's response to the RFR, submitted by the deadline for responses, to provide health care coverage to MassHealth Members;

WHEREAS, EOHHS and the Contractor entered into the Contract effective January 1, 2023, and with an Operational Start Date of April 1, 2023, and entered into various amendments thereafter; and

WHEREAS, in accordance with **Section 5.12** of the Contract, EOHHS and the Contractor desire to amend and restate the Contract effective January 1, 2024; and

WHEREAS, EOHHS and the Contractor agree that the terms stated herein are subject to all required approvals of the federal Centers for Medicare and Medicaid Services (CMS);

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

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APPENDICES

SECTION 1. DEFINITIONS

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

Accountable Care Organizations (ACOs) – certain entities, contracted with EOHHS as accountable care organizations, that enter into population-based payment models with payers, wherein the entities are held financially accountable for the cost and quality of care for an attributed Member population. Entities that enter into Contracts with EOHHS pursuant to the RFR are ACOs.

Accountable Care Partnership Plan (ACPP) – an entity, contracted with EOHHS as an ACPP and the type of ACO the Contractor shall serve as pursuant to this Contract, that is network of primary care providers (PCPs) who have exclusively partnered with one MCO to create a full network that includes PCPs, specialists, behavioral health providers, and hospitals. MassHealth members enrolled in ACPPs use the ACPP's network of providers. An ACPP must also meet the definition of an MCO; provided, however, that an ACPP contracts with EOHHS as an ACPP and not an MCO.

ACO Certification – the ACO certification process developed by the Massachusetts Health Policy Commission (HPC) pursuant to Section 15 of Chapter 6D of the Massachusetts General Laws, which requires the HPC to establish a process for certain registered provider organizations to be certified as accountable care organizations.

ACO – CP Agreements – the Material Subcontracts between the Contractor and Community Partners for the provision of Community Partner supports.

ACO-Eligible Member – a Member who is eligible to enroll in a MassHealth ACO.

Activities of Daily Living (ADLs) – certain basic tasks required for daily living, including the ability to bathe, dress/undress, eat, toilet, transfer in and out of bed or chair, get around inside the home, and manage incontinence.

Advance Directive – a written instruction, such as a living will or durable power of attorney for health care, recognized under State law (whether statutory or as recognized by the courts of the State), relating to the provision of health care when the individual is incapacitated.

Affiliated Hospital – a hospital that has an affiliation with the Contractor for the purposes of this Contract as described in **Section 2.2.F**.

Affiliated Providers – Providers that have affiliations with the Contractor for the purposes of this Contract, as described in **Section 2.2**.

Alternative Formats – provision of Enrollee 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 Enrollee Information read aloud to an Enrollee by an Enrollee services representative.

Alternative Payment Methodologies (APMs) – as further specified by EOHHS, methods of payment, not based on traditional fee-for-service methodologies, that compensate providers for the provision of health care or support services and tie payments to providers to quality of care and outcomes. These include, but are not

limited to, shared savings and shared risk arrangements, bundled payments for acute care episodes, bundled payments for chronic diseases, and global payments. Payments based on traditional fee-for-service methodologies shall not be considered Alternative Payment Methodologies.

Appeals – EOHHS processes for Members to request review of certain actions pursuant to 130 CMR 610.000.

Behavioral Health Clinical Assessment – the comprehensive clinical assessment of an Enrollee that includes a full biopsychosocial and diagnostic evaluation that informs behavioral health treatment planning. A Behavioral Health Clinical Assessment is performed when an Enrollee begins behavioral health treatment and is reviewed and updated during the course of treatment. Behavioral Health Clinical Assessments provided to Enrollees under the age of 21 require the use of the Child and Adolescent Needs and Strengths (CANS) Tool to document and communicate assessment findings.

Behavioral Health Director – one of the Contractor's Key Personnel roles, as described in **Section 2.5.A**.

Behavioral Health Help Line – A statewide, multichannel entry point (telephone, text, chat, website, etc.) providing Behavioral Health information, resources, and referrals in a supportive, coordinated, and user-friendly approach, including 24/7 referral and dispatch to AMCI/YMCI (as described in **Appendix A**) for Behavioral Health crises.

Behavioral Health Services (or BH Services) – mental health and substance use disorder services that are TCOC Included Services and are set forth in detail in **Appendix A.**

Behavioral Health Vendor – the entity with which EOHHS contracts to administer EOHHS's Behavioral Health program for Members enrolled with the Contractor.

BH – Behavioral Health. See Behavioral Health Services.

BH CPs – Behavioral Health Community Partners.

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

Budgets and Budget Narratives – information provided by the Contractor about the Contractor's planned spending of Flexible Services payments, as described in **Section 2.14.B.4.**

Business Associate – a person, organization or entity meeting the definition of a "business associate" for purposes of the Privacy and Security Rules (45 CFR §160.103).

Care Coordinator – a provider-based clinician or other trained individual who is employed or contracted by the Contractor or an Enrollee's PCP. The Care Coordinator is accountable for providing care coordination activities, which include ensuring appropriate referrals and timely two-way transmission of useful patient information; obtaining reliable and timely information about services other than those provided by the PCP; participating in the Enrollee's Comprehensive Assessment, if any; and supporting safe transitions in care for Enrollees moving between settings in accordance with the Contractor's Transitional Care Management program. The Care Coordinator may serve on one or more Care Teams, and coordinates and facilitates meetings and other activities of those Care Teams.

Care Management – the provision of person-centered, coordinated activities to support Enrollees' goals as described in **Section 2.4**.

Care Needs Screening – a screening to identify an Enrollee's care needs and other characteristics as described in **Section 2.3.B.2.**

Care Plan – the plan of care developed by the Enrollee and other individuals involved in the Enrollee's care or Care Management, as described in **Section 2.3.B.5**.

Care Team – a multidisciplinary team responsible for coordinating certain aspects of a member's care, as further described in **Section 2.4.C.**

Care Team Point of Contact – A member of a BH CP-Engaged Enrollee's Care Team responsible for ongoing communication with the Care Team. The Care Team Point of Contact may be the Enrollee's PCP or PCP Designee, or the Contractor's staff member that has face-to-face contact with the PCP or the Care Team.

Centers for Medicare and Medicaid Services (CMS) – the federal agency which oversees state Medical Assistance programs under Titles XIX and XXI of the Social Security Act and waivers thereof.

Chief Financial Officer – one of the Contractor's Key Personnel roles, as described in **Section 2.5.A**.

Chief Medical Officer/Medical Director – one of the Contractor's Key Personnel roles, as described in **Section 2.5.A**.

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 Mental Health Services and Community Based Acute Treatment Services as described in **Appendix A**. 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 Enrollees under the age of 21.

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 Members under the age of 21 into a comprehensive system of community-based, culturally competent care.

Children's Behavioral Health Initiative Services (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 Mobile Crisis Intervention.

Clinical Advice and Support Line – a phone line that provides Enrollees with information to support access to and coordination of appropriate care, as described in **Section 2.3.G**.

Clinical Care Manager – as used in **Appendix G** a licensed Registered Nurse or other individual, employed by the Contractor or an Enrollee's PCP and licensed to provide clinical care management, including intensive monitoring, follow-up, and care coordination, and clinical management of high-risk Enrollees, as further specified by EOHHS.

Clinical Quality Measures – clinical information from Enrollees' medical records used to determine the overall quality of care received by Enrollees or Members. Clinical Quality Measures are a subset of Quality Measures and are set forth in **Appendix B**.

Cold-call Marketing – any unsolicited personal contact by the Contractor, its employees, Providers, agents or

Material Subcontractors with a Member who is not enrolled in the Contractor's plan that EOHHS can reasonably interpret as influencing the Member to enroll in the Contractor's plan or either not to enroll in, or to disenroll from, another ACO, Managed Care Organization (MCO), or the PCC Plan. Cold-call 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.

Community Behavioral Health Center (CBHC) - A comprehensive community behavioral health center offering crisis, urgent, and routine substance use disorder and mental health services, care coordination, peer supports, and screening and coordination with primary care. A CBHC will provide access to same-day and next-day services and expanded service hours including evenings and weekends. A CBHC must provide services to adults and youth, including infants and young children, and their families. CBHC services for adults are collectively referred to as the "adult component," and CBHC services for youth are referred to as the "youth component." CBHCs include an Adult Mobile Crisis Intervention (AMCI), Youth Mobile Crisis Intervention (YMCI), Adult Community Crisis Stabilization (Adult CCS) and Youth Community Crisis Stabilization (YCCS).

Community Partners (CPs) – entities qualified by EOHHS to enter into contract with ACOs and MCOs to coordinate care for certain Enrollees, as further specified by EOHHS. There are two types of CPs – Long-Term Services and Supports CPs (LTSS CPs) and Behavioral Health CPs (BH CPs).

Community Partner (CP) Enrollee – An Enrollee who is enrolled in the CP program and assigned to a BH or LTSS CP (BH CP Enrollee and LTSS CP Enrollee, respectively).

Community Partner (CP) Quality Score – a score calculated by EOHHS based on the CP's performance on CP Quality Measures, as described in **Appendix B**.

Community Resource Directory (CRD) – a directory of available community resources that at a minimum can address Enrollee's Health-Related Social Needs. The directory contains community resources at least within the Contractor's geographic areas; is web-based; includes a searchable map; is searchable by proximity, service type, and language; is regularly updated; may have electronic referral capabilities to the community resources; and may be able to receive information from the community resources about whether Enrollees actually received support, along with other relevant information.

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 Service.

Comprehensive Assessment – a person-centered assessment of an Enrollee's care needs, functional needs, accessibility needs, goals, and other characteristics, as described in **Section 2.3.B.4.Contract** – this agreement executed between EOHHS and the Contractor pursuant to the RFR and any amendments thereto. The Contract incorporates by reference all attachments and appendices thereto, including the Contractor's response to the RFR.

Contract Effective Date – the date on which the Contract is effective, which shall be January 1, 2023.

Contract Operational Start Date – the date on which the Contractor starts to provide the services and activities

described in this Contract to Enrollees, which shall be April 1, 2023.

Contract Year (CY) – Contract Year 1 is a nine-month period commencing April 1, 2023, and ending December 31, 2023, unless otherwise specified by EOHHS. For other Contract Years, a twelve-month period commencing January 1 and ending December 31, unless otherwise specified by EOHHS.

Contractor (or "Primary Care Accountable Care Organization," or "Primary Care ACO") – any entity that enters into an agreement with EOHHS for the provision of services described in the Contract, as set forth in **Appendix K**.

Contractor's Governing Board – a board or other legal entity with sole and exclusive authority to execute the functions in this Contract, make final decisions on behalf of Contractor, and the members of which have a fiduciary duty to Contractor (e.g., Board of Directors).

Coverage Type – a scope of medical services, other benefits, or both, that are available to members who meet specific MassHealth eligibility criteria. EOHHS's current Coverage Types with Members who may be enrolled with the Contractor are: Standard, Family Assistance, CarePlus and CommonHealth. See 130 CMR 450.105 for an explanation of each Coverage Type.

Covered Entity – shall have the meaning given to this term in the Privacy and Security Rules.

CP Supports – see **Appendix G**.

Cultural and Linguistic Competence – competence, understanding, and awareness with respect to Culturally and Linguistically Appropriate Services.

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

Customer Service Center (CSC) Vendor – EOHHS's enrollment broker that provides Members with a single point of access to a wide range of customer services, including enrolling Members into MCOs and the PCC Plan.

DCF – the Massachusetts Department of Children and Families.

DDS – the Massachusetts Department of Developmental Services.

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.

DPH – the Massachusetts Department of Public Health.

DTA – the Massachusetts Department of Transitional Assistance.

DYS – the Massachusetts Department of Youth Services.

Digital Quality Measures (dQMs) – quality measures expressed in a digital format using standardized language and data definitions that enable sharing of the specified measure electronically between systems. dQMs are

developed for HEDIS measure reporting.

Disability Coordinator – one of the Contractor's Key Personnel roles, as described in **Section 2.5.A**.

Discharge Planning – the evaluation of an Enrollee's medical and Behavioral Health care needs and coordination of any other support services in order to arrange for safe and appropriate care and living situation after discharge from one care setting (e.g., acute hospital, inpatient behavioral health facility) to another care setting (e.g., rehabilitation hospital, group home), including referral to and coordination of appropriate services.

Disease Management – the Contractor's ongoing services and assistance for specific disease and/or conditions. Services include specific interventions, education and outreach targeted to Enrollees with, or at risk for, these diseases or conditions.

Division of Insurance (DOI) – The Massachusetts Division of Insurance.

Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) – the delivery of health care services to MassHealth Standard and CommonHealth Members under the age of 21, pursuant to 42 USC 1396d(a)(4), 42 CFR Part 441, Subpart B, 130 CMR 450.140-149 and § 1115 Medicaid Research and Demonstration Waiver.

Effective Date of Disenrollment – up to 11:59 p.m. on the last day, as determined by EOHHS, on which the Contractor is responsible for providing the activities described in this Contract to an Enrollee, as further defined by EOHHS.

Effective Date of Enrollment – as of 12:01 a.m. on the first day on which the Contractor is responsible for providing the activities described in this Contract to an Enrollee, as further defined by EOHHS.

Electronic Clinical Quality Measure (eCQM) – quality measures expressed in a digital format using standardized language and data definitions that enable sharing of the specified measure electronically between systems. eCQMs were originally developed for the Centers for Medicare & Medicaid Services and are designed for eligible providers or hospitals and primarily use EHR data for calculating results.

Electronic Clinical Data System (ECDS) – the network of data structured such that automated quality measurement queries can be consistently and reliably executed. Data systems that may be eligible for ECDS reporting include, but are not limited to, administrative claims, clinical registries, health information exchanges, immunization information systems, disease/case management systems and electronic health records.

Electronic Health Record (EHR) – A digital version of a patient's paper chart. EHRs are real-time, patient-centered records that make information available instantly and securely to authorized users, often including a patient's medical history, diagnoses, medications, treatment plans, immunization dates, allergies, radiology images, and/or laboratory and test results. EHR systems are able to share patient information with other authorized health care providers and organizations.

Eligible Clinicians – Eligible clinician means "eligible professional" as defined in section 1848(k)(3) of the Social Security Act, as identified by a unique TIN and NPI combination and, includes any of the following:

1) A physician,

2) A practitioner described in section 1842(b)(18)(C) of the Act,

3) A physical or occupational therapist or a qualified speech-language pathologist, or

4) A qualified audiologist (as defined in section 1861(ll)(3)(B) of the Act).

Eligibility Verification System (EVS) – the online and telephonic system Providers must access to verify eligibility, managed care enrollment, and available third-party liability information about Members.

Emergency Services – TCOC Included inpatient and outpatient services, including Behavioral Health Services, which are furnished to an Enrollee by a Provider that is qualified to furnish such services under Title XIX of the Social Security Act, and are needed to evaluate or stabilize an Enrollee's Emergency Medical Condition.

Enrollee – a Member enrolled with the Contractor, either by choice, or by assignment by EOHHS. A Member shall be considered an Enrollee beginning on the Effective Date of Enrollment, including retroactive enrollment periods. A Member shall cease to be considered an Enrollee following the Effective Date of Disenrollment, including retroactive disenrollment periods.

Enrollee Incentive – any compensation in cash or cash equivalent, or in-kind gifts, granted to an Enrollee as a result of engagement, or lack of engagement, in a targeted behavior, such as guideline-recommended clinical screenings, Primary Care Provider (PCP) visits, or Wellness Initiatives.

Enrollee Information – information about a Primary Care ACO for Enrollees that includes, but is not limited to, a Provider directory that meets the requirements of **Section 2.6.D**. and an Enrollee handbook that contains all of the information in **Section 2.6.C.**

Enrollees with Special Health Care Needs – Enrollees who meet the following characteristics:

- Have complex or chronic medical needs requiring specialized health care services, including persons with multiple chronic conditions, co-morbidities, and/or co-existing functional impairments, and including persons with physical, mental/substance use, and/or developmental disabilities, such as persons with cognitive, intellectual, mobility, psychiatric, and/or sensory disabilities described below:

  - Cognitive Disability – a condition that leads to disturbances in brain functions, such as memory, orientation, aware ness, perception, reasoning, and judgment. Many conditions can cause cognitive disabilities, including but not limited to Alzheimer's disease, bipolar disorder, Parkinson disease, traumatic injury, stroke, depression, alcoholism, and chronic fatigue syndrome.

  - Intellectual Disability – is a disability characterized by significant limitations both in intellectual functioning and in adaptive behavior that affect many everyday social and practical skills.

  - Mobility Disability - an impairment or condition that limits or makes difficult the major life activity of moving a person's body or a portion of their body. "Mobility disability" includes, but is not limited to, orthopedic and neuro-motor disabilities and any other impairment or condition that limits an individual's ability to walk, maneuver around objects, ascend or descend steps or slopes, and/or operate controls. An individual with a mobility disability may use a wheelchair or other assistive device for mobility or may be semi-ambulatory.

  - Psychiatric Disability – a mental disorder that is a health condition characterized by alterations in thinking, mood, or behavior (or some combination thereof) associated with distress and/or impaired functioning. Examples include, but are not limited to, depression, bipolar disorder, anxiety disorder, schizophrenia, and addiction.

- Sensory Disability - any condition that substantially affects hearing, speech, or vision.

- Are children/adolescents who have, or are at increased risk for, chronic physical, developmental, behavioral, or emotional conditions and who also require health and related services of a type and amount beyond that required by children generally;

- Are at high risk for admission/readmission to a 24-hour level of care within the next six months;

- Are at high risk of institutionalization;

- Have been diagnosed with a Serious Emotional Disturbance, a Serious and Persistent Mental Illness, or a substance use disorder, or otherwise have significant BH needs;

- Are chronically homeless;

- Are at high risk of inpatient admission or emergency department visits, including certain Enrollees transitioning care across acute hospital, chronic disease and rehabilitation hospital or nursing facility setting; or

- Receive care from other state agency programs, including but not limited to programs through Department of Mental Health (DMH), Department of Developmental Services (DDS), Department of Children and Families (DCF), and Department of Youth Services (DYS).

Enrollment Broker – the EOHHS-contracted entity that provides MassHealth Members with assistance in enrollment into MassHealth Managed Care plans, including the PCC Plan. See Customer Service Center (CSC) Vendor.

EOHHS-Certified ENS Vendor – An ENS vendor that is certified by EOHHS under 101 CMR 20.11

EOHLC – the Executive Office of Housing and Livable Communities (formerly known as the Massachusetts Department of Housing and Community Development (DHCD)).

Event Notification Service (ENS) – A service that provides real-time alerts about certain patient medical service encounters, for example, at the time of hospitalization, to a permitted recipient with an existing treatment relationship to the patient, such as a primary care provider.

Executive Office of Health and Human Services (EOHHS) – the single state agency responsible for the administration of the MassHealth program, pursuant to M.G.L. c. 118E and Titles XIX and XXI of the Social Security Act, the Section 1115 Medicaid Research and Demonstration Waiver, and other applicable laws and waivers.

External Quality Review Activities (EQR Activities) – activities performed by an entity with which EOHHS contracts in accordance with 42 CFR 438.358.

External Quality Review Organization (EQRO) – the entity with which EOHHS contracts to perform External Quality Review Activities (EQR Activities), in accordance with 42 CFR 438.358.

Family Resource Centers (FRCs) of Massachusetts – A statewide network that provides services to strengthen families and keep them connected to resources within their own community. There are FRCs in every county in

the Commonwealth. In addition to assisting families, the FRCs support the children of those families that may have behavioral issues and need additional supports.

Flexible Services – certain services to address Health-Related Social Needs, as described in **Section 2.14.B** and **Appendix E**.

Graduation from CP Program – Disenrollment from CP Supports due to completion and sustained maintenance of the goals in the Enrollee's Care Plan, as determined by the Enrollee and the CP, in consultation with the Contractor and with DMH, as applicable.

Grievance – any expression of dissatisfaction by an Enrollee or an Enrollee's representative about any action or inaction by the Contractor. 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 Enrollee's rights.

Health Equity – The opportunity for everyone to attain their full health potential. No one is disadvantaged from achieving this potential because of their social position (e.g., class, socioeconomic status) or socially assigned circumstance (e.g., race, gender identity/gender expression, ethnicity, religion, sexual orientation, geography, etc.).

Health Equity Score – a score calculated by EOHHS based on the Contractor's performance on Health Equity measures, as described in **Appendix B**.

Health Equity Partner Hospital – as further specified by EOHHS, a hospital participating in EOHHS' hospital Health Equity incentive program with which the Contractor has an agreement regarding a shared commitment to advancing Health Equity goals.

Health Information Technology (HIT) – the application of information processing involving both computer hardware and software related to the storage, retrieval, sharing, and use of health care information, data, and knowledge for communication and decision-making.

Health Quality and Equity Committee – a committee which regularly reviews and sets goals to improve the Contractor's performance on their Health Equity strategy and the Quality and Equity Incentive Program.

Health-Related Social Needs (HRSN) – The immediate daily necessities that arise from the inequities caused by the Social Determinants of Health. These needs are often defined by a lack of access to basic resources like stable housing, an environment free of life-threatening toxins, healthy food, utilities including heating and internet access, transportation, physical and mental health care, safety from violence, education and employment, and social connection. When they go unmet, Health-Related Social Needs not only reduce an individual's ability to take care of their health, but also increase health care costs and lead to avoidable health care utilization.

High Cost Drugs – Unless otherwise specified by EOHHS, drugs identified by EOHHS as High Cost Drugs that have a typical treatment cost greater than $200,000 per patient per year, an FDA orphan designation, and treat an applicable condition that affects fewer than 20,000 individuals nationwide.

Historic TCOC – an amount calculated by EOHHS based on the Contractor's historic baseline for TCOC as described in **Section 4.3.A.**

Homeless Management Information Systems (HMIS) – A federal requirement for agencies that receive funding

for services/housing for people experiencing homelessness. Specifically, local homeless planning groups, known as continuums of care, are required to develop and implement a local HMIS to collect client-level data and data on the provision of housing and services to individuals experiencing homelessness and families and persons at risk of homelessness.

HPC – the Massachusetts Health Policy Commission

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.

Instrumental Activities of Daily Living (IADLs) – certain basic environmental tasks required for daily living, including the ability to prepare meals, do housework, laundry, and shopping, get around outside, use transportation, manage money, perform care and maintenance of wheelchairs and adaptive devices, and use the telephone.

Key Contact – one of the Contractor's Key Personnel roles, as described in **Section 2.5.A**.

Key Personnel – a defined subset of the Contractor's staff roles as described in **Section 2.5.A**.

Long-Term Services and Supports (LTSS) – a wide variety of services and supports that help certain members meet their daily needs for assistance and improve the quality of their lives. Examples include assistance with bathing, dressing and other basic activities of daily life and self-care, as well as support for everyday tasks such as laundry, shopping, and transportation. LTSS are provided over an extended period, predominantly in homes and communities, but also in facility-based settings such as nursing facilities.

Losses – the amount by which the Contractor's TCOC Performance exceeds the Contractor's TCOC Benchmark as described in **Section 4.3**.

LTSS – Long-Term Services and Supports.

LTSS CPs – Long-Term Services and Supports Community Partners.

Managed Care Organizations (MCO) – any entity that provides, or arranges for the provision of, covered services under a capitated payment arrangement, that is licensed and accredited by the Massachusetts Division of Insurance as a Health Maintenance Organization (HMO), and is organized primarily for the purpose of providing health care services, that (a) meets Advance Directives requirements of 42 CFR Part 489, subpart I; (b) makes the services it provides to its enrollees as accessible (in terms of timeliness, amount, duration, and scope) as those services are to other Members within the area served by the entity; (c) meets the EOHHS's solvency standards; (d) assures that its enrollees will not be liable for the MCO's debts if the MCO becomes insolvent; (e) is located in the United States; (f) is independent from EOHHS' enrollment broker, as identified by EOHHS; and (g) is not an excluded entity described in 42 CFR 438.808(b).

Market-Rate TCOC – an amount calculated by EOHHS based on the Contractor's anticipated TCOC based on the total eligible population as described in **Section 4.3.D.2.**

Marketing – any communication from the Contractor, its employees, Providers, agents or Material Subcontractors to a Member who is not enrolled with the Contractor that EOHHS can reasonably interpret as

influencing the Member to enroll with the Contractor or either not to enroll in, or to disenroll from, another Primary Care ACO, Accountable Care Partnership Plan, MCO, or the PCC Plan. 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, online, 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 Health Information Highway (**Mass HIway)** – a health information exchange program within the Commonwealth of Massachusetts' Executive Office of Health and Human Services.

MassHealth – the Commonwealth's Medicaid and Children's Health Insurance Program. MassHealth provides comprehensive, affordable health care coverage for over two million low-income Massachusetts residents, including 40% of all Massachusetts children and 60% of all residents with disabilities. MassHealth's mission is to improve the health outcomes of our diverse members and their families by providing access to integrated health care services that sustainably and equitably promote health, well-being, independence, and quality of life.

MassHealth ACO Program – collectively, MassHealth's Accountable Care Partnership Plans, MassHealth's Primary Care ACOs, and MassHealth's MCO-Administered ACOs.

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 the age of 18, and certain working or non-working disabled adults between the ages of 18 and 64.

MassHealth Executive Director – one of the Contractor's Key Personnel roles, as described in **Section 2.5.A**.

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

Material Subcontractor – any entity from which the Contractor procures, re-procures, or proposes to subcontract with, for the provision of all, or part, of its responsibilities under this Contract for Care Delivery, Care Coordination and Care Management, data analysis, enrollee services, Flexible Services, and/or risk stratification, and any other Contract responsibilities as specified by EOHHS. Contracts with Material Subcontractors shall be referred to as Material Subcontracts.

Medicaid – see "MassHealth." In addition, Medicaid shall mean any other state's Title XIX program.

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

Medically Necessary – in accordance with 130 CMR 450.204, Medically Necessary services are those services (1) which are reasonably calculated to prevent, diagnose, prevent the worsening of, alleviate, correct, or cure conditions in the Enrollee that endanger life, cause suffering or pain, cause physical deformity or malfunction, threaten to cause or to aggravate a disability, or result in illness or infirmity; and (2) for which there is no other medical service or site of service, comparable in effect, available, and suitable for the Enrollee requesting the service, that is more conservative or less costly. Medically Necessary services must be of a quality that meets professionally recognized standards of health care, and must be substantiated by records including evidence of such medical necessity and quality.

Medicare ACO – accountable care contracts administered by the Medicare program, including the Medicare Shared Savings Program, the Pioneer ACO program, and the CMS Next Generation ACO program.

Medication for Opioid Use Disorder (MOUD) – the use of FDA approved medications for the treatment of substance use disorders; formerly known as Medication Assisted Treatment (MAT).

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

New Enrollee – any Enrollee enrolled by EOHHS pursuant to **Section 2.6** who has not been previously enrolled in the Contractor within the preceding 12 months, or within another timeframe as determined by EOHHS.

Non-Medical Programs and Services – an item or service, including an Enrollee Incentive, the Contractor decides to make available to its Enrollees, which is not a TCOC Included Service or any other MassHealth covered service. The Contractor must use its own funds to provide such Non-Medical Programs and Services and may not include the costs of such Non-Medical Programs and Services as medical service costs or administrative costs for purposes of any MassHealth rate or benchmark development, as further specified by EOHHS.

Nurse Practitioner – a registered nurse who holds authorization in advanced nursing practice under Massachusetts General Laws Ch. 112 Section 80B and its implementing regulations.

Office of the National Coordinator for Health Information Technology (ONC) – the ONC is a staff division of the Office of the Secretary, within the U.S. Department of Health and Human Services.

Ombudsman – a neutral entity that has been contracted by MassHealth to assist Enrollees (including their families, caregivers, representatives and/or advocates) with information, issues, or concerns.

Organized Health Care Arrangement – shall have the meaning given to this term in the Privacy and Security Rules.

Participating PCP – a PCP that contracts with the Contractor for the purposes of this Contract as described in **Section 2.2.A**.

Patient and Family Advisory Committee – a committee that gathers the perspectives of patients and families on the Contractor's operations and regularly informs the Contractor's Governing Board.

Patient Experience Survey – a survey of Enrollees' experiences of care, performed to evaluate the Contractor's performance, as described in **Appendix B**.

PCP Designee – a licensed clinician appointed by an Enrollee's PCP to participate in the Enrollee's care planning process and who has contact with the Enrollee's PCP. The PCP Designee must be a Registered Nurse (RN) or another licensed medical professional such as a Medical Doctor (MD), Doctor of Osteopathic Medicine (DO), Nurse Practitioner (NP), or Physician's Assistant (PA). If requested by the Enrollee and agreed to by the Enrollee's PCP, the PCP Designee may also be a specialist, such as an Enrollee's cardiologist or neurologist, who meets the requirements of a PCP Designee. If agreed to by the Enrollee and by the Enrollee's PCP, the PCP Designee may also be an ACO clinical staff person who meets the requirements of a PCP Designee.

Peer Supports – activities to support recovery and rehabilitation provided by other consumers of behavioral health services.

Potential Enrollee – a MassHealth Member who is subject to mandatory enrollment in managed care or may voluntarily elect to enroll in a given managed care program, but is not yet an enrollee of the Contractor's Plan.

Practice PID/SL – A practice site in MassHealth's Medicaid Management Information System (MMIS). This Practice PID/SL is 10 characters, made up of a 9-digit base number and an alpha service location (e.g., 123456789A).

Prevalent Languages – those languages spoken by a significant percentage of Enrollees. EOHHS has determined the current Prevalent Languages spoken by MassHealth 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 – the provision of coordinated, comprehensive medical services, on both a first contact and a continuous basis, to an Enrollee. The provision of Primary Care incorporates an initial medical history intake, medical diagnosis and treatment, communication of information about illness prevention, health maintenance, and referral services.

Primary Care Accountable Care Organization (Primary Care ACO) – an entity contracted with EOHHS to be a Primary Care ACO consisting of a network of primary care providers who contract directly with MassHealth, using MassHealth's provider network, to provide integrated and coordinated care for members. MassHealth members enrolled in Primary Care ACOs receive behavioral health services through MassHealth's behavioral health vendor.

Primary Care Clinician (PCC) Plan – a managed care option administered by EOHHS through which enrolled MassHealth Members receive Primary Care and certain other medical services. See 130 CMR 450.118.

Primary Care Entity – An entity that may be made up of one or more unique Practice PID/SLs. For the purposes of Primary Care Sub-Capitation Program, this entity is the Tax ID for Contract Year 2023.

Primary Care Provider (PCP) – an EOHHS-contracted primary care practitioner participating in the managed care program pursuant to 130 CMR 450.119. PCPs provide comprehensive Primary Care and certain other medical services to Primary Care ACO Enrollees and function as the referral source for most other MassHealth services.

Primary Care Sub-Capitation Included Services – the service codes that are included in calculating the Primary Care Sub-Capitation Payment, as further specified by EOHHS.

Primary Care Sub-Capitation Payment – a per Member per Month payment from EOHHS to the Contractor based on a defined set of Primary Care Sub-Capitation Included Services, in accordance with the provisions of this Contract.

Primary Care Sub-Capitation Program – an EOHHS-specified primary care initiative, as described in Section 2.14.A and Appendix D.

Privacy and Security Rules – the privacy, security and related regulations promulgated under the Health Insurance Portability and Accountability Act of 1996, as amended (HIPAA) (found at 45 CFR Parts 160 and 164).

Progress Reports – information provided by the Contractor on the Contractor's activities under this Contract, as described in **Section 2.13.E**.

Protected Information (PI) – shall mean any Protected Health Information, any "personal data" as defined in M.G.L. c. 66A, any "patient identifying information" as used in 42 CFR Part 2, any "personally identifiable information" as used in 45 CFR §155.260, "personal information" as defined in M.GL. c. 93H, and any other individually identifiable information that is treated as confidential under Applicable Law or agreement (including, for example, any state and federal tax return information) that the Contractor uses, maintains, discloses, receives, creates, transmits or otherwise obtains from EOHHS. Information, including aggregate information, is considered PI if it is not fully de-identified in accord with 45 CFR §§164.514(a)-(c).

Providers – an individual, group, facility, agency, institution, organization, or business that furnishes or has furnished medical services to Members.

Quality Committee – a committee reporting directly to the Contractor's Governing Board, which regularly reviews and sets goals to improve the Contractor's performance on clinical quality or health outcomes, Enrollee experience measures, other Quality Measures, and disparities.

Quality Improvement Goals – standardized quality areas in which EOHHS measures Primary Care ACOs' performance against, and implements interventions to achieve, established objectives on a two-year cycle. EOHHS selects which quality improvement goals and topics shall constitute the Quality Improvement Goals for the measurement period.

Quality Measures – Measures used to evaluate the quality of the Contractor's Enrollee care as described in **Appendix B**.

Quality Sample – a subset of Enrollees defined by EOHHS used for measurement of Clinical Quality Measures as set forth in **Appendix B**.

Quality Score – a score calculated by EOHHS based on the Contractor's performance on Quality Measures, as described in **Appendix B**.

Query and Retrieve – Or, query-based exchange, refers to the ability for providers to find and/or request information on a patient from other providers, often used for unplanned care.

Rating Category – An identifier used by EOHHS to identify a specific grouping of Enrollees for which a discrete TCOC applies pursuant to the Contract. See **Section 4.1** of the Contract for more information on Rating Categories.

Referral Circle – a subset of Affiliated Providers for whom Participating PCP referral requirements are modified

as set forth in 130 CMR 450.119 and as specified in **Section 2.2.B**.

Region – A geographic area used for the purposes of payment and the development of TCOC. See **Section 4**.

Repayment Mechanism – a funding mechanism approved by EOHHS, such as a performance bond, available for EOHHS to draw upon to satisfy any Shared Losses obligations of the Contractor, as described in **Section 2.1.D**.

Request for Responses (RFR) – the Request for Responses for Accountable Care Organizations issued by EOHHS and the RFR from which this Contract resulted.

Restoration Center – a site that provides Behavioral Health Services to individuals 18 and older, who are at risk of becoming involved with the criminal justice system due to their behavioral health status, and who could benefit from urgent access to Behavioral Health Services that could prevent law enforcement contact, including diverting individuals experiencing suffering from mental health or substance use disorder crises conditions from arrest the court system and from emergency department utilization.

Risk Track – one of the financial accountability arrangements described in **Section 4.5.C**.

Savings – the amount by which the Contractor's TCOC Benchmark exceeds the Contractor's TCOC Performance as described in **Section 4.5.B**.

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

Secure File Transfer Protocol (SFTP) – SSH File Transfer protocol

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 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 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 with 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 general medical condition not elsewhere classified; or (d) substance-related disorders.

Shared Losses – the amount to be paid by the Contractor to EOHHS under the Contractor's Risk Track, in the event the Contractor has Losses, as described in **Section 4.5**.

Shared Savings – the amount to be paid by EOHHS to the Contractor under the Contractor's Risk Track, in the event the Contractor has Savings, as described in **Section 4.5**.

Significant BH Needs – substance use disorder, SED, SPMI and other BH conditions as specified by EOHHS.

Social Service Organization – A community-based organization that provides services or goods in the area of Health-Related Social Needs.

Statewide ENS Framework – An event notification service framework created as a Mass HIway-facilitated service by the EOHHS under 101 CMR 20.11.

State Agency Liaison – one of the Contractor's Key Personnel roles, as described in **Section 2.5.A**.

Taxpayer Identification Number (TIN or Tax ID) – as defined by the Internal Revenue Service (IRS), an identification number issued by the IRS or by the Social Security Administration (SSA). A Social Security number (SSN) is issued by the SSA whereas all other TINs are issued by the IRS.

Tier Designation – The single Tier to which a primary care practice is assigned, based on meeting the criteria specified in **Appendix D**.

TCOC Benchmark – a target measure of the Contractor's TCOC for the Contract Year, as described in **Section 4.3.A**.

TCOC Included Services – the services that are included in calculating the Contractor's TCOC, as set forth in **Appendix A**.

TCOC Performance – a measure of the Contractor's performance on TCOC during the Contract Year, as described in **Section 4.5.D**.

Total Cost of Care (TCOC) – a measure of the costs of care for a population of Members during a defined period, as described in **Section 4.3.A**.

Transitional Care Management – the evaluation of an Enrollee's medical 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, as described in **Section 2.3.F**.

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

Utilization Management – a process of evaluating and determining coverage for, and appropriateness of, medical care services and Behavioral Health Services, as well as providing needed assistance to clinicians or patients, in cooperation with other parties, to ensure appropriate use of resources, which can be done on a prospective or retrospective basis, including service authorization and prior authorization.

Virtual Gateway (or EOHHS Web Portal) – an internet portal designed and maintained by EOHHS to provide the general public, medical providers, community-based organizations, MassHealth Managed Care plans, including the Contractor, and EOHHS staff with online access to health and human services.

Wellness Initiatives – planned health education activities intended to promote healthy behaviors and lifestyle changes.

SECTION 2. CONTRACTOR RESPONSIBILITIES

Section 2.1 Contractor Qualifications

As further specified by EOHHS, the Contractor shall meet, and demonstrate to EOHHS that it meets, the following qualifications:

A. At all times during the Contract Term, the Contractor shall have a governance structure that includes:

1. A Governing Board.

   Such Governing Board shall:

   a. Be seventy-five percent controlled by providers or their designated representatives;

   b. Include at least one MassHealth consumer or MassHealth consumer advocate as a voting member. Such consumer or consumer advocate shall not be included in either the numerator or the denominator in calculating the seventy-five percent control threshold requirement of **Section 2.1.A.1.a**;

   c. The Contractor shall submit to EOHHS a list of the members of its Governing Board as of the Contract Effective Date and an updated list whenever any changes are made; and

   d. Nothing in this Section shall absolve the Contractor of any responsibility to EOHHS to perform the requirements of this Contract.

2. Representation from a variety of provider types, including, at a minimum, representation from primary care, pediatric care, oral health, mental health, and substance use disorder treatment providers.

3. A Patient and Family Advisory Committee (PFAC).

   a. Duties of the PFAC include, but are not limited to:

      1) Providing regular feedback to the Governing Board on issues of Enrollee care and services;

      2) Identifying and advocating for preventive care practices to be utilized by the Contractor;

      3) Being involved with the development and updating of cultural and linguistic policy and procedure decisions, including those related to quality improvement, education, and operational and cultural competency issues affecting groups who speak a primary language other than English;

      4) Advising on the cultural appropriateness and member-centeredness of

necessary member or provider targeted services, programs, and trainings; Contractor Marketing Materials and campaigns; and Contractor partnerships;

5) Providing input and advice on member experience survey results and other appropriate data/assessments;

b. The PFAC shall be exclusively made up of Enrollees and their family members.

c. The composition of the PFAC shall, to the extent possible, reflect the diversity of the MassHealth population, with a membership that:

1) Considers cultural, linguistic, racial, health, disability, sexual orientation, and gender identities, among others; and

2) Includes representatives from parents or guardians of Enrollees under the age of 21.

d. The Contractor shall ensure that:

1) Reasonable accommodations, including interpreter services, as well as other resources are provided as may be needed to support participation by Enrollees and their family members; and

2) That the process and/or opportunity for joining the PFAC is publicized such that any Enrollee (or their family member as applicable) may have the opportunity to apply to participate or otherwise join.

e. The Contractor shall report on the PFAC as part of its Health Equity report as set forth in **Appendix F**.

f. Provision of reasonable compensation to Enrollees for participation in the Contractor's Governing Board, Patient and Family Advisory Committee, or other Contractor efforts focused on seeking input from Enrollees shall not be considered Enrollee Incentives. The Contractor shall ensure that any such compensation complies with all applicable state and federal law. As directed by EOHHS, the Contractor shall submit to EOHHS information relating to any such reasonable compensation, in a form and format and at a frequency specified by EOHHS.

4. A Quality Committee.

B. The Contractor shall acquire and maintain Health Policy Commission (HPC) ACO certification.

C. The Contractor shall remain fiscally sound as demonstrated by the following:

1. DOI Certification

The Contractor shall obtain and, at all times after the Contract Operational Start Date, maintain

a Risk Certificate for Risk-Bearing Provider Organizations (RBPO) or a Risk Certificate Waiver for RBPO, as defined by the Massachusetts Division of Insurance (DOI), and as further directed by EOHHS.

2. Cash Flow

The Contractor shall maintain sufficient cash flow and liquidity to meet obligations as they become due. The Contractor shall submit to EOHHS upon request a cash flow statement to demonstrate compliance with this requirement and a statement of its projected cash flow for a period specified by EOHHS.

3. Insolvency Protection

Throughout the term of this Contract, the Contractor shall remain financially stable and maintain adequate protection against insolvency, as determined by EOHHS.

4. Right to Audit and Inspect Books

The Contractor shall provide EOHHS or the Secretary of the U.S. Department of Health and Human Services or his designee its books and records for audit and inspection of:

a. The Contractor's capacity to bear the risk of potential financial losses; and

b. Services performed or the determination of amounts payable under the Contract.

5. Other Information

The Contractor shall provide EOHHS with any other information that CMS or EOHHS deems necessary to adequately monitor and evaluate the financial strength of the Contractor or that must be provided to CMS or EOHHS by law, as further specified by EOHHS.

D. At all times after the Contract Operational Start Date, the Contractor shall have a Repayment Mechanism in an amount equal to or greater than the maximum amount of the Contractor's potential Shared Losses provided, however, that in the sole discretion of EOHHS, the Contractor may propose for EOHHS' approval a Repayment Mechanism in an amount equal to the 95th percentile of potential Shared Losses, as further specified by EOHHS.

E. The Contractor shall use best efforts to have a minimum of approximately ten thousand (10,000) Enrollees, except if the Contractor has prior written approval from EOHHS to have fewer Enrollees.

F. At all times during the Contract Term, the Contractor shall:

1. Be located within the United States;

2. Not have, nor may any of the Contractor's Material Subcontractors have, any financial, legal, contractual or other business interest in EOHHS's enrollment broker, or in such vendor's subcontractors, if any; and

3. Not have, nor may any of the Contractor's Material Subcontractors have, any financial, legal, contractual or other business interest in EOHHS's External Quality Review Organization contractor, or in such vendor's subcontractors, if any.

Section 2.2 Relationships with Affiliated Providers

The Contractor shall establish and maintain relationships with Affiliated Providers as follows:

A. Participating PCPs

The Contractor shall contract with one or more PCPs to serve as Participating PCPs. The Contractor shall:

1. Ensure that the Contractor's contract with each Participating PCP:

a. Requires the Participating PCP to:

1) Participate in the Primary Care Sub-Capitation Program, as described in **Section 2.14.A;**

2) Share clinical data on Enrollees with the Contractor, including but not limited to data to support the Quality Measure reporting requirements described in **Section 2.5.B.1**, in accordance with **Appendix B,** and data to support the Quality and Equity Incentive Program, as described in **Section 2.12.E**, subject to all applicable laws and regulations;

3) Observe and comply with the member rights and protections in this Contract;

4) Provide care to Enrollees in accordance with the care model requirements described in **Section 2.3 and 2.4**;

5) Otherwise assist the Contractor with meeting the requirements of this Contract, including documenting information in an Enrollee's medical record; and

6) When directed by EOHHS, be enrolled with MassHealth as specified by EOHHS.

b. Requires that the Participating PCP shall not contract as a:

1) Participating PCP with any entity, except the Contractor, that is participating as part of the MassHealth ACO Program;

2) PCP for an entity serving as an MCO, except when such PCP is serving a Special Kids Special Care (SKSC) Program enrollee; or

3) Primary Care Clinician within MassHealth's PCC Plan;

c. For Contract Year 1, have a minimum term of 9 months from the Contract Operational Start Date. For all other Contract Years, have a term of no less than one year, ending not before the last day of the calendar year; and

d. May only be terminated for cause;

2. In addition to implementing the Primary Care Sub-Capitation Program, the Contractor shall develop, implement, and maintain alternative payment methodologies for Participating PCPs. Such alternative payment methodologies:

a. Shall be subject to prior approval by EOHHS;

b. Shall be implemented in accordance with any guidance or requirements issued by EOHHS;

c. Shall not replace payment Participating PCPs receive for providing TCOC Included services to Enrollees, including payment Participating PCPs receive from EOHHS;

d. Shall shift financial incentives away from volume-based, fee-for-service delivery;

e. May include:

1) Stand-alone performance incentives or prize pools for Participating PCPs based on performance on process or outcomes measures identified by the Contractor that are related to costs of care performance and quality measures identified by EOHHS, and utilization;

2) Additional payments (e.g., supplemental medical home loads) paid to Participating PCPs that augment MassHealth rates to support new costs associated with their responsibilities. Such payments shall include adjustments for performance; and

3) Partial distribution of the Contractor's Shared Savings payments or responsibility for contributing to the Contractor's Shared Losses payments to Participating PCPs based on performance;

3. As requested by EOHHS, the Contractor shall provide information to EOHHS, in a form and format specified by EOHHS, about its Participating PCPs including but not limited to, a list of Participating PCPs, each Participating PCP's MassHealth billing ID, provider ID/service location (PID/SL), NPI, tax ID (or TIN), and known affiliations to other providers, whether each Participating PCP is enrolled as a MassHealth provider, and any other information requested by EOHHS; and

4. Participating PCP Modifications

a. The Contractor may request EOHHS' approval annually for changes to the Contractor's Participating PCPs through the Accountable Care Organization Primary Care Provider

Change Process, as further specified by EOHHS. If the change is approved, EOHHS shall add or remove the Participating PCP for an effective date to be further specified by EOHHS. The Contractor shall provide supporting documentation, including from the PCP, as requested by EOHHS.

b. The Contractor may request EOHHS' approval annually for changes to the Tier Designation of Participating Primary Care Practice PID/SLs, under the Primary Care Sub-Capitation Program described in **Section 2.14.A,** as further specified by EOHHS. If the change is approved, EOHHS shall update the Participating Primary Care Practice PID/SLs Tier Designation for an effective date to be further specified by EOHHS. The Contractor shall provide supporting documentation, including from the Participating Primary Care Practice PID/SL, as requested by EOHHS.

c. For new Enrollees enrolled pursuant to this Section, the Contractor shall collaborate with and support EOHHS in ensuring uninterrupted care as described in **Section 2.6.A.4**.

d. For certain Participating PCP modifications, as further specified by EOHHS, the Contractor shall participate in EOHHS's provider file maintenance process.

e. EOHHS shall provide the Contractor with specifications about the Accountable Care Organization Primary Care Provider Change Process and provider file maintenance process. Such specifications may include when the Contractor must use each process depending on a number of factors, including but not limited to any association between a proposed PCP's TIN and either the Contractor's TIN or an existing PCP's TIN.

f. Other Changes to Participating PCPs

1) The Contractor shall satisfy the requirements in this Section for any significant changes to its Participating PCPs outside of the annual process set forth by EOHHS. A significant change shall include, but may not be limited to:

a) The end of a Participating PCP contract, including but not limited to as a result of the proposed termination of a Participating PCP pursuant to **Section 2.2.A.1.d**, the non-renewal of a Participating PCP contract, or the closure of a Participating PCP; and

b) changes in hours, access, or staffing that results in there being no other, or a limited number, of PCPs or PCP sites, available in a given geographic area;

2) The Contractor shall provide written notice to EOHHS of any significant change to its Participating PCPs as follows:

a) The Contractor Shall provide written notice to EOHHS at least 90 days prior to the proposed effective date of any such change; provided, however, that if the Contractor seeks to terminate the Participating

PCP based on concerns that implicate the health, safety, or welfare of Enrollees, the Contractor shall provide written notice to EOHHS as soon as practicable, but in no event less than 3 business days prior to the proposed effective date of termination.

b) In the form and format specified by EOHHS, the Contractor shall include all relevant information about the proposed change, including but not limited to:

(i) The number of affected Enrollees,

(ii) the Contractor' s proposed transition plans for affected Enrollees;

(iii) the specific steps the Contractor proposes to take to ensure continuity of care for Medically Necessary Services, as well as Community Partner supports and Flexible Services if applicable;

(iv) the Contractor's proposed plan for communication with Enrollees affected by the significant change, including but not limited to the plan for providing required Enrollee notifications, and any proposed provider communications; and

(v) any relevant next steps;

3) The Contractor shall follow the processes approved by EOHHS for transitioning Enrollees, continuity of care, Enrollee communication, and any provider communications.

4) The Contractor shall provide any other information requested by EOHHS pertaining to any such significant change within seven calendar days of the request.

5) The Contractor shall not effectuate any significant change without EOHHS' prior approval of the Contractor's proposed plans for transition, continuity of care, and communication, as described in this Section. Such prior approval shall not be unreasonably withheld.

B. Referral Circle

1. Subject to approval by EOHHS, the Contractor may establish a Referral Circle. EOHHS may approve, reject, or propose modifications to the Referral Circle in its discretion;

2. If the Contractor chooses to establish a Referral Circle and EOHHS approves such Referral Circle, the Contractor shall ensure, and shall demonstrate to EOHHS' satisfaction, that the Referral Circle observes and complies with member protections set forth in **Section 2.9.G**; and

3. EOHHS may modify or withdraw its approval of Contractor's Referral Circle at EOHHS'

discretion, including based on Member Grievances.

C. Affiliated Hospitals

1. The Contractor shall have agreements with at least one hospital to support Contractor's activities under this Contract and as further specified by EOHHS. Such hospital(s) shall be Affiliated Hospital(s).

2. The Contractor shall develop, implement, and maintain protocols with each Affiliated Hospital that support the coordination of Enrollees' care, including transitions of care, as part of the Contractor's Transitional Care Management program as described in **Section 2.3.F**.

D. Other Affiliated Providers

1. The Contractor may establish agreements with other Affiliated Providers to support the Contractor's activities under this Contract. The Contractor shall disclose such agreements to EOHHS.

2. The Contractor shall establish affiliations with Providers including with Community Service Agencies (CSAs) in the Contractor's geographic area, as determined by EOHHS and organizations as necessary to fulfill the requirements of this **Section 2.2**, including affiliations with CPs and other community-based organizations and Social Services Organizations; and

3. The Contractor shall report information on Affiliated Providers as necessary to facilitate data reporting, as further directed by EOHHS.

E. Policies and Procedures

1. The Contractor shall establish and implement policies and procedures to increase the Contractor's capabilities to share information among providers involved in Enrollees' care, including:

   a. Increasing connection rates of Affiliated Providers to the Mass HIway;

   b. Adopting and integrating interoperable certified Electronic Health Records (EHR) technologies (such as those certified by the Office of the National Coordinator (ONC); and

   c. Enhancing interoperability;

2. Increasing the use of real time notification of events in care (such as but not limited to admission of an Enrollee to an emergency room or other care delivery setting).

3. The Contractor shall not adopt policies and procedures to avoid costs of TCOC Included Services by referring Enrollees to publicly supported health care resources.

F. HIPAA Certification

1. By executing this Contract, and to memorialize compliance for permitted disclosures under applicable law, including those for Treatment, Payment, and Health Care Operations purposes, as those terms are defined in HIPAA - 45 CFR 164.506, the Contractor certifies that: (i) the Contractor, together with its Participating PCPs, is a Covered Entity; or (ii) the Contractor is a Covered Entity and has entered into an Organized Health Care Arrangement with its Participating PCPs; or (iii) the Contractor is a Business Associate of its Participating PCPs or an Organized Health Care Arrangement to which its Participating PCPs belong for purposes of, at a minimum, performing or providing activities, functions and/or services relating to minimizing the total cost and maximizing the quality of care providing to Enrollees.

2. Upon request, the Contractor shall produce documentation supporting its status as a Covered Entity or Business Associate, as set forth above, its relationship with its Participating PCPs and/or its authority to receive data related to Enrollees for the performance of the Contractor's responsibilities as set forth in this Contract.

3. The Contractor's obligations relating to performance for activities under this Contract shall be specified in **Section 6**. The Contractor's obligations for performance of certain activities in this Contract that are identified in and performed under the Business Associate Data Management and Confidentiality Agreement found at **Appendix H**, are subject to additional terms and conditions. Such terms include compliance with Business Associate Agreement requirements under HIPAA, requirements for "holders" under M.G.L. c. 66A, "lawful holders" under 42 CFR Part 2, and any other applicable federal or state law or regulation pertaining to the use, disclosure, maintenance, privacy or security of PI. If **Appendix H** is not part of the Contractor's obligations, **Appendix H** shall be left blank as attached to this Contract.

Section 2.3 Care Delivery

In addition to Members' other rights, the Contractor shall ensure that all Enrollees experience care that is integrated across providers, that is Member-centered, and that connects Enrollees to the right care in the right settings, as described in this Section and as further specified by EOHHS.

A. General Care Delivery Requirements

In accordance with all other applicable Contractor requirements, the Contractor shall ensure that all Enrollees receive appropriate care. The Contractor shall:

1. Ensure that all Enrollees may access:

    a. Care that is timely, accessible, and Culturally and Linguistically Appropriate. The Contractor shall regularly evaluate the population of Enrollees to identify language needs, including needs experienced by Enrollees who are deaf or hard of hearing, and needs related to health literacy, and to identify needs related to cultural appropriateness of care (including through the Care Needs Screening as described in **Section 2.3.B.2**). The Contractor shall identify opportunities to improve the availability of fluent staff or skilled translation services in Enrollees' preferred languages and opportunities to improve the cultural appropriateness of Enrollees' care;

b. As further specified by EOHHS, Primary Care or Urgent Care during extended hours to reduce avoidable inpatient admissions and emergency department visits;

c. Primary Care services consistent with all Contract requirements, including but not limited to those related to the Primary Care Sub-Capitation Program;

d. Medical and diagnostic equipment that is accessible to the Enrollee; and

e. All Medically Necessary services, including Behavioral Health Services, other specialty services, and any other services delivered to the Enrollee by entities other than the Contractor, in a timely, coordinated, and person-centered manner and in accordance with the Enrollee's wishes, as necessary and appropriate;

2. Ensure that each Enrollee, including but not limited to Enrollees with Special Health Care Needs, has access to Providers with expertise in treating the full range of medical conditions of the Enrollee;

3. Perform coordination to assist Enrollees with accessing transportation to medical appointments, where Medically Necessary, for the Enrollee to access medical care;

4. Ensure provision of Early Periodic Screening, Diagnosis, and Treatment (EPSDT) and Preventive Pediatric Health Care Screening and Diagnosis (PPHSD) services to all Enrollees under the age of 21;

5. Ensure the use of the CANS Tool by appropriately qualified Primary Care and Behavioral Health Providers for all Enrollees under the age of 21, as further directed by EOHHS, and otherwise ensure that Enrollees under the age of 21 have access to appropriate care;

6. Ensure that all Enrollees under the age of 21 have access to Medically Necessary services under the Children's Behavioral Health Initiative, including through partnering with Community Service Agencies, as identified by EOHHS. Such services shall include but not be limited to:

   a. Intensive Care Coordination;

   b. Family Support and Training Services;

   c. In-Home Behavioral Services (including Behavior Management Therapy and Behavior Management Monitoring);

   d. Therapeutic Mentoring Services;

   e. In-Home Therapy Services (including Therapeutic Clinical Intervention and Ongoing Therapeutic Training and Support); and

   f. Youth Mobile Crisis Intervention Services (MCI);

7. Ensure that all Enrollees have access to emergency Behavioral Health Services, including

immediate and unrestricted access to Adult and Youth Mobile Crisis Intervention services in the community and BH evaluation at emergency departments 24 hours a day, seven days a week;

8. Ensure that criminal justice involved Enrollees have access to medically necessary services, including Behavioral Health Services, and Care Management and care coordination as appropriate, as otherwise provided in this Contract;

9. Follow up with an Enrollee within 24 hours of when the Enrollee accesses emergency Behavioral Health Services, including AMCI/YMCI services;

B. Screening, Assessment, Care Plans, and Follow Up

1. General Requirements

a. The Contractor shall ensure that a clinical expert reviews the tools the Contractor uses to conduct the Care Needs Screening, Comprehensive Assessment, Health-Related Social Needs screening and Care Plan as follows:

1) Such clinical experts shall have appropriate expertise in the screening or assessment they are reviewing. Such expertise shall include experience working directly with Enrollees and identifying and navigating Enrollees to services or supports.

2) The Contractor shall ensure its Designated Pediatric Expert reviews any questions related to the needs of Enrollees under the age of 21 years in the Care Needs Screening, Comprehensive Assessment, Health-Related Social Needs screening and Care Plan tools. The Contractor shall provide any clinical expert's and Designated Pediatric Expert's qualifications to EOHHS upon request.

3) The Contractor shall provide its Care Needs Screening, Heath-Related Social Needs screening tool, Comprehensive Assessment tool, and Care Plan tool to EOHHS upon request for review and shall make any changes to such tools as directed by EOHHS. EOHHS may require the Contractor to use a specific tool in place of the Contractor's proposed tool.

4) The Contractor shall report on Care Needs Screenings, Comprehensive Assessments, Health-Related Social Needs screenings, and Care Plans in a form and format as specified by EOHHS, in accordance with **Appendix F**. The Contractor shall also report on the Health-Related Social Needs screening in a form and format as specified by EOHHS, in accordance with **Appendix B**.

5) In addition to the Care Needs Screening, Health-Related Social Needs screening, and Comprehensive Assessment set forth in this Section, the Contractor shall employ other means to evaluate Enrollees' care needs,

including but not limited to regular analysis of available claims, encounter, and clinical data on Enrollees' diagnoses and patterns of care.

2. Care Needs Screening

The Contractor shall complete an initial Care Needs Screening for each Enrollee, including but not limited to using a tool that meets all Contract requirements, within 90 days of the Enrollee's Effective Date of Enrollment. The Care Needs Screening shall, at a minimum:

a. Use a survey-based instrument;

b. Be made available to Enrollees in multiple formats including through the internet, print, and telephone;

c. Be conducted with the consent of the Enrollee;

d. Include disclosures to the Enrollee about how information will be used;

e. Elicit Enrollee demographics as further specified by EOHHS, personal health history, including chronic illnesses and current treatment; and self-perceived health status;

f. Identify whether the Enrollee is an Enrollee with Special Health Care Needs;

g. Identify the Enrollee's needs for Culturally and Linguistically Appropriate Services, including but not limited to hearing and vision impairment and language preference;

h. Identify the Enrollee's needs for accessible medical and diagnostic equipment;

i. Identify the Enrollee's health concerns and goals;

j. Determine care needs experienced by children, including evaluating characteristics of the Enrollee's family and home;

k. Evaluate each Enrollee's needs for Behavioral Health-related services, including but not limited to:

1) Unmet needs

2) The Enrollees' appropriateness for the BH CP program;

3) The Enrollee's current use of BH Services, if any, including substance use disorder treatment services;

4) The presence of mental health diagnoses or conditions, if any;

5) The presence of any substance use disorders, if any; and

6) The Enrollee's affiliation with any state agency that provides behavioral health

-related care management or other activities, including the Department of Mental Health (DMH) and the Bureau of Substance Abuse Services (BSAS);

l. Evaluate each Enrollee's needs for LTSS and LTSS-related services, including but not limited to:

1) Unmet needs;

2) Whether the Enrollee currently is the only adult in their home environment;

3) The Enrollees' appropriateness for the LTSS CP program;

4) Current use of LTSS and LTSS-related services;

5) Affiliation with any state agency that provides HCBS Waiver-like services, such as those provided by the Department of Developmental Services (DDS), Executive Office of Elder Affairs (EOEA), Massachusetts Commission for the Blind (MCB), Department of Public Health (DPH), Massachusetts Commission for the Deaf and Hard of Hearing, or Massachusetts Rehabilitation Commission (MRC);

6) Need for assistance with Activities of Daily Living (ADLs) or Instrumental Activities of Daily Living;

7) Risk for institutionalization; and

8) Any other clinical presentation that indicates a potential need for LTSS care, such as an indicated necessity for home-based nursing;

m. Evaluate each Enrollee's Health-Related Social Needs, as described in **Section 2.3.B.3**, provided, however that a Comprehensive Assessment or HRSN screening in accordance with all Contract requirements may satisfy this requirement as further specified by EOHHS;

n. Evaluate each Enrollee's needs for care that is Culturally and Linguistically Appropriate, including identifying Enrollees' preferred language(s); and

o. Identify each Enrollee's risk factors and relevant health and functional needs, as further directed by EOHHS;

3. Health-Related Social Needs Screening

a. The Contractor shall conduct a Health-Related Social Needs (HRSN) screening for all Enrollees upon enrollment and annually thereafter.

b. The HRSN screening may occur as a unique screening, as part of the Care Needs Screening, as part of the Comprehensive Assessment, or through or in combination

with any other tool deemed appropriate by the Contractor so long as the HRSN screening conducted fulfills the requirements of this Section and in accordance with the ACO Quality and Equity Incentive Program Arrangement.

c. Health-Related Social Needs screenings shall:

1) Be made available to Enrollees in multiple formats including through the internet, print, and telephone;

2) Include disclosures to the Enrollee about how information will be used;

3) Describe potential services or assistance available to the Enrollee for identified needs;

4) Screen all Enrollees for needs in the following domains:

a) Housing instability;

b) Food insecurity, such as lack of access to healthy, culturally appropriate foods;

c) Utility difficulties, including lack of access to electricity, heating, and internet;

d) Transportation needs; and

e) Experience of violence.

5) In addition to the domains set forth above, the Contractor shall screen Enrollees under the age of 21 for either school and/or early childhood education-related needs, as appropriate to the Enrollee's age.

d. When the Contractor identifies a HRSN for an Enrollee, whether through the HRSN screening or through another means, the Contractor shall:

1) Inquire whether the Enrollee would like to receive services or assistance to address identified Health-Related Social Needs, including but not limited to:

a) Housing supports;

b) Nutrition supports;

c) Utility assistance, including heating and access to the internet;

d) Transportation services;

e) Support for Enrollees who have experienced violence; and

f) Education supports and services for pediatric Enrollees, including early childhood education-related supports;

2) If the Enrollee would like to receive services, provide care coordination for the

Enrollee and provide appropriate referrals and follow-up to help the Enrollee address the HRSN in accordance with **Section 2.4.A.5**.

3) Ensure screenings are documented in the Enrollee's EHR. If the Contractor is participating in the ACO Quality and Equity Incentive Program Arrangement, screenings and screening results must be reported as further specified by EOHHS.

4) Submit to EOHHS aggregate reports of the identified HRSN of its Enrollees, as well as how those Enrollees were referred to appropriate resources to address those identified HRSN, in a form, format, and frequency specified by EOHHS.

5) Provide a Flexible Services screening and consider referring the Enrollee for Flexible Services as described in **Section 2.14.B**, as appropriate and as further specified by EOHHS.

e. The Contractor shall train staff to collect HRSN data using culturally competent and trauma informed approaches.

4. Comprehensive Assessments

a. The Contractor shall provide, at a minimum, a Comprehensive Assessment to at least the following Enrollees:

1) Enrollees with Special Health Care Needs;

2) High- or rising-risk Enrollees enrolled in enhanced care coordination as described in **Section 2.4.C**;

3) BH CP or LTSS CP Enrollees. For any such BH CP or LTSS CP Enrollee, the Contractor shall require its BH CPs and LTSS CPs to provide comprehensive assessments for such Enrollees;

4) Provided, however, that unless clinically appropriate, the Contractor shall not conduct a new Comprehensive Assessment if an Enrollee has had a Comprehensive Assessment within the last calendar year that includes all domains and considerations described in **Section 2.3.B.4.b**.

b. The Contractor shall ensure Comprehensive Assessments meet the following requirements:

1) The Comprehensive Assessment shall inform the Enrollee's care, including but not limited to any Care Coordination activities;

2) The Comprehensive Assessment shall be a person-centered assessment of an Enrollee's care needs and, as applicable and clinically appropriate, the Enrollee's functional needs, accessibility needs, goals, and other

characteristics;

3) The Contractor shall ensure that Enrollees requiring a Comprehensive Assessment are comprehensively assessed in a timely manner to inform the development of the member-centered Care Plan as described in this Section;

4) The Contractor shall record Comprehensive Assessments in the Enrollee's medical record;

5) The Contractor shall ensure that the Comprehensive Assessment is completed by an individual who is not financially or otherwise conflicted, as further specified by EOHHS;

6) Comprehensive Assessments shall be appropriate to the Enrollee, shall be Enrollee-centered, and shall take place in a location that meets the Enrollee's needs, including home-based assessments as appropriate;

7) Comprehensive Assessments shall include domains and considerations appropriate for the population receiving the Comprehensive Assessment, as further specified by EOHHS, and shall include, but may not be limited to, the following:

   a) Immediate care needs and current services, including but not limited to any care coordination or management activities and any services being provided by state agencies;

   b) Health conditions;

   c) Medications; provided, however, for CP Enrollees, medications shall be included as further specified in **Appendix G**;

   d) Enrollee's ability to communicate concerns, symptoms, or care goals;

   e) Functional status and needs, including LTSS needs or needs for assistance with any Activities of Daily Living (ADLs) or Instrumental Activities of Daily Living (IADLs);

   f) Self-identified strengths, weaknesses, interests, choices, care goals, and personal goals;

   g) Current and past mental health and substance use;

   h) Accessibility requirements, including but not limited to preferred language and specific communication needs, transportation needs, and equipment needs;

   i) For Enrollees under the age of 21, educational supports and services, including but not limited to special education needs, coordination with school nurse, early childhood education-related supports, and other risk factors;

j) Available informal, caregiver, or social supports, including Peer Supports;

k) Risk factors for abuse or neglect;

l) HRSN as described in **Section 2.3.B.3**, provided, however that a Care Needs Screening or HRSN screening in accordance with all Contract requirements may satisfy this requirement, as further specified by EOHHS;

m) Advance Directives status and preferences and guardianship status; and

n) Other domains and considerations identified by EOHHS;

c. For Enrollees receiving care coordination services through Intensive Care Coordination or through MassHealth CARES for Kids as described in **Appendix A**, the assessment the Enrollee receives through Intensive Care Coordination or MassHealth CARES for Kids shall be considered the Comprehensive Assessment for the Enrollee;

d. For Enrollees in enhanced care coordination, the Contractor shall complete Comprehensive Assessments within 90 days of enrollment into a CP or ACO Care Management program;

e. The Contractor shall update Comprehensive Assessments as follows:

1) At least annually;

2) Whenever an Enrollee experiences a major change in health status that is due to progressive disease, functional decline, or resolution of a problem or condition that represents a consistent pattern of changes that is not self-limiting, impacts more than one area of the Enrollee's health status, and requires a review by the Enrollee's Care Team;

f. The Contractor shall provide EOHHS with copies of the Enrollee's Comprehensive Assessments upon request, as directed by EOHHS;

g. The Contractor shall ensure results of Comprehensive Assessments are:

1) Communicated to the Enrollee;

2) Documented in the Enrollee's medical record;

3) Shared with the Enrollee's providers, as appropriate;

5. Care Plans

a. The Contractor shall, at a minimum, provide documented Care Plans to:

1) Enrollees with Special Health Care Needs;

2) High or rising risk Enrollees enrolled in enhanced care coordination as described in **Section 2.4.C**;

3) BH CP and LTSS CP Enrollees. For any such BH CP or LTSS CP Enrollees, the Contractor shall require its BH CPs and LTSS CPs to provide such Care Plans;

b. The Contractor shall ensure Enrollees receive Care Plans as follows:

1) Care Plans shall be developed in accordance with any applicable EOHHS quality assurance and utilization review standards;

2) The Contractor shall ensure the Enrollee's PCP or PCP Designee are involved in the creation and/or review of the Care Plan;

3) Care Plans shall be unique to each Enrollee;

4) Care Plans shall be in writing;

5) Care Plans shall reflect the results of the Enrollee's Comprehensive Assessment;

6) Care Plans shall be Enrollee-centered and developed under the direction of the Enrollee (or the Enrollee's authorized representative, if applicable). Enrollees shall be provided with any necessary assistance and accommodations to prepare for, fully participate in, and to the extent preferred, direct the care planning process;

7) Care Plans shall be signed or otherwise approved by the Enrollee (or the Enrollee's authorized representative, if any). The Contractor shall establish and maintain policies and procedures to ensure an Enrollee can sign or otherwise convey approval of the Care Plan when it is developed or subsequently modified. Such policies and procedures shall include:

a) Informing Enrollees of their right to approve the Care Plan;

b) Providing mechanisms for the Enrollee to sign or otherwise convey approval of the Care Plan, including a process for allowing electronic signature, which may be used to meet this requirement. Such mechanisms shall meet the Enrollee's accessibility needs;

c) Documenting the Enrollee's verbal approval of the Care Plan in the Enrollee's medical record, including a description of the accommodation need that does not permit the Enrollee to sign the Care Plan. In the absence of an accommodation need, the Contractor shall document the reason a signature was not obtainable and shall

obtain a signature from the Enrollee within three (3) months of the verbal approval.

8) The Contractor shall provide the Care Plan and any update to the Care Plan in writing to the Enrollee in an appropriate and accessible format, as indicated by the Enrollee's accommodation needs and including but not limited to alternative methods or formats and translation into the primary language of the Enrollee (or authorized representative, if any) and documented in the Enrollee's EHR;

9) Care Plans shall inform an Enrollee of their right to an Appeal of any denial, termination, suspension, or reduction in services, or any other change in providers, services, or medications included in the Care Plan; and

10) Care Plans shall inform an Enrollee of the availability of and access to Ombudsman services in accordance with **Section 2.9.G.2**.

c. The Contractor shall complete Care Plans, including being signed or otherwise approved by the Enrollee, within five (5) calendar months of Enrollee's enrollment into an enhanced care coordination program, if applicable.

d. The Contractor shall share the completed Care Plan with parties who need the Care Plan in connection with treating the Enrollee, providing services to the Enrollee, or related operational activities involving the Enrollee, including members of the Enrollee's Care Team, the Enrollee's PCP, and other providers who serve the Enrollee, including case managers from other state agencies involved in Enrollees, to the extent allowed by law.

e. Care Plans shall include, at a minimum, the following:

1) A cover sheet, as further specified by EOHHS, that includes contact information for the Enrollee; the Enrollee's Care Coordinator(s); the Enrollee's PCP or PCP Designee; additional Care Team members; and, for Enrollees under the age of 21, the Enrollee's school or early childhood supports, and any state agency supports, if applicable;

2) Current needs or conditions identified by the Comprehensive Assessment and other screenings or assessments and prioritized by the Enrollee;

3) List of Enrollee's strengths, interests, preferences, and cultural considerations;

4) Measurable goals with an estimated timeframe for achievement and plan for follow-up;

5) Recommended action step(s) for each goal with associated responsible Care Team member and any related accessibility requirements;

6) Identification of barriers to meeting goals;

7) Additional needs or conditions that the Enrollee would like to address in the future;

8) List of current services the Enrollee is receiving to meet current needs or conditions identified by the Comprehensive Assessment and from other screenings or assessments;

9) Back-up or contingency plan; and

10) Identified HRSN through the HRSN screening and through any other Encounters, as well as the Contractor's plan to address the Enrollee's identified HRSN.

f. Care Plans shall be updated as follows:

1) Care Plans shall be updated at least annually and be informed by the annual Comprehensive Assessment;

2) The Contractor shall update Care Plans following transitions of care, and whenever an Enrollee experiences a major change in health status that is due to progressive disease, functional decline, or resolution of a problem or condition that represents a consistent pattern of changes that is not self-limiting, impacts more than one area of the Enrollee's health status, and requires a review by the Enrollee's Care Team;

3) The process for updating an Enrollee's Care Plan shall include the following activities, at a minimum:

a) Determining the Enrollee's progress toward goals;

b) Reassessing the Enrollee's health status;

c) Reassessing the Enrollee's goals;

d) Monitoring the Enrollee's adherence to the Care Plan;

e) Documenting recommendations for follow-up;

f) Making necessary changes in writing, as necessary, to reflect these activities.

g) The Enrollee signing or otherwise approving the updates to Care Plans; and

h) Notifying the Enrollee's PCP or PCP Designee of the update;

g. For Enrollees receiving care coordination services through Intensive Care Coordination or through MassHealth CARES for Kids as described in **Appendix A** the Care Plan the

Enrollee receives through Intensive Care Coordination or MassHealth CARES for Kids shall be considered the Care Plan for the Enrollee.

6. Appropriate Follow Up

The Contractor shall ensure that Enrollees receive Medically Necessary TCOC Included Services and appropriate follow-up care based on their needs identified through any of the above assessments or screenings, including but not limited to as part of care coordination as further described in **Section 2.4**.

C. Wellness Initiatives

The Contractor shall develop, implement, and maintain Wellness Initiatives as follows and as further directed by EOHHS:

1. Such Wellness Initiatives shall include, but not be limited to:

a. General health education classes, including how to access appropriate levels of health care;

b. Tobacco cessation programs, with targeted outreach for adolescents and pregnant individuals;

c. Childbirth education, breastfeeding education, and infant care classes;

d. Nutrition counseling, with targeted outreach for pregnant individuals, older Enrollees, and Enrollees with Special Health Care Needs;

e. Education about the signs and symptoms of common diseases, conditions and complications (e.g., hypertension, strokes, diabetes, depression, postpartum hemorrhage);

f. Early detection of mental health issues in children;

g. Early intervention and risk reduction strategies to avoid complications of disability and chronic illness;

h. Chronic disease self-management;

i. Prevention and treatment of opioid, alcohol, and substance use disorders;

j. Coping with losses resulting from disability or aging;

k. Self-care training, including self-examination; and

l. Over-the-counter medication management, including the importance of understanding how to take over-the-counter and prescribed medications and how to coordinate all

such medications.

2. The Contractor shall comply with all applicable state and federal statutes and regulations on Wellness Initiatives; and

3. The Contractor shall ensure that Wellness Initiatives include Culturally and Linguistically Appropriate materials.

D. Disease Management

The Contractor shall develop, implement, and maintain Disease Management programs as follows and as further directed by EOHHS:

1. The Contractor shall establish programs that address the specific needs of Enrollees with certain diseases or conditions which may place such Enrollees at high risk for adverse health outcomes;

2. The Contractor shall utilize information resulting from its risk stratification processes described in **Section 2.4.B** to inform the development of Disease Management programs. Such programs shall include activities such as, but not limited to:

   a. Education of Enrollees about their disease or condition, and about the care available and the importance of proactive approaches to the management of the disease or condition (including self-care);

   b. Outreach to Enrollees to encourage participation in the appropriate level of care and care management for their disease or condition;

   c. Facilitation of prompt and easy access to care appropriate to the disease or condition in line with applicable and appropriate clinical guidelines;

   d. Mechanisms designed to ensure that pre-treatment protocols, such as laboratory testing and drug pre-authorization, are conducted in a timely manner to ensure that treatment regimens are implemented as expeditiously as possible; and

   e. Education of Providers, including, but not limited to, clinically appropriate guidelines and Enrollee-specific information with respect to an Enrollee's disease or condition, including relevant indicators.

E. Emergency Departments

The Contractor shall make best efforts to minimize Enrollees waiting in emergency departments for disposition to BH services as follows:

1. The Contractor shall ensure timely access to medically necessary behavioral health services for Enrollees determined by EOHHS to be disproportionately boarded in emergency departments, including but not limited to, Enrollees with:

a. Autism Spectrum Disorder (ASD);

b. Intellectual or Developmental Disabilities (IDD);

c. Dual diagnosis of mental health and substance use disorder;

d. Co-morbid medical conditions; and

e. Assaultive or combative presentation resulting in the need for special accommodation in an inpatient psychiatric hospital setting;

2. In accordance with **Appendix F** the Contractor shall report to EOHHS on any Enrollee awaiting placement in a 24-hour level of behavioral health care who remains in an emergency department for 24 hours or longer, as further specified by EOHHS;

3. The Contractor shall report and participate in data collection and systems improvement efforts to reduce times Enrollees spend boarded in emergency departments and improve care for Enrollees in accordance with EOHHS initiatives to minimize Enrollees waiting in emergency departments across the spectrum of care;

4. The Contractor shall take initiatives to help minimize Enrollees waiting in emergency departments, including but not limited to proactively identifying Enrollees who are at risk of hospitalization for behavioral health needs as part of the Care Needs Screening described in **Section 2.3.B.2**.

F. Transitional Care Management and Discharge Planning

1. The Contractor shall have a Transitional Care Management program. The Contractor shall develop, implement, and maintain protocols for transitional care management with all Affiliated Hospitals. Such protocols shall:

a. Ensure follow-up with an Enrollee within 72 hours of when the Enrollee is discharged from any type of Affiliated Hospital inpatient stay or emergency department visit, through a home visit, in-office appointment, telehealth visit, or phone conversation, as appropriate, with the Enrollee;

b. Ensure post-discharge activities are appropriate to the needs of the Enrollee, including identifying the need for follow-up services;

c. Be developed in partnership with and specify the role of the Contractor's BH CPs and LTSS CPs in managing transitional care for Enrollees with BH and LTSS needs;

d. Integrate the Contractor's other Care Management activities for Enrollees, such as ensuring that an Enrollee's Care Coordinator or Clinical Care Manager is involved in Discharge Planning and follow-up;

e. Include elements such as but not limited to the following:

1) Event notification protocols that ensure key providers and individuals involved in an Enrollee's care are notified of admission, transfer, discharge, and other important care events, for example, through accessing or receiving event notifications from an EOHHS-Certified ENS Vendor participating in the Statewide ENS Framework. Such key providers shall include but not be limited to an Enrollee's PCP, BH Provider if any, and LTSS Provider (e.g., Personal Care Attendant) if any;

2) Medication reconciliation;

3) Criteria that trigger an in-person rather than telephonic post-discharge follow-up;

4) Home visits post-discharge for certain Enrollees with complex needs;

5) Policies and procedures to ensure inclusion of Enrollees and Enrollees' family members, guardians and caregivers, as applicable, in Discharge Planning and follow-up, and to ensure appropriate education of Enrollees, family members, guardians, and caregivers on post-discharge care instructions;

6) Inclusion of the Enrollee's BH Provider, if any, Recovery Support Navigator, if any, and LTSS Provider (e.g., Personal Care Attendant) if any in Discharge Planning and follow-up;

f. Include protocols for documenting all efforts related to Transitional Care Management, including the Enrollee's active participation in any Discharge Planning;

g. Include protocols for documenting all efforts related to Transitional Care Management, including the Enrollee's active participation in any Discharge Planning;

2. The Contractor shall assist hospitals, including but not limited to Affiliated Hospitals, in Discharge Planning activities for Enrollees at Risk of Homelessness and Enrollees Experiencing Homelessness, as further specified by EOHHS. The Contractor shall document any such assistance in the Enrollee's medical record.

3. For the purposes of this **Section 2.3.F**,

a. Enrollees Experiencing Homelessness shall be any Enrollee who lacks a fixed, regular, and adequate nighttime residence and who:

1) has a primary nighttime residence that is a public or private place not designed for or ordinarily used as a regular sleeping accommodation for human beings including a car, park, abandoned building, bus or train station, airport, or camping group;

2) is living in a supervised publicly or privately operated emergency shelter

designated to provide temporary living arrangements, including congregate shelters, transitional housing, and hotels and motels paid for by charitable organizations or by federal, state, or local government programs for low-income individuals; or

3) is chronically homeless as defined by the US Department of Housing and Urban Development;

b. Enrollees at Risk of Homelessness shall be any Enrollee who does not have sufficient resources or support networks (e.g., family, friends, faith-based or other social networks) immediately available to prevent them from moving to an emergency shelter or another place not meant for human habitation.

G. Clinical Advice and Support Line

1. The Contractor shall maintain a Clinical Advice and Support Line, accessible by Enrollees 24 hours a day, seven days a week, as described in this Section.

2. General

The Contractor's Clinical Advice and Support Line shall:

a. Be easily accessible to Enrollees;

b. Have a dedicated toll-free telephone number;

c. Offer all services in all Prevalent Languages, at a minimum;

d. Make oral interpretation services available free-of-charge to Enrollees in all non-English languages spoken by Enrollees;

e. Maintain the availability of services for the deaf and hard of hearing, such as TTY services or comparable services; and

f. Be staffed by a registered nurse or similarly licensed and qualified clinician, and shall provide direct access to such clinician

3. To support the Clinical Advice and Support Line, the Contractor shall:

a. Make a clinician available to respond to Enrollee questions about health or medical concerns and to provide medical triage, based on industry standard guidelines and as further directed by EOHHS, to assist Enrollees in determining the most appropriate level of care for their illness or condition;

b. Have documented protocols for determining an Enrollee's acuity and need for emergent, urgent, or elective follow-up care, and for directing an Enrollee to present at an emergency room, urgent care center, and/or primary care;

c. Have protocols to facilitate coordination of Enrollee care as follows:

1) The Clinical Advice and Support Line's clinicians shall have access to information about Enrollees and providers, including, at a minimum:

a) The ability to identify an Enrollee who calls the Clinical Advice and Support Line;

b) The name, contact information, and hours of operation of the Enrollee's PCP; and

c) The name and contact information of the Enrollee's Care Coordinator, if applicable;

2) The Clinical Advice and Support Line's clinicians shall have policies and procedures for integrating with care coordination and ACO Care Management, such as:

a) Notifying providers and Care Team members that the Enrollee has contacted the Clinical Advice and Support Line, particularly if the call indicates a need to modify the Enrollee's documented Care Plan or course of treatment or a need for follow-up;

b) Accessing relevant information from an Enrollee's Care Plan or medical record; and

c) Providing appropriate information and navigation to assist Enrollees in connecting to appropriate Providers;

4. The Clinical Advice and Support Line shall otherwise coordinate with an Enrollee's PCP or Care Coordinator, as applicable, including through providing "warm handoffs" to such individuals through direct transfer protocols and processes and capabilities to share information with such individuals;

5. The Clinical Advice and Support Line shall provide general health information to Enrollees and answer general health and wellness-related questions.

Section 2.4 Coordinating Care for Enrollees

A. Baseline Care Coordination

1. The Contractor shall perform baseline care coordination supports for all Enrollees. Baseline care coordination supports include but are not limited to:

a. Assigning Enrollees to a Primary Care Provider and ensuring such provider delivers services in accordance with the requirements described in **Section 2.3.A.1.c**;

b. In accordance with **Section 2.3.B**, ensuring Enrollees are screened for physical health, Behavioral Health, and LTSS needs, and Health-Related Social Needs;

c. Ensuring such Enrollees receive appropriate services and referrals to address their care needs;

d. Ensuring that providers follow up on tests, treatments, and services in a systematic and timely manner;

e. Ensuring Enrollees are provided with information and impartial counseling about available options;

f. Coordinating with service providers, community services organizations, and state agencies to improve integration of Enrollee's care;

g. When appropriate, facilitating the transition of an Enrollee to a different level of care, setting of care, frequency of care, or provider, to better match the Enrollee's needs, as well as providing basic support and follow-up during and after transitions of care;

h. Facilitating communication between the Enrollee and the Enrollee's providers and among such providers (e.g., through the use of the Mass HIway);

i. Ensuring appropriate information is recorded in the Enrollee's medical record, including but not limited to information on Comprehensive Assessments, Care Plans, and screenings;

j. Ensuring that all Enrollees and the guardian or caregiver for Enrollees under the age of 21 receive information about how to contact the Contractor to access care coordination;

k. Ensuring the Enrollee's PCP and any involved providers and Care Team members communicate and share records;

l. Sharing information about identification and assessment of needs conducted by the Contractor with appropriate treating providers or other members of the Enrollee's Care Team;

m. For Enrollees with identified Behavioral Health needs, ensuring that appropriate Behavioral Health Clinical Assessments and treatment planning are performed as described in **Section 2.3.B**;

n. Ensure that Enrollees receiving care coordination supports are notified of any changes to care coordination supports, including during times when the Contractor is ending an ACO/MCO – CP Agreement or when a Contractor is discontinuing Care Management activities that the Enrollee is engaged in, if applicable.

2. In addition to the activities listed above, for Enrollees under the age of 21 the Contractor shall:

a. Utilize a family-centered approach, in which caregivers are active members of the Enrollee's care, and coordinate with the Enrollee's caregiver or guardian; and

b. As applicable, coordinate with school or early childhood supports, Community Case Management (CCM), Children's Behavioral Health Initiative (CBHI) services, and any state agency supports (e.g., DPH, DCF, DMH, DDS, DYS).

3. The Contractor shall ensure that in the process of coordinating care, each Enrollee's privacy is protected in accordance with state and federal privacy requirements.

4. For Enrollees with identified Health-Related Social Needs (HRSN), the Contractor shall:

   a. Provide the Enrollee with information about available HRSN-related supports, how to contact such supports, and the accessibility of such supports;

   b. Ensure such Enrollees are referred to HRSN-related supports provided by the Contractor or a Social Service Organization as applicable;

      1) The Contractor shall refer the Enrollee to a Social Service Organization that has capacity and capability to address the Enrollee's HRSN and has agreed to receive referrals from the Contractor for the supports the Enrollee needs.

      2) The Contractor shall ensure the Social Service Organizations, including but not limited to Social Service Organizations with which the Contractor has not previously worked, are capable of providing the supports for which the Contractor has referred the Enrollee. Such actions may include connecting with the Social Service Organization to identify the supports it is able to provide and its capacity to serve new Enrollees.

   c. Ensure that its strategy for coordinating HRSN supports is integrated with the Contractor's overall Health Equity strategy;

   d. Establish and maintain at least one relationship with a provider or Social Services Organization that can assist Enrollees in obtaining WIC and SNAP;

   e. Utilize its Community Resource Database, as described in **Section 2.11.B.6**, to identify supports;

   f. Consider referral to the Flexible Services Program, as set forth in **Section 2.14.B**;

   g. As appropriate, refer the Enrollee to SNAP, WIC, or related programs to address Enrollee's needs;

   h. For Enrollees identified for referral to Flexible Services, SNAP, or WIC the Contractor shall:

      1) Provide the Enrollee's contact and information about the identified HRSN to the entity receiving the referral; and

      2) Follow up with the Enrollee to ensure the Enrollee's identified needs are being

met.

5. For Enrollees receiving Community Support Program (CSP) services, including Community Support Program Tenancy Preservation Program (CSP-TPP), Community Support Program for Homeless Individuals (CSP-HI), and Community Support Program Services for Individuals with Justice Involvement (CSP-JI), the Contractor shall:

    a. Actively communicate with CSP providers regarding the provision of CSP services to Enrollees, including coordinating care to ensure that Enrollees' needs are met;

    b. Designate a single point of contact for CSP providers and EOHHS as further specified by EOHHS; and

    c. Collect and maintain appropriate written documentation about housing status for Enrollees receiving CSP-HI and CSP-TPP.

B. Risk Stratification

1. The Contractor shall implement policies and procedures for conducting risk stratification as described in this Section. The Contractor shall document and detail its approach (e.g., use of specific risk assessment tools) and criteria employed to define and assign Enrollees to risk categories and shall provide such information to EOHHS upon request. The Contractor shall submit to EOHHS data resulting from its risk stratification process in a form and format specified by EOHHS, in accordance with **Appendix F**.

2. The Contractor shall have a methodology to predictively model, stratify and assign the Enrollee population into risk categories. The methodology shall:

    a. At a minimum, utilize medical records, claims data, discharge data, pharmacy data, laboratory data, referrals, data related to Utilization Management, and other relevant sources of information identified by the Contractor or EOHHS, to assess the Enrollee's risk for high cost, high utilization, admission, re-admission, or adverse health outcomes;

    b. Incorporate the results of any screenings or assessments, including Care Needs Screenings, Health-Related Social Needs screenings, and Comprehensive Assessments as set forth in **Section 2.3.B** and the Flexible Services Screening as set forth in **Section 2.14.B.2**;

    c. Differentiate criteria and assessment for Enrollees under 21 years old and Enrollees ages 21 through 65; and

    d. Stratify new Enrollees within 120 days of enrollment, and re-stratify all Enrollees twice per year, at a minimum.

3. The Contractor shall evaluate and update its predictive modeling for bias, including evaluation

of the data inputs to the modeling, twice per year, at a minimum.

4. The Contractor shall use its risk stratification process to identify high- and rising-risk Enrollees.

5. The Contractor shall evaluate such high- and rising-risk Enrollees to determine their appropriateness for enhanced care coordination as set forth in **Section 2.4.C**.

    a. The Contractor shall develop, maintain, and provide to EOHHS its process for identifying Enrollees appropriate for referral to an enhanced care coordination program, as well as a process for accepting and evaluating internal and external provider referrals, Care Team referrals, and Enrollee self-referrals to ACO Care Management and to the CP Program;

    b. In determining which Enrollees are appropriate for enhanced care coordination programs, the Contractor shall consider:

        1) Enrollees experiencing SED/SPMI and/or SUD;

        2) Enrollees with a history of waiting in EDs for disposition to Behavioral Health Services;

        3) Enrollees who are chronically homeless, experiencing homelessness, or housing unstable (particularly those being discharged from inpatient care);

        4) Child and adult Enrollees with medical complexity (e.g., multiple co-morbidities, co-existing functional impairments);

        5) Enrollees with unmet LTSS needs;

        6) Enrollees with Special Health Care Needs;

        7) Enrollees transitioning between sites of care across hospital, chronic/rehabilitation hospital, nursing facility or other settings or levels of care;

        8) Enrollees identified by EOHHS as appropriate for an enhanced care coordination program;

        9) Enrollees who self-identify to the Contractor as potentially benefiting from an enhanced care coordination program;

        10) High-risk perinatal Enrollees, including but not limited to those with:

            a) Any history of complex or severe BH diagnosis;

            b) Any history of substance use disorder, including opioids, alcohol, or tobacco;

c) Any current chronic physical health diagnosis which may complicate the perinatal period (e.g., hypertension, diabetes, HIV);

d) Any history of adverse perinatal or neonatal outcomes in previous pregnancies, including any instances of severe maternal morbidity; or

e) Any current complex social conditions which could impact outcomes during the perinatal period (e.g., unsafe living environment, significantly late prenatal care initiation, nutrition or housing insecurity).

11) Other Enrollees the Contractor deems appropriate for receiving enhanced care coordination supports, or as further specified by EOHHS.

c. The Contractor shall determine a perinatal Enrollee's appropriateness for an enhanced care coordination program based on criteria set forth in **Section 2.4.B.5.b.10** during pregnancy and within six weeks following the end of pregnancy.

6. The Contractor shall additionally use its risk stratification process to monitor and address high emergency department (ED) utilization.

a. The Contractor shall conduct a review of ED utilization to identify over-utilization patterns for high utilizing Enrollees. Specifically, the Contractor shall identify Enrollees with 5 or more ED visits in 12 consecutive months and perform analyses on Enrollee utilization and cost. The Contractor shall utilize the results to develop appropriate interventions or ACO Care Management programs aimed at reducing ED utilization.

b. The Contractor shall monitor ED utilization by using the New York University Emergency Department (NYU ED) visit severity algorithm or a similar algorithm approved by EOHHS to classify ED visits. The visit classifications shall include:

1) Non-Emergent

2) Emergent/Primary Care Treatable

3) Emergent- ED Care Needed – Preventable/Avoidable

4) Emergent-ED Care Needed- Not Preventable/Avoidable

C. Enhanced Care Coordination

The Contractor shall provide enhanced care coordination supports as follows:

1. Of the Enrollees the Contractor identifies as appropriate for enhanced care coordination as described in **Section 2.4.B**, the Contractor shall enroll Enrollees in an ACO Care Management program as set forth in **Section 2.4.D** or in a CP as set forth in **Section 2.4.E**. The Contractor may enroll Enrollees in both an ACO Care Management program and a CP as appropriate and as further specified by EOHHS.

a. The Contractor shall identify and consider the following Enrollees for enrollment in a CP:

1) For BH CP, Enrollees ages 18-64 with predominant behavioral health need(s), such as Serious and Persistent Mental Illness (SPMI), Serious Emotional Disturbance (SED), substance use disorder (SUD), or co-occurring SPMI/SUD.

2) For LTSS CP, Enrollees ages 3-64 with predominant LTSS needs, such as significant functional impairments, a history of high and sustained LTSS utilization, or LTSS related diagnoses including but not limited to Enrollees with physical disabilities, Enrollees with acquired or traumatic brain injury or other cognitive impairments, Enrollees with intellectual or developmental disabilities (ID/DD) including Enrollees with Autism Spectrum Disorder.

b. In accordance with **Appendix F**, the Contractor shall report, in a form and format specified by EOHHS, on its Enrollees identified as high- and rising-risk and appropriate for and receiving enhanced care coordination.

2. The Contractor shall provide the enhanced care coordination supports described in **Section 2.4.C**, including but not limited to Comprehensive Assessments and Care Plans, for Enrollees who are both enrolled in an enhanced care coordination program and are receiving Community Support Program (CSP) as set forth in **Appendix A**.

a. The Contractor shall:

1) Obtain consent from the Enrollee to receive enhanced care coordination supports. Consent shall include permission for the Contractor to share information about an Enrollee's care with the Enrollee's providers, as appropriate;

2) Assign a Care Coordinator to the Enrollee who will serve as the main point of contact for the Enrollee and the Enrollee's guardian or caregivers, as appropriate;

3) Notify Enrollees and providers of the lead entity for the Enrollee's care coordination upon enrollment into an ACO Care Management program or a CP;

b. For Enrollees enrolled in both a BH CP or LTSS CP and ACO Care Management, the Contractor shall:

1) Ensure that the CP serves as the lead care coordination entity, including leading the Comprehensive Assessment and the development of the Enrollee's Care Plan;

2) Notify the CP that the Enrollee is enrolled in both the CP program and an ACO Care Management program; and

3) Ensure that an ACO Care Management team member participates in the Care Team convened and led by the CP.

c. For Enrollees under the age of 21 assigned to ACO Care Management who are receiving Intensive Care Coordination services or MassHealth CARES for Kids services as described in **Appendix A**, the Provider of such services will serve as the lead entity responsible for coordinating care.

d. For perinatal Enrollees identified as high-risk, as described in **Section 2.4.B.5.b.10**, and assigned to an enhanced care coordination program, the Contractor shall ensure such Enrollees receive enhanced care coordination during the perinatal period.

3. The Contractor shall make best efforts to successfully outreach and engage Enrollees enrolled in an enhanced care coordination program, including but not limited to using multiple attempts and modalities to conduct at least one outreach activity within 30 days of the Enrollee's assignment to the enhanced care coordination program.

a. Outreach activities may include but are not limited to:

1) Calling the Enrollee;

2) Visiting locations which the Enrollee is known to reside or frequent;

3) Contacting Enrollees' providers to verify or obtain contact information;

4) Conducting face-to-face visits with the Enrollee; and

5) Utilizing electronic communication to contact the Enrollee.

b. Engagement activities may include but are not limited to:

1) Providing the Enrollee information about the benefits, design, and purpose of the enhanced care coordination supports;

2) Providing the Enrollee information on the process for engaging with the enhanced care coordination program; and

3) Providing opportunities for an Enrollee to decline to receive enhanced care coordination supports.

4. For Enrollees enrolled in an enhanced care coordination program, the Contractor shall designate a multi-disciplinary Care Team, in accordance with the needs and preferences of the Enrollee. The Contractor shall encourage the Enrollee to identify individuals to participate and shall include such individuals on the Enrollee's Care Team. The Contractor shall:

a. Ensure that the Enrollee's Care Team consists of the following individuals as applicable and appropriate:

1) The Enrollee's Providers (e.g., PCP, BH and/or LTSS providers, specialists);

2) The Enrollee's CP Care Coordinator, for Enrollees enrolled in the CP program;

3) Enrollee's ACO Care Management Care Coordinator, for Enrollees enrolled in ACO Care Management;

4) Enrollee's guardian or caregivers;

5) State agency or other case managers;

6) If the Enrollee is experiencing homelessness or has unstable housing, any homeless provider agencies working with the Enrollee;

7) Community Behavioral Health Center (CBHC) staff member from the CBHC at which the Enrollee is receiving services, if applicable;

8) For Enrollees under the age of 21, as applicable, school or early childhood supports, Community Case Management (CCM), Children's Behavioral Health Initiative (CBHI), and state agency staff (e.g., DPH, DCF, DMH, DDS, DYS);

9) Enrollee's Care Team Point of Contact; and

10) Any additional individuals requested by the Enrollee or the Enrollee's guardian or caregiver, such as advocates or other family members.

b. Ensure that each Care Team member has a defined role appropriate to their licensure or training and relationship to the Enrollee;

c. Ensure that the names and contact information of each member of the Care Team is documented in the Enrollee's medical record;

d. Ensure that members of the Care Team are responsible for the following:

1) Maintaining high-functioning relationships and open communication with all parties involved in the Enrollee's care, including but not limited to PCPs, specialty providers, hospitals and health systems, Social Service Organizations, schools and early education programs, Family Resource Centers, CSP providers, and other state agencies, as appropriate;

2) Facilitating coordination with such parties (e.g., joint clinical rounding, regular Care Plan reviews, and updates);

3) Providing intensive support for transitions of care as described in **Section 2.4.C.5**; and

4) Coordinating supports to address HRSN, including:

a) Assisting the Enrollee in attending the referred appointment, including activities such as coordinating transportation assistance and following up after missed appointments;

b) For Enrollees in the CP Program, the Contractor shall ensure that the CP directly introduces the Enrollee to the supports provider, if co-located, during a visit;

c) Utilizing electronic referral (e.g., electronic referral platform, secure e-mail) to connect the Enrollee with the appropriate provider or Social Service Organization, if the Social Service Organization has electronic referral capabilities, including sharing relevant patient information;

d) Following up electronically (e.g., electronic referral platform, secure e-mail) with the provider or Social Services Organization, if the Social Services Organization has electronic follow-up capabilities, as needed, to ensure the Enrollee's needs are met.

5. In addition to having a Transitional Care Management program as well as meeting the requirements for Discharge Planning for Enrollees experiencing homelessness or Enrollees at risk of homelessness as set forth in **Section 2.3.F.2**, the Contractor shall support transitions of care as follows for Enrollees enrolled in an enhanced care coordination program:

a. For purposes of this Section, transitions of care shall include inpatient discharge or transition, including but not limited to discharge from an acute inpatient hospital, nursing facility, chronic disease and rehabilitation, psychiatric inpatient hospital, substance abuse hospital, collectively referred to as "inpatient discharge" for the purposes of this **Section 2.4.C**, twenty-four (24) hour diversionary setting discharge, emergency department (ED) discharge, or any other change in treatment setting;

b. Prior to a transition in care, the Contractor shall ensure the Care Team assists in the development of an appropriate discharge or transition plan, including on-site presence in acute settings if appropriate;

c. For CP Enrollees, the Contractor shall ensure that a CP staff member is present at discharge planning meetings, as appropriate;

d. Within seven (7) calendar days following an Enrollee's emergency department (ED) discharge, an Enrollee's inpatient discharge, discharge from twenty-four (24) hour diversionary setting, or transition to a community setting, the Contractor shall ensure the Care Coordinator at a minimum:

1) Follows up with the Enrollee face-to-face or via telehealth (e.g., telephone or videoconference, or as further specified by EOHHS); provided, however, for CP Enrollees, this visit must be in accordance with **Appendix G**;

2) Updates the Enrollee's Care Plan; and

3) Coordinates clinical services and other supports for the Enrollee, as needed.

e. Following an Enrollee's emergency department (ED) discharge, inpatient discharge, discharge from twenty-four (24) hour diversionary setting, or transition to a community setting, the Contractor shall ensure that a registered nurse (RN) or a licensed practical nurse (LPN) under the oversight and supervision of an RN:

1) Reviews the updated Care Plan, if applicable;

2) Conducts a Medication Review in accordance with **Section 2.4.C.6**; and

3) Discusses with the Care Team plans to better support the Enrollee to prevent future admissions or re-admissions, as appropriate.

f. The Contractor shall ensure it receives updates from the Care Coordinator on the Enrollee's status following transitions in care;

g. The Contractor shall ensure that the Care Coordinator assists Enrollees in accessing supports to which they are referred following a transition of care; provided, however, for CP Enrollees, such assistance shall be as further specified in **Appendix G**;

h. For Enrollees enrolled in an enhanced care coordination program, the Enrollee's Care Team shall support transitions of care.

6. The Contractor shall perform medication review for Enrollees enrolled in an enhanced care coordination program.

a. At minimum, the Contractor shall ensure that a medication review of the Enrollee's medications is performed:

1) During the Enrollee's initial and annual Comprehensive Assessment, as described in **Section 2.3.B.4**;

2) Following a transition of care, as described in **Section 2.4.C.5**, within 7 calendar days unless further specified by EOHHS;

3) When the Contractor is informed of a change (e.g., from the Enrollee, the Enrollee's PCP or designee, Care Team member, review of the Enrollee's EMR) in the Enrollee's medication regimen; and

4) At least once annually thereafter.

b. The Contractor shall ensure that medication review is performed by a licensed pharmacist, a registered nurse (RN), or by a licensed practical nurse (LPN) under the oversight and supervision of an RN. Such oversight and supervision shall include the LPN reviewing the medications with an RN and documenting such review in the Enrollee's health record.

c. Medication review shall include, but is not limited to, the following:

1) Generating a list of the Enrollee's medications, such as using individual recall or records from recent provider visits, pharmacies, and hospitalizations;

2) Collaborating with the Enrollee to identify any confusion or discrepancies in the Enrollee's medication regimen;

3) Collaborating with the Enrollee to identify any barriers the Enrollee may have to adhering to their medication regimen;

4) Supporting the Enrollee in understanding the regimen and developing strategies to maintain adherence to the medication regimen; and

5) Supporting the Care Team in considering potential medication changes for an Enrollee with a change in their clinical or functional presentation.

7. The Contractor shall conduct health and wellness coaching activities as indicated in the Enrollee's Care Plan. The Contractor's health and wellness coaching activities may include, but are not limited to:

a. Assisting the Enrollee in setting health and wellness goals;

b. Educating the Enrollee about their health conditions and strengthening self-management skills;

c. Providing health education, coaching, and symptom management support to improve the Enrollee's knowledge of prevention and management of chronic medical conditions;

d. Educating the Enrollee on how to reduce high-risk behaviors and health risk factors; and

e. Assisting the Enrollee in establishing links to health promotion activities such as smoking cessation and appropriate exercise.

8. The Contractor shall ensure that its enhanced care coordination programs address the needs specific to Enrollees under the age of 21. The Contractor shall ensure that such programs, as appropriate:

a. Provide educational supports and coordination (e.g., navigating the special education system, participating in individualized educational plans (IEPs) meetings, as appropriate);

b. Communicate with school nurses or key school personnel; and

c. Support transitional age youth in transitioning to adult care.

9. The Contractor shall ensure that the Enrollee's PCP considers recommendations in the Enrollee's Care Plan for referrals to TCOC Included Services and non-TCOC Included Services;

10. For Enrollees receiving services from other state agencies (e.g., DCF, DMH, DDS, DYS, DPH), receiving an TCOC Included Service (e.g., CBHI ICC) or other program (e.g., Community Case Management (CCM)) that coordinates care for Enrollees, or receiving services from a Community Behavioral Health Center, the Contractor shall coordinate with such entities;

11. For CP Enrollees, the Contractor shall ensure that its CPs meet all requirements in this Section.

D. ACO Care Management

The Contractor shall:

1. Develop, implement, and maintain policies and procedures for providing ACO Care Management that meets the requirements described in **Sections 2.4.C-D** and shall provide those policies and procedures to EOHHS as further specified by EOHHS.

2. Utilize the results of its risk stratification process to inform its development and implementation of appropriate ACO Care Management programs.

3. Enroll approximately 3-4%, of the Contractor's Enrollees in ACO Care Management, or other number as further specified by EOHHS.

    a. Enrollees in both ACO Care Management and a CP count toward the minimum enrollment requirements as described in **Section 2.4.D** and **Section 2.4.E**, for both programs, up to a maximum of 1% of the Contractor's total number of Enrollees.

    b. EOHHS shall monitor the Contractor's CM program enrollment quarterly (or at another frequency specified by EOHHS) by reviewing CM enrollment in the preceding quarter (or other time period specified by EOHHS).

4. Use an enrollment platform as specified by EOHHS to manage ACO Care Management enrollment and disenrollment in real-time.

5. Tailor ACO Care Management programs to the needs of the Contractor's population and support the Contractor's overall population health strategy.

6. Ensure that for Enrollees in ACO Care Management, the Enrollee's Care Team shall meet at least annually and after any major events in the Enrollee's care or changes in health status, or more frequently if indicated.

7. Ensure ACO Care Management supports occur, at a minimum, in the following settings:

    a. Adult and family homeless shelters, for Enrollees who are experiencing homelessness;

    b. The Enrollee's home;

c. The Enrollee's place of employment or school;

d. Foster homes, group homes, residential schools, and other residential placements locations;

e. Day health sites, for Enrollees in Adult Day Health programs; and

f. 24-hour level of care facilities for Behavioral Health or substance use disorder treatment.

8. Establish criteria for disenrollment from ACO Care Management, as appropriate.

9. Appropriately document the ACO Care Management supports each Enrollee receives, as further specified by EOHHS.

10. Implement appropriate staffing ratios and caseloads for Care Coordinators and other staff involved in ACO Care Management activities, in line with standard industry practices.

11. Ensure that a Designated Pediatric Expert is involved in the development of and review the Contractor's ACO Care Management strategy for Enrollees under the age of 21.

12. Ensure that ACO Care Management policies and procedures address prevalent conditions for Enrollees under the age of 21 including but not limited to asthma.

13. Manage the Contractor's ACO Care Management Programs by performing, at a minimum, the following tasks and using such outcomes to improve ACO Care Management programs:

a. Evaluating the effectiveness and quality of the Contractor's ACO Care Management programs, including by identifying relevant metrics and using valid quantitative methods to assess those metrics against performance goals;

b. Reporting to EOHHS about ACO Care Management programs and activities, population health strategies and predictive modeling, in a form and format specified by EOHHS, in accordance with **Appendix F**; and

c. Reporting on completion rates of Comprehensive Assessments and Care Plans for Enrollees in ACO Care Management programs, in a form and format specified by EOHHS, in accordance with **Appendix F**.

E. Behavioral Health Community Partners (BH CP) and Long-Term Services and Supports Community Partners (LTSS CP) Programs

The Contractor shall maintain contracts with Community Partners as follows:

1. At all times as of the Contract Operational Start Date, the Contractor shall maintain subcontracts (also known as ACO-CP Agreements) with at least one BH CP and at least one LTSS CP that serve each of the Contractor's service areas, as further specified by EOHHS.

a. The Contractor shall modify their CP subcontracts or subcontract with different CPs upon request from EOHHS, including if a CP is determined to be no longer qualified by EOHHS.

b. The Contractor shall submit advance notice to EOHHS at least 90 days prior to terminating a subcontract with a CP.

c. If so notified by EOHHS, the Contractor shall not be required to maintain subcontract(s) with BH CPs. Reasons for such notification may include the Contractor having a limited number of Enrollees over the age of 21, or other reasons specified by EOHHS; and

d. The Contractor shall not permit a Contractor's Material Subcontractor for BH Services to enter into CP subcontracts on behalf of the Contractor.

2. The Contractor shall delegate the enhanced care coordination requirements described in **Section 2.4.C** for CP Enrollees to its CPs. The Contractor shall ensure its CPs meet the requirements of **Sections 2.4.C** and **2.4.E**, and **Appendix G**.

3. The Contractor shall engage with EOHHS and its CPs in performance management and compliance activities as follows and as further specified by EOHHS:

   a. The Contractor shall use data sources such as monthly claims reports, quality measures calculated by EOHHS, and performance data and reports, to monitor CP performance in areas including, but not limited to, the following domains:

      1) Fidelity to CP supports care model ;

      2) Critical incident reporting;

      3) Grievances;

      4) Record keeping;

      5) Performance on quality measures; and

      6) Qualifying Activities (QAs).

   b. The Contractor shall report to EOHHS on CP performance and inform EOHHS of early warning indicators of performance concerns in a form and format specified by EOHHS in accordance with **Appendix F**.

   c. The Contractor shall report to EOHHS on severe performance and compliance concerns with CPs and any corrective action plans it implements with CPs in accordance with **Appendix F**.

4. The Contractor shall enroll its Enrollees in CPs as follows:

a. The Contractor shall enroll approximately 3% of its Enrollees in BH CPs (if applicable pursuant to **Section 2.4.E.1.c**), or other number as further specified by EOHHS.

b. The Contractor shall enroll approximately 1% of its Enrollees in LTSS CPs, or other number as further specified by EOHHS.

c. Enrollees in both ACO Care Management and a CP count toward the minimum enrollment requirements described in **Section 2.4.D** and **Section 2.4.E**, for both programs, up to a maximum of 1% of the Contractor's total number of Enrollees.

d. EOHHS shall monitor the Contractor's CP program enrollment quarterly (or at another frequency specified by EOHHS) by reviewing CP enrollment in the preceding quarter (or other time period specified by EOHHS).

e. When referrals are received from CBHCs, the Contractor shall enroll the Enrollee in the CP Program, unless the Contractor determines another Enhanced Care Coordination Program is better suited for the Enrollee.

5. On a monthly basis or as further specified by EOHHS, the Contractor shall enroll Enrollees in CPs:

   a. With which the Contractor has a subcontract;

   b. That serve the geographic area in which the Enrollee lives, as further specified by EOHHS; and

   c. That have confirmed capacity to accept the assignment.

   d. In addition, the Contractor shall ensure Enrollees are not enrolled in both:

      1) BH CP and any of the following programs or services: Program of Assertive Community Treatment (PACT), MassHealth CARES for Kids, or other programs and services as specified by EOHHS.

      2) LTSS CP and any of the following programs or services: Program of Assertive Community Treatment (PACT), MassHealth CARES for Kids, CBHI ICC, or other programs and services as specified by EOHHS.

   e. The Contractor shall use an enrollment platform as specified by EOHHS to manage CP enrollment and disenrollment in real-time. This shall include:

      1) Communicating enrollments to the CPs in a form, format, and cadence specified by EOHHS;

      2) Sharing processing statuses for CP enrollees with CPs;

      3) Responding to CP inquiries about Enrollee processing status;

4) Monitoring Enrollee status and resolving CP enrollment issues; and

5) Communicating resolution of enrollment issues to the CPs.

6. As further specified by EOHHS, the Contractor shall develop, implement, and maintain processes for disenrolling CP Enrollees enrolled in the CP Program, including:

   a. When the Contractor, in consultation with the Enrollee and the Enrollee's CP, determines that the Enrollee has successfully completed Graduation from CP Program;

   b. When the CP finds that the Enrollee is unreachable after multiple outreach efforts;

   c. When the Enrollee has declined to participate in the CP program;

   d. When the Enrollee moves out of the Service Area(s) served by the CP;

   e. When the CP has not submitted any Qualifying Activities after four (4) months of the Enrollee's enrollment in the CP, or the CP has not submitted any Qualifying Activities other than outreach after six (6) months of the Enrollee's enrollment in the CP; and

   f. When it is appropriate to transition responsibility for enhanced care coordination supports from the CP to the Contractor for Enrollees who have certain medical complexities, as further specified by EOHHS;

7. The Contractor shall make best efforts to promptly begin coordinating with a CP within seven (7) days of an Enrollee's enrollment in that CP. Such coordination shall include, but not be limited to:

   a. Providing the CP with the name, contact information, and other available, necessary and appropriate information regarding the CP Enrollee to assist in outreach and engagement for the Enrollee;

   b. Communicating with the CP to coordinate plans to outreach to and engage the CP Enrollee;

   c. Providing the CP with a Comprehensive Assessment or Care Plan that has been completed by the Contractor prior to the Enrollee's enrollment in the CP program; and

   d. Other forms of coordination as appropriate.

8. The Contractor shall accommodate requests from CP Enrollees to enroll in a different CP, as follows:

   a. The Contractor shall develop and maintain policies and procedures for receiving, evaluating, and making determinations regarding such requests. Such policies and procedures shall account for the Enrollee's preferences;

b. For Enrollees that are Department of Mental Health (DMH) ACCS clients and enrolled in a CP, the Contractor shall:

1) Accommodate requests from the Enrollee and from DMH on behalf of the Enrollee to enroll the Enrollee in a different CP;

2) Consult with DMH prior to enrolling the Enrollee in a different CP; and

3) Make best efforts to accommodate such requests in accordance with the Contractor's policies and procedures, subject to availability, including CP capacity, within thirty (30) calendar days of receiving a request from such Enrollee or DMH;

c. The Contractor shall notify CP Enrollees of the Contractor's decision to enroll the Enrollee in a different CP, as further specified by EOHHS; and

d. The Contractor shall transfer care-related information about a CP Enrollee to the new CP in which such CP Enrollee has been enrolled, including but not limited to the results of any Comprehensive Assessment and specified information from the CP Enrollee's Care Plan.

9. The Contractor shall pay CPs as follows and as further specified by EOHHS:

a. The Contractor shall pay its CPs a panel-based payment as set forth in **Appendix G** and as further specified by EOHHS. This panel-based payment shall be at least the amount specified by EOHHS, and account for certain add-ons, as set forth in **Appendix G**. The applicable cost of the panel-based payment to CPs shall be reflected in Administrative Payments, as further specified in **Section 4.2**.

b. The Contractor shall make annual quality performance-based payments to CPs as set forth in **Appendix G** and as further specified by EOHHS.

c. For each payment above:

1) The Contractor shall make such payments using, as applicable, CP enrollment and quality performance information, including the CP Quality Score, provided by EOHHS.

2) The Contractor shall submit a report to EOHHS in a format and format specified by EOHHS in accordance with **Appendix F**, to demonstrate that the Contractor has made all required payments.

3) EOHHS may audit the Contractor's related records.

10. Data, reporting, and information exchange

a. The Contractor shall accept and utilize Electronic Data Interchange, HIPAA-compliant

XL12 files from EOHHS, including the 834 daily and monthly audit files, and other files as specified by EOHHS, for the purposes of managing the Contractor's roster of CP Enrollees and for and program management.

b. The Contractor shall establish policies and procedures with CPs for bi-directional, electronic sharing of information necessary for CP Enrollee care, in a form and format approved by both parties, including but not limited to processes for the exchange of:

1) CP Enrollee contact information and PCP assignment;

2) CP Enrollee screening and assessment results;

3) CP Enrollee Care Plans;

4) CP Enrollee outreach status;

5) Real-time event notification of CP Enrollee admissions, discharges and transfers; and

6) Other relevant information regarding CP Enrollee's health status, as further specified by EOHHS.

11. The Contractor shall submit reports to EOHHS regarding CP enrollment, engagement, and performance in accordance with **Appendix F** and as further specified by EOHHS.

12. The Contractor shall designate appropriate administrative staff to satisfy the requirements of this **Section 2.4.E** and **Appendix G**, including at a minimum:

a. One (1) key contact from each of the Contractor and the ACO Partner responsible for regular communication with CPs about matters such as: data exchange; care coordination; issue escalation and resolution; and PCP or PCP practice communication. The Contractor shall provide its CPs with information about each such key contact, including the contact's name, title, organizational affiliation, and contact information. The Contractor shall provide its CPs with timely notification if such key contacts change; and

b. For each CP Enrollee, one (1) Care Team Point of Contact who serves as a member of the Enrollee's Care Team. This individual shall be responsible for acting as a liaison for the Contractor on the Enrollee's Care Team as well as ensuring the CP receives information regarding any ED and inpatient admissions, Medically Necessary specialty care or referrals the Enrollee may have had, and is included in Discharge Planning for the CP Enrollee.

13. The Contractor shall:

a. Ensure that PCPs have received trainings related to the CP program; and

b. Make PCPs and other providers aware of their responsibilities in working with CPs.

14. As requested by EOHHS, the Contractor shall support EOHHS' management of the BH CPs' provision of CP Supports to certain CP Enrollees who screen positive on Preadmission Screening and Resident Review Level II as further specified by EOHHS.

15. Continuity of CP Supports

a. When directed by EOHHS, ensure continuity of CP Supports for new Enrollees who were previous CP Enrollees, as further specified by EOHHS.

b. As further specified by EOHHS, the Contractor shall ensure that new Enrollees who were previously enrolled in a CP are transitioned to a CP that has a subcontract with the Contractor is sub-contracted, as appropriate and no later than 30 days after the Enrollee's Effective Date of Enrollment.

Section 2.5 Contract Management, Reporting, and Administration

A. Key Personnel and Other Staff

The Contractor shall have Key Personnel and other staff as set forth in this Section.

1. The following roles shall be filled by the Contractor's Key Personnel:

a. The Contractor's MassHealth Executive Director, who shall have primary responsibility for the management of this Contract and shall be authorized and empowered to represent the Contractor regarding all matters pertaining to this Contract;

b. The Contractor's Chief Medical Officer/Medical Director, who shall be a clinician licensed to practice in Massachusetts and shall oversee the Contractor's Care Delivery responsibilities and Care Management activities as described in **Section 2.4**, and all clinical initiatives including quality improvement activities, including but not limited to clinical initiatives related to addressing the care needs of children;

c. The Contractor's Pharmacy Contact who shall be responsible for the Contractor's activities related to pharmacy TCOC Included Services;

d. The Contractor's Behavioral Health Director, who shall be responsible for the Contractor's activities related to BH Services and related care delivery responsibilities and Care Management activities as described in **Section 2.3**, and for all BH-related interaction with EOHHS and coordination with the Behavioral Health Vendor as described in **Section 2.8**;

e. The Contractor's Chief Financial Officer, who shall be authorized to sign and certify the Contractor's financial condition, including but not limited to attesting to the accuracy of Contractor's financial documents submitted to EOHHS, as described in this Contract and further specified by EOHHS;

f. The Contractor's Chief Data Officer, who shall have primary responsibility for ensuring management and compliance of all activities under **Section 2.11** and **Appendix H**;

g. The Contractor's Disability Access Coordinator, whose responsibilities shall include, but may not be limited to:

1) Ensuring that the Contractor complies with federal and state laws and regulations pertaining to persons with disabilities;

2) Monitoring and advising on the development of, updating and maintenance of, and compliance with disability-related policies, procedures, operations and activities, including program accessibility and accommodations in such areas as health care services, facilities, transportation, and communications;

3) Working with other Contractor staff on receiving, investigating, and resolving Inquiries and Grievances related to issues of disability from Enrollees. Such individual shall be the point person for all Inquiries and Grievances related to issues of disabilities from Enrollees;

4) Working with designated EOHHS and Massachusetts Office of Disability staff as directed by EOHHS, including being available to assist in the resolution of any problems or issues related to Enrollees; and

5) Upon request of EOHHS, participate in meetings or workgroups related to the needs and care of Enrollees with disabilities;

h. The Contractor's State Agency Liaison, who shall coordinate the Contractor's interaction with state agencies with which Enrollees may have an affiliation, including but not limited to the Department of Mental Health (DMH), the Department of Developmental Services (DDS), the Department of Children and Families (DCF), the Department of Youth Services (DYS), the Department of Public Health (DPH) and the DPH Bureau of Substance Abuse Services (BSAS). Such Liaison shall act as or shall oversee:

1) A designated DCF liaison that works with DCF, including the DCF health and medical services team and DCF medical social workers. Such liaison shall:

a) Have at least two years of care management experience, at least one of which shall include working with children in state custody;

b) Actively participate in the planning and management of services for children in the care or custody of DCF, including children in foster care, guardianship arrangements, and adoptive homes. This shall include but not be limited to:

(i) Working with DCF, including the DCF Ombudsman's Office, the DCF health and medical services team, and the DCF medical

social workers, to assist EOHHS and DCF in the resolution of any problems or issues that may arise with an Enrollee;

(ii) Upon request of DCF, participating in regional informational and educational meetings with DCF staff and, as directed by DCF, with foster parent(s), guardians, and adoptive parent(s);

(iii) If requested by DCF, work with providers to coordinate Discharge Planning;

(iv) As requested by EOHHS, actively participate in any joint meetings or workgroups with EOHHS agencies and other Accountable Care Partnership Plans and MCOs; and

(v) Perform other functions necessary to comply with the requirements of this Contract.

c) A designated DYS liaison. Such liaison shall:

(i) Have at least two years of care management experience, at least one of which shall include working with children in state custody;

(ii) Work with designated DYS staff and be available to assist EOHHS and DYS in the resolution of any problems or issues that may arise with a DYS-affiliated Enrollee;

(iii) If requested by DYS, work with providers to coordinate Discharge Planning;

(iv) As requested by EOHHS, actively participate in any joint meetings or workgroups with EOHHS agencies and other Accountable Care Partnership Plans and MCOs;

(v) Upon request by DYS, participate in regional informational and educational meetings with DYS staff;

(vi) Perform other functions necessary to comply with this Contract.

d) A designated DMH liaison. Such liaison shall:

(i) Have at least two years of care management experience, at least one of which shall be working with individuals with significant behavioral health needs;

(ii) Actively participate in the planning and management of services for Enrollees who are affiliated with DMH, including adult community clinical services (ACCS) clients engaged with CPs. This shall include, but not be limited to:

(a) Working with DMH, including designated DMH case managers, as identified by DMH, and assisting EOHHS

and DMH in resolving any problems or issues that may arise with a DMH-affiliated Enrollee;

(b) Upon request of DMH, participating in regional informational and educational meetings with DMH staff and, as directed by DMH, Enrollees' family members and Peer Supports;

(c) If requested by DMH, working with providers to coordinate Discharge Planning;

(d) As requested by EOHHS, actively participating in any joint meetings or workgroups with EOHHS agencies and other Accountable Care Partnership Plans and MCOs;

(e) Coordinating with CPs and facilitating communication between CPs and DMH regarding CP Enrollees who are ACCS clients;

(f) Performing other functions necessary to comply with the requirements of this Contract;

i. The Contractor's Ombudsman Liaison, who shall liaise with EOHHS' Ombudsman to resolve issues raised by Enrollees;

j. The Contractor's Key Contact, who shall liaise with EOHHS and serve as the point of contact for EOHHS for all communications and requests related to this Contract;

k. The Contractor's Quality Key Contact, who shall oversee the Contractor's quality management and quality improvement activities under this Contract, including those described in **Section 2.10** and other quality activities as further specified by EOHHS;

l. The Contractor's Leadership Contact, who shall serve as the contact person for EOHHS's Assistant Secretary for MassHealth and as a leadership or escalation point of contact for other MassHealth program staff;

m. The Contractor's Care Coordination Contact, who shall liaise with EOHHS on matters related to care coordination, ACO Care Management, and the Community Partners program;

n. The Contractor's Designated Pediatric Expert, who shall assist with ACO Care Management strategy matters, screening matters, and other matters as they relate to Enrollees under the age of 21 as further described in this Contract, including but not limited to in **Sections 2.3 and 2.4**; and

o. Any other positions designated by EOHHS.

2. The Contractor shall appoint Key Personnel as follows:

a. The Contractor shall appoint an individual to each of the roles listed in **Section 2.5.A**. The Contractor may appoint a single individual to more than one such role;

b. The Contractor shall have appointments to all Key Personnel roles no later than ninety (90) days prior to the Contract Operational Start Date, and shall notify EOHHS of such initial appointments and provide the resumes of such individuals to EOHHS no later than ten (10) days after such appointments are made;

c. All individuals assigned to Key Personnel roles shall, for the duration of the Contract, be employed by the Contractor, shall not be subcontractors, and be assigned primarily to perform their job functions related to this Contract;

d. The Contractor shall, when subsequently hiring, replacing, or appointing individuals to Key Personnel roles, notify EOHHS of such a change and provide the resumes of such individuals to EOHHS no less than ten (10) days after such a change is made;

e. If EOHHS informs the Contractor that EOHHS is concerned that any Key Personnel are not performing the responsibilities described in this Contract or are otherwise hindering the Contractor's successful performance of the responsibilities of this Contract, the Contractor shall investigate such concerns promptly, take any actions the Contractor reasonably determines necessary to ensure full compliance with the terms of this Contract, and notify EOHHS of such actions. If such actions fail to ensure such compliance to EOHHS' satisfaction, EOHHS may invoke the remedies for poor performance described in **Section 5.22**.

3. Administrative Staff

The Contractor shall employ sufficient Massachusetts-based, dedicated administrative staff and have sufficient organizational structures in place to comply with all of the requirements set forth herein, including, but not limited to, specifically designated administrative staff dedicated to the Contractor's activities related to:

a. The Contractor's relationships with CPs and management of the CP Contracts;

b. Risk stratification;

c. Care Management;

d. Administration of the Flexible Services program, including managing relationships with Social Service Organizations; and

e. Population health initiatives and programs.

B. Other Reporting and Documentation Requirements

In addition to all other reporting and documentation requirements set forth in this Contract, the Contractor shall provide reports and documentation as provided in this Section.

1. Quality Measure Reporting

As further specified by EOHHS, and in a form and format specified by EOHHS, the Contractor shall provide EOHHS with data on the Clinical Quality Measures set forth in **Appendix B** for each Quality Sample as follows:

a. For each Clinical Quality Measure, the Contractor shall provide EOHHS with complete and accurate medical records data as requested by EOHHS for each Enrollee in the Quality Sample;

b. The Contractor shall provide all requested clinical data in a form and format determined by EOHHS, no later than thirty (30) days after receiving such request. The Contractor shall provide such data in aggregate form, if so requested by EOHHS; and

c. The Contractor shall provide EOHHS with any additional data or information as requested by EOHHS to audit or validate the quality data the Contactor provides in accordance with this Section.

2. Documentation

Upon EOHHS' request, the Contractor shall submit any and all documentation and materials pertaining to its performance under this Contract in a form and format designated by EOHHS. Such documentation shall include, but shall not be limited to the Contractor's:

a. Participating PCPs, and documentation demonstrating the Contractor's compliance with the requirements of **Section 2.2.A**, including but not limited to model and executed contracts between the Contractor and Participating PCPs;

b. Provider contracts;

c. Marketing plan and Marketing Materials as described in **Section 2.7**;

d. Grievance policies and procedures as described in **Section 2.9.G.1**; and

e. Any other documentation and materials requested by EOHHS.

3. Contract-Related Reports

Such reports shall include, but shall not be limited to, reports related to Contract performance, management and strategy.

a. The Contractor shall submit **Appendix F** reports in accordance with the timeframes and other requirements specified in **Appendix F.** For any report that indicates the Contractor is not meeting the targets set by EOHHS, the Contractor shall provide immediate notice explaining the corrective actions it is taking to improve performance. Such notice shall include root cause analysis of the problem the data indicates, the steps the Contractor has taken to improve performance, and the results of the steps

taken to date. The Contractor may also include an executive summary to highlight key areas of high performance and improvement.

b. Failure to meet the reporting requirements in **Appendix F** shall be considered a breach of Contract.

C. Responsiveness to EOHHS

In addition to the other requirements of this Contract, the Contractor shall ensure and demonstrate responsiveness to EOHHS requests related to this Contract, as follows:

1. Performance reviews

a. The Contractor shall attend regular performance review meetings as directed by EOHHS;

b. The Contractor shall ensure that Key Personnel and other staff with appropriate expertise, as requested by EOHHS, attend such meetings;

c. The Contractor shall prepare materials and information for such meetings as further directed by EOHHS, including but not limited to materials and information such as:

1) Reporting in a form and format approved by EOHHS on the Contractor's performance under this Contract, including but not limited to measures such as:

a) Costs of care for Enrollees;

b) Performance reporting information

c) Quality Measure performance;

d) Measures of utilization across categories of service and other indicators of changes in patterns of care;

e) Variation and trends in any such performance measures at the Participating PCP level;

f) Completeness and validity of any data submissions made to EOHHS;

g) Opportunities the Contractor identifies to improve performance, and plans to improve such performance, including plans proposed to be implemented by the Contractor for Participating PCPs or other Affiliated Providers;

h) Changes in the Contractor's staffing and organizational development;

i) Performance of Material Subcontractors including but not limited to any changes in or additions to Material Subcontractor relationships;

j) Health Equity data completion and disparities reduction metrics as

further specified by EOHHS; and

k) Any other measures deemed relevant by the Contractor or requested by EOHHS;

2) Updates and analytic findings from any reviews requested by EOHHS, such as reviews of data irregularities; and

3) Updates on any action items and requested follow-ups from prior meetings or communications with EOHHS;

d. The Contractor shall, within two business days following each performance review meeting, prepare and submit to EOHHS for review and approval a list of any action items, requested follow-ups for the next meeting, and estimated timelines for delivery, in a form and format specified by EOHHS;

2. Timely Response to EOHHS Requests

a. The Contractor shall respond to any EOHHS requests for review, analysis, information, or other materials related to the Contractor's performance of this Contract by the deadlines specified by EOHHS, including but not limited to, for most requests such as those described in this Section, providing a sufficient response within one week of receiving the request. Such requests may include but are not limited to requests for:

1) Records or data to assist the Contractor and EOHHS in identifying and resolving issues and inconsistencies in the Contractor's data submissions to EOHHS;

2) Analysis of utilization, patterns of care, cost, and other characteristics to identify opportunities to improve the Contractor's performance on any cost or quality measures related to this Contract;

3) Documentation and information related to the Contractor's care delivery, Care Management, or Community Partners responsibilities, to assist EOHHS with understanding the Contractor's activities pursuant to these requirements;

4) Information about the Contractor's member protections activities, including Grievances; and

5) Cooperation and coordination with EOHHS, the Massachusetts Office of the Attorney General, and the Massachusetts Office of the State Auditor in any fraud detection and control activities, or other activities as requested by EOHHS;

b. If the Contractor fails to satisfactorily respond within the time requested by EOHHS without prior approval from EOHHS for a late response, EOHHS may take corrective action or impose sanctions in accordance with the Contract.

3. Ad Hoc Meetings

   a. The Contractor shall attend ad hoc meetings at EOHHS' offices, or at another location determined by EOHHS, as requested by EOHHS;

   b. The Contractor shall ensure that Key Personnel and other staff with appropriate expertise are present in person at such meetings, as requested by EOHHS, including but not limited to the Contractor's MassHealth Executive Director; and

   c. The Contractor shall prepare materials and information for such meetings as further directed by EOHHS.

4. Participation in EOHHS Efforts

   As directed by EOHHS, the Contractor shall participate in any:

   a. Efforts to promote the delivery of services in a Culturally and Linguistically Competent manner to all Enrollees, including those with limited English proficiency, diverse cultural and ethnic backgrounds, and physical or mental disabilities, and regardless of gender, sexual orientation, or gender identity;

   b. EOHHS activities related to Health Equity;

   c. EOHHS activities related to Program Integrity;

   d. Activities to verify or improve the accuracy, completeness, or usefulness of the Contractor's data submissions to EOHHS, including but not limited to validation studies of such data;

   e. Activities related to EOHHS' implementation and administration of its ACO Program efforts, including but not limited to efforts related to validation of provider identification mapping;

   f. ACO learning collaboratives, joint performance management activities, and other meetings or initiatives by EOHHS to facilitate information sharing and identify best practices among ACOs. The Contractor shall share information with EOHHS and others as directed by EOHHS regarding the Contractor's performance under this Contract, including but not limited to information on the Contractor's business practices, procedures, infrastructure, and information technology;

   g. EOHHS efforts related to the development of EOHHS policies or programs, as well as measurement, analytics, and reporting relating to such policies and programs, including but not limited to The Roadmap to Behavioral Health Reform (or the BH Roadmap);

   h. Enrollment, disenrollment, or attribution activities related to this Contract;

i. Training programs;

j. Coordination with EOHHS, the Massachusetts Office of the Attorney General, and the Massachusetts Office of the State Auditor;

k. Workgroups and councils, including but not limited to workgroups related to reporting or data submission specifications;

l. EOHHS efforts related to the development of policies or programs, as well as measurement, analytics, and reporting relating to such policies and programs, including substance use treatment related to the opioid epidemic and which facilitate access to appropriate BH services and timely discharge from the emergency department. Such policies or programs may include, but are not limited to, the development of:

1) Specialized inpatient services;

2) New diversionary and urgent levels of care;

3) Expanded substance use disorder treatment services; and

4) Services and supports tailored to populations with significant behavioral health needs, including justice involved and populations experiencing homelessness;

m. Educational sessions for EOHHS staff, such as but not limited to trainings for EOHHS' Customer Service Center;

n. Site visits and other reviews and assessments by EOHHS;

o. Any other activities related to this Contract; and

p. As directed by EOHHS, the Contractor shall comply with all applicable requirements resulting from EOHHS initiatives.

5. Policies and Procedures for Core Functions

The Contractor shall develop, maintain, and provide to EOHHS upon request, policies and procedures for all core functions necessary to manage the MassHealth population effectively and efficiently and meet the requirements outlined in this Contract. All policies and procedures requiring EOHHS approval shall be documented and shall include the dates of approval by EOHHS. These policies and procedures shall include, but are not limited to, the following topics:

a. Response to violations of Enrollees' privacy rights by staff or Subcontractors;

b. Non-discrimination of MassHealth Enrollees;

c. Enrollee cooperation with those providing health care services;

d. Marketing activities and the Contractor's procedures for monitoring these activities;

e. Advance Directives;

f. Assisting Enrollees in understanding their benefits and how to access them;

g. Enrollees' right to be free from restraint or seclusion used as a means of coercion or retaliation;

h. The provision of Culturally and Linguistically Appropriate Services;

i. Practice guidelines in quality measurement and improvement activities;

j. Handling of complaints/Grievances sent directly to EOHHS;

k. Process used to monitor PCP and Subcontractor implementation of amendments and improvements;

l. Retention of medical records;

m. Engagement and coordination with BH CPs and LTSS CPs, as described in **Section 2.4.E**;

n. Care Management;

o. Public health emergencies; and

p. Risk stratification.

D. Readiness Review Overview

1. Contract Readiness Workplan

a. No later than five business days following the Contract Effective Date, or other date as specified by EOHHS, the Contractor shall submit to EOHHS, for its review and approval, a workplan which shall be used by EOHHS to monitor the Contractor's progress toward achieving Contract readiness, as detailed in **Section 2.5.D** below, in accordance with timelines specified by EOHHS. The workplan shall:

1) Address all of the items listed in **Section 2.5.D.3**, at a minimum;

2) List each task, the date by which it will be completed, how it will be completed, and the documentation that will be provided to EOHHS as evidence that the task has been completed.

b. EOHHS may, in its discretion, modify or reject any such workplan, in whole or in part;

c. The Contractor shall modify its workplan as specified by EOHHS and resubmit for approval.

2. EOHHS will conduct a Readiness Review of the Contractor that may include, at a minimum, one on-site review, as determined appropriate by EOHHS. This Readiness Review shall be conducted prior to enrollment of Members into the Contractor, 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 eligible for enrollment with the Contractor.

3. The scope of the Readiness Review will include, but is not limited to, a review of the following elements:

   a. Operational and Administration, specifically:

      1) Staffing and resources, including Key Personnel and functions directly impacting on Enrollees (e.g., adequacy of Enrollee Services staffing), in accordance with **Section 2.5.A**;

      2) Delegation and oversight of Contractor responsibilities, including but not limited to capabilities of Material Subcontractors in accordance with **Section 5.17**;

      3) Enrollee and Provider communications;

      4) Internal Grievance policies and procedures, in accordance with **Section 2.9**;

   b. Service Delivery

      1) Case management, care coordination, and service planning in accordance with **Section 2.4**;

      2) Quality improvement, including comprehensiveness of quality management/quality improvement strategies, in accordance with **Section 2.10**; and

   c. A review of other items specified in the Contract, including but not limited to:

      1) Marketing Materials, in accordance with **Section 2.7**;

      2) Content of Participating PCP and Affiliated Provider contracts in accordance with **Sections 2.2.A and 2.2.D**;

      3) Content of Material Subcontracts with Community Partners, in accordance with **Sections 2.4.F**; and

4) Primary care sub-capitation policies and procedures, in accordance with **Section 2.14.A.2.**

4. Completing Readiness Review

a. The Contractor shall demonstrate to EOHHS's satisfaction that the Contractor and its Material Subcontractors, if any, are ready and able to meet readiness review requirements in sufficient time prior to the Contract Operational Start Date. The Contractor shall provide EOHHS with a certification, in a form and format specified by EOHHS, demonstrating such readiness.

b. If EOHHS identifies any deficiency in the Contractor satisfying readiness review requirements, the Contractor shall provide EOHHS, in a form and format specified by EOHHS, a remedy plan within five business days of being informed of such deficiency. EOHHS, may, in its discretion, modify or reject any such remedy plan, in whole or in part.

c. MassHealth Members shall not be enrolled with the Contractor unless and until EOHHS determines that the Contractor is ready and able to perform its obligations under the Contract as demonstrated during the readiness review, except as provided below.

1) EOHHS may, in its discretion, postpone the Contract Operational Start Date for any Contractor that does not satisfy all readiness review requirements.

2) Alternatively, EOHHS may, in its discretion, enroll MassHealth Enrollees into the Contractor's Plan as of the Contract Operational Start Date provided the Contractor and EOHHS agree on a corrective action plan to remedy any deficiencies EOHHS identifies pursuant to this Section.

d. If, for any reason, the Contractor does not fully demonstrate to EOHHS that it is ready and able to perform its obligations under the Contract prior to the Contract Operational 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 subject to a corrective action plan, then EOHHS may terminate the Contract and shall be entitled to recover damages from the Contractor.

Section 2.6 Enrollment and Education Activities

A. Member Enrollment

The Contractor shall:

1. Assist EOHHS with activities related to enrollment of Enrollees, as directed by EOHHS, including, but not limited to, activities such as making preliminary assignments of Enrollees to Participating PCPs and reporting such assignments to EOHHS in a form and format specified by EOHHS;

2. Accept for enrollment all Members, as further specified by EOHHS, referred by EOHHS in the order in which they are referred without restriction; and

3. Accept for enrollment in the Contractor's Plan, 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.

4. For new Enrollees enrolled pursuant to **Section 2.2.A.4** the Contractor shall collaborate with and support EOHHS in ensuring uninterrupted care. Such collaboration and support shall include, but not be limited to, participating in Enrollee outreach; and identifying specific issues and working with EOHHS to resolve those issues.

B. Identification Card

The Contractor shall provide new Enrollees with an identification card for the Contractor's plan. The Contractor shall:

1. Mail an identification card to all Enrollees no later than 15 business days after the Enrollee's Effective Date of Enrollment;

2. Ensure (pursuant to 42 USC 1396u-2(g)) that all identification cards issued by the Contractor to Enrollees include a code or some other means of allowing a hospital and other providers to identify the Enrollee as a MassHealth Member. The Enrollee identification card must also include:

   a. The name of the Contractor;

   b. The Enrollee's name;

   c. A unique identification number for the Enrollee other than the Enrollee's social security number;

   d. The Enrollee's MassHealth identification number;

   e. The name and relevant telephone number(s) of the Contractor's customer service number; and

   f. The name and customer service number of the Behavioral Health Vendor.

C. New Enrollee Information

The Contractor shall provide New Enrollees with Enrollee Information that meets the requirements of **Section 2.9.C** including a Provider directory that meets the requirements of **Section 2.6.D** and an Enrollee handbook based on a model provided by EOHHS, as further directed by EOHHS, that contains

the Enrollee Information specified below. The Contractor must submit such Enrollee Information to be reviewed and approved by EOHHS at least 60 days prior to publication. Such Enrollee Information must be written in a manner, format and language that is easily understood at a reading level of 6.0 and below. The Enrollee Information must be made available in Prevalent Languages and in Alternative Formats free-of-charge, including American Sign Language video clips. The Contractor shall provide the Enrollee Information to each Enrollee within a reasonable time after receiving notice of the Enrollee's enrollment. The Enrollee Information, shall include, but not be limited to, a description of the following:

1. How to access Contractor's BH CPs and LTSS CPs, including through self-referral, and information about BH CPs and LTSS CPs;

2. The role of the PCP, the process for selecting and changing the Enrollee's PCP, and the policies on referrals for specialty care and for other benefits not furnished by the Enrollee's PCP;

3. The extent to which, and how, after-hours and Emergency Services and Poststabilization 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 Community Based Health Centers and how to access them;

    f. How to access and use the Behavioral Health Help Line, including how the Contractor's Clinical Advice and Support line will interface with the Behavioral Health Help Line;

    g. The locations of any emergency settings and other locations at which Providers and hospitals furnish Emergency Services; and

    h. The fact that the Enrollee has a right to use any hospital or other setting for Emergency Services;

4. The availability of free oral interpretation services from the Contractor in all non-English languages spoken by Enrollees and how to obtain such oral interpretation services;

5. The availability of all written materials that are produced by the Contractor for Enrollees in Prevalent Languages and how to obtain translated materials;

6. The availability of all written materials that are produced by the Contractor for Enrollees in Alternative Formats free-of-charge and how to access written materials in those formats and

the availability of free auxiliary aids and services, including at a minimum, services for Enrollees with disabilities;

7. The toll-free Enrollee customer services telephone number and hours of operation, and the telephone number for any other unit providing services directly to Enrollees;

8. The rights and responsibilities of Enrollees, including but not limited to, those Enrollee rights described in **Section 2.9.G.7**;

9. Information on Grievances and Appeals and Ombudsman processes, and Board of Hearing (BOH) procedures and timeframes, pursuant to **Section 2.9.G.1** and **2.9.G.2** including:

    a. The right to file Grievances and Appeals;

    b. The requirements and timeframes for filing a Grievance;

    c. The availability of assistance in the filing process;

    d. The toll-free numbers that the Enrollee can use to file a Grievance or an Appeal by phone;

    e. The right to obtain a BOH hearing;

    f. The method for obtaining a BOH hearing;

    g. The rules that govern representation at the BOH hearing; and

    h. The right to file a grievance directly with EOHHS, how to do so, and EOHHS contact information;

10. Information about the availability of and access to Ombudsman services;

11. Information on Advance Directives in accordance with **Section 2.5.C.5.e**;

12. Information on how to report suspected fraud or abuse;

13. Information about continuity and transition of care for new Enrollees;

14. Information about how to access MassHealth services including the amount, duration, and scope of available MassHealth services in sufficient detail to ensure that Enrollees understand the benefits to which they are entitled and the procedures for obtaining such benefits, including authorization requirements, any cost sharing, if applicable, and how transportation to such services may be requested. The Contractor shall also inform Enrollees of the availability of assistance through the MassHealth Customer Service Center for help determining where to access such services;

15. Information about Early and Periodic Screening, Diagnosis and Treatment (EPSDT) and

Preventative Pediatric Healthcare Screening and Diagnosis (PPHS), as further directed by EOHHS;

16. The services for which MassHealth does not require authorization or referral from the Enrollee's Primary Care Provider (PCP), for example, family planning services or individual behavioral health outpatient therapy;

17. The extent to which, and how, Enrollees may obtain benefits, including Emergency Services and family planning services, from non-MassHealth providers;

18. How to obtain information about MassHealth providers;

19. Enrollee cost sharing;

20. Any restrictions on freedom of choice among MassHealth providers; and

21. Information about Behavioral Health Services provided through the MassHealth Behavioral Health Vendor.

D. Provider Directory

The Contractor shall:

1. Maintain a searchable Provider directory (or directories) of Participating PCPs and other Affiliated Providers as further specified by EOHHS that is made available in Prevalent Languages and Alternative Formats, upon request, and includes, at a minimum, the following information for each such provider:

    a. Alphabetical list including any specialty and group affiliation as appropriate;

    b. Geographic list of Providers by town;

    c. Office address and telephone numbers as well as website URL as appropriate;

    d. Office hours for each Provider;

    e. Cultural and Linguistic Competence and capabilities, including languages spoken by the Provider or by skilled medical interpreter at site, including ASL, and whether the Provider has completed cultural competence training;

    f. Whether or not the Provider's office or facility has accommodations for people with physical disabilities, including offices, exam rooms, and equipment; and

    g. Whether the Provider is accepting new patients.

2. Provide EOHHS with an updated electronic submission of its Provider directory (or directories) upon request, and on a semi-annual basis, if updated, and an electronic submission of changes

to the Provider Directory monthly.

3. Provide the Provider directory to its Enrollees as follows:

   a. The Contractor shall provide a copy in paper form to Enrollees upon request. The Contractor shall update its paper-version of its Provider directory monthly if the Contractor does not have a mobile-enabled, electronic directory as further specified by EOHHS and quarterly if the Contractor has such mobile-enabled electronic directory as further specified by EOHHS;

   b. The Contractor shall include written and oral offers of such Provider directory in its outreach and orientation sessions for New Enrollees; and

   c. The Contractor shall include an electronic copy of its Provider directory on the Contractor's website in a machine-readable file and format. The Contractor shall update its electronic version of its Provider directory no later than 30 calendar days after being made aware of any change in information.

4. The Contractor shall provide to EOHHS, in accordance with **Appendix F** and as requested by EOHHS, an ad hoc report of all rates paid to a parent organization or a subsidiary in the previous Contract Year;

5. The Contractor shall develop, maintain and update information about Participating PCPs, with areas of special experience, skills, and training including, but not limited to, Providers with expertise in treating: children, adolescents, people with HIV, persons experiencing homelessness, people with disabilities, people with Autism Spectrum Disorder, people who are deaf or hard-of-hearing, people who are blind or visually impaired, and children in the care or custody of DCF or youth affiliated with DYS (either detained or committed. The Contractor shall make available to EOHHS, Members, and Enrollees, such information upon request.

E. Notice of Termination to Enrollees

The Contractor shall provide written notice of termination of a Participating PCP, within 15 days after receipt or issuance of the termination notice, to each Enrollee who received their Primary Care from the terminated Participating PCP. Such written notice shall describe how the Enrollee's continuing need for services shall be met. The Contractor shall provide such notice to Enrollees at least 30 days prior to the effective date of such Provider termination.

F. Notice of Practice Closure to Enrollees

The Contractor shall provide written notice of closure of a Participating PCP, no later than 30 days prior to the practice closure effective date, to each Enrollee who received their Primary Care from the closing Participating PCP. Such written notice shall describe how the Enrollee's continuing need for services shall be met. Notices to Enrollees of Participating PCP closure notices must be approved by MassHealth.

G. Other

The Contractor shall make available, upon request, the following additional information in a format approved by EOHHS:

1. Information on the structure and operation of the Contractor; and

2. Information on physician incentive plans.

Section 2.7 Marketing and Communication

A. General Requirements

In conducting any Marketing activities described herein, the Contractor shall:

1. Ensure that all Marketing Materials clearly state that information regarding all MassHealth managed care enrollment options including, but not limited to, the 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's customer service center, if any. EOHHS, in its sole discretion, may exempt, in writing, promotional materials or activities from this requirement upon written request by the Contractor;

2. Submit all Marketing Materials to EOHHS for approval prior to distribution. The Contractor shall submit Marketing Materials to EOHHS for approval 60 days prior to distribution or as early as possible;

3. Distribute and/or publish Marketing Materials in a non-targeted manner, as further specified by EOHHS, 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 (1) to a part of the Contractor's service area as defined by EOHHS; or (2) 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;

4. Provide EOHHS with a copy of all press releases pertaining to the Contractor's MassHealth line of business for prior review and approval;

5. Report any costs associated with Marketing or Marketing incentives, or Non-Medical Programs or Services as further directed by EOHHS; and

6. Comply with all applicable information requirements set forth in 42 CFR 438.10 when conducting Marketing activities and preparing Marketing Materials;

B. Permissible Marketing Activities

The Contractor may only engage in the following Marketing activities:

1. A health fair or community activity sponsored by the Contractor, provided that the Contractor shall notify all MCOs, Accountable Care Partnership Plans, and Primary Care ACOs 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 MCOs, Accountable Care Partnership Plans, or Primary Care ACOs 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 such MCOs, Accountable Care Partnership Plans, and Primary Care ACOs. The Contractor may conduct or participate in Marketing at Contractor or non-Contractor sponsored health fairs and other community activities only if:

    a. Any Marketing Materials the Contractor distributes have been pre-approved by EOHHS; and

    b. 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 Contractor's Plan.

2. The Contractor may participate in health benefit fairs sponsored by EOHHS, as further specified by EOHHS;

3. The Contractor may Market to Members in accordance with **Section 2.7.A**, by distributing and/or publishing Marketing Materials in a non-targeted manner or implementing a targeted Marketing campaign that is pre-approved by EOHHS. The methods for distributing and/or publishing Marketing Materials may include:

    a. Posting written Marketing Materials that have been pre-approved by EOHHS at Provider sites and other locations as further specified by EOHHS;

    b. Initiating mailing campaigns that have been pre-approved by EOHHS, where the Contractor distributes Marketing Materials by mail; and

    c. Television, radio, newspaper, website postings, and other audio or visual advertising.

C. Prohibitions on Marketing and Enrollment Activities

The Contractor shall **not**:

1. Distribute any Marketing Material that has not been pre-approved by EOHHS;

2. 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:

    a. The recipient of the Marketing Material must enroll with the Contractor in order to obtain benefits or in order to not lose benefits;

b. The Contractor is endorsed by CMS, the federal or state government or similar entity;

c. Seek to influence a Member's enrollment into the Contractor's Plan in conjunction with the sale or offering of any private or non-health insurance products (e.g., life insurance);

d. Seek to influence a Member's enrollment into the Contractor 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, or any other Cold-call Marketing activities;

f. Engage in any Marketing activities which could mislead, confuse or defraud Members or Enrollees, or misrepresent MassHealth, EOHHS, the Contractor, or CMS;

g. Conduct any Provider-site Marketing, except as approved by EOHHS; or

h. Engage in Marketing activities which target Members on the basis of health status or future need for health care services or which otherwise may discriminate against individuals eligible for health care services.

D. Marketing Plan and Schedules

1. The Contractor shall make available to EOHHS, upon request, for review and approval:

a. A comprehensive Marketing plan including proposed Marketing approaches to groups and individuals; and

b. Current schedules of all Marketing activities, including the methods, modes, and media through which Marketing Materials will be distributed.

2. As requested by EOHHS, the Contractor shall present its Marketing plan in person to EOHHS for review and approval.

3. As requested by EOHHS, the Contractor shall 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 the state.

E. Information to Enrollees

Nothing herein shall be deemed to prohibit the Contractor from providing non-Marketing information to Enrollees consistent with this Contract, regarding new services, personnel, Enrollee education materials, Care Management programs, advantages of being enrolled with the Contractor, and Provider sites.

F. Contractor Website

The Contractor shall develop and maintain a website that is accurate and up-to-date, and that is designed in a way that enables Enrollees and Providers to locate all relevant information quickly and easily, as specified by EOHHS. If directed by EOHHS, the Contractor shall establish appropriate links on the Contractor's website that direct users back to the EOHHS website portal.

G. MassHealth Benefit Request and Eligibility Redetermination Assistance

1. As directed by EOHHS, 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.

2. If directed by EOHHS, the Contractor is authorized to communicate with Enrollees to help them renew their MassHealth coverage. The Contractor is authorized and directed to make appropriate use of prerecorded or artificial autodialed calls and automated texts in compliance with the Federal Communications Commission January 23, 2023, Declaratory Ruling. The Contractor shall consult its legal counsel about the appropriate use of autodialed calls and automated texts to Enrollees pursuant to the FCC Declaratory Ruling. The Contractor shall be responsible for complying with the ruling.

Section 2.8 Behavioral Health Vendor

As further specified by EOHHS, the Contractor shall:

A. Develop, implement, and maintain protocols to share information and coordinate with EOHHS' Behavioral Health Vendor to ensure appropriate and non-duplicative care coordination and Care Management for Enrollees with BH needs as described in **Section 2.4**;

B. Accept any payment from the Behavioral Health Vendor on behalf of EOHHS, including payment of a portion of the Contractor's Shared Savings Payment; and

C. Participate in any efforts by EOHHS or by EOHHS' Behavioral Health Vendor to support the administration of this Contract, including efforts to clarify the enrollment or billing information for any Affiliated Providers that provide BH services as part of the Behavioral Health Vendor's network.

Section 2.9 Enrollee Services

A. Written Materials

The Contractor shall unless otherwise provided in this Contract, ensure that all written materials provided by the Contractor to Enrollees:

1. Are Linguistically and Culturally Appropriate, reflecting the diversity of the Contractor's membership;

2. Are produced in a manner, format, and language that may be easily understood by persons with limited English proficiency;

3. Are translated into Prevalent Languages of the Contractor's membership;

4. Are made available in Alternative Formats upon request free-of-charge, including video and audio, and information is provided about how to access written materials in those formats and about the availability of auxiliary aids and services, including, at a minimum, services for Enrollees with disabilities;

5. Are mailed with a language card that indicates that the enclosed materials are important and should be translated immediately, and that provides information on how the Enrollee may obtain help with getting the materials translated;

6. Use a font size no smaller than 12 point; and

7. Include a large print tagline (i.e., no smaller than 18 point font size).

B. Requirements for Providing Materials Electronically

The Contractor shall not provide Enrollee information required by this Contract electronically unless all of the following are met:

1. The format is readily accessible;

2. The information is placed in a location on the Contractors website that is prominent and readily accessible;

3. The information is provided in an electronic form which can be electronically retained and printed;

4. The information is consistent with the content and language requirements of this Contract; and

5. The Enrollee 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.

C. Enrollee Information

The Contractor shall provide Enrollee Information to Enrollees and, upon request, to Members, including all the items detailed in **Section 2.6.C**. The Contractor shall make available written translations of Enrollee Information in Prevalent Languages and inform Enrollees how to obtain

translated Enrollee Information or how to obtain an oral translation in a language other than a Prevalent Language. The Contractor shall make available Enrollee Information in Alternative Formats and inform Enrollees how to obtain such Enrollee Information.

The Contractor shall provide Enrollee Information as follows:

1. Mail a printed copy of the information to the Enrollee's mailing address;

2. Provide the information by email after obtaining the Enrollee's agreement to receive information by email;

3. Post the information on the Contractor's website and advise the Enrollees in paper or electronic form that the information is available on the Internet and include the applicable Internet address, provided that Enrollees with disabilities who cannot access this information online are provided free auxiliary aids and services; or

4. Provide the information by any other method that can reasonably be expected to result in the Enrollee receiving that information.

D. Orientation Packet

The Contractor shall provide each Enrollee with an Orientation Packet. The Contractor shall submit such Orientation Packet to EOHHS for prior approval, and such Orientation Packet shall contain, at a minimum:

1. Enrollee Information as described in **Section 2.6.C**;

2. The Contractor's responsibilities, as set forth in this Contract; and

3. Any other information as specified by EOHHS.

E. Oral Interpretation Services

The Contractor shall make oral interpretation services for all non-English languages available free of charge to Enrollees and notify Enrollees of this service and how to access it.

F. Website Requirements

The Contractor shall post on its website in a prominent place, in Prevalent Languages and Alternative Formats:

1. Enrollee Information;

2. Contact information for EOHHS' Ombudsman;

3. A method for submitting inquiries, providing feedback, and initiating Grievances, including for Enrollees who do not have access to email;

4. The Provider Directory;

5. How Enrollees may access oral interpretation services free-of-charge in any non-English language spoken by Enrollees;

6. How Enrollees may access written materials in Prevalent Languages and Alternative Formats; and

7. Additional information as specified by EOHHS.

G. Member Protections

The Contractor shall provide the following member protections:

1. The Contractor shall develop, implement, and maintain written policies and procedures for the receipt and timely resolution of Enrollees' Grievances, as follows:

   a. Policies and procedures shall be subject to approval by EOHHS.

   b. Policies and procedures shall not limit, replace, or eliminate Enrollee's access to EOHHS Grievance policies and procedures.

   c. The Contractor shall not seek to limit Enrollee's access to or discourage Enrollees from using the EOHHS Grievance process.

   d. The Contractor shall:

      1) Within 30 days of the Contract Operational Start Date, provide Enrollees, information on the Contractor's Grievance procedures, including the right to file Grievances, the requirements and timeframes for filing and resolving a Grievance, and the availability of assistance in the filing process;

      2) Notify Enrollees of their access to the EOHHS Appeals and Ombudsman processes, and not in any way attempt to limit an Enrollee's access or utilization of said processes;

      3) Notify Enrollees of the receipt, orally or in writing, of a Grievance within one (1) business days of receipt of said Grievance; and

      4) Resolve and notify Enrollees of the outcome of a Grievance proceeding within thirty (30) calendar days from the date the Contractor received the Grievance, either orally or in writing, from the Enrollee or their representative.

2. In addition to other obligations set forth in this Contract related to Ombudsman Services, the Contractor shall support Enrollee access to, and work with, the Ombudsman to address Enrollee and Potential Enrollee requests for information, issues, or concerns related to the MassHealth ACO Program, by:

a. Providing Enrollees with education and information about the availability of Ombudsman services including when Enrollees contact the Contractor with requests for information, issues, concerns, complaint, Grievances, or BOH Appeals; and

b. Communicating and cooperating with Ombudsman staff as needed for such staff to address Enrollee or potential Enrollee requests for information, issues, or concerns related to the Contractor, including:

1) Providing Ombudsman staff, with the Enrollee's appropriate permission, with access to records related to the Enrollee; and

2) Engaging in ongoing communication and cooperation with Ombudsman staff until the Enrollee's or potential Enrollee's request or concern is addressed or resolved, as appropriate, including but not limited to providing updates on progress made towards resolution.

3. The Contractor shall ensure that Enrollees are not limited to obtaining services only from Affiliated Providers. The Contractor shall:

a. Ensure Participating PCPs make referrals to any Provider, as appropriate, regardless of the Provider's affiliation with the Contractor. The Contractor shall not restrict Participating PCPs from making referrals to Providers who are not within the Referral Circle or are not otherwise Affiliated Providers;

b. Not impose additional requirements for referrals to Providers who are not within the Referral Circle or are not otherwise Affiliated Providers;

c. Not impede Enrollees' access to or freedom of choice of Providers;

d. Not reduce or impede access to Medically Necessary services; and

e. Ensure that Enrollees may obtain emergency services from any Provider, regardless of its affiliation with the Contractor, including but not limited to receiving services from CBHCs;

4. The Contractor shall contract with a sufficient number of Participating PCPs to offer each Enrollee a choice of at least two appropriate PCPs with open panels as further specified by EOHHS.

5. The Contractor's Request for Enrollee Disenrollment

a. The Contractor shall not request the disenrollment of any Enrollee because of:

1) an adverse change in the Enrollee's health status;

2) the Enrollee's utilization of medical services, including but not limited to the Enrollee making treatment decisions with which a provider or the Contractor

disagrees (such as declining treatment or diagnostic testing);

3) missed appointments by the Enrollee;

4) the Enrollee's diminished mental capacity,

5) or the Enrollee's uncooperative or disruptive behavior resulting from their special needs (except when the Enrollee's enrollment seriously impairs the Contractor's ability to furnish services to either the particular Enrollee or other Enrollees.

b. As further specified by EOHHS, and in accordance with 130 CMR 508.003(D), the Contractor may submit a written request to EOHHS to disenroll an Enrollee as follows:

1) The Contractor shall submit the written request in a form and format specified by EOHHS and accompanied by supporting documentation specified by EOHHS;

2) The Contractor shall follow all policies and procedures specified by EOHHS relating to such request, including but not limited to the following:

a) The Contractor shall take all serious and reasonable efforts specified by EOHHS prior to making the request. Such efforts include, but are not limited to:

(i) Assisting the particular Enrollee to receive Medically Necessary TCOC Included Services through at least three PCPs or other relevant Providers;

(ii) Attempting to provide all resources routinely used by the Contractor to meet Enrollees' needs, including but not limited to, Behavioral Health Services and Care Management;

b) The Contractor shall include with any request the information and supporting documentation specified by EOHHS, including demonstrating that the Contractor took the serious and reasonable efforts specified by EOHHS and, despite such efforts, the Enrollee's continued enrollment with the Contractor seriously impairs the Contractor's ability to furnish services to either the particular Enrollee or other Enrollees; and

c) The Contractor shall provide any EOHHS-specified notices to the Enrollee relating to the request.

c. EOHHS reserves the right, at its sole discretion, to determine when and if a Contractor's request to terminate the enrollment of an Enrollee will be granted in accordance with this Section and related EOHHS policies. In addition, if EOHHS determines that the Contractor too frequently requests termination of enrollment for

Enrollees, 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 Enrollees.

6. Involuntary Changes in PCPs

   a. The Contractor shall not request EOHHS to involuntarily, or without the Enrollee's request, transfer an Enrollee from their current PCP to a new PCP because of:

      1) an adverse change in the Enrollee's health status;

      2) the Enrollee's utilization of medical services, including but not limited to the Enrollee making treatment decisions with which a provider, including the PCP, or the Contractor disagrees (such as declining treatment or diagnostic testing);

      3) missed appointments by the Enrollee;

      4) the Enrollee's diminished mental capacity, or

      5) the Enrollee's uncooperative or disruptive behavior resulting from their special needs (except when the Enrollee's continued enrollment with the PCP seriously impairs the PCP's ability to furnish services to either the particular Enrollee or other Enrollees).

   b. The Contractor may request EOHHS to involuntarily transfer an Enrollee from their current PCP to a new PCP if the Contractor follows all policies and procedures specified by EOHHS relating to such transfer, including but not limited to the following:

      1) The Contractor shall, and shall require the PCPs to, take all serious and reasonable efforts specified by EOHHS prior to such a transfer;

      2) The Contractor shall provide EOHHS and require the PCP to include with any request the PCP makes to the Contractor to transfer an Enrollee, the information and supporting documentation specified by EOHHS, including demonstrating that the PCP took the serious and reasonable efforts specified by EOHHS and, despite such efforts, the Enrollee's continued enrollment with the PCP seriously impairs the PCP's ability to furnish services to either the particular Enrollee or other Enrollees;

      3) The Contractor and PCP shall provide any EOHHS-specified notices to the Enrollee relating to the request; and

      4) The Enrollee's new PCP to which EOHHS transfers the Enrollee shall be determined by EOHHS and may, but is not required to be, be the PCP suggested by the Contractor.

7. The Contractor shall provide Enrollees with, and have written policies ensuring Enrollees are guaranteed, the following rights, and ensure that the Contractor's employees and Material

Subcontractors observe and protect these rights:

a. The right to receive written information in accordance with **Section 2.10.A.**;

b. The right to be treated with respect and with due consideration for their dignity and privacy;

c. The right to be afforded privacy and confidentiality in all interactions with the Contractor and its Affiliated Providers, unless otherwise required by law;

d. The right to receive information on available treatment options and alternatives, presented in a manner appropriate to the Enrollee's condition, culture, functional status, language needs, required modes of communication, and other accessibility needs;

e. The right to participate in all aspects of care and to exercise all rights of Appeal;

f. The right to be fully involved in maintaining their health and making decisions about their health care, including the right to refuse treatment if desired, and to be appropriately informed and supported to this end;

g. The right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation, in accordance with applicable federal law;

h. The right to request and receive any of their medical records in the Contractor's possession, and be notified of the process for requesting amendments or corrections to such records;

i. The right to freely exercise their rights set forth in this Section and not have the exercise of those rights adversely affect the manner in which the Contractor or any Affiliated Provider treats the Enrollee;

j. The right to be notified of these rights and considerations at least annually, in a manner that they can understand, that takes into consideration their culture, functional status, language needs, and required modes of communication. This right shall include the right to request and obtain Enrollee Information at least once per year, and the right to receive notice of any significant change in Enrollee Information at least 30 days prior to the intended effective date of the change;

k. The right to not be discriminated against because of their race, ethnicity, national origin, religion, sex, gender identity, age, sexual orientation, medical or claims history, mental or physical disability, genetic information, or source of payment;

l. The right to have all the Contractor's options and rules fully explained to them, including through use of a qualified interpreter or alternate communication mode if

needed or requested;

m. The right to choose a plan and Provider that they qualify for at any time during their annual plan selection period, including disenrolling from the Contractor and enrolling in another MassHealth ACO, a MassHealth MCO, or the MassHealth PCC Plan;

n. The right to receive timely information about changes to the benefits or programs offered by the Contractor and Contractor's providers, including Participating PCPs, at least 30 days prior to the intended date of the change;

o. The right to designate a representative if they are unable to participate fully in treatment decisions. This includes the right to have translation services available to make information appropriately accessible to them or to their representative;

p. The right to receive a copy of and to approve their Care Plan, if any;

q. The right to expect timely, accessible, Culturally and Linguistically Competent, and evidence-based treatments;

r. The right to obtain emergency care 24 hours a day, seven days a week from any hospital or other emergency care setting;

s. The right to determine who is involved in their Care Team, including family members, advocates, or other providers of their choosing;

t. The right to receive a second opinion on a medical procedure;

u. The right to experience care as described in this Contract, including to receive a Care Needs Screening and appropriate follow-up;

v. The right to have Advance Directives explained and to establish them;

w. The right to file Grievances as described in this Contract, and the right to access EOHHS' Appeals processes; and

x. The right to be protected from liability for payment of any fees that are the obligation of the Contractor.

H. Indian Health Care Provider

1. The Contractor shall 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 as a Participating PCP that has capacity to provide such services.

2. The Contractor shall permit Indian Enrollees to obtain Primary Care services from Indian Health Care Providers who are not Participating PCPs from whom the enrollee is otherwise eligible to receive such services.

3. The Contractor shall demonstrate that it has sufficient access to Indian Health Care Providers to ensure access to Primary Care for Indian Enrollees.

I. Discrimination Policy

The Contractor shall not, in any way, discriminate or use any policy or practice that has the effect of discriminating against Enrollees on the basis of health status or need for health care services, race, color, national origin, sex, sexual orientation, gender identity, or disability.

J. Adult and Youth Mobile Intervention Crisis services

The Contractor shall facilitate Enrollees' immediate and unrestricted access to Adult and Youth Mobile Crisis Intervention services at hospital emergency departments and in the community, including through CBHCs, 24 hours a day, seven days a week.

K. Other

The Contractor shall:

1. Otherwise provide Enrollees with care in accordance with the Contractor's responsibilities under **Section 2.3** of this Contract;

2. Provide additional information that may be required by Enrollees and Potential Enrollees to understand the requirements and benefits of enrollment with the Contractor;

3. Adopt definitions as specified by EOHHS, consistent with 42 CFR 438.10(c)(4)(i); and

4. Inform pregnant Enrollees of the benefits of choosing a MassHealth health plan and Primary Care Provider for the Enrollee's newborn soon after the newborn's birth and advise the Enrollee to contact MassHealth Customer Service or MassHealthChoices.com for additional information and options.

L. Notices to Enrollees

As further directed by EOHHS, the Contractor's notices to Enrollees shall conform to models provided by EOHHS.

M. Enrollee Services Department

The Contractor shall maintain an Enrollee services department to assist Enrollees, Enrollees' family members or guardians, and other interested parties in learning about and obtaining MassHealth services.

N. Enrollee Services Department Standards

The Contractor shall maintain employment standards and requirements (e.g., education, training, and experience) for Enrollee services department staff and provide a sufficient number of staff for the

Enrollee services department;

O. Enrollee Services Department Staff

The Contractor shall ensure that Enrollee services department staff have access to:

1. The Contractor's Enrollee database;

2. The Eligibility Verification System (EVS); and

3. An electronic Provider directory that includes, but is not limited to, the information specified in **Section 2.6.D**. of this Contract;

P. Enrollee Services Telephone Line

The Contractor shall operate a toll-free Enrollee services telephone line a minimum of nine hours per day during normal business hours, Monday through Friday, as follows and as further specified by EOHHS. Such telephone line shall:

1. Make oral interpretation services available free-of-charge to Members and Enrollees in all non-English languages spoken by Members and Enrollees; and

2. Maintain the availability of services free-of-charge, such as TTY services or comparable services, for the deaf and hard of hearing.

Q. Information for Enrollees and Potential Enrollees

The Contractor shall ensure that Enrollee service department representatives shall, upon request, make available to Enrollees and Potential Enrollees in the Contractor's Plan information concerning the following:

1. The identity, locations, qualifications, and availability of Primary Care Providers;

2. The rights and responsibilities of Enrollees including, but not limited to, those Enrollee rights described in **Section 2.9.G**.;

3. How Enrollees and Potential Enrollees may access oral interpretation services free-of-charge in any non-English language spoken by Enrollees and Potential Enrollees;

4. How Enrollees and Potential Enrollees may access written materials in Prevalent Languages and Alternative Formats;

5. All MassHealth services that are available to Enrollees either directly or through referral or authorization; and

6. Additional information that may be required by Enrollees and Potential Enrollees to understand MassHealth requirements and benefits.

R. Miscellaneous Customer Service Requirements

The Contractor shall ensure that its customer services representatives who are assigned to respond to MassHealth specific inquiries:

1. Understand and have a working knowledge of the Contract between EOHHS and the Contractor;

2. Answer Enrollee inquiries, including those related to enrollment status and accessing care;

3. Refer Enrollee inquiries that are of a clinical nature, but non-behavioral health, to clinical staff with the appropriate clinical expertise to adequately respond;

4. Refer Enrollee Inquiries related to behavioral health to the EOHHS Behavioral Health Vendor, including inquiries that are solely administrative in content; and

5. Have the ability to answer Enrollee Inquiries in the Enrollee's primary language free-of-charge through an alternative language device or interpreter;

S. Customer Service Training

The Contractor shall establish a schedule of intensive training for newly-hired and current customer service representatives about when, where and how Enrollees may obtain EPSDT screenings, diagnosis and treatment services.

Section 2.10 Quality Management and Enrollee Incentives

A. QM/QI Program

The Contractor shall maintain a well-defined, robust QM/QI organizational and program structure that supports the application of the principles of Clinical Quality improvement (CQI) to all aspects of the Contractor's service delivery system. The QM/QI program shall be communicated in a manner that is accessible and understandable to internal and external individuals and entities, as appropriate. The Contractor's QM/QI organizational and program structure shall comply with all applicable provisions of 42 CFR Part 438, including Subparts D and E, Quality Assessment and Performance Improvement.

The Contractor shall:

1. Establish a clearly defined set of QM/QI functions and responsibilities that are proportionate to, and adequate for, the planned number and types of QM/QI initiatives and for the completion of QM/QI initiatives in a competent and timely manner;

2. Ensure that such QM/QI functions and responsibilities are assigned to individuals with the appropriate skill set to oversee and implement an organization-wide, cross-functional commitment to, and application of, CQI to all clinical and non-clinical aspects of the Contractor's service delivery system;

3. Establish internal processes to ensure that the QM activities include all of the activities in this

Section 2.10 and, in addition, the following elements:

a. A process to collect race, ethnicity, language and other demographic data elements (e.g., disability status, sexual orientation, gender identity, Health-Related Social Needs) to support stratification of quality measure results to identify disparities and address Health Equity.

b. A process to utilize quality measure performance data, including stratified by social risk or demographic factors, for the identification of health inequities and to inform design of QM/QI activities to address Health Equity.

c. A process for including Enrollees and their families in Quality Management activities, as evidenced by participation in Enrollee and family advisory councils.

4. Have in place a written description of the QM/QI Program that delineates the structure, goals, and objectives of the Contractor's QM/QI initiatives. Such description shall be updated and submitted to EHS annually and at minimum shall:

a. Address all aspects of health care quality improvement, including Health-Related Social Needs, and Health Equity. Behavioral health aspects of the QM/QI program may be included in the QM/QI description, or in a separate QM/QI Plan referenced in the QM/QI description;

b. Include mechanisms for the collection and submission of performance measurement data including those set forth in **Section 2.10.A** and **Appendix B** of this contract;

c. Include mechanisms to assess both underutilization and overutilization of services;

d. Include identified resources dedicated to the QM/QI program, including staff, or data sources, and analytic programs or IT systems;

e. Include any evaluations of QI or QM initiatives conducted over the previous year.

5. Submit to EOHHS an annual QM/QI Work Plan that broadly describes the Contractor's annual QI activities under its QI program, and that includes the following components or other components as directed by EOHHS:

a. Planned clinical and non-clinical initiatives;

b. The objectives for planned clinical and non-clinical initiatives;

c. The short- and long- term time frames within which each clinical and non-clinical initiative's objectives are to be achieved;

d. The individual(s) responsible for each clinical and non-clinical initiative;

e. Any issues identified by the Contractor, EOHHS, Enrollees, and providers, and how

those issues are tracked and resolved over time; and

f. The evaluations of clinical and non-clinical initiatives.

6. Evaluate the results QM/QI initiatives at least annually and submit the results of the evaluation to the EOHHS QM manager. The evaluation of the QM/QI program initiatives shall include, but not be limited to, the results of activities that demonstrate the Contractor's assessment of the clinical quality of care rendered, initiatives focusing on Health Equity and Health-Related Social Needs, as well as accomplishments and compliance and/or deficiencies in meeting the previous year's QM/QI Strategic Work Plan;

7. Performance Measurement and Improvement Projects

The Contractor shall engage in performance measurement activities, designed to achieve, through ongoing measurement and intervention, significant improvements, sustained over time, in clinical care and non-clinical care processes, outcomes, Enrollee satisfaction (i.e., member experience) as well as reductions in health inequities. Measurement and improvement projects shall be conducted in accordance with 42 CFR 438.330, and at EOHHS's direction, and shall include, but are not limited to:

a. Performance Measurement

1) As further specified by EOHHS, the Contractor shall report the results of, or submit to EOHHS data (inclusive of any required supplemental data) which enables EOHHS to calculate and determine, the Performance Measures set forth in **Appendix B**, in accordance with 42 CFR 438.330(c). Such Performance Measures may include those specified by CMS in accordance with 42 CFR 438.330(a)(2).

2) At the direction of EOHHS, the Contractor shall support Health Equity initiatives through the stratification of select performance measures or the submission of data elements including but not limited to social risk factors such as race, ethnicity, language, disability status, age, sexual orientation, gender identity, and Health-Related Social Needs.

3) EOHHS may, at its discretion and at any time, identify certain thresholds for Performance Measures which the Contractor must meet, and the Contractor shall work with EOHHS on such thresholds upon EOHHS request. If EOHHS is concerned with the Contractor's performance on such measures, the Contractor shall discuss such performance with EOHSS, and as further specified by EOHHS:

a) Provide EOHHS with an analysis as to why the Contractor's performance is at the level it reports; and

b) Provide EOHHS with, and implement as approved by EOHHS, a

concrete plan for improving its performance;

4) The Contractor shall demonstrate how to utilize Performance Measure results or stratified measures in designing ongoing QM/QI initiatives, to measure, monitor, and improve quality and Health Equity.

b. Performance Improvement Projects

To achieve significant and sustained improvement in equity outcomes and promote system wide impacts, the Contractor shall partner with Acute Hospitals to implement two Health Equity focused Performance Improvement Projects (PIPs). PIPs will be focused on two of three MassHealth-defined domain areas: 1) Care Coordination/Integration, 2) Care for Acute and Chronic Conditions, and 3) Maternal Morbidity. All processes relating to performance improvement projects as directed by EOHHS are as follows:

1) Implement well-designed, innovative, targeted, and measurable quality improvement interventions, in a Culturally and Linguistically competent manner, to achieve reduction in health inequities;

2) Evaluate the effectiveness of quality improvement interventions incorporating specified targets and measures for performance. Measures for performance should be aligned with quality measure identified in **Appendix B, Section 2.a**;

3) Plan and initiate processes to sustain achievements and continue improvements; and

4) Submit to EOHHS comprehensive written reports using the format, submission guidelines and frequency specified by EOHHS. Such reports shall include information regarding progress towards achieving improvement goals, barriers encountered and new knowledge gained.

c. CMS-Specified Performance Measurement and Performance Improvement Projects

The Contractor shall conduct additional performance measurement or performance improvement projects if mandated by CMS pursuant to 42 CFR 438.330.

B. External Quality Review (EQR) Activities

1. The Contractor shall take all steps necessary to support the External Quality Review Organization (EQRO) contracted by EOHHS to conduct External Quality Review (EQR) Activities, in accordance with 42 CFR 438.358. EQR Activities shall include, but are not limited to:

a. Annual validation of performance measures reported to EOHHS, as directed by EOHHS, or calculated by EOHHS; and

b. Annual validation of performance improvement projects required by EOHHS;

c. At least once every three years, review of compliance with certain standards mandated by 42 CFR Part 438, Subpart D, and at the direction of EOHHS, such as those regarding structure and operations;

2. The Contractor shall take all steps necessary to support the EQRO in conducting EQR Activities including, but not limited to:

a. Designating a qualified individual to serve as Project Director for each EQR Activity who shall, at a minimum:

1) Oversee and be accountable for compliance with all aspects of the EQR activity;

2) Coordinate with staff responsible for aspects of the EQR activity and ensure that staff respond to requests by the EQRO and EOHHS staff in a timely manner;

3) Serve as the liaison to the EQRO and EOHHS and answer questions or coordinate responses to questions from the EQRO and EOHHS in a timely manner; and

4) Ensure timely access to information systems, data, and other resources, as necessary for the EQRO to perform the EQR Activity and as requested by the EQRO or EOHHS;

b. Maintaining data and other documentation necessary for completion of EQR Activities specified above. The Contractor shall maintain such documentation for a minimum of seven years;

c. Reviewing the EQRO's draft EQR report and offering comments and documentation to support the correction of any factual errors or omissions, in a timely manner, to the EQRO or EOHHS;

d. Participating in meetings relating to the EQR process, EQR findings, and/or EQR trainings with the EQRO and EOHHS;

e. Implementing actions, as directed by EOHHS, to address recommendations for quality improvement made by the EQRO, and sharing outcomes and results of such activities with the EQRO and EOHHS in subsequent years; and

f. Participating in any other activities deemed necessary by the EQRO and approved by EOHHS.

C. Quality Incentive Arrangement

1. The Contractor shall make all appropriate efforts to meet a set of performance targets for individual Quality Measures as set forth in **Appendix B**.

2. EOHHS shall calculate, annually, the Contractor's Quality Score based on the Contractor's performance with respect to the Quality Measures set forth in **Appendix B**.

    a. Such score shall be based on the Contractor's meeting or improvement towards meeting the targets and a statewide performance metric, as further specified by EOHHS and as set forth in **Appendix B.**

    b. Such score shall be a number between zero (0) and one (1).

3. For such calculations described above, EOHHS shall use data reported by the Contractor, or other data as further specified by EOHHS.

4. Based on the Contractor's performance, EOHHS shall pay the Contractor in accordance with **Section 4.2.C.2.**

D. Enrollee Incentives

1. The Contractor may implement Enrollee Incentives, as appropriate, to promote engagement in specific behaviors (e.g., guideline-recommended clinical screenings and PCP visits, Wellness Initiatives). The Contractor shall:

    a. Take measures to monitor the effectiveness of such Enrollee Incentives, and to revise incentives as appropriate, with consideration of Enrollee feedback;

    b. Ensure that the nominal value of Enrollee Incentives does not exceed $100; and

    c. Submit to EOHHS, at the direction of EOHHS, ad hoc report information relating to planned and implemented Enrollee Incentives and assure that all such Enrollee Incentives comply with all applicable state and federal laws.

Section 2.11 Data Management, Information Systems Requirements, and Reporting Requirements

A. General Requirements

The Contractor shall maintain Information Systems (Systems) that will enable the Contractor to meet all of EOHHS' requirements as outlined in this Contract, as described in this Section and as further directed by EOHHS;

1. Ensure a secure, HIPAA-compliant exchange of Member and Enrollee information between the Contractor and EOHHS and any other entity deemed appropriate by EOHHS. Such files shall be transmitted to and from EOHHS through secure FTP, HTS, or a similar secure data exchange as determined by EOHHS, as further directed by EOHHS;

2. Develop and maintain a website that is accurate and up-to-date, and that is designed in a way that enables Enrollees and Providers to locate all relevant information quickly and easily, as specified by EOHHS. If directed by EOHHS, establish appropriate links on the Contractor's website that direct users back to the EOHHS website portal;

3. Fully cooperate with EOHHS in its efforts to verify the accuracy of all Contractor data submissions to EOHHS; and

4. Actively participate in any EOHHS data management workgroup, as directed by EOHHS. The Workgroup shall meet in the location and on a schedule determined by EOHHS, as further directed by EOHHS.

B. Health Information Technology and Health Information Exchange

1. The Contractor shall, as further specified by EOHHS, establish and implement policies and procedures to:

   a. Enhance interoperability of its health information technology through health information exchange technologies;

   b. Increase utilization of health information exchange services operated or promoted by the Mass HIway, including but not limited to direct messaging, Statewide event notification service (ENS) Framework, and Query and Retrieve functionality;

   c. Upon notification by EOHHS that additional Mass HIway services are developed, operated, or promoted, establish and implement policies and procedures to increase connectivity to such services and work with its Participating PCPs to increase their connectivity;

   d. Increase its ability to make electronic Health-Related Social Needs (HRSN) referrals (e.g., secure email, SFTP, platform integrated into EHRs) and to receive updates from Social Services Organizations providing HRSN supports to Enrollees;

2. The Contractor shall provide EOHHS with such policies and procedures described above upon EOHHS request;

3. The Contractor shall plan to develop, establish, or enhance existing Electronic Clinical Data Systems (ECDS), with the capability to collect data to calculate Electronic Clinical Quality Measures (eCQMs) or Digital Quality Measures (dQMs) as directed by EOHHS. The Contractor shall submit data or results for eCQM, dQM or other electronic measures to EOHHS as directed by EOHHS;

4. The Contractor shall ensure that its Participating PCPs are able to access or receive event notifications from an EOHHS-Certified ENS Vendor participating in the Statewide ENS Framework. The Contractor shall also establish and implement policies and procedures for its Participating PCPs to integrate such event notifications into appropriate Care Management or population health management workflows;

5. The Contractor shall ensure that its Participating PCPs enable and utilize Query and Retrieve functionality that is natively available in the Network PCPs' EHRs, as further specified by EOHHS;

6. The Contractor shall make available or ensure availability to relevant Providers, staff, and subcontractors, including but not limited to Community Partners, an up-to-date electronic community resource database (CRD) that can be used to identify providers and supports that can address identified HRSN. The Contractor shall provide necessary education and training to relevant providers, staff, and sub-Contractors (e.g., Community Partners) about how to use the CRD;

7. The Contractor shall have at least 75% of its Providers who are EHR Eligible Clinicians adopt and integrate interoperable Electronic Health Records (EHR) certified by the Office of the National Coordinator (ONC) using ONC's 2015 certification edition, along with subsequent edits to the 2015 certification edition pursuant to the 21st Century Cures Act.

C. Health Information System (HIS) Requirements

The Contractor shall maintain a health information system (HIS) as follows:

1. Such Systems shall enable the Contractor to meet all of EOHHS' requirements as outlined in this Contract. The Contractor's Systems shall be able to support current EOHHS requirements, and any future IT architecture or program changes. Such requirements include, but are not limited to, the following EOHHS standards as they may be updated from time to time:

    a. The EOHHS Unified Process Methodology User Guide;

    b. The User Experience and Style Guide Version 2.0;

    c. Information Technology Architecture Version 2.0; and

    d. Enterprise Web Accessibility Standards 2.0.

2. The HIS shall intake, analyze, integrate, and report data, including, but not limited to information regarding:

    a. Medical and pharmacy claims;

    b. Enrollee enrollment spans and roster information;

    c. Enrollee-level risk score files;

    d. Enrollee 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 wheel chair use, and characteristics gathered through such Plan contact with Enrollees, e.g., Care Needs Screenings administered upon enrollment, Care Management, or other reliable means;

    e. Enrollee participation in Care Management programs by type of Care Management program, and identification of Enrollees as belonging to any of the special populations or subgroups identified in the definition of Enrollees with Special Health Care Needs;

3. Design Requirements

a. The Contractor shall comply with EOHHS requirements, policies, and standards in the design and maintenance of its HIS in order to successfully meet the requirements of this Contract;

b. The Contractor's HIS shall interface with EOHHS's MMIS system, the EOHHS Virtual Gateway, and other EOHHS IT architecture as further specified by EOHHS;

c. The Contractor shall conform to HIPAA compliant standards for data management and information exchange;

d. The Contractor shall demonstrate controls to maintain information integrity;

e. The Contractor shall maintain appropriate internal processes to determine the validity and completeness of data submitted to EOHHS;

4. The Contractor shall have the ability to securely exchange and ingest raw data files from EOHHS in a HIPAA-compliant manner, including but not limited to Enrollee roster, Enrollee enrollment span, medical and pharmacy raw claims, and member-level risk score files. Files shall be transmitted from EOHHS through SFTP, HTS, secure email, or similar secure data exchange.

D. Data and Reporting

1. The Contractor shall provide to its Participating PCPs a set of data supports and reports to allow the PCP to meaningful understand their performance on cost, quality measures, member experience, Utilization Management as well as engage in Care Management and population health management of their Enrollees, provided that the PCP has appropriate HIPAA-compliant information systems.

a. Data supports include but are not limited to Enrollee enrollment span files, and Enrollee rosters, actionable Enrollee lists, member lists flagging high or rising risk Enrollees or Enrollees flagged for Care Management or Community Partner (CP) Program;

b. Reports include but are not limited to the following aggregate reports:

1) Financial reports tracking most recent savings and losses projections, member cost trends, costs for specific service lines or categories of service, costs for different populations of Enrollees including those with higher incidence of social determinants of health or with a specific condition, and comparisons against other PCPs;

2) Utilization reports tracking utilization rates for different service lines or categories of service, utilization rates for different populations of Enrollees including those with higher incidence of social determinants of health or with

specific conditions, and comparisons against other PCPs;

3) Quality Measure reports tracking more recent quality measure rates and comparison against other PCPs;

4) Raw medical and pharmacy claims, and Enrollee roster and enrollment files from EOHHS.

c. The Contractor and its Participating PCPs shall have documented agreement on the types, frequencies, and timeliness of the set of data supports and reports provided by the Contractor to the Participating PCPs. This agreement shall additionally include an agreed upon cadence for the Contractor and the PCPs, including their practice site leaders, to engage on the output of reports to identify and jointly agree upon areas to improve Enrollee care and PCP's performance on financial, quality, and utilization goals.

Section 2.12 Health Equity

A. Health Quality and Equity Committee

1. At all times during the Contract Term, the Contractor shall have, a Health Quality and Equity Committee (HQEC) designated by, and accountable to, the Governing Board. Such Health Quality and Equity Committee may be an existing Health Equity committee, so long as the committee meets the criteria of this Section.

2. The composition of the Health Quality and Equity Committee shall, to the extent possible, include individuals that represent the diversity of the MassHealth population. The HQEC shall have representation from various stakeholders of the Contractor, including but not limited to:

a. Contractor representatives;

b. Representatives from Participating PCPs that are high performers in Health Equity as determined by the Contractor, including FQHCs;

c. At least two MassHealth ACO Enrollees or family members of MassHealth ACO Enrollees;

d. Providers; and

e. Frontline staff (e.g., Community Health Workers).

3. Responsibilities of the Health Quality and Equity Committee include but are not limited to:

a. Developing and steering implementation of the Contractor's Health Equity strategy;

b. Monitoring progress towards addressing inequities;

c. Developing Health Equity reporting in accordance with **Appendix F**; and

d. Sharing all relevant information with the Contractor's PFAC.

B. Population and Community Needs Assessment

1. The Contractor shall conduct a population and community needs assessment that provides a description of the Contractor's Enrollee population and community, including:

a. A brief description of the population of Enrollees the Contractor serves and the communities in which they live;

b. A description of the characteristics of such population and communities, including at a minimum:

1) The approximate number of Enrollees in the population;

2) The population's demographic characteristics, including but not limited to age, race, ethnicity, languages spoken, disability status, sexual orientation, gender identity, and;

3) A description of any other salient characteristics of the population that inform the Contractor's strategy for improving the quality and cost of enrollee care, such as any particular public or environmental health concerns.

c. A description of the health, functional, and other care needs of such population and communities, including but not limited to:

1) A list and description of prevalent conditions in the population, including chronic diseases;

2) A description of the population's behavioral health needs;

3) A description of the population's LTSS needs; and

4) A description of the population's Health-Related Social Needs.

d. A description of the community resources that currently exist in such communities.

2. The Contractor shall submit its initial Population and Community Needs Assessment, as further specified by EOHHS, and shall conduct an updated Population and Community Needs Assessment prior to the start of Contract Year 3.

3. The Contractor must submit this Population and Community Needs Assessment upon EOHHS request.

4. The Contractor may leverage existing community needs assessments, including those required

of FQHCs and hospitals, to develop its Population and Community Needs Assessment, as long as the assessment meets the requirements of this **Section 2.12.B**.

C. Health Quality and Equity Strategic Plan and Reporting

1. The Contractor, with input from its Health Quality and Equity Committee, shall create, monitor, and update as needed a five-year Health Quality and Equity Strategic Plan, which shall be submitted to EOHHS for review and approval in accordance with **Appendix F**. In developing the Contractor's Health Quality and Equity Strategic Plan, the Contractor shall seek input from the Health Quality and Equity Committee, providers such as community hospitals, other community-based providers, Community Partners, Enrollees, and Enrollees' families.

2. The plan shall describe:

   a. How the Contractor sought and incorporated input from the Health Quality and Equity Committee, providers such as community hospitals, other community-based providers, Community Partners, Enrollees, and Enrollees' families;

   b. How the Contractor partners with hospitals affiliated with the Contractor for the purposes of the hospital Health Equity incentive program to further joint Health Equity goals, including a description of joint priorities and how they were determined, as well as joint governance over any included workstreams;

   c. The Contractor's approaches to establishing a culture of equity that recognizes and prioritizes the elimination of inequities through respect, fairness, cultural competency, and advocacy, including through the provision of trainings for Health Equity, implicit bias, anti-racism, and related trainings to all staff (contracted or directly employed) that interact with Medicaid enrollees;

   d. The Contractor's approach to ensure all Contractor policy and procedures consider health inequities and are designed to promote Health Equity where possible and in accordance with all federal and state law, including but not limited to: 1) marketing strategy; 2) enrollment and disenrollment, 3) medical, behavioral health, and other health services policies; 4) enrollee and provider outreach; 5) PFACs; 6) grievances and appeals; 7) Utilization Management; and 8) the Flexible Services program;

   e. How the Contractor used its Population and Community Needs Assessment to inform the plan;

   f. The Contractor's planned approaches to maintaining robust structures to identify and understand inequities to support the implementation of evidence-based interventions, including to:

      1) Engage Enrollees and communities to inform Health Equity initiatives;

      2) Achieve complete and comprehensive member-reported social risk factor data

as further specified by EOHHS (e.g., race, ethnicity, language, disability, sexual orientation, gender identity, Health-Related Social Needs);

3) Report on performance measures including but not limited to the ACO Quality Measures, stratified by social risk factors, which may include but are not limited to race, ethnicity, language, disability, sexual orientation, and gender identity;

g. The Contractor's planned interventions to reduce inequities, including how it will:

1) Collaborate and partner with other sectors that influence the health of individuals;

2) Ensure equitable access to healthcare;

3) Deliver high-quality care that continuously reduces inequities.

h. The Contractor's targeted Health Equity-related milestones, including Quality Measure-specific disparity reduction targets for each year of the Contract and for the entire five-year Contract; and

3. The Contractor shall include in the plan an executive summary, in a form and format as further specified by EOHHS, and include an overview of all the key sections of the plan;

4. In accordance with **Appendix F,** the Contractor shall regularly report to EOHHS, in a form and format as further specified by EOHHS, on items related to its Health Quality and Equity Strategic Plan, including but not limited to:

a. Any modifications to the organization's Health Quality and Equity Strategic Plan;

b. Health Quality and Equity Committee composition, activities, and how MassHealth Enrollees and front-line staffs' feedback is incorporated into decision making processes or otherwise utilized as part of the Health Equity work;

c. PFAC composition, summary of activities, and a summary of how consumer feedback is utilized;

d. Progress towards targeted milestones and any other achievements in the preceding year and since the beginning of the contract period related to:

1) Establishing a culture of equity, including reporting on Health Equity, anti-racism, implicit bias, and related staff trainings, as described in **Section 2.12.D**;

2) Establishing necessary structures and partnerships (including but not limited to, with community providers and community hospitals) to support Health Equity;

3) Developing necessary capacity to report on key performance indicators stratified by social risk factors including but not limited to race, ethnicity, language, disability, sexual orientation, and gender identity;

e. State of implementation of cultural competence/CLAS standards as defined in **Section 1**;

f. Progress towards targeted milestones in the preceding year and since the beginning of the contract period on implementing interventions related to:

1) Collaborating and partnering with other sectors that impact the health of individuals;

2) Ensuring equitable access;

3) Delivering high quality care that continuously reduces inequities;

4) Other interventions to reduce health inequities experienced by MassHealth Enrollees

g. Progress towards annual improvement targets for specified Health Equity improvement key performance indicators, supplemented by a description of what contributed to successful achievement of annual targets;

h. Gaps in achievement of targeted annual Health Quality and Equity Strategic Plan goals, observed barriers to achieving goals, and specific plans for the upcoming year to overcome such gaps.

5. At EOHHS's request, the Contractor shall meet with EOHHS to discuss its reporting on items in **Section 2.12.C.4**;

6. The Contractor shall publicly post the executive summaries of its Health Quality and Equity Strategic Plan and its annual Health Equity summary reports on its website, and make these documents available to EOHHS for posting on EOHHS' website.

D. Health Equity, Anti-Racism, Implicit Bias, and Related Trainings

The Contractor shall ensure that meaningful and appropriate trainings to advance Health Equity are periodically received by all staff and Network Providers (contracted or directly employed) that interact with Medicaid Enrollees (through operations, delivery of services, or other patient interfacing roles (e.g., security officer or receptionist)), as further specified by EOHHS.

E. Quality and Equity Incentive Program Arrangement

1. The Contractor shall make all appropriate efforts to meet a set of performance targets for individual Health Equity measures as set forth in **Appendix B**.

2. EOHHS shall calculate, annually, the Contractor's Health Equity Score based on the Contractor's performance with respect to the Health Equity measures set forth in **Appendix B**.

    a. Such score shall be based on the Contractor's meeting or improvement towards meeting the targets and a statewide performance metric, as further specified by EOHHS and as set forth in **Appendix B** and shall account for:

        1) Collection of complete and accurate self-reported social risk factor data for its Enrollees, which may include race, ethnicity, language, disability status, sexual orientation, and gender identity;

        2) Identification and monitoring of health care inequities through stratified reporting of performance metrics as further specified by EOHHS; and

        3) Reduction of identified disparities through targeted and evidence-based interventions as demonstrated through performance metrics as further specified by EOHHS.

    b. Such score shall be a number between zero (0) and one (1).

3. For such calculations described above, EOHHS shall use data reported by the Contractor, or other data further specified by EOHHS.

4. Based on the Contractor's performance, EOHHS shall pay the Contractor in accordance with **Section 4.2.C.3**.

5. The Contractor shall identify any Health Equity Partner Hospitals to EOHHS in accordance with **Appendix F**.

F. [Reserved]

G. Data Collection

The Contractor shall ensure that every member is given an opportunity to update their social risk factor data (e.g., race, ethnicity, language, disability, sexual orientation and gender identity) as requested.

Section 2.13 Contractor COVID-19 Efforts

The Contractor shall, as set forth in this Contract and as further directed by EOHHS, help manage the 2019 novel Coronavirus (COVID-19) as set forth in this Section.

A. As further specified by EOHHS, the Contractor shall help manage COVID-19 for at least the duration of the state of emergency declared via Executive Order No. 591 that began on March 10, 2020, and as set forth in MassHealth bulletins, including but not limited to MassHealth managed care entity bulletins, and other MassHealth guidance. Such activities to help manage COVID-19 shall include, but may not be limited to:

1. Taking all necessary steps to enable Enrollees to obtain medically necessary and appropriate testing and treatment.

2. Minimizing barriers to prompt testing and treatment.

3. Communicating, with EOHHS prior approval, relevant benefits, prevention, screening, testing, and treatment options to Enrollees and guidelines for contacting an Enrollee's local board of health or health care provider.

Section 2.14 Additional ACO Responsibilities

A. Primary Care Sub-Capitation Program

1. Primary Care Sub-Capitation Program Requirements

The Contractor shall implement the Primary Care Sub-Capitation Program as follows and as further specified by EOHHS:

a. Ensure that all Participating PCPs participate in the Primary Care Sub-Capitation Program as described in this Section;

b. As further specified by EOHHS, designate each Participating Primary Care Practice PID/SL as meeting the care model requirements of Primary Care Sub-Capitation Tier 1, 2, or 3, as set forth in **Appendix D**;

1) The Contractor shall make such designations annually as specified by EOHHS and in accordance with **Section 3.6**;

2) If during the Contract Year, a Network Primary Care Practice PID/SL's designated Tier must be changed to a lower Tier than that designated for the Contract Year:

a) If such change is initiated by the Contractor, the Contractor shall propose the Tier change to EOHHS for approval.

b) As further specified by EOHHS, if the Contractor's proposal for a Tier change is approved by EOHHS, or if EOHHS initiates the Tier change, the Contractor shall:

(i) Pay the Primary Care Entity the sub-capitation rate described in **Appendix J** for the new Tier as of the date specified by EOHHS; and

(ii) Hold any portion of the Estimated Capitation Payment identified by EOHHS as resulting from the Network Primary Care Practice PID/SL originally being designated to the higher Tier in escrow and, after the end of the Contract Year,

distribute escrowed funds in aggregate across Network Primary Care Practice PID/SLs.

c) For any Tier changes described in this Section:

(i) EOHHS and the Contractor shall adjust the corresponding Sub-Capitation Rates for Primary Care Entities in **Appendix J**; and

(ii) The Contractor shall submit reports as specified by EOHHS.

c. Ensure Participating Primary Care Practice PID/SLs that are FQHCs meet the Tier Designation criteria for Tier 3, as described in **Appendix D,** and participate in the Primary Care Sub-Capitation Program with a Tier Designation of Tier 3; provided however that a FQHC Practice PID/SL may participate with a Tier Designation of Tier 1 or Tier 2 with written approval from EOHHS;

d. Ensure that all Participating Primary Care PID/SLs meet the requirements of their designated Tier as follows and as further specified by EOHHS:

1) All Participating Primary Care Practice PID/SLs with a Tier Designation of Tier 1 shall fulfill all Tier 1 requirements as described in **Appendix D**.

2) All Participating Primary Care Practice PID/SLs with a Tier Designation of Tier 2 shall fulfill all Tier 1 and Tier 2 requirements as described in **Appendix D**.

3) All Participating Primary Care Practice PID/SLs with a Tier Designation of Tier 3 shall fulfill all Tier 1, Tier 2, and Tier 3 requirements as described in **Appendix D**.

e. For each Participating Primary Care Practice PID/SL, maintain at all times a copy of **Appendix D, Exhibit 1** signed by both the Contractor and the corresponding Primary Care Practice PID/SL;

f. As further specified by EOHHS, comply with all program integrity and audit activities related to the Primary Care Sub-Capitation Program;

g. Comply with all reporting and data requirements related to the EOHHS Primary Care Sub-Capitation Program as further specified by EOHHS;

h. As follows and as further specified by EOHHS, make monthly, prospective payments to Primary Care Entities (PCEs) for the delivery of a defined set of services for Primary Care and behavioral health integration (Primary Care Sub-Capitation Included Services):

1) For each Primary Care Entity, make a monthly payment, based on enrollment, at a rate that is no less than 90% of the rate set forth for such PCE in **Appendix J** except as set forth in this Section.

2) For each PCE that is a FQHC, make a monthly payment, based on enrollment, at a rate that is no less than 100% of the rate set forth for such PCE in **Appendix J**.

3) Ensure PCEs allocate such payments regularly to each Participating Primary Care Practice PID/SL based on the Tier Designation for that Participating Primary Care Practice PID/SL.

4) Ensure that payments under the Primary Care Sub-Capitation Program are distributed in accordance with **Section 2.14.A**, and are not based on Enrollees' utilization of services.

5) Report to EOHHS on all Primary Care Sub-Capitation Program payments in a form, format, and frequency specified by EOHHS.

6) EOHHS intends to adjust the Total PCE Sub-Capitation Rates for Primary Care Entities, as set forth in **Appendix J**, to reflect the Rating Category mix of Enrollees attributed to each PCE. At least annually, EOHHS intends to re-calculate the Total PCE-specific Primary Care Sub-Capitation Rates for Primary Care Entities Rates All RC rate to reflect the actual Rating Category mix of Enrollees attributed to each PCE during the Contract Year, as specified by EOHHS. EOHHS shall determine the Contractor's compliance with **Section 2.14.A.1.h** and **2.14.A.1.i.2** using such adjusted Total PCE Sub-Capitation Rates All RC rates for Primary Care Entities.

i. The Contractor shall:

1) Ensure that Practicing Primary Care Practice PID/SLs submit claims for Primary Care Sub-Capitation Included Services as further specified by EOHHS;

2) Annually pay a total amount in aggregate to all Participating Primary Care Practice PID/SLs for the Primary Care Sub-Capitation Included Services that is no less than the sum of each PCE's individual rate, as specified in **Appendix J** multiplied by the PCE's actual member months;

3) Coordinate with EOHHS' Behavioral Health vendor to ensure the requirements of this Section are met; and

4) Report to EOHHS on its payment methodology and arrangements with its participating PCPs related to its implementation of the EOHHS Primary Care Sub-Capitation Program, in accordance with **Appendix F** and as further specified by EOHHS.

B. Flexible Services Program

1. Flexible Services program Requirements

The Contractor shall:

a. Implement at least one Flexible Services program in each of the tenancy and nutrition domains, at a minimum;

b. Employ sufficient, appropriate administrative staff dedicated to Flexible Services activities for the purposes of:

    1) Completing all requirements as laid out in this **Section 2.14.B** of this Contract;

    2) Oversight and administration of the Flexible Services program including liaising with EOHHS and serving as the point of contact for all EOHHS communications related to Flexible Services;

    3) Collaboration with practice sites to establish, launch, and maintain Flexible Services programs;

    4) Timely responsiveness to any EOHHS requests for information, reports, analysis, or other materials related to the Flexible Services program;

    5) Budgeting and spending of at least 75% of their Flexible Services Allocation for the Contract Year, or an amount further specified by EOHHS;

c. Develop, implement, and maintain processes for collecting, sharing, and reporting Flexible Services member data and analytics with EOHHS and relevant partners.

d. Utilize electronic systems (e.g., secure e-mail, secure file transfer protocol, electronic platform) to refer Enrollees to Social Services Organizations for Flexible Services and follow up with Social Services Organizations post-referral.

e. Ensure that at least 1% of Enrollees are participating in the Flexible Services program, as specified by EOHHS. To assess Enrollee participation in the Flexible Services program annually (or at another frequency or time specified by EOHHS) EOHHS shall divide a count of unique Enrollees receiving Flexible Services in the previous year (or other period specified by EOHHS), as determined by EOHHS, by a count of unique Enrollees in the Contractor's plan during the same specified time period, as specified by EOHHS.

f. Ensure that the percentage of Enrollees participating in Flexible Services up to age 21 is roughly proportional to the percentage of the Contractor's Enrollee that is under age 21. To assess the participation of Enrollees up to age 21 in the Flexible Services program annually (or at another frequency or time specified by EOHHS), EOHHS shall:

    1) Divide a count of unique Enrollees up to age 21 receiving Flexible Services in the previous year (or other period specified by EOHHS), as determined by EOHHS, by a count of total unique Enrollees receiving Flexible Services at any time during the same specified time period, as determined by EOHHS;

2) Divide a count of unique Enrollees up to age 21 in the Contractor's plan, as determined by EOHHS, by a count of total unique Enrollees in the Contractor's plan, as determined by EOHHS, during the same specified time period; and

3) Compare the results in **Sections 2.14.B.1.f.1** and **2.14.B.1.f.2** above.

g. Budget and spend at least 75% of the Contractor's total Flexible Services allocation for the Contract Year. The Contractor shall roll over no more than 25% of their yearly Flexible Services allocation between Contract Years.

h. Ensure that at least one of their Flexible Services programs is aligned with their Health Quality and Equity Strategic Plan as described in **Section 2.12**.

i. Have a plan to address potential disparities in access to and outcomes from Flexible Services, as further specified by EOHHS.

j. Ensure that Enrollees receiving Flexible Services are notified of any changes to Flexible Services supports, including if the Contractor is ending a Flexible Services Program or when a Contractor is discontinuing Flexible Services that the Enrollee is engaged in, if applicable.

2. Flexible Services Screening and Flexible Services Plan

The Contractor shall ensure that a Flexible Services screening and a Flexible Services plan are completed for each Enrollee receiving Flexible Services, as follows and as further specified by EOHHS:

a. Flexible services screenings and plans shall be conducted, documented in writing, agreed to by the Enrollee, and approved by the Contractor prior to the delivery of any Flexible Services.

b. The Contractor shall have at least one in-person meeting with the Enrollee during the assessment and planning process. The in-person assessment and planning may include telehealth (e.g., telephone or videoconference), provided that:

1) The Enrollee has provided informed consent to receive assessments and planning performed by telehealth;

2) Such informed consent is documented by the Enrollee; and

3) The Enrollee receives the support needed to have the assessment conducted via telehealth (including any on-site support needed by the Enrollee).

c. An Enrollee's Flexible Services screening shall be conducted using screening tools and methods that align with approved program eligibility requirements, as further specified by EOHHS;

d. An Enrollee's Flexible Services plan shall describe Flexible Services specific to the Enrollee's needs, as identified by the Enrollee's Flexible Services screening;

e. A Flexible Services plan approved by the Enrollee and the Contractor is valid for up to 12 months from the date of approval by the Contractor;

f. The Contractor shall establish and maintain a review process for Flexible Services plans, including standard review and expedited review; and

g. The Contractor shall maintain Flexible Services screening, planning, and referral information for each Enrollee in a form and format specified by EOHHS and shall provide EOHHS with such information upon request.

h. The Contractor shall ensure that, at a minimum, appropriate Flexible Services have been delivered to Enrollees with approved Flexible Services plans.

3. Flexible Services Participation Plan

a. At all times during the contract term, the Contractor shall maintain an EOHHS-approved Flexible Services Participation Plan, in a form and format specified by EOHHS and as described in this Section. As further specified by EOHHS, the Contractor's Flexible Services Participation Plan and its spending plan, shall include, at a minimum the following:

1) Specific Flexible Services programs the Contractor will support with Flexible Services funds. Such Flexible Services programs shall fit within EOHHS-approved categories of Flexible Services, as further specified by, and which may be updated from time to time by, EOHHS. Such EOHHS-approved categories are:

a) Tenancy Preservation Supports; and

b) Nutrition Sustaining Supports;

2) A description of how the Contractor used its Population and Community Needs Assessment as set forth in **Section 2.12.B** to inform its approach for its Flexible Services programs;

3) The Contractor's target populations for its Flexible Services program(s);

4) The Contractor shall ensure its Flexible Services program(s) do not duplicate other Federal, State, or other publicly funded programs;

5) Specific goals and evaluation plans for the Contractor's Flexible Services program(s), as further specified by EOHHS;

6) A description of how the Contractor plans to address potential disparities in access to and outcomes from Flexible Services, as further specified by EOHHS;

and

7) A description of the Contractor's sustainability plan for its Flexible Services programs;

b. The Contractor shall submit its Flexible Services Participation Plan to EOHHS for approval within 30 calendar days of EOHHS' request, or as further specified by EOHHS;

c. The Contractor shall update and resubmit its Flexible Services Participation Plan to EOHHS for approval upon any significant anticipated changes in the Contractor's future activities or programs under its Flexible Services Participation Plan as follows or as otherwise requested by EOHHS:

1) For any significant anticipated changes in the Contractor's future activities or programs identified by the Contractor, the Contractor shall update and resubmit its Flexible Services Participation Plan to EOHHS for approval, provided however that the Contractor may not request modification to its Flexible Services Participation Plan within 75 calendar days of the end of the current Contract Year;

2) The Contractor's Flexible Services Participation Plan shall be subject to review and approval by EOHHS. EOHHS may withhold the Contractor's Flexible Services payment until EOHHS approves the Contractor's Flexible Services Participation Plan;

4. Flexible Services Budget and Budget Narratives

The Contractor shall submit Flexible Services Budgets and Budget Narratives to EOHHS as follows:

a. The Budget and Budget Narrative shall be in form and format specified by EOHHS;

b. The Contractor shall submit the Budget and Budget Narrative annually for each Contract Year, within 30 calendar days of EOHHS' request, or as further specified by EOHHS;

c. The Contractor shall update and resubmit its Budget and Budget Narrative to EOHHS for approval upon any significant anticipated changes in the Contractor's future activities or programs under its Budget and Budget Narrative as follows or as otherwise requested by EOHHS:

1) For any significant anticipated changes in the Contractor's future activities or programs identified by the Contractor, the Contractor shall update and resubmit its Budget and Budget Narrative to EOHHS for approval, provided however that the Contractor may not request modification to its Budget and Budget Narrative within 75 calendar days of the end of the current Contract

Year;

2) For any significant anticipated changes in the Contractor's future activities or programs identified by EOHHS, the Contractor shall submit its modified budget and budget narrative to EOHHS for approval within 30 calendar days of EOHHS' request, or as further specified by EOHHS;

d. The Budget shall show how the Contractor proposes to spend Flexible Services allocation on the Contractor's Flexible Services program(s) for the Contract Year, and the Budget Narrative shall describe how this spending will support Contractor's Flexible Services Participation Plan and Contractor's activities under this Contract;

e. EOHHS may withhold the Contractor's Flexible Services payment until EOHHS approves the Contractor's Budget and Budget Narrative for that Contract Year;

5. Flexible Services Progress Reports

The Contractor shall submit Flexible Services Progress Reports to EOHHS as follows:

a. The Progress Reports shall be in form and format specified by EOHHS;

b. Contractor shall submit the Progress Reports semiannually, or at another frequency specified by EOHHS;

c. The Progress Reports shall describe Contractor's activities under Contractor's Flexible Services Participation Plan and under this Contract, including challenges, successes, and requested modifications to the Participation Plan and other information, as further specified by EOHHS;

d. The Progress Reports shall contain updated financial accountings of the Contractor's spending of Flexible Services payments;

e. As further specified by EOHHS, the Progress Reports shall contain numbers of Enrollees screened eligible for Flexible Services, the number of Enrollees approved for Flexible Services that were referred to entities delivering Flexible Services, and other relevant information as specified by EOHHS;

f. Based on Enrollees that received Flexible Services, Progress Reports shall include an equity analysis to identify any potential disparities in access to Flexible Services and outcomes from Flexible Services, as specified by EOHHS;

g. The Progress Reports shall be subject to modification and approval by EOHHS;

h. EOHHS may withhold the Contractor's Flexible Services payment until EOHHS approves the Contractor's to-date Progress Reports; and

i. EOHHS may reduce the Contractor's future Flexible Services allocation or otherwise

recoup payment from the Contractor, in accordance with **Section 5.21.C**, if, upon review of the financial accountings contained in such Progress Reports, EOHHS determines that Contractor has not spent all the Contractor's Flexible Services payments in accordance with the Contractor's Flexible Services Participation Plan or with the requirements of this Contract.

6. Contractor's Community Partners (CPs) and Flexible Services

   At a minimum, the Contractor shall inform a CP when the Contractor's CP Enrollees receive Flexible Services, in a form and format specified by EOHHS.

7. Other requirements for Flexible Services

   a. The Contractor shall pay Social Service Organizations delivering Flexible Services within forty-five (45) calendar days of receiving an invoice, if paying retrospectively.

   b. The Contractor shall ensure that all Flexible Services are provided by individuals who have education (e.g., Bachelor's degree, Associate's degree, certificate) in a human/social services field or a relevant field, or at least 1 year of relevant professional experience or training in the field of service; and have knowledge of principles, methods and procedures of such services, as further specified by EOHHS.

   c. The Contractor shall ensure that entities delivering Flexible Services that also perform Flexible Services planning, verification, or screening for Flexible Services eligibility take appropriate steps to avoid conflicts of interest, as further specified by EOHHS.

   d. The Contractor shall report to EOHHS on a quarterly basis describing the Contractor's Enrollees that have received Flexible Services, as well as Enrollees screened for services that did not receive services in a form and format specified by EOHHS.

   e. As further specified by EOHHS, the Contractor shall submit Flexible Services member facing materials and other relevant materials prior to launching each individual Flexible Services program.

   f. The Contractor shall have a point of contact for all Social Services Organizations with which it has contracted to deliver Flexible Services or perform administrative functions.

8. Use of Flexible Services Payment Information

   The Contractor shall ensure and demonstrate to EOHHS' satisfaction that the Contractor's Flexible Services payments are spent as follows:

   a. The Contractor shall spend its Flexible Services payments in accordance with the Contractor's EOHHS-approved Flexible Services Participation Plan, Progress Reports, Budgets, and Budget Narratives.

   b. The Contractor shall ensure that its Flexible Services payments are not duplicative with

funding available through other publicly available programs.

9. Flexible Services Payments

Subject to other terms and conditions of the Contract, including but not limited to EOHHS' receipt of all necessary federal and state approvals, EOHHS shall pay the Contractor Flexible Services payments as follows:

a. EOHHS shall determine a per-Enrollee Flexible Services Allocation for each Contract Year;

b. EOHHS shall calculate the number of Enrollees to use in determining the Contractor's total Flexible Services Allocation each Contract Year based on a schedule determined by EOHHS, as further specified by EOHHS;

c. EOHHS shall make such payments each Contract Year in four equal quarterly installments, or at another frequency and in other divisions specified by EOHHS. Installment amounts will depend on the Contractor's approved Flexible Services programs. Flexible Services payments shall be used for services that meet the following requirements, in EOHHS' sole determination:

1) Fit into an EOHHS-approved category of Flexible Services as described in **Appendix E**;

2) Are health-related;

3) Are not otherwise MassHealth covered services under the Massachusetts state plan, the MassHealth 1115 Demonstration Waiver, or other publicly-funded programs, including Home and Community-Based Waiver programs;

4) Are provided to Flexible Service eligible Enrollees, as described in **Appendix E**;

5) Are consistent with and documented in the Enrollee's Flexible Service plan;

6) Are determined to be informed by evidence that the service may reduce total cost of care and health disparities and either improve health outcomes or prevent worsening of health outcomes, in EOHHS' sole determination; and

7) Meet any additional requirements specified by EOHHS;

d. If the Contract is terminated, then the Contractor shall return to EOHHS any unspent Flexible Services payments within 30 calendar days of the end of the Contract. Furthermore, the Contractor shall not receive any additional Flexible Services Payments after a notification of termination has been provided by either EOHHS or the Contractor.

10. Conditions

All Flexible Services payments are subject to federal approval and availability of funds. EOHHS reserves the right to reduce the amount of Flexible Services payments or to recoup some part of the Flexible Services payments if available funds are reduced including but not limited to if federal authority for the Flexible Services program is reduced.

11. Defer Flexible Services Payment

EOHHS may defer making a Contract Year's Flexible Services payments by up to one year from the end of such Contract Year, as further specified by EOHHS, including but not limited to due to the availability of funds.

12. Failure to Meet Requirements of This Section

As further specified by EOHHS, if the Contractor does not meet the requirements of this **Section 2.14.B,** EOHHS, at its discretion, may reduce the Contractor's Flexible Services allocation or further limit the amount of Flexible Services allocation the Contractor may roll over in accordance with **Section 5.21.C**.

C. Health-Related Social Needs (HRSN) Services

As further directed by EOHHS, the Contractor shall complete tasks associated with implementing HRSN services into the Contract as TCOC Included Services effective Contract Year 2025, including but not limited to:

1. Partnering with the Massachusetts Behavioral Health Partnership (MBHP) to support the delivery of its HRSN services for 2025.

2. In conjunction with MBHP, working on the overall design of the HRSN services including, but not limited to, the services and goods offered, the method of delivery, and the providers utilized to deliver the services.

SECTION 3. EOHHS RESPONSIBILITIES

Section 3.1 Contract Management

EOHHS shall:

A. Provide certain documents, data, reports, materials and other information to assist the Contractor in performing under the Contract;

B. Pay the Contractor in accordance with Section 4;

C. Evaluate reports and materials submitted by the Contractor for approval as specified in this Contract, including but not limited to the Contractor's Budgets and Budget Narratives, and the Contractor's Progress Reports; and

D. Designate an individual authorized to represent EOHHS regarding all aspects of the Contract. EOHHS' representative shall act as a liaison between the Contractor and EOHHS during the Contract Term. The representative shall be responsible for:

1. Monitoring compliance with the terms of the Contract;

2. Receiving and responding to all inquiries and requests made by the Contractor under this Contract;

3. Meeting with the Contractor's representative on a periodic or as-needed basis for purposes including but not limited to discussing issues which arise under the Contract; and

4. Coordinating with the Contractor, as appropriate, on Contractor requests for EOHHS staff to provide assistance or coordination on Contractor responsibilities.

Section 3.2 Quality Measurement

EOHHS shall:

A. Administer the Patient Experience Survey. Such survey may include, but shall not be limited to, questions about the Enrollee's experience of care from their Participating PCP. EOHHS may modify the Patient Experience Survey in EOHHS' sole discretion;

B. Provide the Contractor with the Quality Sample for each Clinical Quality Measure within the final sixty (60) days of each Performance Year, or at another time specified by EOHHS; and

C. Calculate the total Quality Score for the Contractor.

Section 3.3 Enrollment and Attribution

A. EOHHS shall inform Eligible Members of their enrollment options in an unbiased manner, including the option of becoming Enrollees for the Contractor or another ACO in the MassHealth ACO program, and

shall inform each Member at the time of enrollment of their right to change enrollment without cause within 90 days and at other times in accordance with applicable rules and regulations.

B. EOHHS may assign Members that fail to make a selection prior to the Contract Operational Start Date to the Contractor and one of the Contractor's Participating PCPs, including but not limited to if the Member has an existing relationship with one of the Contractor's Participating PCPs in EOHHS' determination.

C. EOHHS shall provide the Contractor with a list of its Enrollees and periodic updates to such a list.

D. Except as otherwise provided under federal law or waiver, an Enrollee may disenroll voluntarily:

1. For cause, at any time, in accordance with 42 CFR 438.56(d)(2) and 130 CMR 508.003(C)(3); and

2. Without cause, at any time during a plan selection period as set forth in 130 CMR 508.003(C)(1) and 130 CMR 508.003(E)(2).

E. In the case that EOHHS fails to make a disenrollment determination for an Enrollee by the first day of the second month following the month in which the Enrollee requests disenrollment or the Contractor refers the request to the state, the disenrollment shall be considered approved for the effective date that would have been established had EOHHS made a determination in the specified timeframe.

Section 3.4 Call Center and Member Protections

A. EOHHS shall provide a Customer Service Center for use by Enrollees. Enrollees will be able to contact the EOHHS call center for information on available services, available primary and secondary care Providers, Providers' status in a Contractor's Referral Circle, and other information necessary for the receipt of services.

B. EOHHS shall provide Appeals and Ombudsman processes to Enrollees.

Section 3.5 Community Partners

A. EOHHS shall qualify Community Partners through a Qualified Vendor List (QVL) and notify the Contractor of available qualified Community Partners.

B. EOHHS shall provide the Contractor with necessary reporting required to administer the CP Program, including reports on enrollment, performance, payment, and quality, at a cadence further specified by EOHHS.

C. EOHHS shall monitor the Contractor's performance in the CP program and may engage the Contractor and its subcontracted CPs in performance management and compliance activities.

Section 3.6 Participating PCP Modification Process

EOHHS shall maintain, and may update from time to time, an annual process for the Contractor to request

EOHHS' approval for changes to the Contractor's Participating PCPs, including ending affiliations with Participating PCPs, adding new Participating PCPs, and changing the Primary Care Sub-Capitation Tier Designation of existing Primary Care Practice PID/SLs. Such changes shall in all cases be subject to EOHHS' approval. The Contractor shall submit requests for any such changes pursuant to EOHHS' defined process, including timelines, and the effective date of any such changes shall be as described by EOHHS' defined process.

SECTION 4. PAYMENT

Subject to other terms and conditions of the Contract, including but not limited to EOHHS' receipt of all necessary federal and state approvals, EOHHS shall pay the Contractor in accordance with the following provisions:

Section 4.1 Primary Care Accountable Care Organization Rating Categories

Subject to all required federal approvals, EOHHS shall pay the Contractor, in accordance with **Section 4**, by the designated Coverage Type, for providing Primary Care Sub-Capitation Included Services to Enrollees in following Rating Categories (RCs): RC I Child, RC I Adult, RC II Child, RC II Adult, RC IX (Adults only), and RC X (Adults only). EOHHS determines the Rating Category for each Enrollee.

A. RC I Child

RC I Child includes Enrollees who are non-disabled, under the age of 21, and in the MassHealth Standard or the Family Assistance coverage types as described in 130 CMR 505.

B. RC I Adult

RC I Adult includes Enrollees who are non-disabled, age 21 to 64, and in the MassHealth Standard or the Family Assistance coverage types as described in 130 CMR 505.

C. RC II Child

RC II Child includes Enrollees who are disabled, under the age of 21, and in MassHealth Standard or CommonHealth as described in 130 CMR 505.

D. RC II Adult

RC II Adult includes Enrollees who are disabled, age 21 to 64, and in MassHealth Standard or CommonHealth as described in 130 CMR 505.

E. RC IX

RC IX includes Enrollees who are age 21 to 64, and in CarePlus as described in 130 CMR 505 who are not receiving Emergency Aid to the Elderly, Disabled and Children (EAEDC) through the Massachusetts Department of Transitional Assistance. RC IX shall also include Enrollees who have identified themselves to MassHealth as medically frail in accordance with 130 CMR 505.008(F), and therefore are in the MassHealth Standard coverage type.

F. RC X

RC X includes Enrollees who are age 21 to 64, and in CarePlus as described in 130 CMR 505 who are receiving Emergency Aid to the Elderly, Disabled and Children (EAEDC) through the Massachusetts

Department of Transitional Assistance.

Section 4.2 Payment Methodology

A. General

EOHHS shall make Primary Care Sub-Capitation Payments to the Contractor for Primary Care Sub-Capitation Included Services and administrative payments (together "PCACO Payments") to the Contractor, in accordance with the payment provisions in this **Section 4** and **Appendix I**.

B. Primary Care Sub-Capitation Payments

Primary Care Sub-Capitation Payments shall reflect the applicable costs related to Primary Care Sub-Capitation Included Services as outlined in **Section 2.14.A.2**. For the Contract Year, the Contractor's Primary Care Sub-Capitation Payments shall be as set forth in **Appendix I**. EOHHS shall account for such payments in the TCOC Benchmarks as set forth in **Section 4.3**.

C. Non-Medical Payments

1. Administrative Payments

EOHHS shall pay the Contractor administrative payments in accordance with **Appendix I**. Such administrative payments shall reflect the applicable cost of administrative services, underwriting gain, care management, the Community Partners Program, and any other non-medical costs not otherwise paid for under the Contract, including but not limited to administering the Flexible Services Program and activities related to advancing Health Equity.

2. Quality Incentive Payment

EOHHS shall pay the Contractor a payment based on the Contractor's Quality Score as set forth in **Appendix B**. Such payment shall equal no more than 0.75 percent of the product of: by Region and Rating Category, the Contractor's TCOC Benchmark, for the Contract Year, as set forth in **Appendix I**, per member, per month; the Contractor's experienced member months for the Contract Year as determined by EOHHS; and the Contractor's concurrent risk scores.

3. Quality and Equity Incentive Program Payment

EOHHS shall pay the Contractor a payment based on the Contractor's Health Equity Score described in **Section 2.12.E** and as further set forth in **Appendix B**. Such payment shall equal no more than 0.75 percent of the product of: by Region and Rating Category, the Contractor's TCOC Benchmark, for the Contract Year, as set forth in **Appendix I**, per member, per month; the Contractor's experienced member months for the Contract Year as determined by EOHHS; and the Contractor's concurrent risk scores.

D. PCACO Payment Methodology

PCACO Payments shall be paid per-Enrollee, per-month, or in another manner specified by EOHHS.

E. Risk Adjusted PCACO Payments

1. EOHHS may risk adjust the Administrative Payments. EOHHS shall use a statistical methodology to calculate diagnosis-based risk-adjusters using a generally accepted diagnosis grouper beginning on the Contract Operational Start Date to reflect the different health status (acuity) of Enrollees enrolled in the Contractor's Plan. Such risk adjustment shall be based on an aggregation of the individual risk scores of Enrollees enrolled with the Contractor. EOHHS may risk adjust the Administrative Payments at least annually.

2. EOHHS may also adjust the Administrative Payment to reflect certain social risk factors as further specified by EOHHS.

3. The Risk Adjusted PCACO Payment shall equal the sum of the Administrative Payments after the above adjustments have been made, if any, has been applied as determined by EOHHS, and the Primary Care Sub-Capitation Payments set forth in **Appendix I**. The Contractor shall accept as payment in full such Risk Adjusted PCACO Payments.

F. Flexible Services Allocation

As described in **Section 2.14.B**, EOHHS shall pay the Contractor for the Flexible Services as set forth in **Appendix E.**

G. Shared Savings / Shared Losses Payment

EOHHS shall calculate a Shared Savings / Shared Losses Payment for the Contract Year as set forth in **Section 4.5**.

Section 4.3 TCOC Benchmarks Development Methodology

A. TCOC Benchmarks Development

1. EOHHS shall annually develop the TCOC Benchmarks and PCACO Payments for each Rating Category in each Region.

2. EOHHS shall calculate the Contractor's TCOC Benchmarks each Contract Year as follows:

a. EOHHS shall calculate the Contractor's Historic TCOC and the Contractor's Market-Rate TCOC as described in this Section;

b. EOHHS shall blend the Contractor's Historic TCOC and the Contractor's Market-Rate TCOC as further specified by EOHHS. EOHHS may increase each Contract Year the portion of the blend that is based on the Contractor's Market Rate TCOC, as further specified by EOHHS. The resulting amount shall be the Contractor's TCOC Benchmarks;

c. EOHHS shall calculate the Contractor's Historic TCOC as follows:

1) EOHHS shall calculate the Contractor's TCOC during a baseline period, as

further specified by EOHHS;

2) EOHHS shall adjust such TCOC to account for anticipated trend between the baseline period and the Contract Year, and to account for the anticipated impact of changes to the MassHealth program to ensure that the Contractor is not unfairly penalized or rewarded for such program changes, as further specified by EOHHS. Such amount shall include adjustments related to the Primary Care Sub-Capitation Payments as set forth in **Section 4.2.B**;

3) Such adjusted TCOC shall be the Contractor's Historic TCOC.

d. EOHHS shall calculate the Contractor's Market-Rate TCOC as follows:

1) The Market-Rate TCOC shall be a risk-adjusted per-Enrollee, per month amount representing the average anticipated cost for the Contractor's population of Enrollees based on the market benchmarks of all ACO-Eligible Members, as described in this Section and further specified by EOHHS;

2) EOHHS shall calculate base rates for each EOHHS Rating Category based on the costs of care for all ACO-Eligible Members in each such Rating Category during a baseline period, as further specified by EOHHS, and using similar adjustments and exclusions as described in **Section 4.5.D** for TCOC calculations;

3) EOHHS shall average these base rates across the Contractor's population of Enrollees based on the number of Enrollees the Contractor has in each Rating Category, as further specified by EOHHS;

4) The resulting amount shall be the Contractor's Market-Rate TCOC.

e. EOHHS shall calculate the Contractor's preliminary TCOC Benchmarks for a Contract Year prior to the start of the Contract Year;

f. Preliminary TCOC benchmarks shall be concurrently risk adjusted using the methodology as set forth in **Section 4.2.E**. Final TCOC benchmarks shall be further adjusted at the end of the Contract Year as described in **Section 4.5.D**.

g. Final TCOC benchmarks shall be used in the Shared Savings / Shared Losses Payment calculation as set forth in **Section 4.5**.

Section 4.4 Contractor's Agreement to PCACO Payments and TCOC Benchmarks

A. PCACO Payments and TCOC Benchmarks

1. EOHHS shall meet with the Contractor annually, upon request, to announce and explain the TCOC Benchmarks and PCACO Payments.

2. Prior to the beginning of the Contract year, EOHHS shall incorporate, by amendment, the TCOC Benchmarks and PCACO Payments by RC and Region into the Contract at **Appendix I**.

B. Acceptance of PCACO Payment and TCOC Benchmarks

1. Prior to the beginning of the Contract Year, the Contractor shall accept the TCOC Benchmarks and PCACO Payments for the new Contract Year as follows:

   a. In writing, in a form and format specified by EOHHS, by a deadline specified by EOHHS.

   b. Prior to the beginning of the Contract year, by executing an amendment to the Contract incorporating the new TCOC Benchmarks and PCACO Payments, as described above.

2. Prior to the beginning of the Contract year, the Contractor shall notify EOHHS in writing, in a form and format specified by EOHHS, of the Contractor's selected Risk Track as set forth in **Section 4.5.C** and minimum savings and losses threshold as described in **Section 4.5.C**.

3. EOHHS may amend the TCOC Benchmarks or PCACO Payments at such other times as may be necessary as determined by EOHHS, or as a result of changes in federal or state law, including but not limited to, to account for changes in eligibility or TCOC Included Services.

C. Failure to Accept TCOC Benchmarks and PCACO Payments

1. In the event that the Contractor fails to execute an amendment to the contract incorporating the new TCOC Benchmarks and PCACO Payments for the new Contract Year as described above, EOHHS shall, starting January 1, pay the Contractor in accordance with **Section 4.2** using the new Contract Year's PCACO Payments less 1.5% of such payments and adjust the TCOC Benchmarks downward by 1.5%. The Contractor shall accept such PCACO Payments as payment in full under the Contract. EOHHS shall pay the PCACO Payments and adjust the TCOC Benchmarks as described in this Section until either the Contractor accepts the new Contract Year's TCOC Benchmarks and PCACO Payments in accordance with **Section 4.2.D** above or until EOHHS terminates the Contract. EOHHS shall reflect any downward adjustment to the TCOC Benchmarks in the calculations described in **Section 4.5**.

2. In the event that the Contractor does not accept in writing the TCOC Benchmarks and PCACO Payments for the new Contract Year as described above, EOHHS may halt all new Enrollee assignments to the Contractor's Plan until the Contractor accepts the TCOC Benchmarks and PCACO Payments offered by EOHHS.

3. In the event that the Contractor does not execute the amendment incorporating the new TCOC Benchmarks and PCACO Payments for the new Contract Year within 60 days following the end of the prior Contract Year, EOHHS may terminate the Contract.

   a. EOHHS will provide the Contractor notice of contract termination, and the Contract shall be terminated on a date determined by EOHHS.

b. The Contractor shall continue to provide Primary Sub-Capitation Included Services and meet all other obligations to Enrollees under this Contract, until such time as all Enrollees are disenrolled from the Contractor's Plan as described in **Section 5.23.H**.

4. For any period of time where the Contractor is providing TCOC Included Services pursuant to Continued Obligations under **Section 5.23.H**, EOHHS shall pay Primary Care Sub-Capitation Payments in accordance with **Section 4.2.B**. If the Contractor does not execute an amendment to incorporate the new TCOC Benchmarks and PCACO Payments by the end of the prior Contract Year in accordance with **Section 4.4.B**, as described above, EOHHS may require the Contractor to pay any lost Federal Financial Participation or other lost federal funding to EOHHS, as further specified by EOHHS.

Section 4.5 Shared Savings and Losses for Total Cost of Care (TCOC)

A. Market-Wide Risk Sharing Arrangement ("Market Corridor") for the Contract Year

1. Overall Approach

As further described in this Section, this risk sharing arrangement shall be based on certain revenue and expenditures across MassHealth managed care plans, described as Market Corridor revenue and Market Corridor expenditures, respectively.

2. Market Corridor Revenue

EOHHS shall first determine the Market Corridor revenue. For each MassHealth Accountable Care Partnership Plan ("ACPP"), Managed Care Organization ("MCO"), Primary Care Accountable Care Organization ("PCACO"), and the Primary Care Clinician Plan ("PCC Plan") (each a "plan"), EOHHS shall multiply by Region and Rating Category each plan's respective Core Medical component of the Base Capitation Rate or total cost of care (TCOC) benchmarks, as applicable, for the Contract Year, per member, per month, by each plan's experienced member months for the Contract Year as determined by EOHHS, and by each plan's concurrent risk scores. The sum of such calculation across plans shall equal the Market Corridor revenue.

3. Market Corridor Expenditures

EOHHS shall then determine the Market Corridor expenditures. Such expenditures shall equal the sum across plans of Core Medical actual medical expenditures related to Included Services in TCOC in **Appendix A**, covered services (for ACPPs and MCOs), and comparable services for the PCC Plan for the applicable Contract Year in aggregate across all Regions and Rating Categories, as applicable, and based on EOHHS data for the Contractor and the PCC Plan and data provided by ACPPs and MCOs to EOHHS.

EOHHS may make appropriate adjustments as necessary, including, but not limited to, ACPP, MCO, PCACO, and PCC Plan specific adjustments, related to the Market Corridor expenditure calculation described above.

4. If the Market Corridor expenditures, as determined by EOHHS in accordance with the above

provisions, are greater than or less than the Market Corridor revenue, as determined by EOHHS in accordance with the above provisions, the Contractor's share of the resulting loss or gain shall be an adjustment applied to the Contractor's TCOC Benchmarks for the purposes of calculating the Contractor's Shared Savings or Shared Losses in **Section 4.5.B** below. The Contractor shall share in the resulting loss or gain in accordance with **Appendix I**.

5. EOHHS shall exclude from all calculations related to this risk sharing arrangement any reinsurance premiums paid by plans and any recovery revenues received if plans choose to purchase reinsurance.

B. Shared Savings/Shared Losses Calculations

EOHHS shall calculate the Contractor's Shared Savings or Shared Losses payment for each Contract Year as follows:

1. EOHHS shall calculate the Contractor's TCOC Benchmarks as described in **Section 4.3**;

2. EOHHS shall calculate the Contractor's TCOC Performance as described in **Section 4.5.D**;

3. EOHHS shall subtract the Contractor's TCOC Performance from Contractor's TCOC Benchmarks set forth in **Appendix I, Exhibit 4**. If such difference is equal to an amount greater than zero (0), such difference shall be the Contractor's Savings. If such difference is equal to an amount less than zero (0), such difference shall be the Contractor's Losses. If such difference equals zero (0) and the Contractor's TCOC Performance and TCOC Benchmarks are equal to each other, the Contractor shall have neither Savings nor Losses for the Contract Year;

4. If the Contractor has Savings or Losses, EOHHS shall calculate the Contractor's Shared Savings payment amount or the Contractor's Shared Losses payment amount, respectively, based on the Contractor's Risk Track, as described in **Section 4.5.C**. If the Contractor has neither Savings nor Losses for the Contract Year, the Contractor shall have neither a Shared Savings payment nor a Shared Losses payment;

C. Risk Tracks

1. The Contractor shall, prior to the Contract Operational Start Date or other date as determined by EOHHS, select Contractor's Risk Track and notify EOHHS in writing of such selection. The Contractor's Risk Track for the TCOC Benchmarks shall be either Risk Track 1 – Full Accountability (as described in **Section 4.5.C**) or Risk Track 2 – Shared Accountability (as described in **Section 4.5.C**) or Risk Track 3 – Narrow Accountability (as described in **Section 4.5.C)**. As further specified by EOHHS, the Contractor may annually change the Contractor's Risk Track, as approved in writing by EOHHS. The Contractor shall choose its Risk Track for each Contract Year as set forth in **Section 4.4.B.2**. The Contractor may not change the Contractor's chosen Risk Track until the process begins for the next Contract Year.

2. EOHHS shall calculate Shared Savings and Shared Losses payments for the TCOC Benchmarks subject to the following risk corridor provisions:

a. The minimum savings and losses threshold shall both be equal to either one percent (1%) or two percent (2%) of the TCOC Benchmarks aggregated across all Regions and Rating Categories, as chosen by the Contractor through a defined process and according to a timeline specified by EOHHS. If the Contractor's Savings aggregated across all Regions and Rating Categories or the absolute value of the Contractor's Losses aggregated across all Regions and Rating Categories are less than the Contractor's chosen threshold of the TCOC Benchmarks, there shall be no Shared Savings or Shared Losses payment. The Contractor shall choose its minimum savings and losses threshold as set forth in **Section 4.4.B.2**. The Contractor may not change the Contractor's chosen minimum savings and losses threshold until the process begins for the next Contract Year.

b. The savings and losses cap shall be equal to 10% of the TCOC Benchmarks (hereinafter referred to as "the cap"). If the Contractor's Savings for the TCOC Benchmarks are greater than the cap, the Contractor's Shared Savings payment shall be calculated as if the Contractor's Savings were equal to the cap, and the Contractor shall receive no additional Shared Savings payment for any Savings beyond the cap. If the absolute value of the Contractor's Losses for the TCOC Benchmarks are greater than the cap, the Contractor's Shared Losses payment shall be calculated as if the absolute value of the Contractor's Losses were equal to the cap, and the Contractor shall make no additional Shared Losses payment for any Losses beyond the cap.

c. Risk Track 1 – Full Accountability

If the Contractor selects Risk Track 1 – Full Accountability, then subject to the provisions in **Section 4.5.B**, the Contractor's Shared Savings payment or Shared Losses payment shall be as set forth in **Appendix I, Exhibit 4**.

d. Risk Track 2 – Shared Accountability

If the Contractor selects Risk Track 2 – Shared Accountability, then subject to the provisions in **Section 4.5.B**, the Contractor's Shared Savings payment or Shared Losses payment shall be as set forth in **Appendix I, Exhibit 4**.

e. Risk Track 3 – Narrow Accountability

If the Contractor selects Risk Track 3 – Narrow Accountability, then subject to the provisions in **Section 4.5.B**, the Contractor's Shared Savings payment or Shared Losses payment shall be as set forth in **Appendix I, Exhibit 4**.

3. EOHHS may modify the Risk Tracks by amending this Contract, and the Contractor agrees to negotiate in good faith with EOHHS for any modifications to these Risk Tracks proposed by EOHHS.

D. TCOC Performance Calculation

1. EOHHS shall calculate the Contractor's TCOC Performance for a given period as follows:

a. TCOC Performance shall include all paid claims and encounters with dates of service during such period, where the Member receiving the service was the Contractor's Enrollee on the date of service, except for services that are not TCOC Included Services. TCOC Included Services are listed in **Appendix A**, "Included Services in TCOC Calculation." EOHHS reserves the right to modify the list of included services by amending this Contract;

b. EOHHS shall base TCOC Performance on the amounts paid for such claims and encounters, but shall incorporate certain adjustments to these amounts as further specified by EOHHS to account for effects including but not limited to the different fee schedules historically used by MassHealth and the MassHealth MCOs and price inflation for certain categories of service (e.g., pharmacy);

c. Admission-level stop-loss: EOHHS shall exclude from TCOC Performance an amount equal to 95 percent (95%) of allowed expenditures as further specified by EOHHS in excess of an attachment point per Enrollee hospital inpatient admission as determined by EOHHS and set forth in **Appendix I**; and

d. EOHHS shall adjust the Contractor's TCOC Benchmarks to reflect in accordance with **Section 4.3** above;

e. EOHHS may under certain circumstances make additional, retrospective adjustments to the Contractor's TCOC Benchmarks, to ensure the TCOC Benchmarks is appropriate and to ensure the Contractor is not unfairly penalized or rewarded, as further specified by EOHHS. Such adjustments may include but may not be limited to adjustments such as:

1) Additional program changes not initially captured;

2) Modifications to trend based on unforeseen events; and

3) Adjustments to reflect updated accounting of the number of Enrollees in each rating category.

Section 4.6 Enrollment-related Reconciliations

A. EOHHS shall perform the following monthly reconciliations with a lookback period determined by EOHHS and adjust PCACO Payments (as defined in **Section 4.2.A**) as below:

1. Enrollees Who Change Rating Categories During the Payment Months included in the Lookback Period

EOHHS shall, in the month following the Payment Months in the lookback period, recover from the Contractor the total PCACO Payments issued to the Contractor for Enrollees who change

Rating Categories during any of the Payment Months in the lookback period, and issue pro-rated monthly PCACO payments that reflects the actual number of Enrollee Days in any of the months in the lookback period for each of the affected Rating Categories.

2. Enrollees Who Disenroll During the Payment Month

   EOHHS shall, in the month following the Payment Months in the lookback period, recover from the Contractor the total PCACO Payments issued to the Contractor for Enrollees who disenroll from the Contractor's Plan during any of the Payment Months in the lookback period, and issue pro-rated monthly PCACO Payments to reflect the actual number of Enrollee Days in any of the months in the lookback period.

3. Members Who Enroll During a Payment Month

   For Members who enroll in the Contractor's Plan during the Payment Months in the lookback period but after the PCACO Payments has been issued to the Contractor for any of such Payment Months in the lookback period, EOHHS shall, in the month following the Payment Month, issue pro-rated monthly PCACO Payments to reflect the actual number of Enrollee Days with respect to such Members for any of the payment months in the lookback period.

B. EOHHS shall perform an annual reconciliation of the PCACO Payments to adjust for any enrollment discrepancies not included in the monthly reconciliations with the lookback period determined by EOHHS. Such annual reconciliations shall account for enrollment discrepancies related to Enrollees who have not resided in Massachusetts according to an EOHHS-specified federal report and Enrollees who have become deceased. The Contractor shall work with EOHHS to resolve any discrepancies in any calculations.

C. EOHHS shall remit to the Contractor the full amount of any underpayments it identifies pursuant to the reconciliations in this Section. The Contractor shall remit to EOHHS the full amount of any overpayments identified by EOHHS. The Contractor shall report any such overpayments to EOHHS within 60 calendar days of when the Contractor identifies the overpayment. Such payments shall be made either through a check or, at the discretion of EOHHS, through recoupment from future capitation and/or reconciliation payments as described in **Section 4**.

   1. Overpayments - Overpayments shall constitute the amount actually paid to the Contractor for all Rating Categories in excess of the amount that should have been paid in accordance with EOHHS's reconciliation.

   2. Underpayments – Underpayments shall constitute the amount not paid to the Contractor for all Rating Categories that should have been paid in accordance with EOHHS's reconciliation.

Section 4.7 Loss of Program Authority

As required by CMS, should any part of the scope of work under this contract relate to a state program that is no longer authorized by law (e.g., which has been vacated by a court of law, or for which CMS has withdrawn federal authority, or which is the subject of a legislative repeal), the Contractor must do no work on that part after the effective date of the loss of program authority. The state must adjust payment to remove costs that

are specific to any program or activity that is no longer authorized by law. If the Contractor works on a program or activity no longer authorized by law after the date the legal authority for the work ends, the Contractor will not be paid for that work. If the state paid the Contractor in advance to work on a no-longer-authorized program or activity and under the terms of this contract the work was to be performed after the date the legal authority ended, the payment for that work should be returned to the state. However, if the Contractor worked on a program or activity prior to the date legal authority ended for that program or activity, and the state included the cost of performing that work in its payments to the Contractor, the Contractor may keep the payment for that work even if the payment was made after the date the program or activity lost legal authority.

SECTION 5. ADDITIONAL CONTRACT TERMS AND CONDITIONS

Section 5.1 Contract Term

The Contract shall be effective upon the Contract Effective Date and end on December 31, 2027; provided however, that EOHHS may extend the Contract in any increments up to December 31, 2032, at the sole discretion of EOHHS, upon terms agreed to by the parties. EOHHS reserves the right to further extend the Contract for any reasonable increment it determines necessary to complete a subsequent procurement. Extension of the Contract is subject to future legislative appropriations, continued legislative authorization, EOHHS' determination of satisfactory performance, and mutual agreement on terms by both parties.

Section 5.2 Notification of Administrative Change

The Contractor shall notify EOHHS in writing no later than 30 days prior to any change affecting it, or its performance of its responsibilities under this Contract, but if a change in business structure is voluntary, the Contractor shall provide a minimum of three months' notice to EOHHS.

Section 5.3 Assignment

The Contractor shall not assign or transfer any right, interest, or obligation under this Contract to any successor entity or other entity without the prior written consent of EOHHS.

Section 5.4 Independent Contractor

The Contractor, its employees, and any other of its agents in the performance of this Contract, shall act in an independent capacity and not as officers or employees of EOHHS or the Commonwealth of Massachusetts.

Section 5.5 Program Modifications and New Initiatives

A. EOHHS shall have the option at its sole discretion to modify, increase, reduce or terminate any activity related to this Contract whenever, in the judgment of EOHHS, the goals of the project have been modified or altered in a way that necessitates such changes. In the event that the scope of work or portion thereof must be changed, EOHHS shall provide written notice of such action to the Contractor and the parties shall negotiate in good faith to implement any such changes proposed by EOHHS.

B. EOHHS additionally reserves the right, at its sole discretion, to amend the Contract to implement state or federal statutory or regulatory requirements, judicial orders, settlement agreements, or any state or federal initiatives or changes affecting EOHHS or the Contract.

C. 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. Modifying TCOC Included Services, including but not limited to services related to Behavioral Health services;

   2. Expanding managed care eligible Members to include detained or incarcerated individuals in County Correctional Facilities, the Department of Correction, or hardware-secure facilities operated by the Department of Youth Services;

3. Implementing collective accountability in incentive payments, wherein incentives are tied to collective outcomes across all ACOs rather than outcomes that result from each ACO individually; and

4. Modifying the scope of this Contract to implement other initiatives in its discretion consistent with Delivery System Reform efforts or other MassHealth policy or goals.

D. The parties shall negotiate in good faith to implement any such initiatives proposed by EOHHS. The Contractor's responsibilities are subject to change due to implementation of such initiatives. EOHHS reserves the right to modify the Contract 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.

E. Any changes under this Section shall be subject to appropriate approvals.

Section 5.6 Title and Intellectual Property Rights

A. Definitions

1. The term "Property" as used herein includes the following forms of property: (1) confidential, proprietary, and trade secret information; (2) trademarks, trade names, discoveries, inventions processes, methods and improvements, whether or not patentable or subject to copyright protection and whether or not reduced to tangible form or reduced to practice; and (3) works of authorship, wherein such forms of property are required by the Contractor to develop, test, and install the any product to be developed that may consist of computer programs (in object and source code form), scripts, data, documentation, text, photographs, video, pictures, sound recordings, training materials, images, techniques, methods, program images, text visible on the Internet, illustrations, graphics, pages, storyboards, writings, drawings, sketches, models, samples, data, other technical or business information, reports, and other works of authorship fixed in any tangible medium.

2. The term "Deliverable" as used herein is defined as any work product that the Contractor delivers for the purposes of fulfilling its obligations under the Contract.

B. Contractor Property and License

1. The Contractor will retain all right, title and interest in and to all Property developed by it, i) for clients other than the Commonwealth, and ii) for internal purposes and not yet delivered to any client, including all copyright, patent, trade secret, trademark and other intellectual property rights created by the Contractor in connection with such work (hereinafter the "Contractor Property"). EOHHS acknowledges that its possession, installation or use of Contractor Property will not transfer to it any title to such property. "Contractor Property" also includes Contractor's proprietary tools, methodologies and materials developed prior to the performance of Services and used by Contractor in the performance of its business and specifically set forth in this Contract and which do not contain, and are not derived from,

EOHHS's Confidential Information, EOHHS's Property or the Commonwealth Data.

2. Except as expressly authorized herein, EOHHS will not copy, modify, distribute or transfer by any means, display, sublicense, rent, reverse engineer, decompile or disassemble Contractor Property.

3. The Contractor grants to EOHHS, a fully-paid, royalty-free, non-exclusive, non-transferable, worldwide, irrevocable, perpetual, assignable license to make, have made, use, reproduce, distribute, modify, publicly display, publicly perform, digitally perform, transmit, copy, sublicense to any EOHHS subcontractor for purposes of creating, implementing, maintaining or enhancing a Deliverable, and create derivative works based upon Contractor Property, in any media now known or hereafter known, to the extent the same are embodied in the Deliverables, or otherwise required to exploit the Deliverables. During the Contract Term and immediately upon any expiration or termination thereof for any reason, the Contractor will provide to EOHHS the most current copies of any Contractor Property to which EOHHS has rights pursuant to the foregoing, including any related Documentation.

4. Notwithstanding anything contained herein to the contrary, and notwithstanding EOHHS's use of Contractor Property under the license created herein, the Contractor shall have all the rights and incidents of ownership with respect to Contractor Property, including the right to use such property for any purpose whatsoever and to grant licenses in the same to third parties. The Contractor shall not encumber or otherwise transfer any rights that would preclude a free and clear license grant to the Commonwealth.

C. Commonwealth Property

1. In conformance with the Commonwealth Terms and Conditions, all Deliverables created under this Contract whether made by the Contractor, subcontractor or both are the property of EOHHS, except for the Contractor Property embodied in the Deliverable. The Contractor irrevocably and unconditionally sells, transfers and assigns to EOHHS or its designee(s), the entire right, title, and interest in and to all intellectual property rights that it may now or hereafter possess in said Deliverables, except for the Contractor Property embodied in the Deliverables, and all derivative works thereof. This sale, transfer and assignment shall be effective immediately upon creation of each Deliverable and shall include all copyright, patent, trade secret, trademark and other intellectual property rights created by the Contractor or subcontractor in connection with such work (hereinafter the "Commonwealth Property"). "Commonwealth Property" shall also include the specifications, instructions, designs, information, and/or materials, proprietary tools and methodologies including, but not limited to software and hardware, owned, licensed or leased by EOHHS and which is provided by EOHHS to the Contractor or of which the Contractor otherwise becomes aware as well as EOHHS's Confidential Information, the Commonwealth Data and EOHHS's intellectual property and other information relating to its internal operations.

2. All material contained within a Deliverable and created under this Contract are works made for hire.

3. The Contractor agrees to execute all documents and take all actions that may be reasonably requested by EOHHS to evidence the transfer of ownership of or license to intellectual property rights described in this **Section 5.6** including providing any code used exclusively to develop such Deliverables for EOHHS and the documentation for such code. The Commonwealth retains all right, title and interest in and to all derivative works of Commonwealth Property.

4. EOHHS hereby grants to the Contractor a nonexclusive, revocable license to use, copy, modify and prepare derivative works of Commonwealth Property only during the term and only for the purpose of performing services and developing Deliverables for the EOHHS under this Contract.

5. The Contractor agrees that it will not: (a) permit any third party to use Commonwealth Property; (b) sell, rent, license or otherwise use the Commonwealth Property for any purpose other than as expressly authorized under this Contract; or (c) allow or cause any information accessed or made available through use of the Commonwealth Property to be published, redistributed or retransmitted or used for any purpose other than as expressly authorized under this Contract. The Contractor agrees not to, modify the Commonwealth Property in any way, enhance or otherwise create derivative works based upon the Commonwealth Property or reverse engineer, decompile or otherwise attempt to secure the source code for all or any part of the Commonwealth Property, without EOHHS's express prior consent. EOHHS reserves the right to modify or eliminate any portion of the Commonwealth Property in any way at any time. EOHHS may terminate use of the Commonwealth Property by the Contractor immediately and without prior notice in the event of the failure of such person to comply with the security or confidentiality obligations hereunder. The Commonwealth Property is provided "AS IS" and EOHHS FOR ITSELF, ITS AGENCIES AND ANY RELEVANT AUTHORIZED USERS EXPRESSLY DISCLAIMS ANY AND ALL REPRESENTATIONS AND WARRANTIES CONCERNING THE COMMONWEATH PROPERTY, COMMONWEALTH DATA OR ANY THIRD PARTY CONTENT TO BE PROVIDED HEREUNDER, WHETHER EXPRESS, IMPLIED, OR STATUTORY, INCLUDING WITHOUT LIMITATION ANY IMPLIED WARRANTIES OF NONINFRINGEMENT, MERCHANTABILITY OR FITNESS FOR A PARTICULAR PURPOSE OR QUALITY OF SERVICES.

Section 5.7 No Third-Party Enforcement

This Contract shall be enforceable only by the parties, or officers or agencies of the Commonwealth authorized to act on behalf of EOHHS or its successors. Nothing in this Contract shall be deemed to confer benefits or rights to any other parties.

Section 5.8 Effect of Invalidity of Clauses

If any clause or provision of this Contract is in conflict with any state or federal law or regulation, that clause or provision shall be null and void and any such invalidity shall not affect the validity of the remainder of this Contract.

Section 5.9 Authorizations

This Contract is subject to all necessary federal and state approvals.

Section 5.10 Prohibited Activities and Conflict of Interest

The Contractor certifies and agrees that it, its employees, affiliates, subcontractors, consultants, and those who have a contract with the Contractor shall:

A. Not have any interest that conflicts with the performance of services under the Contract for the duration of the Contract, as determined by EOHHS. The Contractor shall inform EOHHS of any potential conflict of interest, in any degree, arising during the term of this Contract.

B. Not have been debarred by any federal agency, excluded from participation in a program under Titles XVIII, XIX, or XXI of the Social Security Act, or subjected to a civil money penalty under the Social Security Act.

C. In accordance with 42 USC § 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 this 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 such prohibited affiliations identified by the Contractor.

D. 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 5.11 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, including, for the avoidance of doubt, applicable laws relating to the privacy or security including but not limited to those identified by EOHHS, as well as applicable antitrust laws and regulations, federal and state laws and regulations designed to prevent fraud, waste, and abuse, including but not limited to applicable provisions of Federal criminal law, the False Claims Act (31 U.S.C. 3729 et seq) and the anti-kickback statute (42 U.S.C. s. 1320a-7b(b)) and M.G.L. ch. 118E s.41, federal and state laws pertain to Member rights, Title VI of the Civil Rights Act of 1964 as implemented by regulations at 45 CFR part80, the Age Discrimination Act of 1975 as implemented by regulations at 45 CFR part 91, the Rehabilitation Act of 1973, Title IX of the Education Amendments of 1972, Titles II and III of the American with Disabilities Act, and section 1557 of the Patient Protection and Affordable Care Act. EOHHS may unilaterally amend this agreement in order to ensure compliance with such laws and regulations; and, as applicable, the CMS Interoperability and Patient Access Final Rule (CMS-9115-F).

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 statutes, orders, and regulations promulgated by any federal, state, municipal, or other governmental authority. EOHHS may terminate this Contract immediately upon written notice in the event the Contractor fails to agree to any such amendment.

Section 5.12 Amendments

The parties may amend this Contract where such amendment does not violate state or federal statutory, regulatory, or waiver provisions, provided such amendment is in writing, signed by both parties, and attached hereto. The parties agree to negotiate in good faith to cure any omissions, ambiguities, or manifest errors herein.

EOHHS and the Contractor mutually acknowledge that unforeseen policy, operational, methodological, or other issues may arise throughout the course of this Contract. Accordingly, EOHHS and Contractor agree to work together in good faith to address any such circumstances and resolve them, and if necessary, will enter into amendments to this Contract on mutually agreeable terms.

Notwithstanding the forgoing, the Contractor shall promptly execute and comply with any amendment to this Contract, including to **Section 6** or **Appendix H**, that EOHHS determines is necessary to ensure compliance with all applicable statutes, orders, and regulations promulgated by any federal, state, municipal, or other governmental authority pertaining to the privacy or security of PI, including any Applicable Law. Such requisite amendment may cover all activities and PI collected under the original Contract. The Contractor's failure to amend this Agreement in accordance with the foregoing sentence shall be considered a breach of a material provision for purposes of **Section 6** or **Appendix H**. The Parties agree to negotiate in good faith to cure any omissions, ambiguities, or manifest errors herein.

Section 5.13 Counterparts

This 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 5.14 Section Headings

The headings of the sections of this Contract are for convenience only and will not affect the construction hereof.

Section 5.15 Waiver

EOHHS' exercise or non-exercise of any authority under this Contract, including, but not limited to, review and approval of materials submitted in relation to the Contract or of privacy or security practices, 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 acceptance by EOHHS of any unsatisfactory practices or breaches by the Contractor.

Section 5.16 Record Keeping, Quality Review, Audit, and Inspection of Records

A. The Contractor shall maintain all books, records and other compilations of data pertaining to the performance of the provisions and requirements of the Contract, as determined by EOHHS, to the

extent and in such detail as shall properly substantiate claims for payment under the Contract and in accordance with the requirements in **Section 6** of the Commonwealth Terms and Conditions. Specifically, the Contractor shall:

1. Maintain all pertinent records in a cost-effective and easily retrievable format.

2. Maintain an off-site storage facility for EOHHS-specified records that is outside of the disaster range of the Contractor's principal place of business and the meets recognized industry standards for physical and environmental security.

3. Take all reasonable and necessary steps to protect the physical security of personal data or other 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.

4. Immediately notify EOHHS both orally and in writing if the Contractor has any reason to believe that any data applicable to the Contract have been improperly accessed, disseminated, misused, copied or removed.

B. EOHHS, the Governor, the Secretary of Administration and Finance, the Comptroller, the State Auditor, the Attorney General, or any of their duly authorized representatives or designees, or any other state or federal oversight agency shall the have the right at reasonable times and upon reasonable notice to:

1. Examine and copy books, records, and other compilations of data pertaining the performance of this Contract;

2. Evaluate through inspection or other means the quality, appropriateness, and timeliness of the Contractor's performance under the Contract; and

3. Inspect and audit the financial records of the Contractor and its subcontractors related to the performance of this Contract.

C. Pursuant to 42 CFR 438.3(h), EOHHS, other representatives from the Commonwealth of Massachusetts, CMS, the Office of the Inspector General, the Comptroller General, and their designees, may, at any time, inspect and audit any records or documents of the Contractor or its subcontractors, and may, at any time, 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. 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. For the avoidance of doubt, nothing in this **Section 5.16** shall limit the right of access set forth in **Section 6** of this Contract.

Section 5.17 Material Subcontracts/Subcontractors

A. General

1. All Contractor requirements set forth in this Contract that are relevant to the arrangement between the Contractor and Material Subcontractor shall apply to Material Subcontractors as further specified by EOHHS.

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

3. All Material Subcontracts shall be prior approved by EOHHS. To obtain such approval, the Contractor shall make a request in writing and submit with that request a completed Material Subcontractor checklist report as set forth in **Appendix F**. using the template provided by EOHHS as may be modified by EOHHS from time-to-time.

    a. The Contractor shall submit such report to EOHHS at least 60 calendar days prior to the date the Contractor expects to execute the Material Subcontract.

    b. The Contractor shall provide EOHHS with any additional information requested by EOHHS in addition to the information required in the Material Subcontractor checklist report.

4. The Contractor's contract, agreement, or other arrangement with a Material Subcontractor shall:

    a. Be a written agreement;

    b. Specify, and require compliance with, all applicable requirements of this Contract and the activities and reporting responsibilities the Material Subcontractor is obligated to provide;

    c. Provide for imposing sanctions, including contract termination, if the Material Subcontractor's performance is inadequate;

    d. Require the Material Subcontractor to comply with all applicable Medicaid laws, regulations, and applicable subregulatory guidance, including but not limited to federally-required disclosure requirements set forth in this Contract;

    e. Comply with the audit and inspection requirements set forth in 42 CFR 438.230(c)(3), such that the written agreement with the Material Subcontractor requires the Material Subcontractor to agree as follows. See also **Section 5.16**.

        1) 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

2) The Material Subcontractor will make its premises, facilities, equipment, records, and systems available for the purposes of any audit, evaluation, or inspection described immediately above;

f. Stipulate, or the Contractor shall make best efforts to stipulate, that Massachusetts general law or Massachusetts regulation will prevail if there is a conflict between the state law or state regulation where the Material Subcontractor is based.

5. The Contractor shall monitor any Material Subcontractor's performance on an ongoing basis and perform a formal review annually. If any deficiencies or areas for improvement are identified, the Contractor shall require the Material Subcontractor to take corrective action. Upon request, the Contractor shall provide EOHHS with a copy of the annual review and any corrective action plans developed as a result.

6. Upon notifying any Material Subcontractor, or being notified by such Material Subcontractor, of the intention to terminate such subcontract, the Contractor shall notify EOHHS in writing no later than the same day as such notification, and shall otherwise support any necessary member transition or related activities

7. In accordance with **Appendix F**, the Contractor shall regularly submit to EOHHS a report containing a list of all Material Subcontractors. Such report shall also indicate whether any of its Material Subcontractors are a business enterprise (for-profit) or non-profit organization certified by the Commonwealth's Supplier Diversity Office. The Contractor shall submit ad hoc reports, as frequently as necessary or as directed by EOHHS, with any changes to the report.

8. The Contractor shall remain fully responsible for complying with and meeting all of the terms and requirements of the Contract as well as complying with all applicable state and federal laws, regulations, and guidance, regardless of whether the Contractor subcontracts for performance of any Contract responsibility. No subcontract will operate to relieve the Contractor of its legal responsibilities under the Contract.

Section 5.18 Entire Agreement

This 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 this Contract shall prevail notwithstanding any variances with the terms and conditions of any written or verbal communication subsequently occurring, except as otherwise provided herein

Section 5.19 Responsibility of the Contractor

The Contractor is responsible for the professional quality, technical accuracy, and timely completion and delivery of all services furnished by the Contractor under this Contract. The Contractor shall, without additional compensation, correct or revise any errors, omissions, or other deficiencies in its deliverables and other

services.

Section 5.20 Administrative Procedures Not Covered

Administrative procedures not provided for in this Contract will be set forth where necessary in separate memoranda from time to time.

Section 5.21 Intermediate Sanctions

A. General Requirements

1. In addition to Termination under **Section 5.23**, EOHHS may, in its sole discretion, impose any or all of the sanctions in **Section 5.21.B** upon any of the events below; provided, however, that EOHHS shall only impose those sanctions it determines to be reasonable and appropriate for the specific violation(s) identified. Sanctions may be imposed in accordance with this Section if the Contractor:

    a. Discriminates among Enrollees on the basis of health status or need for health care services, including termination of enrollment or refusal to reenroll an Enrollee, except as permitted under **Section 2.9.G.4**, or any practice that would reasonably be expected to discourage enrollment by Enrollees whose medical condition or history indicates probable need for substantial future medical services;

    b. Imposes co-payments, premiums or other charges on Enrollees in excess of any permitted under this Contract;

    c. Misrepresents or falsifies information provided to CMS or EOHHS;

    d. Misrepresents or falsifies information provided to Enrollees, Members, or Providers;

    e. Fails to comply with requirements regarding physician incentive plans;

    f. Fails to comply with applicable federal or state statutory or regulatory requirements related to this Contract;

    g. Violates restrictions or other requirements regarding Marketing;

    h. Fails to comply with any corrective action plan required by EOHHS;

    i. Fails to comply with financial solvency requirements as set forth in **Section 2.1.C**;

    j. Fails to comply with any other requirements of sections 1903(m) or 1932 of the Social Security Act, and any implementing regulations;

    k. Fails to comply with the False Claims provision of the Deficit Reduction Act of 2005;

    l. Submits contract management reports or Care Management reports, that are either late or missing a significant amount of information or data;

m. Fails to comply with any other requirements of this Contract.

2. Such sanctions may include, but are not limited to:

   a. Civil money penalties in accordance with 42 CFR 438.704 and **Section 5.21.A.3**. below;

   b. Financial measures EOHHS determines are appropriate to address the violation;

   c. 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) and 42 CFR 438.706;

   d. Notifying the affected Enrollees of their right to disenroll;

   e. Suspension of enrollment (including assignment of Enrollees);

   f. Suspension of payment to the Contractor for Enrollees enrolled after the effective date of the sanction and until CMS or EOHHS is satisfied that the reason for imposition of the sanction no longer exists and is not likely to recur;

   g. Disenrollment of Enrollees;

   h. Limitation of the Contractor's coverage area;

   i. Additional sanctions allowed under federal law or state statute or regulation that address areas of noncompliance; and

   j. Such other measures as EOHHS determines appropriate to address the violation.

3. Civil money penalties shall be administered in accordance with 42 CFR 438.704 as follows:

   a. The limit is $25,000 for each determination under the following subsections of **Section 5.21.A.1** above:

      1) **5.21.A.1.d** (misrepresentation or false statement to an Enrollee, Member, or Provider)

      2) **5.21.A.1.e** (failure to comply with requirements regarding physician incentive plans); or

      3) **5.21.A.1.f** (violates restrictions or other requirements regarding Marketing).

   b. The limit is $100,000 for each determination under the following subsections of **Section 5.21.A.1** above:

      1) **5.21.A.1.a** (discrimination); or

      2) **5.21.A.2.c** (misrepresentation or false statements to CMS or EOHHS).

c. The limit is $15,000 for each Enrollee EOHHS determines was terminated or not re-enrolled because of a discriminatory practice under **Section 5.21.A.1.a** above (with an overall limit of $100,000 under **Section 5.21.A.3.b** above).

d. The limit is $25,000 or double the amount of the excess charges, whichever is greater, for each determination under **Section 5.21.A.2.c** above.

4. The intermediate sanctions provisions contained in this Contract are pursuant to state authority, unless otherwise specifically provided.

5. Before imposing any of the intermediate sanctions specified in this **Section 5.21**, EOHHS shall give the Contractor written notice that explains the basis and nature of the sanctions not less than 14 calendar days before imposing such sanction.

6. For any Contractor responsibilities for which the Contractor utilizes a Material Subcontractor, if EOHHS identifies any deficiency in the Contractor's performance under the Contract for which the Contractor has not successfully implemented an approved corrective action plan in accordance with **Section 5.22.A**, EOHHS may:

a. Require the Contractor to subcontract with a Material Subcontractor deemed satisfactory by EOHHS; or

b. Otherwise require the Contractor to alter the manner or method in which the Contractor performs such Contractor responsibility.

B. Denial of Payment Sanction

In accordance with 42 CFR 438.726(b) and 42 CFR 438.730(e), EOHHS shall deny payments under this Contract to the Contractor for New Enrollees if CMS denies payment to EOHHS for the same New Enrollees in the following situations:

1. If a CMS determination that the Contractor has acted or failed to act as described in **Section 5.21.A.1-5** of this Contract is affirmed on review pursuant to 42 CFR 438.730(d).

2. If a CMS determination that the Contractor has acted or failed to act as described in **Section 5.21.A.1-5** of this Contract is not timely contested by the Contractor under 42 CFR 438.730(c).

3. For the purposes of this **Section 5.21.F**, New Enrollee shall be defined as an Enrollee that applies for enrollment after the Effective Date of this Sanction (the date determined in accordance with 42 CFR 438.730(f)).

C. Flexible Services Sanction

As further specified by EOHHS, if the Contractor does not meet the requirements of **Section 2.14.B**, EOHHS may reduce the Contractor's Flexible Services payments, otherwise recoup payment from the Contractor, or limit the amount of Flexible Services funding the Contractor may roll over.

Section 5.22 Remedies for Poor Performance

EOHHS may seek remedies for poor performance on the part of the Contractor under this Contract. If the Contractor fails to perform in a manner that is satisfactory to EOHHS, EOHHS may take one or more of the following actions:

A. Require the Contractor to develop and submit a corrective action plan for EOHHS' review and approval. 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. EOHHS may also initiate a corrective action plan for the Contractor to implement. The Contractor shall promptly and diligently implement the corrective action plan as approved by EOHHS. Failure to implement the corrective action plan may subject the Contractor to termination of the Contract by EOHHS;

B. Change the Contractor's Risk Track as defined in **Section 4.5.C**; or

C. Terminate the Contract with or without cause as EOHHS determines appropriate.

Section 5.23 Termination

A. Termination by EOHHS

1. EOHHS may terminate this Contract immediately and without prior written notice upon any of the events below. EOHHS shall provide written notice to the Contractor upon such termination.

    a. The Contractor's application for or consent to the appointment of a receiver, trustee, or liquidator for itself or any of its property;

    b. The Contractor's admission in writing that it is unable to pay its debts as they mature;

    c. The Contractor's assignment for the benefit of creditors;

    d. 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 proceedings;

    e. Commencement of an involuntary proceeding against the Contractor or subcontractor under any bankruptcy, reorganization, insolvency, or readjustment of debt provision of federal or state law which is not dismissed within sixty days;

    f. The Contractor incurs loss of any of the following: (1) licensure at any of the Contractor's facilities; or (2) state approval of the Contractor;

    g. The Contractor is non-compliant with **Section 5.10.C** regarding prohibited affiliations and exclusion of entities and the Secretary, as permitted under federal law, directs EOHHS to terminate, or does not permit EOHHS to extend, renew, or otherwise continue this Contract;

h. Cessation in whole or in part of state or federal funding for this Contract, provided that termination for this reason shall occur no earlier than the last day of the month in which such funding ceases.

2. Termination with Prior Notice

a. EOHHS may terminate this Contract upon breach by the Contractor of any duty or obligation hereunder which breach continues unremedied for 30 days after written notice thereof by EOHHS.

b. EOHHS may terminate this Contract after written notice thereof to the Contractor in the event the Contractor fails to accept any Capitation Rate established by EOHHS.

c. EOHHS may terminate this Contract immediately after written notice in the event the Contractor fails to agree to amend the Contract.

d. EOHHS may terminate this Contract pursuant to its authority under 42 CFR 438.708 in accordance with **Section 5.23.B** of this Contract.

e. EOHHS may terminate this Contract with written notice if the ACO Program is not performing as expected as further described in **Section 5.23.E** below.

f. EOHHS may terminate this Contract with written notice if, in EOHHS' sole determination, Contractor has significant programmatic cause for exit, as described in **Section 5.23.E** below.

3. For reasons for termination set forth in this **Section 5.23.A**, except as otherwise set forth in this **Section 5.23**, including but not limited to for the reasons described in **Section 5.23.A.2.f-g** above, the Contractor and EOHHS shall mutually agree upon the date the Contract shall terminate. If not all Enrollees have been disenrolled from the Contractor's Plan at the time of Contract termination, then the Contractor shall enter Continued Obligations as described in **Section 5.23.H**.

B. Termination Pursuant to 42 CFR 438.708

1. EOHHS may terminate this Contract pursuant to its authority under 42 CFR 438.708.

2. If EOHHS terminates this Contract pursuant to its authority under 42 CFR 438.708, EOHHS shall provide the Contractor with a pre-termination hearing in accordance with 42 CFR 438.710 as follows:

a. EOHHS shall give the Contractor written notice of intent to terminate, the reason for termination, and the time and place of the hearing;

b. After the hearing, EOHHS shall give the Contractor written notice of the decision affirming or reversing the proposed termination of the contract and, for an affirming decision, the effective date of termination; and

c. If the decision is affirmed, EOHHS shall give enrollees notice of the termination and information on their options for receiving MassHealth services following the effective date of termination in accordance with 42 CFR 438.710(b)(2)(iii) and **Section 5.23.H** Of this contract.

C. Termination by the Contractor for EOHHS Breach

The Contractor may terminate this Contract upon a material breach by EOHHS of a duty or obligation in **Section 4** of this Contract that creates significant challenges for the Contractor to continue performing under this Contract. The Contractor and EOHHS shall mutually agree upon the date the Contract shall terminate. If not all Enrollees have been disenrolled from the Contractor's Plan at the time of Contract termination, then the Contractor shall enter Continued Obligations as described in **Section 5.23.H**.

D. Termination by the Contractor Pursuant to Contractor's Annual Option to Terminate Contract

Starting in Contract Year 2, the Contractor may terminate this Contract by providing written notice to EOHHS as further specified in this Section and by EOHHS. The Contractor shall submit such notice between October 1 of the current Contract Year (i.e., October 1 of Contract Year 2 or future years) and 21 days prior to the first day of the new Contract Year (for the purposes of this Section, "Closing Contract Year"). In such instances:

1. The Contractor shall work with EOHHS to ensure a smooth termination of the Contract, including but not limited to transitioning Enrollees and Providers.

2. EOHHS shall amend the Contract as follows, and as further specified by EOHHS:

   a. The duration of the amended Contract shall be for 12 months, and shall terminate at 11:59 p.m. of the last day of the Closing Contract Year;

   b. EOHHS shall pay the Contractor in accordance with **Section 4** and **Appendix I**;

   c. EOHHS may, at its discretion, adjust the Market-Wide Risk Arrangement set forth in **Section 4.5.A** to mitigate risk during the Closing Contract Year;

3. The Contractor shall, to facilitate the transition of Enrollees to another MassHealth ACO, MCO, or the PCC Plan, share information with EOHHS relating to its Enrollees, including but not limited to PCP assignment and Enrollees in care management.

4. The Contractor shall make good faith effort to assist their PCPs in becoming PCPs of other Accountable Care Partnerships Plans, Primary Care ACOs, and MCOs. Such efforts shall include, but not be limited to, providing appropriate and reasonable data on the provider's enrollees to facilitate conversations with other health plans.

5. If, after providing notification of intent to terminate, the Contractor for any reason does not sign an amendment to extend the Contract through the Closing Contract Year under modified terms:

a. The Contractor shall enter into Continued Obligations as described in **Section 5.23.H**, and EOHHS shall pay the Contractor in accordance with such Section;

b. EOHHS shall not pay the MassHealth Share of any Loss due to the Contractor after Risk Sharing Arrangements calculations are complete from the year the contract is terminated, and during the period of Continued Obligations;

c. The Contract will terminate at 11:59 pm of the last day of the Contract Year where notification of termination is provided.

E. Termination without Penalty

1. EOHHS may terminate this Contract if EOHHS determines that the ACO Program is not performing in whole or in part in accordance with EOHHS' expectations or that state or federal health care reform initiatives or state or federal health care cost containment initiatives make termination of the Contract necessary or advisable as determined by EOHHS.

2. Programmatic cause for exit

a. EOHHS may terminate this Contract if, in EOHHS' sole determination, the Contractor has significant programmatic cause for exit, as further specified by EOHHS.

b. The Contractor may request a finding of significant programmatic cause for exit at any time by submitting a written request to EOHHS, in a form and format specified by EOHHS. The Contractor shall provide any additional information requested related to the request;

c. EOHHS may, but is not obligated to, find significant programmatic cause for exit for the following reasons:

1) Losses greater than 5% of the TCOC Benchmark in the last two recently completed Contract Years;

2) The Contractor or its Participating PCPs have merged with another ACO in the MassHealth ACO program;

3. Termination pursuant to this Section will be effective at 11:59 p.m. on the last day of the current Contract Year, unless otherwise specified by EOHHS. If not all Enrollees have been disenrolled from the Contractor's Plan at the time of Contract termination, the Contractor shall enter Continued Obligations as described in **Section 5.23.H**.

F. Termination with Penalty

1. In the event of Contract termination pursuant to any of the following, the Contractor shall be subject to a penalty:

a. **Section 5.23.A.1**, with the exception of **5.23.A.1.h**.

b. **Section 5.23.A.2.a-d**.

2. The penalty shall consist of the greater of either:

   a. 3% of the total annual TCOC Benchmark for the last fully completed Contract Year, plus 3% of the TCOC Benchmark during Continuing Obligations. If a full Contract Year has not been completed, the penalty shall equal 3% of estimated total annual TCOC Benchmark, as estimated by EOHHS; or

   b. The MassHealth share of any Shared Losses for the last fully completed Contract Year, in addition to any Shared Losses accrued during Continued Obligations.

3. If the Contract is terminated pursuant to **Section 5.23.F.1**, EOHHS may at its sole discretion eliminate or reduce any Quality and Quality and Equity Incentive Program Arrangement payments that the Contractor is otherwise eligible to receive.

G. Termination Authority

The termination provisions contained in this Contract are pursuant to state authority, unless otherwise specifically provided.

H. Continued Obligations of the Parties

In the event of termination, expiration, or non-renewal of this Contract:

1. The obligations of the parties hereunder with regard to each Enrollee at the time of such termination, expiration or non-renewal will continue until the Enrollee has been disenrolled from the Contractor's Plan; 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. EOHHS shall be responsible for notifying all Enrollees covered under this Contract of the date of termination and the process by which those Enrollees will continue to receive medical care.

3. The Contractor shall promptly return to EOHHS all payments advanced to the Contractor for coverage of Enrollees for periods after the Effective Date of their Disenrollment.

4. If the Contractor has Continued Obligations as described in this Section, the Contractor shall accept the TCOC Benchmark as established by EOHHS for the Contract Year during which the Continued Obligations period is occurring, with a 1.5% reduction, subject to actuarial soundness as appropriate.

5. EOHHS shall calculate Gain and Loss as described in **Appendix I**, if any, from the end of the Contract Year in which the termination is effective through the completion of all disenrollment activities. The Contractor shall pay EOHHS the MassHealth Share of any Gain. EOHHS shall not be obligated to pay the Contractor the MassHealth Share of any Loss.

6. The Contractor shall, to facilitate the transition of Enrollees to another MassHealth ACO, MCO, or the PCC Plan, share information with EOHHS relating to its Enrollees, including but not limited to PCP assignment, Enrollees in care management, Enrollees with active prior authorizations, and Enrollees' active drug prescriptions.

7. The Contractor shall continue to meet all payment requirements under the Primary Care Sub-Capitation Program as set forth in **Section 2.14.A.1.h** and **Section 2.4.E.8** and shall not reduce any payment amount.

Section 5.24 Suspected Fraud

Contractor Obligations

A. The Contractor shall report to EOHHS in writing within five (5) business days any allegation of fraud, waste, or abuse regarding an EOHHS client or Commonwealth contractor as defined under 42 CFR 455.2 or other applicable law. In the event of suspected fraud, no further contact shall be initiated with such client or contractor on that specific matter without EOHHS' approval.

B. Provide to EOHHS an annual certification, in a form and format specified by EOHHS, attesting that the Contractor satisfies all Contract requirements regarding suspected fraud including but not limited to the requirement to report any allegation of fraud to EOHHS.

C. The Contractor and, where applicable, its subcontractors shall cooperate, as reasonably requested in writing, with the Office of the Attorney General's Medicaid Fraud Division (MFD), the Office of the State Auditor's Bureau of Special Investigations (BSI), or other applicable enforcement agency. Such cooperation shall include, but not be limited to, providing at no charge, prompt access and copies of any documents and other available information determined necessary by such agencies to carry out their responsibilities regarding fraud and abuse, maintaining the confidentiality of any such investigations, and making knowledgeable staff available at no charge to support any investigation, court, or administrative proceeding.

Section 5.25 Certification Requirements

In accordance with 42 CFR 438.600 et seq., the Contractor's Chief Executive Officer or Chief Financial Officer shall, at the time of submission of the types of information, data, and documentation listed below, sign and submit to EOHHS certification checklists in the form and format specified by EOHHS, 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, under the penalty of perjury:

A. Data on which payments to the Contractor are based;

B. All enrollment information and measurement data;

C. Data or information related to protection against the risk of insolvency;

D. Documentation related to requirements around availability and accessibility of services;

E. Information on ownership and control, such as that pursuant to **Section 5.26**; and

F. Data and other information required by EOHHS, including but not limited to, reports and data described in this Contract.

Section 5.26 Disclosure Requirements

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.

A. Federally Required Disclosures

The Contractor shall make the following federally-required disclosures in accordance with 42. CFR § 455.100, et seq. and 42 U.S.C. § 1396b(m)(4)(A) in the form and format specified by EOHHS.

1. Ownership and Control

Upon any 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, both with respect to the Contractor and Material Subcontractors. The Contractor shall complete the validation of federally required disclosure forms for their Material Subcontractors to ensure that the information is complete and individuals are in good stead by conducting routine checks of federal databases.

2. Business Transactions

Within 35 days of a written request by EOHHS, or the U.S. Department of Health and Human Services, the Contractor shall furnish full and complete information to EOHHS, or the U.S. Department of Health and Human Services, as required by 42 CFR 455.105 regarding business transactions.

3. Criminal Convictions

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 as required by 42 CFR 455.106 regarding persons convicted of crimes.

4. Other Disclosures

a. The Contractor shall comply with all reporting and disclosure requirements of 41 USC § 1396b(m)(4)(A) if the Contractor is not a federally qualified health maintenance organization under the Public Health Service Act; and

b. In accordance with Section 1903(m)(4)(B) of the Social Security Act, the Contractor shall make such reports regarding certain transactions with parties of interest available to Enrollees upon reasonable request;

B. Disclosures Form

1. Unless otherwise instructed by EOHHS, for the purposes of making the disclosures to EOHHS set forth above, the Contractor shall fully and accurately complete the EOHHS form developed for such purpose including any EOHHS form for the disclosure and any EOHHS form required to post such disclosure on EOHHS's website in accordance with federal law, often referred to as the MassHealth Federally-Required Disclosures Form and Addendum, respectively. EOHHS may update or replace this form without the need for a Contract amendment.

2. EOHHS may immediately terminate this Contract in whole or in part if the Contractor fails to comply with this **Section 5.26**. 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 5.27 Restrictions of Use of the Commonwealth Seal

Bidders and Contractors are not allowed to display the Commonwealth of Massachusetts Seal in their bid package or subsequent Marketing Materials if they are awarded a Contract because use of the coat of arms and the Great Seal of the Commonwealth for advertising or commercial purposes is prohibited by law.

Section 5.28 Order of Precedence

The Contractor's response and RFR specified below are incorporated by reference into this Contract. Any ambiguity or inconsistency between these documents shall be resolved by applying the following order of precedence:

A. This Contract, including any amendments hereto;

B. The Request for Responses for Accountable Care Organizations issued by EOHHS on April 13, 2022; and

C. The Contractor's Response to the RFR.

Section 5.29 Contractor's Financial Condition and Corporate Structure

As a condition of the Contract, the Contractor shall, at the request of EHS, provide EHS with documentation relating to organizational structure, financial structure and solvency, including but not limited to the following: the name(s) and address(es) of the (1) Contractor's parent organizations, (2) parents of such parent organizations, (3) Contractor's subsidiary organizations, and (4) subsidiaries of any organizations listed in (1), (2), or (3) herein; and the names and occupations of the members of the Board of Directors of the organizations listed in (1)-(4) herein.

Section 5.30 Notices

Notices to the parties as to any matter hereunder will be sufficient if given in writing and sent by certified mail

(return receipt requested), postage prepaid, or delivered in hand or by an overnight delivery service with acknowledgment of receipt:

To EOHHS:

Assistant Secretary for MassHealth
Executive Office of Health and Human Services
One Ashburton Place, 11th Floor
Boston, MA 02108

Director, MassHealth ACO Program
Executive Office of Health and Human Services
One Ashburton Place, 11th Floor
Boston, MA 02108

With Copies to:
General Counsel
Executive Office of Health and Human Services
One Ashburton Place, 11th Floor
Boston, MA 02108

To the Contractor:
Notice to the Contractor will be provided to the individual identified in **Appendix K.**

SECTION 6. DATA MANAGEMENT AND CONFIDENTIALITY

The Contractor shall comply with all state and federal laws and regulations applicable to the privacy and security of personal and other confidential information, including the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the privacy and security regulations promulgated thereunder (45 CFR Parts 160 and 164) (the Privacy and Security Rules), and any other legal obligations regarding the privacy and security of such information to which the Contractor is subject, including any obligations to which the Contractor is subject by virtue of its contractual relationship with its Participating PCPs. The Contractor shall also comply with the additional terms, conditions and obligations relating to the privacy, security and management of personal and other confidential information determined by EOHHS to apply to this Contract.

EOHHS reserves the right to amend the Contract to add any requirement it determines must be included in the Contract in order for EOHHS to comply with all applicable state and federal laws and regulations relating to privacy and security, including but not limited to the Privacy and Security Rules and any other legal obligations regarding the privacy and security of such information to which EOHHS is subject.

If the Contractor wishes to receive member-level data or reports that may be available from EOHHS under the Contract, the Contractor may be required to submit a request to EOHHS and execute a Data Use Agreement (DUA) containing any representations and/or privacy and security requirements applicable to the data and/or report(s) that EOHHS may determine necessary or appropriate. However, the terms of such DUA shall not apply to any PI provided, and defined, under **Appendix H**, as updated from time to time.

For the PI provided under **Appendix H**, as updated from time to time, the Contractor is EOHHS' business associate under the Privacy and Security Rules, and subject to all other terms and conditions therein. If **Appendix H** is not part of the Contractor's obligations, **Appendix H** shall be left blank as attached to this Contract.

The Contractor shall seek and obtain EOHHS prior written authorization for the use of any data pertaining to this Contract for research or any other purposes not directly related to the Contractor's performance under this Contract. The Contractor shall submit to EOHHS the results of any external research projects for which the Contractor has received EOHHS approval to share MassHealth data.

The Contractor shall promptly execute and comply with any amendment to this Contract that EOHHS determines is necessary to ensure compliance with such applicable laws, regulations, and other legal obligations. EOHHS may terminate this Contract immediately upon written notice in the event the Contractor fails to agree to any such amendment.

APPENDIX A

Exhibit 1: Services Included in TCOC Calculations

✓ Denotes a service included in TCOC Calculations

Each of the Services listed below will be included in Total Cost of Care (TCOC) calculations, except for those listed as Services Not Included in TCOC Calculations or listed as Excluded Services. MassHealth reserves the right to amend or modify this list, including but not limited to further defining the services listed below as well as adding or removing services.

	Coverage Types		
Service	**MassHealth Standard & CommonHealth Enrollees**	**MassHealth Family Assistance Enrollees**	**CarePlus**
Acupuncture Treatment	✓	✓	✓
Acute Inpatient Hospital	✓	✓	✓
Ambulatory Surgery/Outpatient Hospital Care	✓	✓	✓
Audiologist	✓	✓	✓
Behavioral Health Services (see below)	✓	✓	✓
Breast Pumps and Breast Milk Storage Bags	✓	✓	✓
Certain COVID-19 Specimen Collection and Testing (until May 11, 2023)	✓	✓	✓
Chiropractic Services	✓	✓	✓
Chronic, Rehabilitation Hospital or Nursing Facility Services, up to 100 days per Contract Year, except stays in Commonwealth designated COVID-19 nursing facility, see non-TCOC Included Services in Exhibit 2.	✓	✓	✓
Emergency Related Dental Services	✓	✓	✓
Diabetes Self-Management Training	✓	✓	✓
Dialysis	✓	✓	✓
Durable Medical Equipment and Medical/Surgical Supplies **1) Durable Medical Equipment** **2) Medical/Surgical Supplies**	✓	✓	✓
Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services	✓		
Early Intervention	✓	✓	

Service	Coverage Types		
	MassHealth Standard & CommonHealth Enrollees	MassHealth Family Assistance Enrollees	CarePlus
Emergency Services	✓	✓	✓
Family Planning	✓	✓	✓
Fluoride Varnish	✓	✓	
Hearing Aids	✓	✓	✓
Home Health Services	✓	✓	✓
Hospice	✓	✓	✓
Infertility, related to an underlying medical condition	✓	✓	✓
Laboratory	✓	✓	✓
MassHealth Coordinating Aligned, Relationship-centered Enhanced Support (CARES) for Kids	✓		
Medical Nutritional Therapy	✓	✓	✓
Orthotics	✓	✓	✓
Oxygen and Respiratory Therapy Equipment	✓	✓	✓
Pharmacy (Please see Exhibit 2 for categories of Pharmacy that are not included in TCOC calculations.) **1) Prescription Drugs, including but not limited to Hepatitis C Viral Drugs (HCV)** **2) Over-the-Counter Drugs** **3) Non-Drug Pharmacy Products** **4) Pharmaceutical Compounded Drugs**	✓	✓	✓
Physician (primary and specialty)	✓	✓	✓
Podiatry	✓	✓	✓
Preventive Pediatric Health Screening and Diagnostic Services		✓	
Prosthetic Services and Devices	✓	✓	✓
Radiology and Diagnostic Tests	✓	✓	✓
Remote Patient Monitoring	✓	✓	✓
School Based Health Center Services	✓	✓	

Service	Coverage Types		
	MassHealth Standard & CommonHealth Enrollees	MassHealth Family Assistance Enrollees	CarePlus
Therapy **1) Physical** **2) Occupational** **3) Speech and Hearing**	✓	✓	✓
Tobacco Cessation Services	✓	✓	✓
Transportation (emergent)	✓	✓	✓
Transportation (non-emergent, to out-of-state location)	✓		✓
Urgent Care Clinic Services	✓	✓	✓
Vaccine Counseling Services	✓	✓	✓
Vision Care (medical component)	✓	✓	✓
Wigs	✓	✓	✓

APPENDIX A

Exhibit 2: Services Not Included in TCOC Calculations

✓ Denotes a service not included in TCOC calculations

These services coordinated by the Contractor are not factored into TCOC calculations.

	Coverage Types		
Service	**MassHealth Standard & CommonHealth Enrollees**	**MassHealth Family Assistance Enrollees**	**CarePlus**
Abortion	✓	✓	✓
Adult Dentures	✓	✓	✓
Adult Day Health	✓		
Adult Foster Care	✓		
Applied Behavioral Analysis for members under 21 years of age (ABA Services)	✓		
Chronic, Rehabilitation Hospital, or Nursing Facility Services, both beyond 100 days per Contract Year, consistent with MassHealth policy, and any stay of any duration in a Commonwealth-designated COVID-19 nursing facility	✓	✓	
Day Habilitation	✓		
Preventative and Basic Dental Services	✓	✓	✓
Doula Services	✓	✓	✓
Group Adult Foster Care	✓		
Isolation and Recovery Site Services	✓	✓	✓
Personal Care Attendant	✓		
Pharmacy – High Cost Drugs	✓	✓	✓
Private Duty Nursing/Continuous Skilled Nursing	✓	✓	
Residential Rehabilitation Services (Level 3.1)	✓	✓	✓
1. Adult Residential Rehabilitation Services for Substance Use Disorders (Level 3.1)	✓	✓	✓
2. Family Residential Rehabilitation Services for Substance Use Disorders (Level 3.1)	✓	✓	✓

Service	Coverage Types		
	MassHealth Standard & CommonHealth Enrollees	MassHealth Family Assistance Enrollees	CarePlus
3. Transitional Age Youth and Young Adult Residential Rehabilitation Services for Substance Use Disorders (Level 3.1)	✓	✓	✓
4. Youth Residential Rehabilitation Services for Substance Use Disorders (Level 3.1)	✓	✓	✓
5. Pregnancy Enhanced Residential Rehabilitation Services for Substance Use Disorders (Level 3.1)	✓	✓	✓
6. Co-Occurring Enhanced Residential Rehabilitation Services (Level 3.1)	✓	✓	✓
Recovery Coaching	✓	✓	✓
Recovery Support Navigators	✓	✓	✓
Transitional Support Services (TSS) for Substance Use Disorders (Level 3)	✓	✓	✓
Transportation (non-emergent, to in-state location or location within 50 miles of the Massachusetts border)	✓		✓
Vision Care (non-medical component)	✓	✓	✓

Appendix A

Exhibit 3: Behavioral Health Services Included in TCOC Calculations

✓ Denotes a service included in TCOC Calculations

	Coverage Types		
Service	**ACO MassHealth Standard & CommonHealth Enrollees**	**ACO MassHealth Family Assistance Enrollees**	**CarePlus**
Inpatient Services			
1. Inpatient Mental Health Services	✓	✓	✓
2. Inpatient Substance Use Disorder Services (Level 4)	✓	✓	✓
3. Observation/Holding Beds	✓	✓	✓
4. Administratively Necessary Day (AND) Services	✓	✓	✓
Diversionary Services			
24-Hour Diversionary Services			
a. Youth and Adult Community Crisis Stabilization	✓	✓	✓
b. Community-Based Acute Treatment for Children and Adolescents (CBAT)	✓	✓	
c. Medically Monitored Intensive Services - Acute Treatment Services (ATS) for Substance Use Disorders (Level 3.7)	✓	✓	✓
d. Clinical Support Services for Substance Use Disorders (Level 3.5)	✓	✓	✓
e. Transitional Care Unit (TCU)	✓	✓	
Non-24-Hour Diversionary Services			
a. Community Support Program (CSP) and Specialized CSP **1. CSP for Justice Involved** **2. CSP for Homeless Individuals** 3. **CSP – Tenancy Preservation Program**	✓	✓	✓
b. Partial Hospitalization (PHP)	✓	✓	✓
c. Psychiatric Day Treatment	✓	✓	✓
d. Structured Outpatient Addiction Program (SOAP)	✓	✓	✓

Service	Coverage Types		
	ACO MassHealth Standard & CommonHealth Enrollees	ACO MassHealth Family Assistance Enrollees	CarePlus
e. Intensive Outpatient Program (IOP)	✓	✓	✓
f. Program of Assertive Community Treatment (PACT)	✓	✓	✓
Outpatient Services			
Standard Outpatient Services			
a. Family Consultation	✓	✓	✓
b. Case Consultation	✓	✓	✓
c. Diagnostic Evaluation	✓	✓	✓
d. Dialectical Behavioral Therapy (DBT)	✓	✓	✓
e. Psychiatric Consultation on an Inpatient Medical Unit	✓	✓	✓
f. Medication Visit	✓	✓	✓
g. Couples/Family Treatment	✓	✓	✓
h. Group Treatment	✓	✓	✓
i. Individual Treatment	✓	✓	✓
j. Inpatient-Outpatient Bridge Visit	✓	✓	✓
k. Assessment for Safe and Appropriate Placement (ASAP)	✓	✓	
l. Collateral Contact	✓	✓	
m. Acupuncture Treatment	✓	✓	✓
n. Opioid Treatment Services	✓	✓	✓
o. Ambulatory Withdrawal Management (Level 2WM)	✓	✓	✓
p. Psychological Testing	✓	✓	✓
q. Special Education Psychological Testing	✓	✓	
r. Early Intensive Behavioral Intervention (EIBI)	✓	✓	
s. Preventive Behavioral Health Services	✓	✓	
Intensive Home or Community-Based Services for Youth			
a. Family Support and Training	✓		

Service	Coverage Types		
	ACO MassHealth Standard & CommonHealth Enrollees	ACO MassHealth Family Assistance Enrollees	CarePlus
b. Intensive Care Coordination	✓		
c. In-Home Behavioral Services 1) Behavior Management Therapy 2) Behavior Management Monitoring	✓		
d. In-Home Therapy Services 1) Therapeutic Clinical Intervention 2) Ongoing Therapeutic Training and Support	✓	✓	
e. Therapeutic Mentoring Services	✓		
Crisis Services			
1. Adult Mobile Crisis Intervention (AMCI) Encounter	✓	✓	✓
2. Youth Mobile Crisis Intervention (YMCI)	✓	✓	
3. Behavioral Health Crisis Evaluation Services in Acute Medical Setting	✓	✓	✓
4. Behavioral Health Crisis Management Services in Acute Medical Settings	✓	✓	✓
Other Behavioral Health Services			
1. Electro-Convulsive Therapy (ECT)	✓	✓	✓
2. Repetitive Transcranial Magnetic Stimulation (rTMS)	✓	✓	✓
3. Specialing	✓	✓	✓

APPENDIX A

Exhibit 4: MassHealth Excluded Services – All Coverage Types

Except as otherwise noted or determined Medically Necessary by EOHHS, the following services are not covered under MassHealth and as such are not included in the Contractor's TCOC.

1. Cosmetic surgery, except as determined by the Contractor to be necessary for:
   a. correction or repair of damage following an injury or illness;
   b. mammoplasty following a mastectomy; or
   c. any other medical necessity as determined by the Contractor.

2. Treatment for infertility, including in-vitro fertilization and gamete intra-fallopian tube (GIFT) procedures.

3. Experimental treatment.

4. Personal comfort items including air conditioners, radios, telephones, and televisions (effective upon promulgation by EOHHS of regulations at 130 CMR regarding non-coverage of air conditioners).

5. Non-covered laboratory services as specified in 130 CMR 401.411.

6. Services not otherwise covered by MassHealth, except as determined by EOHHS to be Medically Necessary for MassHealth Standard or MassHealth CommonHealth Enrollees under age 21. In accordance with EPSDT requirements, such services will be included in the Contractor's TCOC under the Contract.

Appendix B
EOHHS Accountable Care Organization Quality and Health Equity Appendix

This Appendix details how EOHHS will determine the Contractor's Quality and Health Equity Performance as described in the Contract. EOHHS may modify the methodology set forth herein after the execution of the Contract by written amendment. The following information is included. For the purposes of this document, "Performance Year" or "PY" shall mean "Contract Year" as defined in Section 1 of the Contract, unless otherwise specified by EOHHS.

Section 1.1. OVERVIEW OF QUALITY AND HEALTH EQUITY PERFORMANCE AND SCORING

Section 1.2 SCORING METHODOLOGY FOR ACO QUALITY SCORE

- **A. List of Quality Measures for ACO Quality Score**
- **B. Measure Level Scoring Methodology (Achievement and Improvement Points)**
- **C. Domain Level Scoring Methodology**

Section 1.3 SCORING METHODOLOGY FOR ACO QUALITY AND EQUITY INCENTIVE PROGRAM (QEIP) HEALTH EQUITY SCORE

Section 1.4 SCORING METHODOLOGY FOR COMMUNITY PARTNERS QUALITY SCORE

- **A. List of Quality Measures for CP Quality Score**

Section 1.5 METHODOLOGY FOR ESTABLISHING PERFORMANCE BENCHMARKS FOR QUALITY MEASURES

Section 1.6 QUALITY AND HEALTH EQUITY PERFORMANCE FINANCIAL APPLICATION

Section 1.1 Overview of Quality Performance and Scoring and Health Equity Performance and Scoring

The Contractor shall receive, for each Performance Year, an ACO Quality Score that shall determine the Quality Incentive payment amount available to the Contractor as prescribed in **Section 2.10** of the Contract. The Contractor shall also receive, for each Performance Year, an ACO Health Equity Score that shall determine the Quality and Equity incentive payment amount available to the Contractor as prescribed in **Sections 2.12** and **2.12.E** of the Contract. The Contractor shall also receive, for each Performance Year, a CP Quality Score (calculated by EOHHS) for each Community Partner subcontractor as described in **Section 2.4.E** of the Contract. The CP Quality Score shall be used in the determination of incentive payments made by the Contractor to each of its subcontracted CPs.

This Section of the Appendix describes the individual measures, and general methodology EOHHS will use to calculate the Contractor's scores (i.e., ACO Quality Score, ACO Health Equity Score, and CP Quality Score), as further specified by EOHHS.

Section 1.2 Scoring Methodology for ACO Quality Score

The Contractor's Quality Score is based on the Contractor's performance across a set of benchmarks and improvement targets for individual measures that are grouped into three domains. EOHHS will weight and sum the Contractor's performance across domains to calculate one overall ACO Quality Score per performance year. For any measure where the Contractor does not meet minimum denominator requirements, as determined by EOHHS, then the measure's weight will be equally distributed to other measures within the same domain.

For ACOs serving primarily pediatric members (e.g., $\geq$ 75% of the ACO's Enrollees are ages 0-17 years), EOHHS shall replace adult focused measures (i.e., measures applicable to 18+ populations only) with measure(s) applicable to pediatric populations only ("pediatric replacement measures") as further specified by EOHHS. Quality Performance on these pediatric replacement measures will be scored as described above.

EOHHS, at its discretion, may also implement a pay-for-reporting component added to the overall ACO Quality Score methodology. As further specified by EOHHS, this component may include benchmarks or other requirements pertaining to the calculation/reporting of electronic-based quality measures (e.g., ECDS, eCQM) beginning with PY2023.

A. List of Quality Measures for ACO Quality Score

Quality Measures include claims-based measures, clinical quality measures, and member experience surveys across the following three domains:

- Preventive and Pediatric Care
- Care Coordination / Care for Chronic & Acute Conditions
- Member Experience

See Exhibit 2 for the list of Quality Measures.

EXHIBIT 2 – ACO Quality Measures

Domain	Measure Name	Measure Description	Data Source	Measure Steward	NQF No.	P4P Transition Year
Preventive and Pediatric Care	Developmental Screening in the First 3 Years of Life	The percentage of children screened for risk of developmental, behavioral and social delays using a standardized screening tool in the 12 months preceding or on their first, second, or third birthday.	Claims/ Hybrid	OHSU	1448	2025
	Immunizations for Adolescents	Percentage of members 13 years of age who received all recommended vaccines, including the HPV series	Hybrid	NCQA	1407	2024
	Childhood Immunization Status	Percentage of members 2 years of age who received all recommended vaccines by their second birthday	Hybrid	NCQA	0038	2024
	Prenatal and Postpartum Care	Percentage of deliveries in which the member received a prenatal care visit in the first trimester or within 42 days of enrollment	Hybrid	NCQA	N/A	2023

Domain	Measure Name	Measure Description	Data Source	Measure Steward	NQF No.	P4P Transition Year
		Percentage of deliveries in which women had a postpartum visit on or between 7 and 84 days after delivery				
	Topical Fluoride for Children, Dental or Oral Health Services	Percentage of children aged 1–20 years who received at least 2 topical fluoride applications as dental or oral health services within the reporting year	Claims	ADA DQA	3700	2024[1]
	Screening for Depression and Follow Up Plan	Percentage of members 12 to 64 years of age screened for depression on the date of the encounter using an age appropriate standardized depression screening tool AND if positive, a follow-up plan is documented on the date of the positive screen	Hybrid	CMS	0418	2023

[1] EOHHS will calculate pay for performance metrics for ages 1 through 5 only. For ages 6 – 20, this subpopulation will be for monitoring purposes only.

Domain	Measure Name	Measure Description	Data Source	Measure Steward	NQF No.	P4P Transition Year
Care Coordination/ Care for Acute and Chronic Conditions	Follow-Up After Emergency Department Visit for Mental Illness (7 days)	Percentage of emergency department (ED) visits for adults and children 6 years of age and older with a diagnosis of mental illness or intentional self-harm and who received a follow-up visit for mental illness within 7 days	Claims	NCQA	3489	2023
	Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (7 days)	Percentage of emergency department (ED) visits for members 13 years of age and older with a principal diagnosis of AOD abuse or dependence, who has a follow up visit for AOD	Claims	NCQA	3488	2023
	Follow-Up After Hospitalization for Mental Illness (7 days)	Percentage of discharges for members 6 to 64 years of age, hospitalized for mental illness, where the member received follow-up with a mental health practitioner within 7 days of discharge	Claims	NCQA	0576	2023
	Controlling High Blood Pressure	Percentage of members 18 to 64 years of age with hypertension and whose	Hybrid	NCQA	0018	2024

Domain	Measure Name	Measure Description	Data Source	Measure Steward	NQF No.	P4P Transition Year
		blood pressure was adequately controlled				
	Comprehensive Diabetes Care: HBA1c Poor Control	Percentage of members 18 to 64 years of age with diabetes whose most recent HbA1c level demonstrated poor control (> 9.0%)	Hybrid	NCQA	0059	2024
	Asthma Medication Ratio	Percentage of members 5 to 64 years of age who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 0.50 or greater	Claims	NCQA	1800	2024
	Initiation and Engagement of Alcohol, or Other Drug Abuse or Dependence Treatment	Percentage of members 13 to 64 years of age who are diagnosed with a new episode of alcohol, opioid, or other drug abuse or dependency who initiate treatment within 14 days of diagnosis and who receive at ≥2 additional services within 34 days of the initiation visit	Claims	NCQA	0004	2024

Domain	Measure Name	Measure Description	Data Source	Measure Steward	NQF No.	P4P Transition Year
Member Experience	Overall Care Delivery	Composites related to overall experience (e.g., Willingness to Recommend, Communications)	Survey	AHRQ	N/A	2023
	Person-Centered Coordination/Integration of Care	Composites related to coordination of care (e.g., referrals, services etc.) and knowledge of the patient	Survey	AHRQ	N/A	2023

EXHIBIT 2.A – ACO Quality Measures: Pediatric Replacement Measures

Domain	Measure Name	Description	Data Source	Measure Steward	NQF No.	P4P Transition Year
Care Coordination/Care for Acute and Chronic Conditions	Metabolic Monitoring for Children and Adolescents on Antipsychotics *Replacing: Controlling High Blood Pressure and* *Comprehensive Diabetes Care: HBA1c Poor Control*	Percentage of members 1 to 17 years of age who had two or more antipsychotic prescriptions and received metabolic testing	Claims	NCQA	2800	2024

B. Measure Level Scoring Methodology (Achievement and Improvement Points)

1. Achievement Points

The Contractor may receive up to a maximum of ten (10) achievement points for each Quality Measure, as follows:

a. EOHHS will establish an "attainment threshold" and a "goal benchmark" for each Quality Measure

(i) "Attainment threshold" sets the minimum level of performance at which the contractor can earn achievement points

(ii) "Goal benchmark" is a high performance standard above which the Contractor earns the maximum number of achievement points (i.e., 10 points)

b. EOHHS will calculate the Contractor's performance score on the Quality Measure based on the measure specifications

c. EOHHS will award the Contractor between zero (0) and ten (10) achievement points as follows:

(i) If the Contractor's performance score is less than the attainment threshold: 0 achievement points

(ii) If the Contractor's performance score is greater than or equal to the goal benchmark: 10 achievement points

(iii) If the performance score is between the attainment threshold and goal benchmark: achievement points earned are determined by the formula:

(a) 10*((Performance Score – Attainment Threshold) / (Goal Benchmark – Attainment Threshold))

EXHIBIT 3 – Example Calculation of Achievement Points for Measure A

Measure A attainment threshold = 45% (e.g., corresponding to 25th percentile of HEDIS benchmarks) **Measure A goal benchmark** = 80% (e.g., corresponding to 90th percentile of HEDIS benchmarks)
Scenario 1:
• Measure A performance score = 25%
• Achievement points earned = 0 points
Scenario 2:
• Measure A performance score = 90%
• Achievement points earned = 10 points
Scenario 3:
• Measure A performance score = 60%
• Achievement points earned = 10*((60% - 45%) / (80% - 45%)) = 4.29 points

2. Improvement Points

In addition to receiving achievement points based on performance (on a 0 to 10 scale), the Contractor may earn improvement points for reaching established improvement targets for each Quality Measure. Improvement points will be calculated as follows:

a. The Contractor's performance score will be calculated on each Quality Measure based on the measure specifications. Each Quality Measure's specifications will describe the detailed methodology by which this performance score is calculated.

b. Beginning PY2, EOHHS will compare the Contractor's performance score on each Quality Measure to the Contractor's performance score on that same Quality Measure from the highest scoring previous Performance Year.

c. EOHHS will calculate an Improvement Target for each applicable Quality Measure using the following formula (unless otherwise communicated by EOHHS). The Improvement Target is based on at least a 20% improvement each year in the gap between Goal Benchmark and the Attainment Threshold of each ACO measure.

(i) Improvement Target formula = [(Goal Benchmark –Attainment Threshold) /5]

For example, for Measure A, if the Attainment Threshold is 50% and the Goal Benchmark is 60%, the Improvement Target is 2% [(60 – 50)/5)]

(ii) For the purposes of calculating the Improvement Target, the result is rounded to the nearest tenth (i.e., one decimal point).

For example, for Measure B, if the Attainment Threshold is 80% and the Goal Benchmark is 90.2%, the Improvement Target is calculated to 2.04% [(90.2 – 80)/5)] which rounds to 2.0%.

(iii) The Contractor may earn up to five (5) improvement points for increases in measure score which meet or exceed the improvement target.

For example, for Measure B, the Improvement Target is 2.0%. If Contractor performance in PY4 is 54.0% and if Contractor performance in PY5 is 60.0%, the Contractor improvement from PY4 to PY5 is 6.0% [(60.0-54.0)] and the Contractor is awarded 5 improvement points. No points above 5 are awarded for increases in excess of the improvement target.

(iv) For the purposes of calculating the difference in Contractor quality performance over a previous year, the results are rounded to the nearest tenth (i.e., one decimal point). Rounding takes place after the calculation.

For example, for Measure B, if Contractor performance in PY4 is 54.54% and if Contractor performance in PY5 is 60.17%, the Contractor improvement from PY4 to PY5 is 5.63% [(60.17-54.54)], and the Contractor improvement will be rounded to the nearest tenth (i.e., one decimal point) to 5.6%.

(v) The Improvement Target is based on the higher of the original baseline or any year's performance prior to the current PY. This is intended to avoid rewarding regression in performance.

For example, for Measure B, assume Contractor performance in PY1 is 90.0% and the Improvement Target is 2.0%. If in PY4 the performance for the Contractor decreases to 89.0%, in PY5 the Contractor would need to reach 92.0% to reach the Improvement Target.

(vi) There are several special circumstances:

(a) *At or Above Goal*: If the Contractor has prior PY performance scores equal to or greater than the Goal Benchmark then the Contractor may still earn up to five (5) improvement points in each PY if improvement from the highest prior PY is greater than or equal to the Improvement Target.

(b) *At or Below Attainment*: If the Contractor has prior PY performance scores less than the Attainment Threshold then the Contractor may still earn up to five (5) improvement points each PY if improvement from the highest prior PY is greater than or equal to the Improvement Target, and performance in the current PY does not equal or exceed the Attainment Threshold. Additionally, if the Contractor has prior PY performance scores less than the Attainment Threshold and current PY performance scores are equal to or above the Attainment Threshold then the Contractor may still earn up to five (5) improvement points if the improvement is greater than or equal to the Improvement Target.

EXHIBIT 4 – Example Calculation of Improvement Points for Measure B
Measure B Attainment = 48.9% | Goal = 59.4% | Improvement Target = 2.1%

	PY4 Score	PY5 Score	Improvement	Improvement Target Met	Improvement Points Earned
Scenario 1:	50.0%	52.1%	2.1%	Yes	5
Scenario 2:	50.0%	56.7%	6.7%	Yes	5
Scenario 3:	59.5%	63.0%	3.5%	Yes; above Goal Benchmark	5
Scenario 4	45.0%	48.0%	3.0%	Yes; below Attainment Threshold	5

Scenario 5:	46.0%	49.0%	3.0 %	Yes; crossing Attainment	5
Scenario 6:	45.0%	46.0%	1.0%	No	0

C. Domain Level Scoring Methodology

EOHHS will sum the Contractor's achievement and improvement points for all Quality Measures within each Quality Domain. Improvement points earned in one Quality Domain may only be summed with achievement points from the same Quality Domain. The total number of points earned by the Contractor in each domain cannot exceed the maximum number of achievement points available in the domain. The maximum number of achievement points in the domain is calculated by multiplying the number of Pay-for-Performance (P4P) measures in the domain, in the given PY, by the number of available achievement points per measure.

For example, if in PY4, there are ten (10) clinical quality measures in Domain X in Pay-for-Performance, and each measure is worth ten (10) achievement points, the maximum number of achievement points in Domain X would be 100. Assume that in PY5 there are now twelve (12) clinical quality measures in Domain X in Pay-for-Performance, and that each measure is worth ten (10) achievement points, the maximum number of achievement points in Domain X would be 120.

Cumulative Example:
Total number of measures in domain: 2
Maximum number of achievement points in the domain = 20
Measure Attainment = 48.9% | Goal = 59.4%
Improvement Target = [(Goal Benchmark –Attainment Level) /5] = [59.4-48.9]/5 = 2.1

For example, for Measure A, if Contractor performance in PY4 is 54.54% and if Contractor performance in PY5 is 58.17% the Contractor will earn 8.8 Achievement Points [10 * (58.17 – 48.9)/(59.4 – 48.9)]. The Contractor has improved from PY4 to PY5 by 3.63% [(58.17 - 54.54)] which will be rounded to the nearest tenth (e.g., one decimal point) to 3.6% which exceeds the Improvement Target of 2.1%. Thus, the Contractor will earn five (5) improvement points. No points above 5 are awarded for increases in excess of the improvement target.

In this scenario the Contractor would earn 13.8 points.

If there is only one (1) additional measure in the Domain and the Contractor earned 9 total points for this measure; the total score for the Contractor would be 20.0 (out of 20) given that domain scores are capped at the maximum number of achievement points (20) in the domain.

Once the total number of points has been calculated, EOHHS will divide the resulting sum by the maximum number of achievement points that the Contractor is eligible for in the domain to produce the Contractor's Domain Score. Domain Scores are a value between zero (0) and one (1) expressed as a percentage (i.e., 0% to 100%). EOHHS will score the Contractor on each P4P Quality Measure unless the Contractor does not meet eligibility requirements for a specific measure (e.g., it does not meet the minimum denominator requirement). In cases like this, the measure is not factored into the denominator. Reporting measures do not factor into the Domain Score.

Additionally, improvement points do not count towards the denominator; they are therefore "bonus" points. Domain Scores are each capped at a maximum value of 100%.

EXHIBIT 5 – Example Calculation of an Unweighted Domain Score

Example Calculations of Unweighted Domain Score		
Example 1	Domain only has two Quality Measures (Measure A and Measure B)	
	Therefore, maximum number of achievement points is 2x10 = 20 points	
	Measure A:	Achievement points: 1.5
		Improvement Points: 0
	Measure B:	Achievement points: 0
		Improvement Points: 5
	Total achievement points: 1.5 + 0 = 1.5 points	
	Total improvement points: 0 + 5 = 5 points	
	Sum of achievement and improvement points: 1.5 + 5 = 6.5 points	
	Unweighted domain score = 6.5/20 * 100 = 32.5%	
Example 2	Domain only has two Quality Measures (Measure A and Measure B)	
	Therefore, maximum number of achievement points is 2x10 = 20 points	
	Measure A:	Achievement points: 8
		Improvement Points: 5
	Measure B:	Achievement points: 9.3
		Improvement Points: 0
	Total achievement points: 8 + 9.3 = 17.3	
	Total improvement points: 5 points	
	Sum of achievement and improvement points: 17.3 + 5 = 22.3 points	
	However, total number of points cannot exceed maximum number of achievement points (20)	
	Therefore, total domain points = 20	
	Unweighted domain score = 20/20 * 100 = 100%	

Section 1.3 Scoring Methodology for ACO Quality & Equity Incentive Program (QEIP) Health Equity Score

A. Performance Year 1 (CY2023) requirements for the ACO QEIP can be found in Attachment 1 to this Appendix.

B. Performance Years 2-5 (CY2024-2027) requirements for the ACO QEIP are forthcoming and will be provided in Attachment 2 to this Appendix.

Section 1.4 Scoring Methodology for Community Partners Quality Score

EOHHS shall calculate a Community Partner Quality Score for each of the Contractor's subcontracted CPs. Community Partner Quality Scores are based on the performance of each subcontracted CP's MassHealth enrollment, as determined by EOHHS, across a set of benchmarks or improvement targets for individual measures within the BH CP or LTSS CP measure slate as applicable as set forth in Exhibits 5

and 6 below. EOHHS will weight each CP's CP Quality Score by the volume of that CP's enrollment within the ACO relative to the volume of all other CP subcontractors within the same ACO. As further specified by EOHHS, EOHHS shall use the weighted CP Quality Score to determine the Contractor's payment to each CP based on the CP's quality performance. In addition to the above methodology, EOHHS may establish additional quality incentives designed to reward the Contractor's higher performing subcontracted CPs.

A. Quality Measures for CP Quality Score

EXHIBIT 6 – BH CP Quality Measures

Measure Name	Description	Data Source	Measure Steward	NQF No.
Follow-up with BH CP after acute or post-acute stay (x days)	Percentage of discharges from acute or post-acute stays for enrollees 18 to 64 years of age that were succeeded by a follow-up with a BH CP within x business days of discharge	Claims	EOHHS	NA
Follow-up with BH CP after ED visit (x days)	Percentage of ED visits for enrollees 18 to 64 years of age that had a follow-up visit within x days of the ED visit	Claims	EOHHS	NA
Annual Primary Care Visit	Percentage of enrollees 3 to 64 years of age who had at least one comprehensive well-care visit during the measurement year	Claims	EOHHS	NA
Initiation/Engagement of Alcohol, Opioid, or Other Drug Abuse or Dependence Treatment	Percentage of members 13 to 64 years of age who are diagnosed with a new episode of alcohol, opioid, or other drug abuse or dependency who initiate treatment within 14 days of diagnosis and who receive at ≥2 additional services within 34 days of the initiation visit	Claims	NCQA	0004

Measure Name	Description	Data Source	Measure Steward	NQF No.
Follow-Up After Hospitalization for Mental Illness (7 days)	Percentage of discharges for enrollees 18 to 64 years of age, hospitalized for treatment of mental illness, where the member received follow-up with a mental health practitioner within 7 days of discharge	Claims	NCQA	0576
Diabetes Screening for Individuals With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medication	Percentage of enrollees with schizophrenia or bipolar disorder, who were dispensed an antipsychotic medication, and had diabetes screening test during the measurement year	Claims	NCQA	1932
Antidepressant Medication Management	Percentage of members (18-64) treated with antidepressant and had diagnosis of major depression who remained on antidepressant medication treatment	Claims	NCQA	0105
Treatment Plan Completion	TBD	Claims	EOHHS	NA
Member Experience	TBD	Survey	EOHHS	NA

EXHIBIT 7 – LTSS CP Quality Measures

Measure Name	Description	Data Source	Measure Steward	NQF No.
Follow-up with LTSS CP after acute or post-acute stay (x days)	Percentage of discharges from acute or post-acute stays for enrollees 3 to 64 years of age that were succeeded by a follow-up with a LTSS CP within x business days of discharge	Claims	EOHHS	NA

Measure Name	Description	Data Source	Measure Steward	NQF No.
Annual Primary Care Visit	Percentage of enrollees 3 to 64 years of age who had at least one comprehensive well-care visit during the measurement year	Claims	EOHHS	NA
Care Plan Completion	TBD	Claims	EOHHS	NA
Oral Health Evaluation	Percentage of enrollees 3 to 20 years of age who received a comprehensive or periodic oral evaluation within the measurement year	Claims	ADA	NA
All-Cause ED Visits	The rate of ED visits for enrollees 3 to 64 years of age	Admin	EOHHS	NA
Member Experience	TBD	Survey	EOHHS	NA

Section 1.5 Methodology for Establishing Performance Benchmarks for Quality Measures

EOHHS will establish the attainment threshold, goal benchmark, improvement target (and/or any other applicable performance indicator) for each Quality Measure applicable to ACO Quality, ACO Health Equity, and CP Quality scoring methodologies. EOHHS anticipates establishing these performance indicators as follows:

- For Quality Measures based on NCQA HEDIS measures, EOHHS anticipates using NCQA Quality Compass percentiles, as well as MassHealth historical ACO and Community Partners' performance
- For non-HEDIS Quality Measures, EOHHS anticipates using MassHealth historical ACO and Community Partners' performance
- For other Quality Measures where EOHHS does not have access to applicable data, EOHHS anticipates using MassHealth benchmarks based on ACO/CP-attributed populations

Section 1.6 Quality Performance Financial Application

The Contractor's ACO Quality Score and ACO Health Equity Score will be applied to performance incentive payment as described in **Sections 2.10.C and 2.12.E.** Community Partner Quality Scores will be applied to incentive payments to CP subcontractors as described in **Section 2.4.E.**

ATTACHMENT 1

MassHealth "ACO Quality and Equity Incentive Program" Performance Year 1 Implementation Plan

Table of Contents

SECTION 1. BACKGROUND AND OVERVIEW OF THE ACCOUNTABLE CARE ORGANIZATION QUALITY AND EQUITY INCENTIVE PROGRAM

A. Overview

Massachusetts shifted the delivery system at scale to value-based care under the previous MassHealth section 1115 demonstration approval period, transitioning over 80 percent of eligible Medicaid members into accountable care organizations (ACOs) that are at risk to deliver better health outcomes, lower cost, and improved member experience through integrated, coordinated care.

A key goal of the Commonwealth's in this demonstration period is to improve quality of care and advance health equity, with a focus on initiatives addressing health-related social needs (HRSN) and health disparities demonstrated by variation in quality performance. To support achievement of this goal, Massachusetts is centering equity alongside quality as a pillar of value-based care and as a priority for the state's health care system.

To that end, MassHealth will implement aligned quality and equity initiatives across delivery system settings including but not limited to MassHealth's Managed Care Organizations (MCOs), Accountable Care Partnership Plans (ACPPs) and Primary Care ACOs (together "ACOs"), managed behavioral health vendor, and acute hospitals.

Together, this constellation of coordinated quality and equity initiatives will support Massachusetts in achieving its demonstration goal to improve quality of care and advance health equity.

B. Scope of this Implementation Plan

This Performance Year 1 Implementation Plan provides additional detail related to implementation of MassHealth's AQEIP for the first ACO PY from April 1, 2023-December 31, 2023, of the ACO contract (April 1, 2023 – December 31, 2027.) Information pertaining to PYs 2-5, representing Calendar Years 2024-2027, will be forthcoming.

SECTION 2. ACCOUNTABLE CARE ORGANIZATION QUALITY AND EQUITY INCENTIVE PROGRAM (AQEIP) DOMAINS AND GOALS

A. Overview of Targeted Domains for Improvement in the AQEIP

For the AQEIP, ACOs are incentivized to pursue performance improvements in the domains specified in Table 1.

Table 1. Overview of Targeted Domains for Improvement for the AQEIP

Domain 1: Demographic and Health-Related Social Needs Data	Accountable Care Organizations will be assessed on the completeness of beneficiary-reported demographic and health-related social needs data submitted in accordance with the commonwealth's data requirements. Demographic and health-related social needs data will include at least the following categories: race, ethnicity, primary language, disability status, sexual orientation, gender identity, and health-related social needs. Data completeness will be assessed separately for each data element.
Domain 2: Equitable Quality and Access	Accountable Care Organizations will be assessed on performance and demonstrated improvements on access and quality metrics, including associated reductions in disparities. Metrics will focus on overall access; access for individuals with disabilities and/or limited English proficiency; preventive, perinatal, and pediatric care services; care for chronic diseases and behavioral health; and care coordination.
Domain 3: Capacity and Collaboration	Accountable Care Organizations will be assessed on improvements in metrics such as provider and workforce capacity and collaboration within health system providers (e.g. clinical partners) to improve quality and reduce health care disparities.

B. Goals for each Domain of the AQEIP

Goals for each AQEIP domain are summarized below:

1. Demographic and Health-Related Social Needs Data Collection Domain Goals

    a. ACOs are incentivized to achieve certain milestones to meet an interim goal of 80 percent data completeness for self-reported race and ethnicity data for attributed MassHealth members by the end of Performance Year 3 (CY 2025).

    b. ACOs are incentivized to achieve certain milestones to achieve at least 80 percent data completeness for beneficiary-reported other demographic data (including at least primary language, disability status, sexual orientation, and gender identity) for attributed MassHealth members by the end of Performance Year 5 (CY 2027).

    c. ACOs are incentivized to meaningfully improve rates of HRSN screenings from the baseline period (CY 2024 and/or CY 2025) by the end of Performance Year 5 (CY 2027). To meet this goal, ACOs must not only conduct screenings of

beneficiaries, but also establish the capacity to track and report on screenings and referrals.

2. Equitable Quality and Access Domain Goals

   a. ACOs are incentivized for performance on metrics such as those related to access to care (including for individuals with limited English proficiency and/or disability); preventive, perinatal, and pediatric care; care for chronic diseases; behavioral health; care coordination; and/or patient experience.

   b. For up to the first three Performance Years (PY 2023 through PY 2025), ACO performance will be based on:

      (i) Reporting on access and quality metric performance, including reports stratified by demographic factors (such as race, ethnicity, language, disability, sexual orientation, and gender identity); health related social needs; and/or defined by other individual- or community-level markers or indices of social risk;

      (ii) Developing and implementing interventions aimed at improving quality and reducing observed disparities on metrics that account for clinical and social risk factors.

   c. For at least the last two Performance Years (PY2026 and PY2027), ACO performance will be based on improving quality and/or closing disparities as measured through performance on a subset of access and quality metrics.

3. Capacity and Collaboration Domain Goals

   ACOs are incentivized to improve service capacity, workforce development, and health system collaboration to improve quality and reduce disparities. The metrics that assess improvement in this domain may relate to provider cultural competence and achievement of externally validated equity standards.

SECTION 3. AQEIP PERFORMANCE YEAR 1 METRICS

To establish a robust foundation for quality and equity improvement and to begin making progress towards five-year health equity goals, the first performance year of the AQEIP holds ACOs accountable to metrics listed in Table 2 evaluating contributory health system level interventions in each performance domain.

Table 2. AQEIP Performance Year 1 Metrics

Subdomain	Metric (*Steward)*	Performance Year 1 status*
Domain 1. Demographic and Health-Related Social Needs Data		
Demographic Data Collection	Race, Ethnicity, Language, Disability, Sexual Orientation, & Gender Identity Data Completeness (*EOHHS)*	Pay for Reporting (P4R)
Health-Related Social Needs Screening	Screening for Social Drivers of Health (*CMS*): Preparing for Reporting Beginning in PY2	P4R
Domain 2. Equitable Access and Quality		
Equity Reporting	Stratified Reporting of Quality Data (*EOHHS*)	P4R
Equity Improvement	Performance Improvement Projects (*EOHHS*)	P4R
Access	Meaningful Access to Healthcare Services for Persons with Limited English Proficiency (*Oregon Health Authority*)	P4R
	Disability Competencies (*EOHHS*)	P4R
	Accommodation Needs Met *(EOHHS)*	P4R
Domain 3. Capacity and Collaboration		
Capacity	To Be Determined Pending Further Guidance (*NCQA*)	P4R
	Patient Experience: Cultural Competency (*AHRQ)*	P4P

*Reporting/performance requirements for each measure described in relevant metric technical specifications

Recognizing that taking on accountability for equity is new for most ACOs, interim and annual goals for Performance Year 1 are designed to promote essential foundational capacity and readiness to assume progressive risk for health quality and equity performance in Performance Year 2-5. Summarized performance expectations are described in Table 3; detailed performance expectations are described in metric technical specifications.

Table 3. Summary of AQEIP Metric Performance Requirements Performance Year 1

Metric	Performance Expectations for Performance Year 1	Anticipated Deadline
Domain 1. Demographic and Health-Related Social Needs Data		
Race, Ethnicity, Language, Disability, Sexual Orientation, & Gender Identity Data Completeness (EOHHS)	• **Race, Ethnicity, Language, Disability status (RELD) Sexual Orientation, Gender Identity (SOGI) Assessment** – Timely and complete submission to EOHHS of an initial assessment of 1) beneficiary-reported demographic data adequacy and completeness, and 2) a plan for collecting demographic data including data sources and collection questions. • Complete and timely submission to the MassHealth Data Warehouse (DW) of monthly Member Files as specified (beginning no later than Q4 2023). The DW will reject monthly Member File submissions that are non-compliant with the specified format (e.g. previously compliant formats) after Q4 2023. • Data collected by ACPPs will be submitted via the existing encounter submission process, using the enhanced Member File Specification. Data collected by PCACOs will be submitted via a process as further specified by EOHHS.	July 31, 2023 Beginning no later than Q4 2023
Screening for Social Drivers of Health (CMS): Preparing for Reporting Beginning in PY2	• **Health-Related Social Needs (HRSN) Assessment** – Timely and complete submission to EOHHS of an initial assessment of 1) beneficiary-reported HRSN data adequacy and completeness, and 2) strategies employed to provide information about referrals including to community resources and support services. • Complete and timely submission of a report to EOHHS describing: 1) One or more health-related social needs screening tool(s) selected by the ACO for intended use in screening members beginning in PY2; the selected tool(s) must meet requirements for screening tools for the "Screening for Social Drivers of	July 31, 2023 October 27, 2023

	Health" metric and Section 2.5 of the ACPP and MCO Contracts and Section 2.3 of the PCACO Contract; and 2) An implementation plan to begin screening for health-related social needs in Q1 2024 in order to have capacity to report on the "Screening for Social Drivers of Health" metric beginning in Performance Year 2. 3) Develop strategies employed to provide information about community resources and support services available to members who screen positive for HRSNs. 4) An implementation plan describing how the ACO will ensure members enrolled in the Community Partners (CP) program are screened for HRSNs, including how contracted CPs will document screenings, how the CPs will notify the ACO when the screening is conducted, and how the CP will communicate results of the screening with the ACO.	
Domain 2. Equitable Access and Quality		
Stratified Reporting of Quality Data (EOHHS)	Complete and timely submission to EOHHS of performance data, including member-level race and ethnicity for clinical measures selected by EOHHS for stratification from the Quality Incentive Arrangement measure slate.	No sooner than April 1, 2024
Performance Improvement Projects (EOHHS)	Complete and timely submission to EOHHS of quarterly deliverables for at least one Hospital-partnered Performance Improvement Project as follows: • Early Q3: ACO Key Personnel/Institutional Resources Document • Early Q3: Equity Improvement Intervention Partnership Form • Q3: Hospital Key Contact Form and the Mid-Year Planning Report • Q4: Equity Improvement Intervention Planning Report, a comprehensive plan that incorporates information about Performance Improvement Project (PIP) goals and objectives, baseline data,	Early Q3: July 21, 2023 Q3: September 30, 2023 Q4: December 31, 2023

	proposed interventions, and tracking measures. The PIP Planning/Baseline Report will serve as the blueprint for PIP Implementation in PY2.	
Meaningful Access to Healthcare Services for Persons with Limited English Proficiency (*Oregon Health Authority*)	Complete and timely reporting of an organizational self-assessment of capacity related to providing access to high quality language services to members.	December 31, 2023
Disability Competencies (EOHHS)	• Complete and timely submission to EOHHS of the ACO's DCC Team's completed RIC **Disability-Competent Care Self-Assessment Tool (DCCAT)** report • **Disability Competency Self-Assessment** – Timely and complete submission to EOHHS of a report on the results of the disability competencies self-assessment, including identified disability competencies targeted for improvement in PY 2.	December 1, 2023
Accommodation Needs Met (EOHHS)	Complete and timely submission to EOHHS of a report describing the ACO's current practice and future plans for the following: • Screening members for accommodation needs* before or during an outpatient encounter, and how the results of this screening is documented. • Other methods, if any, for documenting accommodation needs. • Asking members to report, during or after an outpatient encounter, if their accommodation needs were met. • Analyses that are performed at the organizational level to understand whether accommodation needs have been met.	December 1, 2023

Domain 3. Capacity and Collaboration		
Achievement of External Standards for Health Equity (EOHHS)	Pending Further Guidance From NCQA	December 31, 2023
Patient Experience: Cultural Competency (AHRQ)	Performance on a subset of items from CAHPS survey reflective of cultural competency during MY23 as selected by EOHHS.	N/A

SECTION 4. AQEIP PAYMENT FOR PERFORMANCE YEAR 1

EOHHS will pay each ACO based on the ACO's health equity score in accordance with **Section 4.6** of the ACPP Contract and **Section 4.2** of the PCACO Contract. EOHHS will make a one-time payment to the ACO after the health equity score has been finalized.

SECTION 5. AQEIP ACCOUNTABILITY FRAMEWORK FOR PERFORMANCE YEAR 1

EOHHS will hold each ACO individually accountable for its performance on the AQEIP performance measures. Total incentive amounts for each ACO for Performance Year 1 will be distributed according to the weighting described in Table 4. Performance expectations for each metric are summarized in Table 3 above and detailed further in technical specifications.

The Performance Year 1 Health Equity Score will be determined by EOHHS's assessment of completeness and timely submission of deliverables associated with each performance measure. The total Health Equity Score will be calculated according to the weights outlined in Table 4 below, with performance on each metric measured by the degree to which the ACO met performance requirements summarized in Table 3, as determined by EOHHS.

Table 4. Performance Year 1 AQEIP Metric Weights

Subdomain	**ACO Quality and Equity Incentive Program Metric (*Steward)***	**Performance Year 1 Weight (%)**
Domain 1. Demographic and Health-Related Social Needs Data		**25**
Demographic Data Collection	Race, Ethnicity, Language, Disability, Sexual Orientation, & Gender Identity Data Completeness (*EOHHS)*	15
Health-Related Social Needs Screening	Screening for Social Drivers of Health (*CMS*)	10
Domain 2. Equitable Access and Quality		**50**
Equity Reporting	Stratified Reporting of Quality Data (*EOHHS*)	10

Equity Improvement	Equity Improvement Interventions (*EOHHS*)	10
Access	Meaningful Access to Healthcare Services for Persons with Limited English Proficiency (*Oregon Health Authority*)	10
	Disability Competencies (*EOHHS*)	10
	Accommodation Needs Met (EOHHS)	10
Domain 3. Capacity and Collaboration		**25**
Capacity	Pending Further Guidance From NCQA	10
	Patient Experience: Cultural Competency (*AHRQ)*	15

ATTACHMENT 2
Performance Years 2024-2027
Implementation Plan for MassHealth Accountable Care Organization Quality and Equity Incentive Program

TABLE OF CONTENTS

SECTION 1. BACKGROUND AND OVERVIEW OF THE ACCOUNTABLE CARE ORGANIZATION QUALITY AND EQUITY INCENTIVE PROGRAM

A. Overview of Statewide Approach to Advance Healthcare Quality and Equity

Massachusetts shifted the delivery system at scale to value-based care under the previous MassHealth section 1115 demonstration approval period, transitioning over 80 percent of eligible Medicaid members into accountable care organizations (ACOs) that are at risk to deliver better health outcomes, lower cost, and improved member experience through integrated, coordinated care.

A key goal of the Commonwealth's in this demonstration period is to improve quality of care and advance health equity, with a focus on initiatives addressing health-related social needs (HRSN) and health disparities demonstrated by variation in quality performance. To support achievement of this goal, Massachusetts is centering equity alongside quality as a pillar of value-based care and as a priority for the state's health care system.

To that end, MassHealth will implement aligned quality and equity initiatives across delivery system settings including but not limited to MassHealth's Managed Care Organizations (MCOs), Accountable Care Partnership Plans (ACPPs) and Primary Care ACOs (together "ACOs"), managed behavioral health vendor, and acute hospitals.

Together, this constellation of coordinated quality and equity initiatives will support Massachusetts in achieving its demonstration goal to improve quality of care and advance health equity.

B. Scope of this PY2-5 Implementation Plan for the ACO Quality and Equity Incentive Program

This ACO Quality and Equity Incentive Program (AQEIP) Implementation Plan provides additional detail related to implementation of MassHealth's AQEIP for ACO Performance Years (PYs) 2-5 from January 1, 2024 – December 31, 2027 of the ACO contract (April 1, 2023 – December 31, 2027.) Additional detail may be forthcoming for future program years.

SECTION 2. ACO QUALITY AND EQUITY INCENTIVE PROGRAM (AQEIP) DOMAINS AND GOALS

A. Overview of Targeted Domains for Improvement in the AQEIP

For the AQEIP, ACOs are incentivized to pursue performance improvements in the domains specified in Table 1.

Table 1. Overview of Targeted Domains for Improvement for the AQEIP

Domain 1: Demographic and Health-Related Social Needs Data	Accountable Care Organizations will be assessed on the completeness of beneficiary-reported demographic and health-related social needs data submitted in accordance with the Commonwealth's data requirements. Demographic and health-related social needs data will include at least the following categories: race, ethnicity, language, disability status, sexual orientation, gender identity, and health-related social needs. Data completeness will be assessed separately for each data element.
Domain 2: Equitable Quality and Access	Accountable Care Organizations will be assessed on performance and demonstrated improvements on access and quality metrics, including associated reductions in disparities. Metrics will focus on overall access; access for individuals with disabilities and/or a preferred language other than English; preventive, perinatal, and pediatric care services; care for chronic diseases and behavioral health; and care coordination.
Domain 3: Capacity and Collaboration	Accountable Care Organizations will be assessed on improvements in metrics such as provider and workforce capacity and collaboration within health system providers (e.g. clinical partners) to improve quality and reduce health care disparities.

B. Goals for each Domain of the AQEIP

Goals for each AQEIP domain are summarized below:

1. Demographic and Health-Related Social Needs Data Collection Domain Goals

    a. ACOs will submit to MassHealth an assessment of beneficiary-reported demographic and HRSN data adequacy and completeness for purposes of the AQEIP by July 1, 2023.

    b. ACOs are incentivized to achieve certain milestones to meet an interim goal of 80 percent data completeness for self-reported race and ethnicity data for attributed MassHealth members by the end of Performance Year 3 (CY 2025).

    c. ACOs are incentivized to achieve certain milestones to achieve at least 80 percent data completeness for beneficiary-reported other demographic data (including at least language, disability status, sexual orientation, and gender identity) for attributed MassHealth members by the end of Performance Year 5 (CY 2027).

d. ACOs are incentivized to meaningfully improve rates of HRSN screenings from the baseline period by the end of Performance Year 5 (CY 2027). To meet this goal, ACOs must not only conduct screenings of beneficiaries, but also establish the capacity to track and report on screenings and referrals.

2. Equitable Quality and Access Domain Goals

a. ACOs are incentivized for performance on metrics such as those related to access to care (including for individuals with a preferred language other than English and/or disability); preventive, perinatal, and pediatric care; care for chronic diseases; behavioral health; care coordination; and/or patient experience.

b. Metric performance expectations shall include, at a minimum:

(i) Reporting on access and quality metric performance, including stratified by demographic factors (such as race, ethnicity, language, disability, sexual orientation, and gender identity); health-related social needs; and/or defined by other individual- or community-level markers or indices of social risk;

(ii) Developing and implementing interventions aimed at improving quality and reducing observed disparities on metrics that account for clinical and social risk factors found through analysis to be associated with lower performance on such metrics and/or other appropriate individual/community-level markers or indices of social vulnerability;

(iii) Improving quality and/or closing disparities as measured through performance on a subset of access and quality metrics.

c. For up to the first three PYs, performance will be based on expectations described in 2(b)(i) and 2(b)(ii), above. For at least the last two PYs, performance will also be based on expectations described in 2(b)(iii), above.

3. Capacity and Collaboration Domain Goals

a. ACOs are incentivized to improve service capacity, workforce development, and health system collaboration to improve quality and reduce disparities. The metrics that assess improvement in this domain may relate to provider cultural competence and achievement of externally validated equity standards.

SECTION 3. AQEIP PERFORMANCE YEAR 2-5 METRICS

Performance years 2-5 of the AQEIP will hold ACOs accountable to metrics evaluating performance in each AQEIP domain. These metrics were developed with input from health systems and providers through requests for information and comment, public meetings, and ongoing stakeholder engagement. Technical specifications for the AQEIP PY2-5 metrics, which may be updated annually or more frequently as necessary. A summary of the AQEIP metrics and anticipated payment status in PY2-5 are provided in Table 2.

Table 2. AQEIP PY 2-5 Metrics

Subdomain	**Metric (*Steward)***	**Anticipated payment status***			
		2024	**2025**	**2026**	**2027**
Domain 1. Demographic and Health-Related Social Needs Data					
Demographic Data Collection	Race, Ethnicity, Language, Disability, Sexual Orientation, & Gender Identity Data Completeness (*EOHHS)*	P4R	P4P	P4P	P4P
Health-Related Social Needs Screening	Health-Related Social Needs Screening (EOHHS)	P4R	P4P	P4P	P4P
Domain 2. Equitable Access and Quality					
Equity Reporting	Quality Performance Disparities Reduction (*EOHHS*)	P4R	P4R	P4P	P4P
Equity Improvement	Equity Improvement Interventions (*EOHHS*)	P4P	P4P	P4P	P4P
Access	Meaningful Access to Healthcare Services for Persons with a Preferred Language other than English (*EOHHS*)	P4R	P4P	P4P	P4P
	Disability Competencies (*EOHHS*)	P4P	P4P	P4P	P4P
	Accommodation Needs Screening and Intervention *(EOHHS)*	P4R	P4P	P4P	P4P
Domain 3. Capacity and Collaboration					
Capacity	Achievement of External Standards for Health Equity (EOHHS/*NCQA*)	P4R	P4P	P4R	P4R
	Patient Experience: Communication, Courtesy, and Respect (EOHHS/*AHRQ)*	P4P	P4P	P4P	P4P

*P4R= Pay for Reporting, P4P= Pay for Performance. Specific performance trajectories are subject to change. Reporting/performance requirements for each measure described in forthcoming metric technical specifications.

The anticipated reporting expectations for PY2 are summarized in Table 3; detailed reporting and performance expectations for PY2 are included in metric technical specifications. Each report outlined in Table 3 shall be submitted by the ACO in a form, format, and frequency to be further specified by EOHHS. Additional and/or revised reporting expectations for PY3-5 will be provided prior to the start of each performance year.

Table 3. Reporting Expectations for PY2

Measure Name	**Reporting Expectations for PY2 (to be further specified by EOHHS)**
Domain 1: Demographic & HRSN Data	
RELDSOGI Data Completeness	1. Submission of "Member Data and Member Enrollment" file 2. Submission of RELDSOGI Mapping Report inclusive of a plan to develop capacity to capture date stamps by PY5
Health-Related Social Needs Screening	1. Submission of administrative and/or supplemental HRSN data
Domain 2: Equitable Access & Quality	
Quality Performance Disparities Reduction	1. Submission of quality data stratified by race and ethnicity
Equity Improvement Interventions	1. Submission of PIP 2 Mid-Year Planning Report 2. Submission of PIP 1 and PIP 2 implementation reports
Meaningful Access to Healthcare Services for Persons with a Preferred Language other than English	1. Submission of Language Access Self-Assessment Survey 2. Submission of Provision of Interpreter Services Data
Disability Competencies	1. Submission of Disability Competency Training Plan 2. Submission of Disability Competency Training Report
Accommodation Needs Screening and Intervention	1. Submission of a disability accommodation needs report
Domain 3: Capacity & Collaboration	
Achievement of External Standards for Health Equity	1. Submission of Accreditation Status Report
Patient Experience: Communication, Courtesy, and Respect	*Reporting expectations are satisfied through the annual CG-CAHPS member experience survey (MHQP Version), administered by EOHHS.*

Section 4. AQEIP Payment for Performance Years 2-5

MassHealth will pay each ACO based on the ACO's health equity score in accordance with **Section 4.6** of the ACPP Contract and **Section 4.2** of the PCACO Contract. EOHHS will make a one-time payment to the ACO after the health equity score has been finalized.

Section 5. AQEIP Accountability Framework for Performance Year 2-5

A. ACO Accountability to MassHealth for the AQEIP

MassHealth will hold each ACO individually accountable for its performance on the AQEIP performance measures. MassHealth's anticipated framework for the AQEIP PAM, which may be adjusted annually as needed (for example to transition measures from pay-for-reporting to pay-for-performance, accommodate new contextual inputs, address extenuating circumstances impacting performance, etc.), is described below. Measure-specific PAM, including benchmarks, improvement targets and measure score calculation approach, will be described in each forthcoming measure specification.

1. **Benchmarking:** MassHealth will establish performance targets or benchmarks no later than the start of the first pay-for-performance period for the metric.

    a. Benchmarks for quantitative measures will include an attainment threshold and goal benchmark and will be set to apply to the full applicable performance period.

    b. Establishment of benchmarks will be informed by inputs such as initial AQEIP performance data, historical ACO data/performance, external data/trends, and/or predetermined performance targets determined by MassHealth.

2. **Improvement Targets:** MassHealth will establish performance improvement targets for performance metrics, as applicable, no later than the start of the first pay-for-performance period for the metric.

    a. Specific improvement targets and the approach for each measure will be set to apply to the full applicable performance period.

    b. The approach and actual improvement target may differ by measure based on factors such as performance trends or type of measure; approaches may include year-over-year self-improvement, gap-to-goal percentage point increase, absolute percentage point increases, set milestones and/or goals for improvement.

3. **Performance Measure Score Calculation**: The performance measure scoring approach will be consistent, as applicable, with other MassHealth incentive programs or other incentive program practices. MassHealth will establish a methodology for performance measure scoring for each measure, to be specified in technical specifications, no later than the first day of the performance period to which the methodology applies.

a. **Pay-for reporting (P4R) measures.** P4R measures will be assessed on a pass/fail basis for which the ACOs who report according to each measure's technical specifications will receive full points or credit for the metric.

b. **Pay-for-performance (P4P) measures.** The performance measure scoring and approach will be consistent, as applicable, with other MassHealth incentive programs or other incentive program practices, described below.

(i) Measure scoring will include the following components for each measure:

1. Attainment points ranging from 0-10 points

2. Improvement points ranging from 0-10 points

3. Potential bonus points (with a cap) to ensure all participating ACOs have incentive to improve, including high-performing ACOs

(ii) Performance measure scores for each measure will be defined as a ratio between 0-1. Scores will be calculated by the sum of the points earned for each measure divided by the maximum number of points allowable for the measure. The maximum number of points allowable for the measure is the sum of the attainment, improvement and potential bonus points with a determined cap. The score will be calculated as follows:

Performance Measure Score = Points earned for each measure / Maximum number of points allowable for the measure.

(iii) Some performance measures may have identified sub-measures for which sub-measure performance scores will be calculated in the same manner, but then typically equally weighted to calculate a composite performance measure score. For sub-measures the score is calculated as follows:

Performance Measure Score = Sum of each (Sub-measure Score X Sub-measure Weighting).

4. **Domain Score Calculation**: The domain scoring and approach will, as applicable, be consistent with other MassHealth incentive programs or other incentive program practices. Domain scoring includes the following components:

a. Using the predetermined weights specified in Table 3, a domain score will be calculated by taking each performance measure score in the domain and calculating the sum of each performance measure score multiplied by its respective performance measure weight:

Domain Score = Sum of each (Performance Measure Score Performance Measure Weight).*

b. If an ACO is not eligible for a measure (e.g., does not meet the denominator criteria or minimum volume), the weighting will be redistributed equally to the eligible performance measures in the domain.

5. **Health Equity Score Calculation**: The overall Health Equity Scoring approach will, as applicable, be consistent with other MassHealth incentive programs or other incentive program practices. The overall Health Equity Score includes the following components. Using the predetermined weights specified in Table 3, a health equity score will be calculated by taking each domain score and calculating the sum of each domain score multiplied by its respective domain weight:

*Health Equity Score = Sum of each (Domain Score * Domain Weight).*

The final Health Equity Score will be used to calculate the ACO's earned incentive payment.

Table 4. PY 2-5 AQEIP Metric Weights

Domain*	Measure Name	Anticipated Measure Weight (%) by Performance Year				Domain Weight (%)
		2024	2025	2026	2027	
DHRSN	Race, Ethnicity, Language, Disability, Sexual Orientation, & Gender Identity Data Completeness	10	10	15	15	25
	Health-Related Social Needs (HRSN) Screening	15	15	10	10	
EAQ	Quality Performance Disparities Reduction	10	10	20	20	50
	Equity Improvement Interventions	10	10	5	5	
	Meaningful Access to Healthcare Services for Persons with a Preferred Language other than English	10	10	10	10	
	Disability Competencies	10	10	5	5	
	Accommodation Needs Screening & Intervention	10	10	10	10	
CC	Achievement of External Standards for Health Equity	15	15	10	10	25
	Patient Experience: Communication, Courtesy, and Respect	10	10	15	15	
TOTAL						**100**

*DHRSN=Demographic and Health-Related Social Needs Data; EAQ=Equitable Access and Quality; CC=Capacity and Collaboration

APPENDIX C
Community Behavioral Health Center (CBHC) List

CBHC	CATCHMENT AREA
North Suffolk Mental Health Association	Greater Boston
Cambridge Health Alliance	Boston/Cambridge
Boston Medical Center	Boston/Brookline
Riverside Community Care	Norwood
Aspire Health Alliance	South Shore
The Brien Center	Berkshires
Clinical Support Options	Greenfield
Clinical Support Options	Northampton
Behavioral Health Network (BHN)	Southern Pioneer
Center for Human Development	Southern Pioneer
Advocates	Metrowest
Clinical Support Options	North County
Community Healthlink	North County
Riverside Community Care	South County
Community Healthlink	Worcester
Eliot Community Health Services	North Essex
Beth Israel Lahey Behavioral Services	Lawrence
Vinfen	Lowell
Eliot Community Health Services	Tri-city
Child and Family Services	Southern Coast
High Point Treatment Center	Brockton

CBHC	CATCHMENT AREA
Bay Cove Human Services	Cape Cod
Fairwinds- Nantucket's Counseling Center	Nantucket
Child and Family Services	Fall River
Community Counseling of Bristol County	Taunton Attleboro

APPENDIX D
Primary Care Sub-Capitation Program

EXHIBIT 1: Practice Tier Designation Attestation

SECTION I: Instructions

The Contractor shall collect and at all times shall maintain a copy of the **Practice Tier Designation Attestation** for **each of its Network Primary Care Practice PID/SLs (ACPP) or Participating Primary Care Practice PID/SLs (PCACO)**, signed by the Contractor and an authorized representative of the Network/Participating Primary Care Practice PID/SL. The Contractor shall provide EOHHS with such copies upon request.

Each Network Primary Care Practice PID/SL or Participating Primary Care Practice PID/SL shall have a single, unique Tier Designation. For the purposes of the Primary Care Sub-Capitation Program, "Practice" shall mean a Network Primary Care Practice PID/SL's or Participating Primary Care Practice PID/SL's unique, 10-digit alpha-numeric Provider ID Site Location (PID/SL) that is unique to a location. With the exception of sole practitioners operating independently, the Primary Care Practice PID/SL shall *not* be unique to a practitioner.

Requirements for Tier Designation

(1) Practices with Tier 1 designation must fulfill **all** Tier 1 care model requirements by a date specified by EOHHS
(2) Practices with Tier 2 designation must fulfill **all** Tier 1 and Tier 2 care model requirements by a date specified by EOHHS
(3) Practices with Tier 3 designation must fulfill **all** Tier 1, 2, and 3 care model requirements by a date specified by EOHHS

SECTION II: Practice Information

Practice Name	
Practice Street Address	
Practice City	
Practice State	
Practice Zip Code	
Practice Tax ID	
Practice MassHealth Provider ID Site/Location (PID/SL)	
Name of Authorized Practice Representative	
Practice Representative Phone Number	
Practice Email	
Proposed Tier Designation (1, 2, or 3)	

SECTION III: Practice Attestation

1. The practice substantially serves (check one or both):

   ☐ Enrollees ages 21-65 (i.e., Family Medicine or Adult)

   ☐ Enrollees ages 0-21 (i.e., Family Medicine or Pediatric)

2. The practice will meet all criteria by a date specified by EOHHS, as specified in Exhibit 2 of this Appendix, of:

   ☐ Tier 1

   ☐ Tier 2

   ☐ Tier 3

3. The practice is not contracted as a Network PCP (ACPP) or Participating PCP (PCACO) for any other MassHealth ACO or MCO, and is not a PCC in the PCC Plan.

   ☐ Check here to agree

I certify under the pains and penalties of perjury that the information on this form and any attached statement that I have provided has been reviewed and signed by me, and is true, accurate, and complete, to the best of my knowledge. I understand that I may be subject to civil penalties or criminal prosecution for any falsification, omission, or concealment of any material fact contained herein.

_____

Printed legal name of authorized Contractor representative

_____

Contractor representative's signature Date

_____

Printed legal name of Practice representative

_____

Practice representative's signature Date

EXHIBIT 2: Primary Care Sub-Capitation Program Tier Criteria

SECTION I: Tier 1 Practice Service Requirements

Requirements to achieve a Tier Designation of Tier 1. Practices shall meet ***all*** Tier 1 requirements to achieve this Tier Designation. Some requirements must be accessible to Enrollees on-site if the Enrollee so chooses, without leaving the practice building, and some requirements may be met exclusively via a central or virtual resource, including being provided by the ACO, as indicated in each requirement description.

A. Care Delivery Requirements

Practices shall:

☐ Traditional primary care: provide accessible, comprehensive, longitudinal, person-centered, and coordinated primary care services including evaluation and management of common health issues, disease prevention, and wellness promotion. While practices may offer some traditional primary care virtually via telehealth, Enrollees must be able to access this requirement on-site.

☐ Referral to specialty care: be able to guide and coordinate referrals and request evaluation of a patient by clinicians outside of the primary care practice for specific concerns. Such referrals shall include the primary care practice's ability to communicate with and receive communications from the specialty practice, with the primary care practice continuing to serve as a central home of health care services for the patient. This includes sub-specialty medical, oral health, mental health, and substance use disorder referrals.

☐ Oral health screening and referral: conduct an annual (every 12 months) structured oral health screening for attributed patients. For example, a clinic tool may use the National Health and Nutrition Examination Survey Oral Health Questionnaire (https://wwwn.cdc.gov/nchs/data/nhanes/2015-2016/questionnaires/OHQ_I.pdf). An on-site dental exam for attributed patients shall meet this requirement. An assessment screening shall clearly define what constitutes a positive screening result versus a negative result and shall assess if the patient currently has access to an oral health provider or a regular and reliable source for oral health needs.

Additionally, retain and provide to patients (and/or their parents/caregivers) a list of local and reasonably-accessible oral health providers who are within the MassHealth network for their particular patients (MassHealth providers are available at: https://provider.masshealth-dental.net/MH_Find_a_Provider#/home). This information shall be updated at least annually for any openings/closings or additions/removals of MassHealth coverage of these providers. Such a list shall be provided to patients with a positive oral health screen and those without an oral health provider. Such a list may be adapted from materials provided by MassHealth of practices and providers currently enrolled in the program.

While practices may offer some oral health screenings and referrals virtually via telehealth, Enrollees must be able to access this requirement on-site.

☐ Behavioral health (BH) and substance use disorder screening: conduct an annual and universal practice-based screening of attributed patients ≥21 years of age. Such a screen shall at minimum assess for depression, tobacco use, unhealthy alcohol use, other substance use, and preexisting mental health disorders using an age-appropriate, evidence-based, standardized screening tool. When any screening is positive, the practice shall respond with appropriate interventions and/or referrals.

See below under this Section 1, subsection C for screening expectations for any attributed patients younger than 21 years of age per the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) protocol and schedule.

While practices may offer some BH and substance use screening virtually via telehealth, Enrollees must be able to access this requirement on-site.

☐ BH referral with bi-directional communication, tracking, and monitoring: retain and provide to patients a list of local and reasonably-accessible BH providers who are within the MassHealth network, including those that offer therapy and counseling services, BH medication management, and intensive outpatient or day treatment programs. The list of local BH providers shall be providers with whom the practice can conduct bi-directional communication about the patient. This can include electronic health record, phone, fax, or other modalities. This communication can be asynchronous, but it shall allow for both the primary care practice and the BH practice to communicate back and forth with each other. The practice shall also regularly assess if such partners continue to have bandwidth to see its patients within reasonable turnaround times.

In addition, track referrals made through the practice and problem-solve for patients who are unable to engage in a referral visit.

☐ BH medication management: prescribe, refill, and adjust medications for the treatment of common BH issues amenable to treatment in the primary care setting, including but not limited to major depressive disorder, generalized anxiety disorder, and attention deficit-hyperactivity disorder. Such services can occur independently or providers may receive assistance from available resources such as the Massachusetts Child Psychiatry Access Program (MCPAP), a clinical pharmacist, psychiatrist, psychiatric clinical nurse specialist, etc. While practices may offer some BH medication management virtually via telehealth, Enrollees must be able to access this requirement on-site.

☐ Health-Related Social Needs (HRSN) screening: conduct universal practice- or ACO-based screening of attributed patients for HRSN using a standardized, evidence-based tool, and shall have the ability to provide a regularly-updated inventory of relevant community-based resources to those with positive screens. Pediatric screening questions shall be reviewed by the ACO's designated Pediatric Expert. HRSN screening may be met exclusively via a central or virtual resource, including being provided by the ACO.

☐ Care coordination: participate in formalized practice-driven and/or ACO-driven care coordination that identifies patients at risk due to medical, BH, HRSN, psychosocial and/or other needs and deploys risk-stratified interventions and approaches to addressing patients' needs.

Such approaches can include but are not limited to communication and information-sharing between care team patients and specialists or ancillary services, identification and rectification of gaps in preventive care or chronic disease management, assisting patients with transitions of care, pre-visit planning, post-hospitalization coordination, and assistance with patient self-management of chronic disease. Such approaches can also include connecting patients to community-based services, state agencies (e.g., Massachusetts Department of Children and Families [DCF], Massachusetts Department of Developmental Services [DDS], Massachusetts Department of Mental Health [DMH], Massachusetts Department of Public Health [DPH], Massachusetts Department of Transitional Assistance [DTA], Massachusetts Department of Youth Services [DYS]), federal programs (e.g., Supplemental Nutrition Assistance Program [SNAP], Special Supplemental Nutrition Assistance Program for Women, Infants, and Children [WIC]), other ACO programs such as the ACO Care Management, Community Partners and Flexible Services programs, and other supports and care management resources.

These services may be provided by practice-based personnel directly, or by ACO- or system-level resources and care pathways that coordinate with the primary care practice. Such interventions shall be standardized and consistent workstreams for the practice and align with the greater ACO's strategies around physical health, BH, HRSN, and other care coordination.

For more information on ACO expectations around care coordination, please refer to Section 2.4 of the Contract. Care coordination may be met exclusively via a central or virtual resource, including being provided by the ACO.

☐ Clinical Advice and Support Line: Ensure patients are made aware of the availability of after-hours telephonic advice, either through the ACO's Clinical Advice and Support Line, or a resource provider by the practice. Clinical advice and support line services may be met exclusively via a central or virtual resource, including being provided by the ACO.

☐ Postpartum depression screening: If caring for infants in the first year of life or for postpartum individuals who are within 12 months of delivery, screen for postpartum depression using an evidence-based and validated tool, such as the Edinburgh Postnatal Depression Scale (EPDS).

For individuals who have a positive screen for postpartum depression, the practice shall be able to provide referral, or follow-up, and/or care coordination for the patient. Care coordination models shall be evidence-based (examples of such models include PRISM - Program In Support of Moms and ROSE - Reach Out Stay Strong Essentials for mothers of newborns). While practices may offer some postpartum depression screenings virtually via telehealth, Enrollees must be able to access this requirement on-site.

☐ Use of Prescription Monitoring Program: All prescribing personnel at the practice site shall have access to and regularly use the Massachusetts Prescription Awareness Tool (Mass PAT) in accordance with Commonwealth of Massachusetts General Law: https://malegislature.gov/Laws/GeneralLaws/PartI/TitleXV/Chapter94C/Section24A.

☐ Long-Acting Reversible Contraception (LARC) provision, referral option: have the ability to discuss options for LARC (e.g., intrauterine device or subdermal implant) with relevant patients and refer patients seeking such options to known in-network providers who can place these for the patient. Providers may also, rather than referring patients, provide and place these directly for patients within the primary care practice.

B. Structure and Staffing Requirements

Practices shall:

☐ Same-day urgent care capacity: make available time slots each day for urgent care needs for its patient population. While practices may offer some urgent care capacity virtually via telehealth, Enrollees must be able to access this requirement on-site.

☐ Video telehealth capability: have the ability to conduct visits with practice staff using a synchronous audio-video telehealth modality in lieu of an in-person patient encounter.

☐ No reduction in hours: Relative to regular practice hours prior to engagement in the sub-capitation program, offer the same or increased number of total regular on-site operating hours and clinical sessions in which patients have been historically seen.

☐ Access to Translation and Interpreter Services: provide interpreter services for attributed patients, in accordance with applicable state and federal laws, including options to accommodate preferred languages and the needs of enrollees who are deaf or hard of hearing. Such services shall be noted to be available in a patient's or their caregiver's preferred language and should come without additional cost to the patient.

C. Population-Specific Requirements

Practices serving Enrollees 21 years of age or younger shall:

☐ Administer, at a minimum, BH, developmental, social, and other screenings and assessments as required under EPSDT. While practices may offer some EPSDT screenings virtually via telehealth, Enrollees must be able to access this requirement on-site.

☐ Screen for SNAP and WIC eligibility, in accordance with Provider Manual Appendix W, if applicable: Practices shall also complete the medical referral form for WIC eligible patients. Patients and families deemed eligible for these programs should be referred to further resources in order to apply for and engage these programs. While practices may offer some SNAP and WIC screenings virtually via telehealth, Enrollees must be able to access this requirement on-site.

☐ Establish and maintain relationships with local Children's Behavioral Health Initiative (CBHI): The practice shall identify its staff member(s) responsible for 1) communicating with and reporting to CBHI program in a closed-loop manner, and 2) maintaining a roster of children attributed to the practice who are receiving CBHI services.

☐ Coordination with MCPAP: enroll with MCPAP at https://www.mcpap.com/. The practice shall consult with and use the services of MCPAP to augment the BH expertise provided within the practice as a means to maintain the management of youth with mild to moderate BH conditions in primary care. Alternatively, the practice can satisfy this requirement by accessing equivalent resources available within their own health system – such as consultation with child and adolescent psychiatrists working in the clinic or a neighboring site or via consultation from an asynchronous resource such as an e-consult. Use of such an alternative resource, however, does not exempt the practice from enrolling with MCPAP.

☐ Coordination with Massachusetts Child Psychiatry Access Program for Moms (M4M): If providing obstetrical services, enroll in the M4M program at https://www.mcpapformoms.org/. The practice shall consult with M4M to augment the BH expertise provided within the practice as a means to maintain the management of perinatal patients with mild to moderate BH conditions in primary care. Alternatively, the practice can satisfy this requirement by accessing equivalent resources available within their own health system – such as consultation with a psychiatrist or appropriately trained Ob/Gyn of suitable expertise working in the clinic or a neighboring site, or via consultation from an asynchronous resource such as an e-consult. Use of such an alternative resource however does not exempt the practice from enrolling with the M4M program. While practices may offer some coordination with MCPAP for Moms virtually via telehealth, Enrollees must be able to access this requirement on-site.

☐ Fluoride varnish for patients ages 6 months up to age 6: assess the need for fluoride varnish at all preventive visits from six (6) months to six (6) years old, and, once teeth are present, must provide application of fluoride varnish on-site in the primary care office at least twice per year for all children, starting when the first tooth erupts and until the patient has another reliable source of dental care (https://publications.aap.org/pediatrics/article/146/6/e2020034637/33536/Fluoride-Use-in-Caries-Prevention-in-the-Primary). For those pediatric patients who do not have a dental home, the practice must share a list of MassHealth dental providers with the parent/caregiver as noted above. If there is a co-located dental office or evidence that the dental office has already provided this service, such may substitute in this requirement for the relevant patients who have access to or have accessed these resources. Enrollees must be able to access this fluoride varnish on-site.

SECTION II: Tier 2 Practice Service Requirements

Requirements to achieve a Tier Designation of Tier 2. Practices shall meet ***all Tier 1 requirements and all Tier 2 requirements*** to achieve this Tier Designation.

A. Care Delivery

The practice shall:

☐ Brief intervention for BH conditions: Provide brief interventions for patients with identified BH needs, as appropriate, such as Screening, Brief Intervention, and Referral to Treatment (SBIRT), brief Cognitive Behavioral Therapy (CBT), or an equivalent model. These may be provided by a front-line clinical provider or by an integrated member of the clinical team, such as a licensed independent clinical social worker (LICSW). While practices may offer some BH interventions for BH conditions virtually via telehealth, Enrollees must be able to access this requirement on-site.

☐ Telehealth-capable BH referral partner: Include at least one BH provider who is capable of providing services via a synchronous audio-video telehealth modality among its local and reasonably-accessible list of BH providers who are within the MassHealth network.

B. Structure and Staffing

The practice shall:

☐ E-consults available in at least three (3) specialties: be capable of asynchronous, consultative, provider-to-provider communications within a shared Electronic Health Record (EHR) or web-based platform between primary care and specialist providers over a secure electronic medium that involves sharing of patient-specific information and discussing clarification or guidance regarding targeted clinical care. E-consults shall be available to clinical staff within the practice to discuss with specialists in at least three distinct and non-redundant American Board of Medical Specialties (ABMS)-recognized specialties. For example, offering e-consults to multiple specialties with board certification under the pathways of Internal Medicine, such as cardiology, endocrinology, and nephrology meets this requirement. On the other hand, multiple specialties with certification under a shared subspecialty would be considered redundant; for example, seeking to count e-consults in general cardiology, clinical cardiac electrophysiology, and interventional cardiology as three distinct specialties would not meet this requirement.

☐ After-hours or weekend session: offer at least four hours for in-person or telehealth visits, with the practice's own providers or with providers from another of the Contractor's Network PCPs (ACPP) or Participating PCPs (PCACO) as further specified below, at least once per week within any of the following periods:

- Monday through Friday: Outside the hours of 8:00 a.m.-5:00 p.m.
- Saturday or Sunday: During any period

These session(s) may be covered by the practice's own providers or with providers from another of the Contractor's Network PCPs (ACPP) or Participating PCPs (PCACO) such that one practice may cover the weekend or after-hours sessions for a maximum of two other practices. If the practice utilizes another practice for this coverage, EOHHS encourages the Contractor to utilize practices that are located in close geographic proximity to the practice. In addition, any providers staffing such sessions (including those at another practice site) must have access to the practice's EHR and must document the visit within the practice's EHR. Sessions cannot be those offered by a third-party or a group unaffiliated with the primary care practice as described above, unable to access the practice's EHR, or unaffiliated with the practice's patient population. The required after-hours or weekend session shall provide behavioral health referral with bi-directional communication, tracking, and monitoring. Providers staffing after-hours or weekend

sessions shall communicate any visits during those sessions to the Enrollee's primary care provider. The Contractor or the practice shall communicate to Enrollees where to access after-hours or weekend sessions.

☐ Team-based staff role: maintain at least one (1) team-based staff role dedicated to the specific primary care site. This role may be met virtually but must be on-site at least monthly. If this role is offered virtually, the practice must have multimedia available for Enrollees to engage with the role from the practice. This role shall consist of any of the following or similar roles:

- Community health worker (CHW)
- Peer (Certified Peer Specialist, Recovery Coach, Family Partner, Family Navigator)
- Social worker (licensed clinical social worker [LCSW], LICSW) or other master's-prepared clinician such as a Master of Social Work (MSW)
- Nurse case manager

Such team-based role shall:

- Be available and doing work on behalf of the specific practice site for at least three or more equivalent 4-hour sessions (i.e., ≥0.3 FTE) per week,
- Conduct activities such as but not limited to team-based huddles, activities on behalf of patients at the site, or patient-facing activities.
- Participate in team activities such as team huddles, i.e., standing team meetings for the purpose of pre-visit planning, population health management, process improvement, etc.

☐ Maintain a consulting independent BH clinician: maintain a dedicated and accessible consulting BH clinician available to assist the practice with cases of moderate complexity. This role shall be a licensed BH provider, such as a psychiatrist, psychologist, psychiatric clinical nurse practitioner, LICSW, licensed mental health counselor (LMHC), or licensed marriage and family therapist (LMFT). This requirement may be fulfilled via a single role fulfilling both this requirement and the team-based staff role requirement above.

- This resource shall be available to assist the practice with cases of moderate BH complexity on a regular basis and assist with co-management of referred cases that can otherwise remain anchored in the primary care setting. Where feasible, this resource shall also be available for team-based huddles and warm-handoffs to support patient care.
- This resource may be virtually available to the practice and can utilize asynchronous means of communication inclusive of e-consult but shall be able to respond to queries within two business days.

C. Population Specific Expectations

Practices serving Enrollees 21 years of age or younger shall:

☐ Staff with children, youth, and family-specific expertise: identify at least one non-clinical team member with demonstrable experience addressing the BH and HRSN of children, youth, and families in a health care setting and/or possessing specialized training, degree, licensing, or certification in such work. This role may be met virtually but shall be on-site at least monthly. This role shall be responsible for communicating with and being the site's primary and reliable point of contact to the CBHI program, Family Resource Centers (FRCs), and schools/early childhood settings.

☐ Provide patients and their families who are eligible for SNAP and WIC application assistance through the practice in order to assist patients and their families to apply for and engage those programs. While practices may offer some assistance virtually, Enrollees must be able to access this requirement on-site.

Practices serving Enrollees ages 21-65 shall:

☐ LARC provision, at least one option: have the on-site ability to place at least one (1) type of long-acting reversible contraceptive (e.g., intrauterine device or subdermal implant). This service shall be available on-site during normal business hours at least one session every other week (i.e., twice monthly). This activity may occur either in the primary care office or from a co-located provider at the same practice site. Enrollees must be able to access this requirement on-site.

☐ Active Buprenorphine Availability: have at least one (1) individual provider actively prescribing buprenorphine for management of opioid use disorder to patients with opioid use disorder as clinically indicated. Actively prescribing means that a provider is either currently prescribing buprenorphine for Enrollees at the practice, or is willing and able to if and when any Enrollee is in need of this service, without having to refer the Enrollee to another location. This provider shall be dedicated and available to patients in the practice on-site or virtually on at least a weekly basis. Providing referrals to SUD care or maintaining agreements with other providers or practices that require the Enrollee to present at a different location does not meet this requirement.

☐ Active Alcohol Use Disorder (AUD) Treatment Availability: at least one provider actively prescribing or willing and able to prescribe relevant medications for management of alcohol use disorder (e.g., Disulfiram, Acamprosate, Naltrexone, etc.). This requirement may be met virtually. However, providers must be capable of asynchronous, consultative, provider-to-provider communications within a shared Electronic Health Record (EHR) or web-based platform between primary care and specialist providers over a secure electronic medium that involves sharing of patient-specific information and discussing clarification or guidance regarding targeted clinical care.

SECTION III: Tier 3 Practice Service Requirements

Requirements to achieve a Tier Designation of Tier 3. Practices shall meet *all Tier 1 requirements, all Tier 2 requirements, and all Tier 3 requirements* to achieve this Tier Designation.

A. Care Delivery

*The practice shall fulfill at least **one** of the following three requirements:*

☐ Clinical pharmacist visits: offer its patients the ability to conduct office-based or virtual appointments with a licensed clinical pharmacist focused on medication management and teaching. This role may conduct its activities virtually. The clinical pharmacist shall be dedicated to the practice for a minimum of three (3) or more equivalent 4-hour sessions per week (i.e., ≥0.3 FTE)

OR

☐ Group visits: offer its patients the ability to participate in office-based or virtual appointments at which services are provided to multiple patients for a shared condition and peer support is elicited (e.g., mental health, substance use disorder, antenatal care, etc.). These visits may be conducted virtually. Group visits shall be offered by staff that are dedicated to the practice for a minimum of three (3) or more equivalent 4-hour sessions per week (i.e., ≥0.3 FTE)

OR

☐ Designated Educational Liaison for pediatric patients: For practices serving pediatric patients, have dedicated staff member that serves as an office-based or virtual resource for families navigating the intersection of the medical and educational systems. This role may conduct its activities virtually. The Educational Liaison shall have knowledge of education and special education systems, including early education settings, and shall create relationships with local schools and early education settings. The Educational Liaison shall provide support to patients with medical, developmental, and/or BH needs and shall be available to provide input to the educational team at schools as needed and shall be dedicated to the practice for a minimum of three (3) or more equivalent 4-hour sessions per week (i.e., ≥0.3 FTE).

B. Structure and Staffing

The practice shall:

☐ E-consults available in at least five (5) specialties: be capable of asynchronous, consultative, provider-to-provider communications within a shared EHR or web-based platform between primary care and specialist providers over a secure electronic medium that involves sharing of patient-specific information and discussing clarification or guidance regarding targeted clinical care. E-consults shall be available to clinical staff within the primary care practice to discuss with specialists in at least five (5) distinct and non-redundant ABMS-recognized specialties. For example, offering e-consults to multiple specialties with board certification under Internal Medicine, such as cardiology, endocrinology, and nephrology meets this requirement. On the other hand, multiple specialties with certification under a shared subspecialty would be considered redundant; for example, general cardiology, clinical cardiac electrophysiology, and interventional cardiology would not meet this requirement.

☐ After-hours or weekend session: offer at least 12 hours for in-person or telehealth visits with the practice's own providers or with providers from another of the Contractor's Network PCPs (ACPP) or Participating PCPs (PCACO) as further specified below, falling within any of the following periods:

- Monday through Friday: Outside the hours of 8:00 a.m.-5:00 p.m.
- Saturday or Sunday: During any period of at least four hours

These session(s) may be covered by the practice's own providers or with providers from another of the Contractor's Network PCPs (ACPP) or Participating PCPs (PCACO) such that one practice site may cover the

weekend or after-hours sessions for a maximum of two other practices. If the practice utilizes another practice site for this coverage, EOHHS encourages the Contractor to utilize practice sites that are located in close geographic proximity to the practice. In addition, any providers staffing such sessions (including those at another practice site) must have access to the practice's EHR and must document the visit within the practice's EHR. Sessions cannot be those offered by a third-party or a group unaffiliated with the primary care practice as described above, unable to access the practice's EHR, or unaffiliated with the practice's patient population. At least 4 hours shall be in-person. At least 4 hours must fall on a weekend day. Providers staffing after-hours or weekend sessions shall communicate any visits during those sessions to the Enrollee's primary care provider. The Contractor or the practice shall communicate to Enrollees where to access after-hours or weekend sessions.

☐ Three team-based staff roles: maintain at least three (3) team-based staff roles dedicated to the specific primary care site. These roles may be met virtually but must be on-site at least monthly. If these roles are offered virtually, the practice must have multimedia available for Enrollees to engage with the role from the practice site. These roles shall consist of the following:

- At least one (1) staff role shall be a licensed BH clinician (e.g., psychologist, LICSW, LCSW)
- At least one (1) staff role shall be a peer, family navigator, CHW, or similar.
- The other staff role(s) may be one of the following, or similar:
  - Peer (Certified Peer Specialist, Recovery Coach, Family Partner, Family Navigator)
  - Social worker (LCSW, LICSW) or other master's-prepared clinician such as a Master of Social Work (MSW)
  - Nurse case manager

Such team-based roles shall:

- Be available and doing work on behalf of the specific practice site for a minimum of three (3) or more equivalent 4-hour sessions per week (i.e., $\geq$0.3 FTE) individually, and at minimum collectively 1.0 FTE per the practice.
- Conduct activities such as but not limited to team-based huddles, activities on behalf of patients at the site, or patient-facing activities.
- Collectively, ensure at least one (1) FTE meeting these staff roles is available and dedicated to the practice at each of the 10 usual business hour sessions (Monday through Friday, mornings and afternoons) to respond in real-time to practice needs.
- All participate in regular team activities such as team huddles (i.e., standing team meetings for the purpose of pre-visit planning), population health management, and/or process improvement

☐ Maintain a consulting BH clinician with prescribing capability: maintain a dedicated and accessible consulting BH clinician on-site or virtually with prescribing capability available to assist the practice with cases of moderate and rising complexity. Such BH clinician shall:

- Have familiarity with titration of BH medications (e.g., psychiatrist or psychiatric clinical nurse practitioner).
- Be regularly available for activities including but not limited to making appointments on behalf of the practice in the same week, participating in case management activities, answering practice queries within two (2) business days, and assisting with co-management of referred cases

C. Population Specific Expectations

Practices serving Enrollees 21 years of age or younger shall:

☐ Full-time staff with children, youth, and family-specific expertise: identify at least one non-clinical team member with experience addressing BH and HRSN of children, youth, and families in a health care setting and/or with specialized degree, license, training, or certification in such work. Such staff shall be available

during normal business hours (Monday through Friday, mornings and afternoons), and shall be responsible for communicating with and being the site's primary and reliable point of contact to the CBHI program, FRCs, and schools/early childhood education settings. This role may be met virtually but shall be on-site at least monthly.

☐ LARC provision, at least one (1) option: have the ability on-site to insert at least one type of LARC (e.g., intrauterine device or subdermal implant). This service shall be available on-site during normal business hours at least one session every other week (i.e., twice monthly). Enrollees must be able to access this requirement on-site.

☐ Active Buprenorphine Availability: must have at least one (1) provider actively prescribing buprenorphine for management of opioid use disorder to patients with opioid use disorder, as clinically indicated. Actively prescribing means that a provider is either currently prescribing buprenorphine for enrollees at the practice, or is willing and able to if and when any Enrollee is in need of this service without having to refer the Enrollee to another location. This provider shall be available to patients in the practice on at least a weekly basis. Providing referrals to SUD care or maintaining agreements with other providers or practices at a different location does not meet this requirement. Providers may leverage the partnership and guidance of MCPAP for guidance on prescribing buprenorphine: www.mcpap.com. This requirement may be met virtually. However, providers must be capable of asynchronous, consultative, provider-to-provider communications within a shared Electronic Health Record (EHR) or web-based platform between primary care and specialist providers over a secure electronic medium that involves sharing of patient-specific information and discussing clarification or guidance regarding targeted clinical care.

Practices serving Enrollees ages 21-65 shall:

☐ LARC provision, multiple options: have the ability on-site to insert multiple forms of LARC (e.g., intrauterine device and subdermal implant). This service shall be available on-site during normal business hours at least one (1) session per week. Enrollees must be able to access this requirement on-site.

☐ Capability for next-business-day Medication for Opioid Use Disorder (MOUD) induction and follow-up: must have an evidence-based written protocol (such as SAMHSA's guidance found here) and the capability to provide in-office or virtual induction (as permitted by federal law, including but not limited to the Ryan Haight Act) of buprenorphine and opioid withdrawal management within one business day of diagnosis of opioid use disorder or treatment of withdrawal or relapse.

- The MOUD induction requirement may be met virtually, including by third party entities. However, the practice must fulfill Tier 2 requirements set forth above regarding maintenance prescribing at the practice.

  Providers must be capable of asynchronous, consultative, provider-to-provider communications within a shared Electronic Health Record (EHR) or web-based platform between primary care and specialist providers over a secure electronic medium that involves sharing of patient-specific information and discussing clarification or guidance regarding targeted clinical care.

SECTION IV: Acronyms & Terms Glossary

Terms

Adult practice	Any primary care practice, either standalone or within a larger building, that primarily provides care to adults and those >21 years of age. An adult practice shall fulfill requirements specific to adult populations. Pediatric practices that serve a small number of adult patients are not adult practices, and do not need to meet the requirements specific to adult populations Please note that EPSDT requirements are required for any MassHealth members 21 years of age or younger, regardless of the practice type.
E-Consult	Asynchronous, consultative, provider-to-provider communications within a shared Electronic Health Record (EHR) or web-based platform between primary care and specialist providers over a secure electronic medium that involves sharing of patient-specific information and discussing clarification or guidance regarding targeted clinical care.
Family Medicine practice	Any primary care practice, either standalone or within a larger building, that provides care to patients across the lifespan. A family medicine practice shall fulfill requirements specific to both pediatric and adult populations. Each Family Medicine practice shall have a single Tier Designation
Pediatric practice	Any primary care practice, either standalone or within a larger building, that primarily provides care to children and adolescent patients 21 years of age or younger. A pediatric practice shall fulfill requirements specific to pediatric populations. Adult practices that serve a small number of patients under age 21 are not pediatric practices, and do not need to meet the requirements specific to adult populations. Please note that EPSDT requirements are required for any MassHealth members 21 years of age or younger, regardless of the practice type.
Session	≥4 consecutive hours of clinical work time, usually defined as a continuous morning or afternoon block of time in which providers see patients.

Acronyms

ABMS	American Board of Medical Specialties
AUD	Alcohol Use Disorder
BH	Behavioral Health
CBHI	Children's Behavioral Health Initiative
CBT	Cognitive Behavioral Therapy
CHW	Community Health Worker
DCF	Massachusetts Department of Children and Families
DDS	Massachusetts Department of Developmental Services
DMH	Massachusetts Department of Mental Health
DPH	Massachusetts Department of Public Health
DTA	Massachusetts Department of Transitional Assistance
DYS	Massachusetts Department of Youth Services
EHR	Electronic Health Record

EPDS	Edinburgh Postnatal Depression Scale
EPSDT	Early and Periodic Screening, Diagnostic and Treatment
FRC	Family Resource Centers
HRSN	Health-Related Social Needs
LARC	Long-Acting Reversible Contraception
LCSW	Licensed Clinical Social Worker
LICSW	Licensed Independent Clinical Social Worker
LMFT	Licensed Marriage and Family Therapist
LMHC	Licensed Mental Health Counselor
M4M	Massachusetts Child Psychiatry Access Program for Moms
Mass PAT	Massachusetts Prescription Awareness Tool
MCPAP	Massachusetts Child Psychiatry Access Program
MOUD	Medication for Opioid Use Disorder
MSW	Master of Social Work
NOI	Notice of intent
SAMHSA	Substance Abuse and Mental Health Services Administration
SBIRT	Screening, Brief Intervention, and Referral to Treatment
SNAP	Supplemental Nutrition Assistance Program
WIC	Special Supplemental Nutrition Assistance Program for Women, Infants, and Children

APPENDIX E
Flexible Services Program

Flexible Services Enrollee Eligibility and Allowable Services

A. The Contractor shall ensure that Enrollees receiving any services that are paid for using Flexible Services funding are:

1. Eligible for MassHealth and enrolled with the Contractor on the following days:

   a. On the date the Flexible Services screening is conducted;

   b. On the first date of a Flexible Services episode of care, which is a set of related Flexible Services (e.g., tenancy sustaining supports, home modifications, nutrition sustaining supports); and

   c. Every subsequent 90 calendar days from the initial date of service for the Flexible Service episode of care until the conclusion of that episode.

2. Have been assessed by the Contractor to meet at least one health needs based criteria and one risk factor, described as follows:

   a. Health Needs Based Criteria:

      i. The individual is assessed to have a behavioral health need (mental health or substance use disorder) requiring improvement, stabilization, or prevention of deterioration of functioning (including the ability to live independently without support); or

      ii. The individual is assessed to have a complex physical health need, which is defined as persistent, disabling, or progressively life-threatening physical health condition(s), requiring improvement, stabilization, or prevention of deterioration of functioning (including the ability to live independently without support); or

      iii. The individual is assessed to have a need for assistance with one or more Activities of Daily Living (ADLs) or Instrumental Activities of Daily Living (IADLs); or

      iv. The individual has repeated incidents of emergency department use (defined as 2 or more visits within six months, or 4 or more visits within a year); or

      v. The individual is pregnant and experiencing high risk pregnancy or complications associated with pregnancy, including:

         a) Individuals 1 year postpartum;

         b) Their children up to one year of age; and

c) Their children born of the pregnancy up to one year of age.

b. Risk Factors:

i. Risk Factor 1: The Enrollee is experiencing homelessness, as defined by the following:

a) An individual, including individual Enrollees that are part of a family unit, who lacks a fixed, regular, and adequate nighttime residence, meaning:

(i) An individual with a primary nighttime residence that is a public or private place not designed for or ordinarily used as a regular sleeping accommodation for human beings, including a car, park, abandoned building, bus or train station, airport, or camping ground;

(ii) An individual living in a supervised publicly or privately operated shelter designated to provide temporary living arrangements (including congregate shelters, transitional housing, and hotels and motels paid for by charitable organizations or by federal, state, or local government programs for low-income individuals); or

(iii) An individual who is exiting an institution where they resided for 90 days or less and who is experiencing Risk Factor 1 (1)(a) or Risk Factor 1 (1)(b);

b) An individual, including individual Enrollees that are part of a family unit, who will imminently lose their primary nighttime residence, provided that:

(i) The primary nighttime residence will be lost within 21 days of the date of verification of Flexible Services eligibility as outlined in Appendix E.2

(ii) No subsequent residence has been identified; and

(iii) The individual lacks the resources or support networks, e.g., family, friends, faith-based or other social networks, needed to obtain other permanent housing;

c) Any individual, including individual Enrollees that are part of a family unit, who:

(i) Is fleeing, or is attempting to flee, domestic violence, dating violence, sexual assault, stalking, or other dangerous, unsafe, or life-threatening conditions that relate to violence, including physical or emotional,

against the individual or a family member, including a child, that has either taken place within the individual's or family's primary nighttime residence or has made the individual or family afraid to return to or stay in their primary nighttime residence;

(ii) Has no other residence; and

(iii) Lacks the resources or support networks, e.g., family, friends, and faith-based or other social networks, to obtain other permanent housing.

ii. Risk Factor 2: The Enrollee is housing unstable as demonstrated by either **Sections A.2.b.ii.a or A.2.b.ii.b** of this **Appendix E**:

a) The member is at risk of homelessness as defined by the following:

(i) Does not have sufficient resources or support networks, e.g., family, friends, faith-based or other social networks, immediately available to prevent them from moving to an emergency shelter or another place not meant for human habitation or a safe haven; and

(ii) Meets one of the following conditions:

(a) Has moved because of economic reasons two or more times during the 60 days immediately preceding the date of verification of Flexible Services eligibility as outlined in Appendix E.2;

(b) Is living in the home of another person because of economic hardship;

(c) Lives in a hotel or motel and the cost of the hotel or motel stay is not paid by charitable organizations or by federal, state, or local government programs for low-income individuals;

(d) Lives in a single-room occupancy or efficiency apartment unit in which there reside more than two persons, or lives in a larger housing unit in which there reside more than 1.5 people per room;

(e) Has a past history of receiving services in a publicly funded institution, or system of care (such as a health-care facility, a mental health

facility, foster care or other youth facility, or correction program or institution); or

(f) Otherwise lives in housing that has characteristics associated with instability and an increased risk of homelessness. Characteristics are defined as:

1) Living in housing that is inadequate as defined as an occupied housing unit that has moderate or severe physical problems (e.g., deficiencies in plumbing, heating, electricity, hallways, and upkeep). Examples of moderate physical problems in a unit include, but are not limited to, two or more breakdowns of the toilets that lasted more than 6 months, unvented primary heating equipment, or lack of a complete kitchen facility in the unit. Severe physical problems include, but are not limited to, lack of running hot or cold water, lack of a working toilet, and exposed wiring; or

2) Rent Arrears (1 or more): Missing one or more monthly rent payment as well as situations such as receiving a Notice to Quit, being referred to Housing Court, receiving complaints from a property manager/landlord, or failure to have one's lease recertified or renewed

b) The member is at risk of homelessness as defined by living in housing that is one of the following:

(i) Unhealthy (i.e., the presence of air or pest characteristics that negatively affect the health of its occupants); or

(ii) Physically inaccessible or unsafe due to a member's disability or medical condition.

iii. Risk Factor 3: The Enrollee is at risk for nutritional deficiency or nutritional imbalance due to food insecurity, defined as having limited or uncertain availability of nutritionally adequate, medically appropriate, and/or safe foods, or limited or uncertain ability to acquire

or prepare acceptable foods in socially acceptable ways. Limited or uncertain is defined as:

a) Reduced quality, variety, or desirability of diet with little or no indication of reduced food intake; or

b) Multiple indications of disrupted eating patterns and reduced food intake.

B. Allowable Flexible Services[1]

The Contractor shall only provide Flexible Services as specified below:

1. Pre-Tenancy Supports – Individual Supports must be one or more of the following:

a. Assessing and documenting the member's preferences related to the tenancy the member seeks, including the type of rental sought, the member's preferred location, the member's roommate preference (and, if applicable, the identification of one or more roommates), and the accommodations needed by the member

b. Assisting the member with budgeting for tenancy/living expenses, and assisting the member with obtaining discretionary or entitlement benefits and credit (e.g., completing, filing, and monitoring applications to obtain discretionary or entitlement benefits and credit as well as obtaining or correcting the documentation needed to complete such applications)

c. Assisting the member with obtaining, completing, and filing applications for community-based tenancy

d. Assisting the member with understanding their rights and obligations as tenants

e. Assisting the member with obtaining services needed to establish a safe and healthy living environment

f. Assisting or providing the member with transportation to any of the approved pre-tenancy supports when needed

2. Pre-Tenancy Supports – Transitional Assistance includes:

a. Assisting the member with locating, obtaining and/or providing the member with transitional goods including one or more of the following:

i. Move in expenses (security deposit, utility activation fees, and payments in arrears in order to start up utilities with any combination of utility fees and payment in arrears not to exceed six months of payments);

[1] Allowable Services subject to change pending CMS approval

ii. Deposits or one-time start-up payments of miscellaneous fees outlined in the lease;

iii. Housing deposits;

iv. Moving costs;

v. Relocation expenses;

vi. Costs for filing applications;

vii. Costs related to obtaining and correcting needed documentation to access housing;

viii. One time household set up expenses needed to establish community-based tenancy (pantry stocking, initial supply of toiletries, initial supply of cleaning supplies, and household goods and furniture); and

ix. Services necessary for member's health and safety in housing (eradication/remediation of conditions prior to occupancy, cleaning prior to occupancy).

b. Assisting or providing the member with transportation to any of the approved pre-tenancy supports when needed

3. Tenancy Sustaining Supports

a. Assisting the member with communicating with the landlord and/or property manager regarding the member's disability, and detailing the accommodations needed by the member

b. Assisting the member with the review, update, and modification of the member's tenancy support needs on a regular basis (e.g., assessing the member's needs on a quarterly basis or more frequently, as needed), to reflect current needs and address existing or recurring barriers to retaining community tenancy

c. Assisting the member with obtaining and maintaining discretionary or entitlement benefits and establishing credit, including, but not limited to obtaining, completing, filing, and monitoring applications

d. Assisting the member with obtaining appropriate sources of tenancy training, including trainings regarding lease compliance and household management

e. Assisting the member in all aspects of the tenancy, including, when needed, legal advocacy (in the form of coaching, supporting, and educating the member) during negotiations with a landlord, and directing a member to appropriate sources of legal services

f. Assisting the member with obtaining or improving the adaptive skills needed to function and live independently and safely in the community and/or family home, including advising the member of the availability of community resources.

g. Assisting or providing the member with transportation to any of the tenancy sustaining supports when needed

4. Home Modification

Home Modifications consist of limited physical adaptations to the member's community-based dwelling, when necessary, to ensure the member's health, welfare, and safety, or to enable the member to function independently in a community-based setting. These may include, but are not limited to:

a. Installation of grab bars and hand showers

b. Doorway modifications

c. In-home environmental risk assessments

d. Refrigerators for medicine such as insulin

e. HEPA filters

f. Vacuum cleaners

g. Pest management supplies and services

h. Air conditioner units

i. Hypoallergenic mattresses and pillow covers

j. Traction or non-skid strips

k. Night lights

l. Training to use such supplies and modifications correctly

5. Nutrition Sustaining Supports

a. Assisting the member with obtaining discretionary or entitlement benefits and credit, including but not limited to completing, filing, and monitoring applications as well as obtaining and correcting the documentation needed to complete such applications

b. Assisting the member with obtaining and/or providing household supplies needed to meet nutritional and dietary need

c. Assisting or providing the member with access to foods that meet nutritional and dietary need that cannot otherwise be obtained through existing discretionary or entitlement programs. If the member is a child/adolescent (0-21 years of age) or a pregnant person meeting the needs-based criteria, additional meal support may be provided for the household.

d. Assisting or providing the member with nutrition education and skills development

e. Providing healthy, well-balanced, home-delivered meals for the member. If the member is a child/adolescent (0-21 years of age) or a pregnant person meeting needs-based criteria, additional meal support may be provided for the household

f. Assisting the member in maintaining access to nutrition benefits including, when needed, legal advocacy (in the form of coaching, supporting, and educating the member) during appeals of benefit actions (e.g., denial, reduction, or termination) and directing member to appropriate sources of legal services

g. Assisting or providing the member with obtaining transportation to any of the NSS services, or transportation supporting the member's ability to meet nutritional and dietary needs (e.g., providing a member with transportation to the grocery store)

C. The Contractor shall not use its Flexible Services Allotment funding for any of the following:

1. Ongoing payment of rent or other room and board costs including, but not limited to, temporary housing, motel stays, and mortgage payments, as well as housing capital and operational expenses
2. Housing adaptations to the dwelling that are of general utility, and are not of direct medical or remedial benefit to the member
3. Housing adaptations that add to the total square footage of the dwelling except when necessary to complete an adaptation that is of direct medical or remedial benefit to the member (e.g., in order to improve entrance/egress to a residence or to configure a bathroom to accommodate a wheelchair)
4. Construction costs (bricks and mortar) or capital investments
5. Housing adaptations that would normally be considered the responsibility of the landlord
6. Cable/television/phone/internet setup or reoccurring payments
7. Ongoing utility payments
8. Building or purchasing new housing
9. One-time rent payments to avoid eviction

10. Legal representation (note, legal education, coaching, and support are allowable, but direct legal representation is not)
11. Meals for an eligible member that exceed more than 3 meals a day
12. Goods exceeding the necessary amount for the specific needs of the member (e.g., food vouchers that enable a member to access more food than they need).
13. Infrastructure costs of the Contractor or any CPs partnering with the Contractor
14. Infrastructure costs associated with a partnering SSO
15. Services or goods that are available through other state, federal, or other publicly funded programs.
16. Services that are duplicative of services a member is already receiving
17. Services where other funding sources are available
18. Supports that a member is eligible to receive under the CP Program
19. Alternative medicine services
20. Medical marijuana
21. Copayments
22. Premiums
23. Gift cards or other cash equivalents with the exception of nutrition or transportation related vouchers or nutrition prescriptions
24. Student loan payments
25. Credit card payments
26. Licenses (drivers, professional, or vocational)
27. Educational supports other than those allowable under tenancy and nutrition
28. Vocational training
29. Childcare
30. Memberships not associated with one of the allowable domains
31. Social Activities
32. Hobbies
33. Goods and services intended for leisure or recreation
34. Clothing
35. Auto repairs
36. Gasoline or mileage
37. Purchase or repair of bicycles or other individually owned vehicles
38. Transportation to anything other than tenancy or nutrition services

39. Transportation for members who are not approved for Flexible Services
40. Goods and services for individuals who are not approved for Flexible Services
41. Training Contractor or designees on the direct delivery of Flexible Services
42. Research grants and expenditures not related to monitoring and evaluation
43. Costs for services in prisons, correctional facilities or services for people who are civilly committed and unable to leave an institutional setting
44. Services provided to individuals who are not lawfully present in the United States or are undocumented
45. Expenditures that supplant services and activities funded by other state and federal governmental entities
46. School-based programs for children that supplant Medicaid state plan programs, or that are funded under the Department of Education and/or state of the local education agency
47. Any other projects or activities not specifically approved by CMS as qualifying for coverage as HRS item or service under this demonstration

APPENDIX F
ACO REPORTING REQUIREMENTS

This Appendix summarizes certain reporting requirements described in the Contract. This summary does not supersede contract language, nor does it capture all possible report requests as part of the Readiness Review. EOHHS may update these requirements from time to time. The Contractor shall submit corresponding Certification Checklists of all reports/submissions listed in **Appendix F** within the timelines specified herein. The Contractor may include a narrative summary to reports/submissions and may include graphs that explain and highlight key trends. All reports must be submitted via OnBase, the EOHHS Contract Management system, unless otherwise indicated below in the *"Target System"* column. Numbering sequence and Report Title that will appear in the OnBase system can be found in **BOLD** in the *"Name of Report"* column.

For all of the reports listed below, unless otherwise specified, if the Contractor meets the target for a given report, the Contractor shall only complete a short narrative description on the report cover sheet. For any report that indicates that the Contractor is not meeting the target, the Contractor shall submit a detailed narrative that includes the results, an explanation as to why the Contractor did not meet the target, and the steps the Contractor is taking to improve performance going forward.

The Contractor shall provide all Reports in the form and format required by EOHHS and shall participate with EOHHS in the development of detailed specifications for these reports. These specifications shall include benchmarks and targets for all reports, as appropriate. Targets shall be changed to reflect improvement in standards over time.

All exhibits referenced herein pertain to **Appendix F**, unless otherwise noted. Such exhibits set forth the form and format the Contractor shall use for each report below. These exhibits shall be provided to the Contractor and may be updated by EOHHS from time to time. EOHHS shall notify the Contractor of any updates to the exhibits.

Reporting Deliverable Schedule

1. **Same Day Notification (Immediate Notice Upon Discovery):** Deliverables due the same day as discovery. If the incident occurs on a Saturday, Sunday, or state or federal holiday, the notice is due the next business day.
2. **Next Day Notifications:** Deliverables due the next day. If the incident occurs on a Saturday, Sunday, or state or federal holiday, the notice is due the next business day.
3. **Two Business Days Notification:** Deliverables due in two business days
4. **Weekly Deliverables:** Deliverables due by close of business/COB on Fridays
5. **Within 7 Calendar Days of Occurrence Notification:** Deliverables due within seven calendar days of occurrence. If the incident occurs on a Saturday, Sunday, or state or federal holiday, the notice is due within 7 calendar days of the next business day.
6. **No later than 30 days prior to execution:** Deliverables due thirty days prior to implementation for review and approval by EOHHS.
7. **Monthly Deliverables:** Deliverables due on a monthly basis, by the last day of the month, following the month included in the data, unless otherwise specified by EOHHS.
8. **Quarterly Deliverables:** Deliverables due on a contract year (CY) quarterly basis, by the last business day of the month following the end of each quarter, unless otherwise specified.

   CY Quarter 1: January 1 – March 31

   CY Quarter 2: April 1 - June 30

   CY Quarter 3: July 1 – September 30

   CY Quarter 4: October 1 – December 31
9. **Semi-Annual Deliverables:** Deliverables due by the last business day of the month following the end of the reporting period, unless otherwise specified. The semi-annual reporting periods are as follows:

   January 1 – June 30

   July 1 – December 31
10. **Annual Deliverables**: Deliverables due by the last business day of the month following the end of the reporting period (Contract Year: January 1 -- December 31), unless otherwise specified by EOHHS.
11. **Ad-Hoc Deliverables**: Deliverables are due whenever the Contractor has relevant changes or information to report, or upon EOHHS request related to Behavioral Health, Contract Management, Financial, Quality, Pharmacy, and Operations deliverables as applicable.

A. Report and Compliance Certification Checklist: Exhibit C-1

Annually - The Contractor shall list, check off, sign and submit a Certification of Data Accuracy for all Contract Management, Behavioral Health, Operations and Quality reports/submissions, certifying that the information, data and documentation being submitted by the Contractor is true, accurate, and complete to the best of the Contractor's knowledge, information and belief, after reasonable inquiry. For each report in the sections below, if an attestation is required with the submission, that information will be included within the reporting template.

B. Contract Management Reports

Certain Contract Management Reports have submission requirements in addition to those listed in the Target System column. Please use the following key:

[1] The Contractor shall additionally send report via regular email to the Contract Manager (in addition to using the Target System).

[2] The Contractor shall additionally send report via secure email to the Contract Manager (in addition to using the Target System).

[3] The Contractor shall notify its Contract Manager upon submission of the report using the Target System.

ACO Contract Exhibit Number	Name of Report	Deliverable Frequency	Target System
CM-03	**CM-03 Member Telephone Statistics** Member Telephone Statistics	Monthly	OnBase
CM-04	**CM-04 Member Education and Related Orientation, Outreach Materials** Member Education and Related Orientation, Outreach Materials (including enrollment materials for MH Customer Service Center (CSC)	Ad-Hoc	OnBase[1]
CM-07	**CM-07 Marketing Materials** Marketing Materials *(60 days in advance of use, including materials to be distributed at Contractor and non-Contractor sponsored health fairs or community events)*	Ad-Hoc	OnBase[1]
CM-08	**CM-08 Marketing Materials- Annual Executive Summary** Marketing Materials- Annual Executive Summary (including a written statement that all of the Contractor's marketing plans and materials are accurate and do not mislead, confuse, or defraud Members or the state)	Annual	OnBase
CM-17-A	**CM-17-A Enrollee Inquiries Summary** Inquiries and Grievances Summary: Enrollee Inquiries	Annual	OnBase

ACO Contract Exhibit Number	Name of Report	Deliverable Frequency	Target System
CM-17-B	**CM-17-B Enrollee Grievances Summary** Inquiries and Grievances Summary: Enrollee Grievances	Annual	OnBase
CM-17-F	**CM-17-F - Grievances Report (per 1,000 Enrollees)** Grievances Report (per 1,000 Enrollees)	Monthly	OnBase
CM-18	**[RETIRED]**		
CM-22	**CM-22 ACO/MCO Organization and Key Personnel Changes** Organization and Key Personnel Changes. The Contractor will also include Behavioral Health subcontractor information if applicable.	Ad-Hoc	OnBase[3]
CM-23	**CM-23 Notification of Termination of Material Subcontractor** Notification of Intention to Terminate a Material Subcontractor (Notification: Same Day)	Ad-Hoc	OnBase[1]
CM-24	**CM-24 Notification of New Material Subcontractor and Checklist** Notification of Intention to Use a New Material Subcontractor and Checklist (Material Subcontract Checklist must be submitted no later than 60 days prior to requested implementation date)	Ad-Hoc	OnBase[1]
CM-25	**CM-25 Material Subcontractor List Annual Summary** Material Subcontractor List Annual Summary	Annual	OnBase
CM-31	**CM-31 Notification of Federally Required Disclosures** Notification of Federally Required Disclosures (in accordance with Section 5.26.A)	Ad-Hoc	POSC[3]
CM-43-A	**CM-43-A Holiday Closures and Other Contractor Office Closures Annual** Holiday Closures and Other Contractor Office Closures. (The Contractor shall also include Behavioral Health subcontractor information, if applicable).	Annual	OnBase
CM-43-B	**CM-43-B Emergency Closures and Other Contractor Office Closures Ad Hoc** Emergency Closures and Other Contractor Office Closures. (The Contractor shall also include Behavioral Health subcontractor information, if applicable).	Ad Hoc	OnBase[3]
CM-44	**CM-44 Strategy-related Reports** Strategy-related Reports	Ad Hoc	OnBase

ACO Contract Exhibit Number	Name of Report	Deliverable Frequency	Target System
CM-45	**[RETIRED]**		
CM-46	**CM-46 Enrollee and Provider Incentives Notification** Enrollee and Provider Incentives Notification	Ad-Hoc	OnBase[3]
CM-48	**CM-48 Copy of Press Releases (pertaining to MassHealth line of business)** Copy of Press Releases (pertaining to MassHealth line of business)	Ad-Hoc	OnBase[1]
CM-49	**CM-49 Written Disclosure of Identified Prohibited Affiliations** Written Disclosure of Identified Prohibited Affiliations	Ad-Hoc	OnBase[3]
CM-50	**[RETIRED]**		
CM-57	**[RETIRED]**		
CM-58	**CM-58 Application for MassHealth Data [for External Research Projects]** Application for MassHealth Data	Ad hoc	Email
CM-C1	**CM-C1 Report and Compliance Certification Checklist** Annual Report and Compliance Certification Checklist	Annual	OnBase
CM-C2	**CM-C2 Supplier Diversity Program (SDP) Spending Report for Prime Contractors** The SDP Spending Report form may be found here: https://www.mass.gov/lists/sdo-forms	Quarterly	Secure Email[2]

C. Care Coordination

ACO Contract Exhibit Number	Name of Report	Deliverable Frequency	Target System
CC-01	**CC-01 Care Needs Screening** Aggregate Care Needs Screening Completion Rates	Ad-hoc	OnBase
CC-02	**CC-02 HRSN Screening** HRSN Screening	Ad-hoc	OnBase
CC-03	**CC-03 HRSN Referrals** HRSN Referrals	Ad-hoc	OnBase
CC-04	**CC-04 Risk Stratification Algorithm**	Annually	OnBase

ACO Contract Exhibit Number	Name of Report	Deliverable Frequency	Target System
	Risk Stratification Algorithm and Narrative		
CC-05	**CC-05 Care Management Program Descriptions and Performance** Care Management Program Descriptions and Performance	Annually	OnBase
CC-06	**CC-06 CP Performance Management** Summary of the Contractor's performance management strategy of the CP Program and overview of Contractor's CP Program performance.	Annually	OnBase
CC-07-A	**CC-7-A CP Quality Payment Receipts** CP Quality Payment Receipts	Annually	SFTP
CC-07-B	**CC-07-B CP Monthly Payment Receipts** CP Monthly Care Coordination Payment Receipts	Monthly	SFTP
CC-07-C	**CC-07-C CP Annual Payment Report** CP Annual Care Coordination Payment Report	Annually	SFTP
CC-08	**CC-08 Early warning indicators of performance concerns, CP Performance and/or Corrective Action Plans** As described in Section 2.4.E.3.b-c, notification within 5 business days of early warning indicators of CP performance concerns, and/or implementation of Performance Improvement Plans, and/or development of Corrective Action Plans	Ad hoc	OnBase
CC-9	**CC-9 Comprehensive Assessment and Care Plans (CM)** Comprehensive Assessment and Care Plan Completion Rates for Care Management	Ad hoc	OnBase
CC-10	**CC-10 Care Management Enrollment** Care Management Enrollment	Monthly	SFTP
CC-11	**CC-11 Care Management Program Budget** Care Management Program Budget	Annual	OnBase

D. Financial Reports

ACO Contract Exhibit Number	Name of Report	Deliverable Frequency	Target System
FR-43-A	**FR-43 Primary Care Sub-Capitation Payment Tracking Report - Monthly** Primary Care Sub-Capitation Payment Tracking Report	Monthly	SFTP
FR-43-B	**FR-43 Primary Care Sub-Capitation Payment Tracking Report – Ad Hoc** Primary Care Sub-Capitation Payment Tracking Report	Ad-Hoc	SFTP

E. ACO Health Equity Reporting

ACO Contract Exhibit Number	Name of Report	Deliverable Frequency	Target System
HQ-23	**HQ-23 ACO/MCO RELD SOGI Mapping**	Ad-Hoc	OnBase
HQ-24	**HQ-24 ACO/MCO Health Quality and Strategic Plan**	Annually	OnBase

F. Operations Reports

ACO Contract Exhibit Number	Name of Report	Deliverable Frequency	Target System
OP-04	**OP-04 Member Discrepancy Report** Member Discrepancy Report	Monthly	OnBase
OP-06	**OP-06 Address Change File** Address Change File	Bi-Weekly	OnBase
OP-07	**OP-07 Multiple ID File** Multiple ID File	Bi-Weekly	OnBase
OP-08	**OP-08 Date of Death Report** Date of Death Report	Bi-Weekly	OnBase

G. Program Integrity

ACO Contract Exhibit Number	Name of Report	Deliverable Frequency	Target System
PI-01	**PI-01 Fraud and Abuse Notification (within 5 days) and Activities** Fraud and Abuse Notification (within 5 days) and Activities	Ad-Hoc	OnBase and Secure E-mail
PI-08	**PI-08 - Self-Reported Disclosures** Self-Reported Disclosures	Ad-Hoc	OnBase

H. Quality Reports

ACO Contract Exhibit Number	Name of Report	Deliverable Frequency	Target System
QR-01	**QR-01 QM/QI Program Description/Workplan** Written description of the QM/QI Program that delineates the structure, goals, and objectives of the Contractor's QM/QI initiatives.	Annually	OnBase
QR-07	**QR-07 Clinical Quality Measures**	Annually	Quality Vendor
QR-08	**QR-08 Supplemental Data for Clinical Quality and Health Equity Measures** Supplemental data files (Format for submission determined and communicated by MassHealth's Comprehensive Quality Measure Vendor (CQMV).	Annually	Inter-change
QR-09	**QR-09 Validation of Performance Measures** Validation of Performance Measures	Annually	EQRO

APPENDIX G

Requirements for the Material Subcontracts Between Accountable Care Organizations (ACOs) and Community Partners (CPs)

The Contractor shall maintain material subcontracts (also known as ACO-CP Agreements) with at least one (1) Behavioral Health Community Partner (BH CP) and at least one (1) Long Term Services and Supports Community Partner (LTSS CP) within each of the Contractor's Service Area(s), as specified in **Section 2.4.E** of the Contract and in this **Appendix G**. The Contractor's CP material subcontracts, referred to in this Appendix as "subcontracts," shall be provided to EOHHS upon request and may be reviewed by EOHHS. All requirements set forth herein are applicable to subcontracts with both BH CPs and LTSS CPs unless otherwise specified.

All terms or their abbreviations, when capitalized in this Appendix, are defined as set forth in the Contract or otherwise defined by EOHHS. The Contractor and the CP with which the Contractor enters into a subcontract are referred to collectively herein as the "Parties."

The Parties' subcontracts must comply with applicable laws and regulations, including but not limited to applicable privacy laws and regulations, and with the Contractor's Contract with EOHHS.

The Parties' subcontracts must, at a minimum, contain the information included in this document.

Section 1.1 PAYMENT

A. The Parties' subcontract shall obligate the Contractor to pay the CP as described in **Section 2.4.E.8**.

1. The Contractor shall pay CPs a monthly panel-based payment that includes the following components, and as further specified by EOHHS.

    a. Base rate for CP Supports: $190 PMPM or a rate as further specified by EOHHS

    b. Add-on payment for CPs serving CP Enrollees who are experiencing homelessness, as determined by EOHHS. The Contractor shall make an add-on payment to applicable CPs as follows:

        (i) Tier 1: 30-60% of the CP's Enrollees are experiencing homelessness – The Contractor shall pay an additional $10 PMPM for all CP Enrollees enrolled in the CP.

        (ii) Tier 2: Over 60% of the CP's Enrollees are experiencing homelessness - The Contractor shall pay an additional $75 PMPM for all CP Enrollees enrolled in the CP).

        (iii) The percentage of a CP's Enrollees that are experiencing homelessness will be determined by EOHHS identified sources.

    c. Add-on payment for CP Enrollees in the Oak Bluffs and Nantucket Service Areas as follows:

(i) For Contract Year 1, BH CP Enrollees only: $100 PMPM;

(ii) For Contract Year 2, for all CP Enrollees: $100 PMPM; or

(iii) As further specified by EOHHS.

2. The Contractor shall pay CPs an annual quality performance-based payment based on calculations provided by EOHHS up to $40 PMPM based on the CP's performance on CP Quality Measures, as determined by EOHHS.

3. The Contractor shall reconcile monthly panel-based payments to CPs as further specified by EOHHS.

Section 1.2 CP Supports

In addition to the enhanced care coordination requirements described in **Section 2.4.C** of the Contract delegated to the CP by the Contractor, the Parties' subcontract shall require the following:

A. Outreach and Engagement

The Parties' subcontract shall require that the CP develop, implement, maintain, and adhere to a protocol for outreach and engagement of CP Enrollees. Such protocol shall include the requirements in **Section 2.4.C.3** of the Contract, as well as the following requirements:

1. Require the CP to attempt at least one face-to-face visit with each CP Enrollee within the first 3 calendar months of the CP Enrollee's enrollment in the CP.

2. For each CP Enrollee who agrees to participate in the CP program, require the CP to:

a. Attest that the CP has performed the outreach and activities described in **Section 2.4.C.3** of the Contract and **Section 1.2** of this **Appendix G** and obtained verbal or written agreement from the CP Enrollee to receive or continue receiving CP supports;

b. Maintain a copy of the attestation and the CP Enrollee's written agreement, or a record of the CP Enrollee's verbal agreement, if applicable, in the CP Enrollee's record; and

c. Explain the Protected Information (PI) the CP intends to obtain, use, and share for purposes of providing CP supports;

d. To the extent deemed necessary by the CP, obtain the CP Enrollee's written authorization to the uses and disclosures of their Protected Information (PI) as necessary for providing CP supports.

3. Require the CP to notify the Contractor if the CP Enrollee declines to participate in the CP program or requests enrollment in a different CP.

4. For BH CPs only, for BH CP Enrollees the BH CP believes are experiencing homelessness or are at risk of homelessness, require the CP use the Homeless Management Information System (HMIS) or other means to:

a. Confirm whether the CP Enrollee is currently experiencing or has a history of experiencing homelessness or unstable housing;

b. Identify which homeless provider agencies and agency staff have worked with the CP Enrollee, if any. If the CP Enrollee is not connected with a homeless provider agency, the CP shall immediately work to connect the CP Enrollee with a homeless provider agency; and

c. Once the homeless provider agencies and agency staff are identified or connected to the CP Enrollee, conduct outreach to the homeless provider agencies to gather additional information and invite the homeless provider to participate in the Care Team and care planning for the CP Enrollee.

B. Comprehensive Assessment

The Parties' subcontract shall require that the CP shall complete a Comprehensive Assessment, as described in **Section 2.3.B.4** of the Contract. The CP shall utilize a Comprehensive Assessment tool of their choosing that meets the requirements as set forth in **Section 2.3.B.4**. In addition to the requirements in **Section 2.3.B.4** of the Contract, the Parties' subcontract shall require the following:

1. For the Medication domain, the CP shall conduct a medication review in accordance with **Section 2.4.C.6** of the Contract and **Section 1.2.H** of this **Appendix.**
2. The CP shall perform Comprehensive Assessments face-to-face unless otherwise specified by EOHHS, and shall take place in a location that meets the CP Enrollee's needs, including home-based assessments as appropriate.
3. A registered nurse (RN) employed by the CP must review and agree to the CP Enrollee's medical history, medical needs, medications, and functional status, including needs for assistance with any Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs).
4. A Clinical Care Manager employed by the CP shall provide final review and approval of the entire Comprehensive Assessment. If the Clinical Care Manager is an RN, review and approval of the Comprehensive Assessment may be completed by one staff member provided all requirements of this Section are met.

C. Health-Related Social Needs Screening and Connection to Community, Social and Flexible Services

The Parties' subcontract shall require that the CP shall complete a health-related social needs (HRSN) Screening, as described in **Section 2.3.B.3** of the Contract, and shall utilize such tool in connecting CP Enrollees to community and social supports and Flexible Services. In addition to the requirements in **Section 2.3.B.3** of the Contract, the Parties' subcontract shall require the CP to do the following:

1. Conduct a health-related social needs (HRSN) screening upon enrollment to the CP for those CP Enrollees who have not had an HRSN screening within the last twelve (12) calendar months that includes all domains and considerations described in **Section 2.3.B.3** of the Contract, and annually thereafter. The HRSN screening may occur as a unique screening, or as part of the Comprehensive Assessment.

2. Utilize the results of any such HRSN screenings when creating a Care Plan and coordinating care.

3. Provide its Heath-Related Social Needs Screening tool to the Contractor and to EOHHS upon request for review and shall make any changes to such tool as directed by EOHHS. EOHHS may require the Contractor to use a specific tool in place of the Contractor's proposed tool.

4. If the CP Enrollee would like supports, identify supports to address the CP Enrollee's identified HRSN(s), including using tools such as the Community Resource Database (CRD) which is provided to the CP by the Contractor, as appropriate;

5. Provide the CP Enrollee with information about available HRSN-related supports, how to contact such supports, and the accessibility of such supports;

6. Ensure such CP Enrollees are referred to HRSN-related supports provided by the Contractor, or a Social Services Organization, as applicable. For CP Enrollees who are referred to a Social Services Organization, the CP shall confirm the Social Services Organization has the capacity to provide services to the CP Enrollee and, if not, arrange a referral to another Social Services Organization;

7. Document relevant ICD-10 codes (such as "Z codes" included in categories Z55-65 and as further specified by EOHHS);

8. Submit to the Contractor aggregate reports of the identified HRSNs of its CP Enrollees, as well as how those CP Enrollees were referred to appropriate resources to address those identified HRSNs, in a form, format, and frequency specified by EOHHS;

9. Coordinate supports to address HRSNs, including:

    a. Assisting the CP Enrollee in attending the referral appointment, including activities such as coordinating transportation assistance and following up after missed appointments;

    b. Directly introducing the CP Enrollee to the service provider, if co-located, during a visit;

    c. Utilizing electronic referral (e.g., electronic referral platform, secure e-mail) to connect the CP Enrollee with the appropriate provider or Social Service Organization, if the Social Service Organization has electronic referral capabilities, including sharing relevant patient information;

    d. Following up electronically (e.g., electronic referral platform, secure e-mail) with the provider or Social Service Organization, if the Social Service Organization has electronic follow-up capabilities, as needed, to ensure the CP Enrollee's needs are met.

10. For CP Enrollees, the CP shall provide HRSN screening and, for CP Enrollees enrolled in an ACO, consider referral to Flexible Services, depending on program availability and CP Enrollee eligibility;

a. For CP Enrollees identified as needing referrals to Flexible Services, Supplemental Nutrition Assistance Program (SNAP), or Special Supplemental Nutrition Program for Women, Infants, and Children (WIC), the CP shall:

(i) Provide the CP Enrollee's contact information and information about the identified HRSN to the entity receiving the referral; and

(ii) Follow up with the CP Enrollee to ensure the CP Enrollee's identified needs are being met.

11. The CP to shall document results of the HRSN screening and include a list of the community and social services resources the CP Enrollee needs in the CP Enrollee's Care Plan, as described in **Section 1.2.D** of this Appendix.

D. Development of Care Plan

The Parties' subcontract shall require that the CP develop a Care Plan as described in **Section 2.3.B.5** of the Contract. The CP shall utilize a Care Plan template approved by the Contractor that meets the requirements of **Section 2.3.B.5** of the Contract. In addition to the requirements in **Section 2.3.B.5**, the Parties' subcontract shall require the following:

1. Care Plans shall be reviewed by a registered nurse (RN) employed by the CP. Care Plans shall receive final review and approval by a Clinical Care Manager employed by the CP.
2. The CP shall document within the CP Enrollee record that the Care Plan was provided to, agreed to, and signed or otherwise approved by the CP Enrollee.
3. The CP shall complete Care Plans within five (5) calendar months of CP Enrollee's enrollment with the CP. A Care Plan shall be considered complete when:

   a. The Care Plan has been approved by a Clinical Care Manager; and

   b. The Care Plan has been signed or otherwise approved by the CP Enrollee (or authorized representative, if any).

4. The CP shall share the completed Care Plan with the Enrollee's PCP or PCP Designee, the Contractor, and other parties who need the Care Plan in connection with their treatment of the CP Enrollee, provision of coverage or benefits to the CP Enrollee, or related operational activities involving the CP Enrollee, including members of the CP Enrollee's Care Team, CBHC staff, if applicable, and other providers who serve the CP Enrollee, including state agency or other case managers, in accordance with all data privacy and data security provisions applicable.

E. Care Team

The Parties' subcontract shall require that the CP take the lead on forming and coordinating a Care Team for CP Enrollees who have agreed to participate in the program, as described in **Section 2.4.C.4** of the Contract. In addition, the CP shall ensure:

1. That the Care Team meets at least once within a 12-month period, and

2. That a representative from the Care Team attends any multidisciplinary team meetings hosted by the Contractor, clinical staff, hospitals and/or other stakeholders to review high-risk Members, if applicable;

F. Care Coordination

The Parties' subcontract shall require that the CP Enrollee's CP Care Coordinator provide ongoing care coordination support to the CP Enrollee in coordination with the CP Enrollee's PCP and other providers as set forth in **Section 2.4.A and Section 2.4.C** of the Contract. In addition, the Parties' subcontract shall:

1. Require CPs to assist CP Enrollees in the following activities:

    a. For CP Enrollees with behavioral health needs, coordinating with the CP Enrollee's behavioral health providers to develop the CP Enrollee's Crisis Prevention Plan to prevent avoidable use of emergency departments, hospitalizations and criminal justice involvement and to provide follow-up if these events occur. The Crisis Prevention Plan shall be documented in the CP Enrollee's record and shared with the CP Enrollee's Care Team and other providers.

    b. For CP Enrollees with LTSS needs, assisting with prior authorization for MassHealth State Plan LTSS as applicable. If a service request is significantly modified or denied by MassHealth, the CP shall work with the CP Enrollee to ensure the Care Plan is adequate to meet the CP Enrollee's needs by working with the CP Enrollee to identify other appropriate supports to meet an unmet need.

    c. In addition to implementing the activities necessary to support the CP Enrollee's Care Plan, as described in **Section 2.3.B.5** of the Contract, ensure the CP Enrollee has timely and coordinated access to primary, medical specialty, LTSS, and behavioral health care. Such additional activities shall include, but are not limited to:

        (i) Explaining PCP, specialist, and other provider directives to the CP Enrollee;

        (ii) Providing well-visit, medical, prenatal, outpatient behavioral health, and preventative care reminders;

        (iii) Assisting the CP Enrollee in scheduling health-related appointments, accessing transportation resources to such appointments, and confirming with the CP Enrollee that such appointments have been kept;

        (iv) Confirming with the CP Enrollee that they are adhering to medication recommendations;

(v) At a minimum, conducting a face-to-face visit at home or in a location agreed upon by the CP Enrollee, with each CP Enrollee on a quarterly basis; and

(vi) Making regular telephone, telehealth, or other appropriate contact with the CP Enrollee between face-to-face visits.

d. Coordinating with a CP Enrollee's ACCS provider, if any, as follows:

(i) Inform the CP Enrollee's ACCS provider of all of the CP Enrollee's routine and specialty medical care including identifiable symptoms that may require routine monitoring;

(ii) Coordinate with the CP Enrollee's ACCS provider to develop the CP Enrollee's crisis plan to prevent use of emergency departments, hospitalizations and criminal justice involvement and to provide follow-up if these events occur; and

(iii) Coordinate with the CP Enrollee's ACCS provider regarding activities for improving the CP Enrollee's health and wellness and to allow ACCS providers to assist and reinforce the Engaged CP Enrollee's health and wellness goals.

e. For LTSS CPs:

(i) Coordinating with other MassHealth programs that provide Case Management. For CP Enrollees who (1) participate in a 1915(c) Home and Community-Based Services (HCBS) Waiver, or (2) are receiving targeted case management through DYS case managers, Adult Community Clinical Services, Community Service Agencies (CSAs) who deliver Children's Behavioral Health Initiative services, or DDS service coordinators, or (3) are receiving Community Case Management (CCM), the CP Enrollee's CP Care Coordinator shall coordinate the provision of LTSS CP Supports with the CP Enrollee's HCBS Waiver case manager, DDS service coordinator, DYS case manager, CSA and CCM, as applicable, to ensure that LTSS CP supports supplement, but do not duplicate, functions performed by HCBS Waiver case managers, DDS service coordinators, DYS case managers, CSA or CCM.

(ii) Coordinating with the Home Care Program. For CP Enrollees who are not in a 1915 (c) Home and Community-Based Services (HCBS) Waiver and who participate in the Home Care Program operated by the Executive Office of Elder Affairs (EOEA), the CP Enrollee's CP Care Coordinator shall coordinate the provision of LTSS CP supports with the CP Enrollee's Home Care Program case manager to ensure that LTSS CP supports supplement, but do not duplicate, functions performed by the Home Care Program case manager.

2. Obligate the Contractor to provide the CP with information pertaining to TCOC Included Services and services not included in the TCOC calculations, as specified in **Appendix A**, including any such services requiring prior authorization or referrals; and

3. Obligate the Parties to develop, maintain, and implement a mutually agreed upon process for how the Contractor will communicate to the CP any PCP referrals for TCOC Included Services and services not included in TCOC calculations. Such process shall include communications between the Parties about any prior authorization decisions (e.g., approval, modification or denial) made by EOHHS.

G. Support for Transitions of Care

In addition to the requirements of **Section 2.4.C.5** of the Contract, the Parties' subcontract shall obligate the CP to:

1. Assist CP Enrollees who are referred to other levels of care, care management programs, or other providers, in accessing these supports. Such assistance may include, but is not limited to:

    a. Facilitating face-to-face contact between the CP Enrollee and the provider or program to which the CP Enrollee has been referred, and directly introducing the CP Enrollee to such provider or an individual associated with such program (i.e., "warm hand-off"), as appropriate; and

    b. Making best efforts to ensure that the CP Enrollee attends the referred appointment, if any, including coordinating transportation assistance and following up after missed appointments.

2. Ensure that the Care Coordinator, at a minimum, offers a face-to-face follow-up visit within seven (7) days following a CP Enrollee's inpatient discharge, discharge from twenty-four (24) hour diversionary setting, or transition to a community setting. If the CP Enrollee declines a face-to-face visit, the CP must document the declination in the CP Enrollee's EHR and then may conduct the visit via telehealth (e.g., telephone or videoconference, or as further specified by EOHHS).

H. Medication Review for CP Enrollees

For CP Enrollees, the Parties' subcontract shall permit CPs to obtain a list of the Enrollee's medications and require the CP to:

1. Note in the CP Enrollee's EHR that they obtained the list; and

2. Identify the source of the list.

I. Connections to options counseling for CP Enrollees with LTSS Needs

The Parties' subcontract shall require the CP to provide information and support to each CP Enrollee with LTSS needs, their guardians/caregivers and other family members, as applicable, about assisting the CP Enrollee to live independently in their community. The Parties subcontract shall require that:

1. Such information includes, but not be limited to:

a. Long-term services and supports;

b. Resources available to pay for the services;

c. The MassOptions program which can provide the CP Enrollee with options counseling.

2. The CP provide CP Enrollees support by:

a. Assisting with referrals and resources as needed;

b. Assisting in making decisions on supportive services, including but not limited to, finding assistance with personal care, household chores, or transportation;

c. Assisting, as appropriate, in connecting to a counselor at MassOptions; and

d. Informing the CP Enrollee about their options for specific LTSS services and programs for which they may be eligible, the differences among the specific types of LTSS services and programs and the available providers that may meet the CP Enrollee's identified LTSS needs.

3. In performing this function, the CP shall document that the CP Enrollee was informed of multiple service options available to meet their needs, as appropriate, and reviewed and provided with access to a list of all MassHealth LTSS providers in their geographic area for each service option, when applicable.

J. Community Collaboration and Coordination

In support of its provision of CP Supports, the CP shall:

1. For BH CPs only, develop and maintain collaborative relationships with all Community Behavioral Health Centers (CBHCs) within its Service Area(s) to facilitate integration among CP Enrollees' Care Coordination entities and clinical providers, including developing document processes that outline the responsibilities and requirements of the CBHC and the Contractor. If the CP does not have a CBHC within its organizational structure, the CP shall hold formalized agreements (e.g., Memorandum of Understanding, Affiliation Agreement, or other formalized agreements) with all CBHCs in its Service Area(s) that include such documented processes. Such documented processes shall describe workflows and standard protocol for CP Enrollee release of information; protocols for communication and data and exchange via EHR or other platforms (e.g., fax, telephone, secure email); and intended processes for Event Notification Services via EHR or other platforms. Such documented processes shall require the CP to:

a. Refer CP Enrollees to CBHCs for services, as appropriate and as needed, after first considering CP Enrollee choice and preexisting clinical relationships, and strive to make direct introductions ("warm hand-offs") whenever possible;

b. Accept and act upon referrals from CBHCs;

c. For CP Enrollees receiving services from CBHCs, include CBHC staff in the CP Enrollee's Care Team;

d. Securely share CP Enrollee information with CBHCs and incorporate CP Enrollee information provided by CBHCs so as to reduce duplication of assessments. Such information shall include, but is not limited to, Comprehensive Assessments, Care Plans, CBHC comprehensive behavioral healthcare plans, outreach plans, transition plans, referrals that have been placed and the status of such referrals, and other CP Enrollee information, as needed and clinically appropriate; and

e. Notify the CBHC within 3 business days when the CP becomes aware that a CP Enrollee who is receiving services from the CBHC has experienced any of the following events:

(i) A transition of care as defined in **Section 2.4.C.5**;

(ii) An Emergency Department discharge;

(iii) A major change in behavioral health status (e.g., overdose or mental health crisis) or physical health status; or

(iv) Any other major incidents that may impact the CP Enrollee's health and wellbeing, including changes in health-related social needs (e.g.., eviction, job loss, food insecurity).

2. Coordinate with state agencies, including but not limited to, as applicable, the Executive Office of Elder Affairs (EOEA), the Department of Children and Families (DCF), the Department of Youth Services, the Department of Mental Health (DMH), the Department of Developmental Services (DDS), the Department of Public Health (DPH), the Massachusetts Rehabilitation Commission (MRC), the Massachusetts Commission for the Deaf and Hard of Hearing, and the Massachusetts Commission for the Blind;

3. Coordinate with community-based organizations in the CP's Service Area(s), and have knowledge of the services and specialties offered by the following specifically:

a. BH and LTSS providers in the CP's Service Area(s);

b. Social Service Organizations and Flexible Services providers in the CP's Service Area(s); and

c. Primary Care Providers and other specialists working with CP Enrollees.

Section 1.3 HEALTH EQUITY

The Parties' subcontract shall require the CP to collaborate with the Contractor on certain metrics and initiatives related to Health Equity, as described in **Section 2.12** of the Contract. Specifically, the Parties' subcontract shall:

A. Require the CP to collect and submit to the Contractor CP Enrollee-level social risk factor data (including race, ethnicity, language, disability status, age, sexual orientation, gender identity,

and health-related social needs) using a screening tool and/or questionnaire provided by the Contractor when requested by the Contractor; and

B. Require the CP to support the Contractor's Health Equity initiatives, including but not limited to development of the Contractor's Health Equity Strategic Plan and Report, when such initiatives would benefit from involvement of the CP.

Section 1.4 REPORTING

The Parties' subcontract shall:

A. Obligate the Contractor to:

1. Report to its CPs monthly on monthly panel-based payments made in a form and format specified by EOHHS;
2. Report to its CPs on quality payments made, on an annual basis, and in a form and format specified by EOHHS;
3. Provide its CPs monthly assignment files as further described by EOHHS in a form and format specified by EOHHS; and
4. Provide its CPs EOHHS renewal and redetermination files.

B. Obligate the CP to:

1. Provide to the Contractor monthly Enrollment and Disenrollment files in a format specified by EOHHS;
2. Provide the Contractor data related to Health Equity as set forth in **Section 1.3.A of this Appendix G**.
3. Provide other reports to the Contractor as identified and agreed upon by both Parties.

Section 1.5 INTEROPERABILITY, RECORD KEEPING, COMMUNICATION AND POINTS OF CONTACT

A. Interoperability and Record Keeping

The Parties subcontract shall include requirements for information and data sharing, including but not limited to record keeping and changes to CP Enrollee's enrollment or engagement in the CP as set forth in **Section 2.4.E.9**, and shall at a minimum:

1. Obligate the Parties to enter into and maintain an agreement governing the CP's use, disclosure, maintenance, creation or receipt of protected health information (PHI) and other personal or confidential information in connection with the subcontract that satisfies the requirements for a contract or other arrangement with a Business Associate under the Privacy and Security Rules, includes any terms and conditions required under a data use agreement between the Contractor and EOHHS and otherwise complies with any other privacy and security laws, regulations and legal obligations to which the Contractor is subject;
2. Include such agreement as an appendix to the subcontract;
3. Specify that no Party to the subcontract may obligate the other Party to use a specific Information Technology, Electronic Health Record system, or Care Management system;

4. Obligate both Parties to develop, maintain, and implement a mutually agreed processes for the exchange of CP Enrollee data between the Parties;

    a. Specify the elements included in such data exchange, which shall include at a minimum: CP Enrollee name; date of birth; MassHealth ID number; MassHealth Assignment Plan; CP Enrollee address and phone number; CP Enrollee Primary Language (if available); and PCP name, address, and phone number;

    b. Specify the frequency of such data exchange, which shall not be less than monthly;

    c. Specify the file type of such data exchange (e.g., Excel file or other mutually agreed upon file type);

    d. Specify the secure transmission method (e.g., secure email or the Mass HIway).

5. Obligate both Parties to develop and implement requirements around record keeping, including that:

    a. The CP shall maintain an information system for collecting, recording, storing and maintaining all data required under the Contract.

    b. The CP shall maintain a secure Electronic Health Record for each CP Enrollee that includes, but is not limited to, a record of:

        (i) All applicable Comprehensive Assessment and Care Plan elements, as described in **Sections 1.2.B** and **1.2.C** of this **Appendix G**;

        (ii) A timely update of communications with the CP Enrollee and any individual who has direct supportive contact with the CP Enrollee (e.g., family members, friends, service providers, specialists, guardians, and housemates), including, at a minimum:

            (a) Date of contact;

            (b) Mode of communication or contact;

            (c) Identification of the individual, if applicable;

            (d) The results of the contact; and

            (e) The initials or electronic signature of the Care Coordinator or other staff person making the entry.

        (iii) CP Enrollee demographic information.

    c. The CP shall ensure that all CP Enrollee Electronic Health Records are current and maintained in accordance with this Contract and any standards as may be established from time to time by EOHHS; and

d. The CP shall provide the Contractor with a copy of the CP Enrollees' Electronic Health Records within thirty (30) calendar days of a request.

6. Obligate both Parties to develop, maintain, and implement a mutually agreed upon process for changes to CP Enrollee enrollment or engagement with the CP, including:

   a. Specify the Contractor's process for processing requests from CP Enrollees to enroll in a different CP or disengage from the CP;

   b. Specify the process by which the Contractor, in consultation with the CP, will determine if CP supports are no longer necessary for a CP Enrollee; and

   c. Specify the form, format and frequency for communications between the Parties regarding changes to CP Enrollee enrollment or engagement and the processes for transitioning such CP Enrollee's care coordination.

7. The Parties' subcontract shall require that the CP maintain a record of Qualifying Activities performed for each CP Enrollee as further specified by EOHHS.

B. Communication and Points of Contact

The Parties' subcontract shall include requirements for communication and identification of points of contact, and shall at a minimum:

1. Obligate both Parties to establish key contact(s) who will be responsible for regular communication between the Parties about matters such as, but not limited to, data exchange, and care coordination, as described in **Section 2.4.E.11** of the Contract.
2. Obligate both Parties to provide the other Party information about key contact(s), including at a minimum the key contact's name, title, organizational affiliation, and contact information;
3. Obligate both Parties to provide each other with timely notification if such key contact(s) change; and
4. Obligate both Parties to develop, implement, and maintain a mutually agreed upon process for reporting of gross misconduct or critical incident involving a CP Enrollee to each other, as described in this **Appendix G**. The Parties' subcontract shall require the CP to develop, implement, maintain, and adhere to procedures to track, review, and report critical incidents. The procedures shall:

   a. Be jointly developed

   b. Require the CP to document critical incidents including:

      (i) Fatalities and near fatalities;

      (ii) Serious injuries;

      (iii) Medication-related events resulting in significant harm;

      (iv) Serious employee misconduct;

(v) Serious threats of harm to CP Enrollees, CP employees or others;

(vi) Require the CP to report critical incidents to the Contractor and the appropriate agencies and authorities;

c. Require the CP to designate key personnel to track, report and monitor critical incidents;

d. Require the CP to review critical incidents by committee which includes a Medical Director and Clinical Care Manager, at least quarterly; and

e. Require the CP to take proactive steps to modify processes to avoid future incidents.

Section 1.6 PERFORMANCE MANAGEMENT AND CONFLICT RESOLUTION

The Parties' subcontract shall include requirements for performance management and compliance as set forth in **Section 2.4.E.3** of the Contract, as well as for conflict resolution. The Parties' subcontract shall, at a minimum:

A. Include a mutually agreed upon process for continued management of the subcontract, including:

1. Specifying the frequency and format of regular meetings between the Parties for the purposes of discussing the Parties' compliance under the Parties' subcontract; and
2. Specifying the intended topics of discussion during such meetings, which may include topics such as, but not limited to, CP Enrollee outreach, engagement, cost, utilization, quality and performance measures, communication between the Parties, and CP Enrollee grievances.
3. Include a mutually agreed upon process for conflict resolution to address and resolve concerns or disagreements between the Parties which may arise, including but not limited to clinical, operational and financial disputes.
4. Outline a mutually agreed upon process for CP performance management that may include but is not limited to the following set of escalating steps: development and implementation of a performance improvement plan, development and implementation of a corrective action plan, non-compliance letter, and contract termination. Such process for performance management shall:

    a. Specify the areas in which the Contractor shall monitor CP performance and relevant data sources for such monitoring

    b. Specify the areas in which the Contractor shall engage in performance management of the CP, which must include: fidelity to CP Supports as outlined in the Parties' subcontract, critical incident reporting, grievances, record keeping, and other responsibilities or performance indicators outlined in the Parties' subcontract.

5. Obligate both Parties to develop processes relating to the types, frequency, and timeliness of bidirectional reports on performance, outcomes, and other metrics;

6. Obligate both Parties to establish a cadence for the Parties' leadership to engage on the output of such reports, in order to identify and jointly agree upon areas to improve CP Enrollee care and performance on financial, quality, and utilization goals, including specifications on who will be responsible for engaging with such reports.

Section 1.7 CP ENROLLEE PROTECTIONS

A. Grievances

The Parties' subcontract shall require that the CP develop, implement, maintain, and adhere to written policies and procedures for the receipt and timely resolution of Grievances from CP Enrollees. Such policies and procedures shall require the CPs to:

1. At least annually, the CP shall notify the Contractor of any grievances the CP received and the resolution of the grievance.

2. At least annually, the Contractor shall notify EOHHS of any grievances the CP or Contractor has received regarding the CP program and the resolution of the grievance.

B. Information and Accessibility Requirements

The Parties' subcontract shall require that:

1. With respect to any written information it provides to CP Enrollees, the CP make such information easily understood as follows:

    a. Make such information available in prevalent non-English languages specified by EOHHS;

    b. Make oral interpretation services available for all non-English languages, including American Sign Language, available free of charge to CP Enrollees and notify CP Enrollees of this service and how to access it; and

    c. Make such information available in alternative formats and in an appropriate manner that takes into consideration the special needs of CP Enrollees, such as visual impairment and limited reading proficiency, and notify CP Enrollees of such alternative formats and how to access those formats.

2. The CP ensures that CP Enrollee visits with Care Coordinators are conducted in a manner to accommodate a CP Enrollee's disability and language needs, including the use of safe and accessible meeting locations, language assistance (e.g., access to qualified interpreters), and auxiliary aids and services (e.g., documents that are accessible to individuals who are blind or have low vision).

C. CP Enrollee Rights

The Parties' subcontract shall require that the CP have written policies ensuring CP Enrollees are guaranteed the rights described in **Section 2.9.G.** of the Contract, and ensure that its employees, Affiliated Partners, and subcontractors observe and protect these rights. The CP

shall be required to inform CP Enrollees of these rights upon CP Enrollees' agreement to participate in the CP program.

Section 1.8 OMBUDSMAN

The Parties' subcontract shall require that the CP supports CP Enrollee access to, and work with, the EOHHS Ombudsman to address CP Enrollee requests for information, issues, or concerns related to the CP or ACO program, as described in **Section 2.9.G.2** of the Contract.

Section 1.9 TERMINATION

A. The Contractor's subcontract shall, at minimum:

1. Obligate both Parties, prior to termination of the subcontract by either Party, to:

    a. Follow all conflict resolution processes, as appropriate, described in this **Appendix G**;

        (i) Provided however that if both Parties agree to terminate the subcontract for reasons other than for-cause, the Parties may terminate the subcontract without following all conflict resolution processes described in this **Appendix G**;

    b. If EOHHS terminates the relevant contract with the Contractor or CP, termination of the subcontract may be made without following all conflict resolution processes described in this **Appendix G**; and

    c. If EOHHS notifies a Party to the subcontract, indicating that the other Party has materially breached its contract with EOHHS, in the sole determination of EOHHS, the first Party may terminate the subcontract without following all conflict resolution processes described in this **Appendix G**;

2. Specify that in the event of termination of the subcontract, the obligations of the Parties under the subcontract, with regard to each shared CP Enrollee at the time of such termination, will continue until the CP has provided a warm hand-off of the CP Enrollee to the Contractor, a new ACO or MCO, or a new CP, if applicable, and the transition of CP Enrollee data in accordance with the Parties' data policies, provided, however, that the Parties shall exercise best efforts to complete all transition activities within one month from the date of termination, expiration, or non-renewal of the subcontract.

APPENDIX H
Business Associate Data Management and Confidentiality Agreement

This Business Associate Data Management and Confidentiality Agreement (this "**Agreement**") is made by and between the Executive Office of Health and Human Services, Office of Medicaid ("**EOHHS**"), and the Contractor identified in **Appendix K** (the "**Contractor**"). EOHHS and the Contractor are sometimes referred to herein individually as a "**Party**" and together as the "**Parties**."

SECTION 1. BACKGROUND, SCOPE AND DEFINITIONS

Section 1.1 Background/Scope

In accordance with the Primary Care Accountable Care Organization Contract (the "Contract") , the Parties are amending the Contract and entering into this Agreement to establish certain privacy, security and related obligations of the Contractor with respect to PI (defined below), including substance use disorder data subject to 42 CFR Part 2, that the Contractor uses, maintains, discloses, receives, creates, transmits or otherwise obtains in connection with its provision of a certain service to, and/or its performance of a certain function or activity for or on behalf of, EOHHS under the Contract.

Section 1.2 Definitions

When used in this Agreement, the following capitalized terms shall have the meanings ascribed to them below:

"**Activities**" shall mean the activities, functions and/or services to be performed or provided by the Contractor for, on behalf of and/or to EOHHS under Sections 2.2.A.2, 2.4.B.5, and 2.4.C.1 of the Contract that requires PI with substance use disorder data governed under 42 CFR Part 2.

"**Applicable Law**" shall mean M.G.L. c. 66A, M.G.L. c. 93H, 801 CMR 3.00, 201 CMR 17, the Health Insurance Portability and Accountability Act (HIPAA) Rules (inclusive of 45 CFR Parts 160, 162, and 164), 42 CFR Part 431, Subpart F, 42 CFR Part 2, 45 CFR §155.260 and any other applicable federal or state law or regulation, each as pertaining to the use, disclosure, maintenance, privacy or security of PI.

"**Breach Notification Rule**" shall mean the Breach Notification Rule at 45 CFR Part 164, Subpart D.

"**Enforcement Rule**" shall mean the HIPAA Enforcement Rule at 45 CFR Part 160, Subparts C, D and E.

"**EOTSS**" shall mean the Massachusetts Executive Office of Technology Services and Security.

"**Event**" shall mean the following, either individually or collectively: 1) any use or disclosure of PI not permitted under this Agreement; 2) any Security Incident; or 3) any other event that would trigger notification obligations under the Breach Notification Rule, M.G.L. c. 93H or other similar Applicable Law requiring notice to consumers and/or oversight agencies in connection with an impermissible use or disclosure or breach of PI.

"**HIPAA Rules**" shall mean the Privacy Rule, the Security Rule, the Breach Notification Rule and the Enforcement Rule.

"**Individual**" shall mean the person to whom the PI refers and shall include a person or organization who qualifies as a personal representative in accord with 45 CFR § 164.502(g).

"**Privacy Rule**" shall mean the Standards of Privacy of Individually Identifiable Health Information at 45 CFR Part 160 and Part 164, Subparts A and E.

"**PI**" shall mean any Protected Health Information, any "personal data" as defined in M.G.L. c. 66A, any "patient identifying information" as used in 42 CFR Part 2, any "personally identifiable information" as used in 45 CFR §155.260, "personal information" as defined in M.GL. c. 93H, and Third Party Data (defined below in **Section 1.3.B**) and any other individually identifiable information that is treated as confidential under Applicable Law or agreement (including, for example, any state and federal tax return information) that the Contractor uses, maintains, discloses, receives, creates, transmits or otherwise obtains in connection with its performance of the Activities under this Agreement. Information, including aggregate information, is considered PI if it is not fully de-identified in accord with 45 CFR §§164.514(a)-(c).

"**Security Rule**" shall mean the Security Standards for the Protection of Electronic Protected Health Information at 45 CFR Part 160 and Part 164, Subparts A and C.

"**System**" shall mean any EOHHS system, database, application or other information technology resource.

When used in this Agreement, the following terms shall have the same meaning as those terms have in the HIPAA Rules: Business Associate, Limited Data Set, Minimum Necessary, Notice of Privacy Practices, Protected Health Information, Required by Law, Secretary, Security Incident and Workforce.

All other terms used in this Agreement but not otherwise defined herein or elsewhere in this Agreement shall be construed in a manner consistent with the HIPAA Rules, M.G.L. c. 66A and all other Applicable Laws.

Section 1.3 <u>Data Management and Confidentiality Obligations of the Contractor</u>

A. **Compliance with Applicable Laws.** The Contractor acknowledges that for the performance of Activities where such performance uses or contains any PI with substance use disorder data subject to 42 CFR Part 2 and/or PI flagged by EOHHS as data governed under this Agreement, the Contractor must comply with all Applicable Laws that may be in effect upon execution of, or as may be effective during the course of, this Agreement, including, but not limited to, the Privacy and Security Rules, 42 CFR 431, Subpart F, 42 CFR Part 2 and M.G.L. c. 66A in addition to all other applicable requirements. The Contractor shall implement appropriate safeguards for PI provided under this Agreement, including keeping PI under this Agreement separate and distinct from the member-level data or reports provided pursuant to the Data Use Agreement (DUA) referenced in Section 7 of the Contract. Without limiting the generality of the foregoing, the Contractor acknowledges and agrees as follows:

1. Obligations under M.G.L. c. 66A. The Contractor acknowledges that in performing the Activities it will create, receive, use, disclose, maintain, transmit or otherwise obtain "personal data" (as defined in M.G.L. c. 66A) and that, in so doing, it will become a "holder" of such data for purposes of M.G.L. c. 66A. The Contractor agrees that in performing the Activities and otherwise complying with this Section it shall, in a manner consistent with the Privacy and Security Rules and other Applicable Laws, comply with M.G.L. c. 66A.

2. Business Associate. In performing the Activities, the Contractor acknowledges and agrees that it is acting as EOHHS' Business Associate and agrees to comply with all requirements of the HIPAA Rules applicable to a Business Associate. To the extent that the Contractor is to carry out an obligation of EOHHS under the Privacy Rule pursuant to this Agreement, the Contractor agrees that it shall comply with the requirements of such Rule that apply to the Contractor as EOHHS's Business Associate in the performance of such obligation.

3. 42 CFR Part 2. The Contractor agrees that with respect to drug or alcohol abuse information that the Contractor receives, stores, processes, uses, creates or transmits that was obtained by EOHHS or a Part 2 Program (as such terms are used in 42 CFR Part 2), it is bound by 42 CFR Part 2 , and shall not use or disclose such information except as permitted under 42 CFR §2.33(b), including, but not limited to, the use of such information for the purposes of Treatment (as defined by 42 CFR Part 2). Notwithstanding any changes to 42 CFR Part 2, or its authorizing statue, 42 U.S. Code § 290dd–2, the Contractor shall not modify its use of such drug or alcohol abuse information, including for the use of Treatment unless approved by the EOHHS Privacy Office in writing, or amendment to this Agreement.

4. Telephonic Laws. To the extent the Activities involve outreach to or other contact with consumers (including Individuals), such contact shall be compliant with all applicable federal and state laws and regulations, including the Telephonic Consumer Protection Act of 1991 (47 U.S.C. §227) and its attendant regulations. To the extent the Activities involve call recording activities, the Contractor shall comply with all federal and state wiretapping and recording laws and regulations, including M.G.L. c. 272 §99.

B. **Compliance with Third Party Agreements.** The Contractor agrees that it shall comply (and shall cause its employees and other workforce members to comply) with any other privacy and security obligation that is required as the result of EOHHS (or EOTSS or another third party, on EOHHS' behalf) having entered into an agreement (any such agreement, a "**Third Party Agreement**") with a third party (such as the Social Security Administration, the Department of Revenue or the Centers for Medicaid and Medicare Services) to obtain or to access PI from a third party (any such PI, "**Third Party Data**") or to access any System containing Third Party Data or through which Third Party Data could be accessed, including, by way of illustration and not limitation, signing a written compliance acknowledgment or confidentiality agreement, undergoing a background check or completing training. The Parties acknowledge and agree that Third Party Data includes, without limitation, all data that EOHHS receives or obtains from Massachusetts Department of Revenue, the Social Security Administration, the Internal Revenue Service, the Department of Homeland Security or through the Federal Data Services Hub and, notwithstanding anything herein to the contrary, the Contractor may not access any such Third Party Data unless disclosure of such data to the Contractor is permitted under the applicable Third Party Agreement(s), all conditions for disclosure under such Agreement(s) have been satisfied and the Contractor's access to such data is otherwise permitted under the terms of this Agreement. Notwithstanding the foregoing, the Contractor shall not be required to comply (or ensure compliance) with a Third Party Agreement under this paragraph unless it has been provided with a copy of the applicable Third Party Agreement or notified of its requirements.

C. **Tracking of PI Governed under this Agreement.** EOHHS shall track PI subject to this Agreement in Exhibit 1. The process for tracking shall be instituted for convenience of the Parties, and the Contractor acknowledges that the inclusion of PI in Exhibit 1 shall not be dispositive to determine the scope of PI subject to this Agreement. PI subject to this Agreement shall be determined by the terms and conditions in Section 1.3.A. Exhibit 1 shall be amended from time to time at the sole discretion of EOHHS and shall not be subject to the amendment process stated in Section 6.13 of the Contract. The Contractor may request a copy of Exhibit 1 at any time.

D. **Sanctions for Improper Access, Use or Disclosure of PI.** The Contractor acknowledges that PI subject to this Agreement is highly regulated and the Contractor and its subcontractors, agents, employees and other workforce members may be subject to civil and criminal penalties under state and federal law for accessing, using or disclosing PI in violation of this Agreement or Applicable Law.

E. **Requirements Applicable to Subcontractors, Agents, Employees and other Workforce Members.**

1. Generally. Access to PI must be limited to approved subcontractors, agents, employees and other workforce members who require access to such PI for purposes of carrying out the Activities. Subcontractors, agents, employees and other workforce members with access to PI must receive appropriate privacy and security training, must be informed of the confidential nature of PI, must agree to comply with limitations of this Agreement and other applicable terms required under the Contract and must be informed of the civil and criminal penalties for misuse or unauthorized disclosure of PI under Applicable Law. Without limiting the generality of the foregoing, all subcontractors, agents, employees and other workforce members with access to unencrypted PI or an encryption key used to secure such PI must sign the Confidentiality Acknowledgement attached hereto as **Exhibit 2** prior to being granted such access.
2. CORI Regulations. The Contractor shall, pursuant to and in accordance with 101 CMR 15.03(1)(B), require and consider the criminal history information pertaining to all employees and workforce members of the Contractor who will be given access or potential access to PI, and all applicants for employment with the Contractor where the position applied for entails access or potential access to PI. The Contractor shall otherwise comply with all applicable terms of 101 CMR 15.00 in connection with the review and consideration of employee and applicant criminal records.
3. Additional Requirements for Material Subcontractors and Agents.

    a. In the event that the Contractor intends to hire and disclose PI under this Agreement to a Material Subcontractor (as defined in the Contract), the Contractor shall hire such Material Subcontractor pursuant to Section 6.18 of the Contract. In the event the Contractor intends to hire and disclose PI under this Agreement to an agent, the Contractor shall notify EOHHS for specific approval of agents. The Contractor shall enter into written agreements memorializing the material requisite terms of this Agreement with each Material Subcontractor and approved agent that will have access to PI under this Agreement (each, a "Subcontract"), and shall maintain such written agreements.

    b. All such Subcontracts must contain all relevant provisions of this Agreement and the Contract (including the Commonwealth Terms and Conditions) related to the privacy and security of PI, and otherwise must be consistent with all such terms and conditions. Without limiting the generality of the foregoing, the Contractor shall ensure that any such Subcontract satisfies all applicable requirements under the Privacy and Security Rules for a contract or other

arrangement with a Business Associate.

c. The Contractor shall require that any Material Subcontractor or approved agent that needs access to Third Party Data or a System containing such Third Party Data or through which it may be accessed to comply (and to cause its employees and other workforce members to comply) with any privacy and/or security obligation that may be required under a Third Party Agreement. The Contractor shall require any such Material Subcontractor or approved agent to satisfy all such obligations prior to being granted access to the Third Party Data or System. The Contractor shall work with EOHHS to ensure that all such obligations are satisfied.

d. The Contractor is fully responsible for any Material Subcontractor's or approved agent's performance and for meeting all terms and requirements of this Agreement. The Contractor will not be relieved of any legal obligation under this Agreement, regardless of whether the Contractor subcontracts for performance of any Agreement responsibility or whether PI or other information was in the hands of a Material Subcontractor or approved agent.

F. **Data Security.**

1. Administrative, Physical and Technical Safeguards. As of the Contract effective date, 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 PI other than as provided for by this Agreement. All such safeguards must meet, at a minimum, and the Contractor shall otherwise comply with, all standards set forth in the Contract, Privacy and Security Rules, as applicable to a Business Associate, and all applicable EOHHS, EOTSS and other Commonwealth security and information technology resource policies, processes and mechanisms, including the EOHHS Acceptable Use Policy (found online at www.mass.gov), the EOTSS Enterprise Information Security Policies and Standards, and any standards contained in any applicable Third Party Agreement (collectively, the "**Standards**"). The Contractor shall comply with any new or updated standards issued by federal, state, or other issuing agency or entity.

   When accessing any System to perform the Activities, the Contractor shall comply with all applicable EOHHS, EOTSS and other Commonwealth security and information technology resource policies, processes and mechanisms regarding access to PI, and any specific security mechanisms and processes adopted by EOHHS for access to the System each to the extent made known by EOHHS in writing to the Contractor. The Contractor shall protect from inappropriate use or disclosure any password, user ID or other mechanism or code permitting access to any System containing PI or through which PI may be accessed. The Contractor shall give EOHHS prior notice of any change in personnel whenever the change requires a termination or modification of any such password, user ID or other security mechanism or code, to maintain the integrity of the System.

   The Contractor shall notify EOHHS of any change in its administrative, technical, or operational environments that compromise or otherwise impact the confidentiality, integrity, or availability of PI or any changes to the Contractor's information controls which alters its conformance with the Standards.

   Upon reasonable advance written notice, the Contractor agrees to allow representatives of EOHHS or, with respect to Third Party Data, other data owners, access to the Contractor's premises where PI is stored for the purpose of inspecting privacy and physical security arrangements implemented

by the Contractor to protect such PI, compliance with Applicable Law, or compliance with Federal grant requirements made known by EOHHS in writing to the Contractor.

2. Periodic Review. The Contractor shall monitor, periodically assess, and update its security controls and related system risks to ensure the continued effectiveness of those controls.

3. Written Information Security Program. The Contractor shall ensure that it maintains a written information security Program (WISP) incompliance with the terms of this Agreement and the requirements set forth in, M.G.L. c. 93H, to the extent that the PI subject to this Agreement meets the definition of "Personal Information", as such term is defined by such statute.

G. **Obligations upon a Non-Permitted Use or Disclosure of PI or Other Event.**

1. Mitigation and Other Activities. Immediately upon becoming aware of an Event, the Contractor shall take all reasonable and appropriate action necessary to: a) retrieve, to the extent practicable, any PI involved in the Event; b) mitigate, to the extent practicable, any harmful effect of the Event known to the Contractor; c) take such other action(s) as may be required in connection with the Event to comply with any Applicable Law.

   Upon becoming aware of an Event, the Contractor shall also perform a root cause analysis, prepare a corrective action plan, and, in accordance with terms and deadlines of subsection 2 below, shall deliver a resolution report to EOHHS including root cause, and actions taken to resolve the Event and prevent its recurrence. If an Event is the result of a data security vulnerability, such as hacking, ransomware, or other data security related instance, the Contract shall provide a written forensics report to EOHHS that shall, at a minimum, describe the attack, security vulnerabilities, and any other information EOHHS deems necessary to determine compliance with this Agreement. Such report shall not be withheld by the Contractor.

   Upon request, the Contractor shall take such further actions as EOHHS may reasonably request or shall take such reasonable additional action to assist EOHHS, to further mitigate any harmful effect of the Event. Any actions to mitigate harmful effects of such Event undertaken by the Contractor on its own initiative or pursuant to EOHHS' request shall not relieve the Contractor of its obligations to report such Event or otherwise comply with this **Section 1.3G,** any other provisions of this Agreement or the Contract or Applicable Law.

2. Notification and Reporting Activities. As soon as possible, but in any event no later than twenty-four (24) hours after Contractor becomes aware of the Event, the Contractor shall verbally report the Event to EOHHS Privacy Office with as much of the details listed below as possible, and shall follow such verbal report within three (3) business days with a written report outlining the Event with the following information to the extent known:

   a. The date of the Event or the estimated date (if date unknown);

   b. The date of the discovery of the Event;

   c. The nature of the Event, including a root cause analysis, containing as much specific detail as possible (e.g., cause, contributing factors, chronology of events);

   d. The nature of the PI involved in the Event (e.g., the types of identifiers and other information involved), together with samples of any forms or documents that were involved in the Event to illustrate the type of PI involved (with personal identifiers removed or redacted);

e. The exact number of individuals whose PI was involved in the Event if known or, if unknown, a reasonable estimate based on known facts (categorized according to the type of PI involved, if different types of PI was involved for different individuals), together with a description of how the number of individuals was determined;

f. A summary of the nature and scope of the Contractor's investigation into the Event;

g. 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 mitigation actions already taken;

h. A summary of steps taken to prevent such Event in the future, including copies of revised policies and procedures, changes in business processes and staff training; and

i. Any additional information and/or documentation that the Contractor is required to provide to EOHHS under 45 CFR §164.410, M.G.L. c. 93H, §3(a) or other similar Applicable Law in connection with the PI.

To the extent that any such information is not available at the time of the report, the Contractor shall provide such information to EOHHS as such information becomes available in one or more subsequent written reports. The Contractor shall provide EOHHS with such additional information regarding the Event as EOHHS may reasonably request, which additional information may include a written risk analysis rebutting any presumption that the Event constituted a breach for purposes of the Breach Notification Rule, if appropriate.

3. Obligations under Consumer Notification Laws. If EOHHS determines, in its sole discretion, that it is required to provide notifications to consumers or state or federal agencies under the Breach Notification Rule, M.G.L. c. 93H or other Applicable Law as a result of the Event, the Contractor shall, at EOHHS' request, assist EOHHS in drafting such notices for EOHHS' review and approval, and shall take such other action(s) as EOHHS may reasonably request in connection with EOHHS' compliance with the Breach Notification Rule, M.G.L. c. 93H or other Applicable Law, but in no event shall the Contractor have the authority to give any such notifications on EOHHS' behalf unless EOHHS authorizes and directs the Contractor to do so in writing. Additionally, at EOHHS' direction, if Contractor is defined as a "Person" under M.G.L. c. 93H, §1, Contractor shall provide credit monitoring services to affected Individuals to the extent required under M.G.L. c. 93H, §3A or other Applicable Law.

4. Reimbursement for Costs. The Contractor shall reimburse and indemnify, defend and hold harmless EOHHS for all costs incurred or sustained by EOHHS in responding to, and mitigating damages caused by, any Event or third party claims or causes of action brought or asserted against EOHHS involving: (a) the Contractor's failure to meet its responsibilities under, or in violation of, any provision of this Agreement or the Contract; (b) the Contractor's violation of Applicable Law; (c) the Contractor's negligence; (d) the Contractor's failure to protect PI under its control with encryption or other security measures that constitute an explicit safe-harbor or exception to any requirement to give notice under Applicable Law; or (e) any activity or omission of the Contractor resulting in or contributing to an Event. Such costs may include, for example and without limitation, losses, damages, liabilities, deficiencies, awards, penalties, fines, costs or expenses, including reasonable attorneys' fees and the costs associated with any notification required under subsection 3, above, including staffing and materials costs. Alternatively, at EOHHS' direction, in lieu of reimbursing EOHHS for such any such costs the Contractor shall, at Contractor's expense,

conduct any such notification or other mitigation related activity on EOHHS' behalf. For the avoidance of doubt, this provision shall apply in addition to any generally applicable indemnification provision applicable to the Contractor in connection with the Activities, including such terms in the Commonwealth Terms and Conditions.

H. **Response to Legal Process.** To the extent legally permissible, the Contractor shall report to EOHHS, both verbally and in writing, any instance where PI or any other data obtained in connection with this Agreement is subpoenaed or becomes the subject of a court or administrative order or other legal process (including a public records request under Massachusetts law). To the extent legally permissible, the Contractor shall provide such report to EOHHS as soon as feasible upon receiving or otherwise becoming aware of the legal process; *provided*, *that* the Contractor shall provide such report no later than five (5) business days prior to the applicable response date. In response to such legal process, and in accordance with instructions from EOHHS, the Contractor shall take all reasonable steps, including objecting to the request when appropriate, to comply with M.G.L. c. 66A § 2(k), 42 CFR § 431.306(f), 42 CFR Part 2 and any other Applicable Law. If EOHHS determines that it shall respond directly, the Contractor shall cooperate and assist EOHHS in its response.

I. **Individual's Privacy Rule Rights.** With respect to any relevant PI in the Contractor's possession, the Contractor shall take such action as may be requested by EOHHS to meet EOHHS' obligations under 45 CFR §§ 164.524, 164.526 or 164.528 or other Applicable Law pertaining to an Individual's right to access, amend or obtain an accounting of uses and/or disclosures of its PI, in sufficient time and manner for EOHHS to meet its obligations under such Privacy Rule provisions or other Applicable Law. If an Individual contacts the Contractor with respect to exercising any rights the Individual may have under 45 CFR §§ 164.524, 164.526 or 164.528 or similar Applicable Law with respect to PI in the Contractor's possession, the Contractor shall respond in accordance with Applicable Law. If an Individual contacts the Contractor with respect to exercising any rights the Individual may have under 45 CFR §§ 164.524, 164.526 or 164.528 or similar Applicable Law with respect to PI that is provided pursuant to the DUA referenced in **Section 7** of the Contract, the Contractor shall notify EOHHS' Privacy Officer within two (2) business days of the Individual's request and cooperate with EOHHS to meet any of its 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 and access to PI as would be necessary for the Contractor or EOHHS to respond to a request by an Individual for an accounting in accord with 45 CFR § 164.528. The Contractor shall also document uses and disclosures of PI and other data access activities to the extent required under M.G.L. c. 66A, § 2(f).

J. **Individual's Direct Authorization to Disclose PI to Third Party.** In the event 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, Contractor shall respond in accordance with Applicable Law. For any third party request for PI provided pursuant to the DUA referenced in **Section 7** of the Contract, within three business days of receipt of such consent, authorization, or other written document, notify EOHHS and shall cooperate with EOHHS in confirming the validity and sufficiency of such document before releasing any PI to the third party.

K. **Record Access.** The Contractor shall make its internal practices, books and records, including policies and procedures, relating to the protection, security, use and disclosure of PI obtained under this Agreement, and the security and integrity of Systems containing PI or through which it may be

accessed, available to EOHHS and the Secretary, in a time and manner designated by the requesting party, for purposes of enabling EOHHS to determine compliance with this Agreement or for purposes of enabling the Secretary to determine compliance with the HIPAA Rules.

L. **Compliance Officer.** The Contractor designates as its Compliance Officer, who shall be responsible for overseeing the Contractor's compliance with this Agreement. Such designations may be changed during the period of this Agreement only by written notice.

M. **Destruction of PI during Contract Term**. The Contractor shall retain PI during the course of the Contract in accordance with the terms of this Agreement and all applicable state and federal retention laws and regulations. If, in accordance with such requirements, Contractor determines that, during the course of the Contract, it is appropriate to destroy PI, it shall do so only after obtaining EOHHS' written permission. In the event destruction is permitted, Contractor shall destroy PI in accord with standards set forth in NIST Special Publication 800-88, Guidelines for Media Sanitization, M.G.L. c. 93I and other Applicable Laws relating to the destruction of confidential information, including PI, all applicable state and federal retention laws and regulations, and all state data security policies including policies issued by EOHHS and EOTSS made known to the Contractor. Within five (5) days of destroying PI in accordance with the requirements of this paragraph, Contractor shall provide EOHHS with a written certification that destruction has been completed in accord with the required standards set forth herein.

Section 1.4 <u>Permitted Uses and Disclosures of PI by the Contractor</u>

Except as otherwise limited in this Agreement, including in this **Section 1.4**, the Contractor may use or disclose PI only as follows:

A. **Activities.** The Contractor may use or disclose PI to perform the Activities or as otherwise required by, and in accordance with, the provisions of this Agreement; *provided*, *that* such use or disclosure would not: (a) violate the Privacy Rule or other Applicable Law if done by EOHHS; (b) violate the EOHHS' Minimum Necessary policies and procedures that are made known to the Contractor or that EOHHS advises the Contractor in writing; or (c) conflict with statements in the MassHealth Notice of Privacy Practices. When using or disclosing PI or when requesting PI from EOHHS or another party in performing the Activities, the Contractor represents that it shall make reasonable efforts to limit the amount of PI used, disclosed or requested to the minimum necessary to accomplish or perform the particular Activity for which the PI is being used, disclosed or requested.

B. **Required by Law.** The Contractor may use or disclose PI as Required by Law, consistent with the restrictions of the HIPAA Rules, 42 CFR Part 431, Subpart F, 42 CFR Part 2, M.G.L. c. 66A, any other Applicable Law or any applicable Third Party Agreement.

C. **Restriction on Contacting Individual.** The Contractor shall not use PI to contact or to attempt to contact an Individual unless such contact is a permitted Activity or made in accordance with EOHHS' written instructions.

D. **Publication Restriction.** The Contractor shall not use PI for any publication, statistical tabulation, research, report or similar purpose, regardless of whether or not the PI can be linked to a specific individual or has otherwise been de-identified in accord with the standards set forth in 45 CFR §164.514, unless the Contractor has obtained EOHHS' prior written consent. In no event shall any resulting publication, report or other material contain PI unless the publication, report or other

material is made available only to EOHHS or the Contractor has obtained the specific written approval of EOHHS' Privacy Officer.

Section 1.5 Data Management and Confidentiality Obligations of EOHHS

A. **Changes in Notice of Privacy Practices.** EOHHS shall notify the Contractor in writing of any change in the MassHealth Notice of Privacy Practices to the extent that such change may affect the Contractor's use or disclosure of PI under this Agreement and shall provide the Contractor with a new copy of the Notice of Privacy Practices reflecting such change.

B. **Notification of Changes in Authorizations to Use or Disclose PI.** EOHHS shall notify the Contractor in writing of any change in, or revocation of, permission by an Individual to use or disclose PI that is known to EOHHS, to the extent that such change may affect the Contractor's use or disclosure of PI under this Agreement.

C. **Notification of Restrictions.** EOHHS shall notify the Contractor in writing of any restriction to the use or disclosure of PI that EOHHS has agreed to in accord with 45 CFR §164.522, to the extent that such restriction may affect the Contractor's use or disclosure of PI under this Agreement.

D. **Requests to Use or Disclose PI.** EOHHS shall not request that the Contractor use or disclose PI in a manner that would violate the Privacy Rule or other Applicable Law if done by EOHHS.

Section 1.6 Effect of Termination

A. Except as provided in subsection B immediately below, upon termination of this Agreement for any reason whatsoever (including expiration), the Contractor shall, at EOHHS' direction, either return or destroy all PI, and the Contractor shall not retain any copies of such PI in any form. In no event shall the Contractor destroy any PI without first obtaining EOHHS' approval. In the event destruction is permitted, the Contractor shall destroy PI in accord with standards set forth in NIST Special Publication 800-88, Guidelines for Media Sanitization, all Applicable Laws and applicable retention laws and regulations and all data security policies including policies issued by EOHHS and EOTSS and made known to the Contractor. This provision shall apply to all PI in the possession of the Contractor's subcontractors, and the Contractor shall require that all such PI in the possession of its subcontractors and agents be returned or destroyed and that no subcontractor or agent shall be permitted to retain any copies of such PI in any form, in accord with EOHHS' instructions. The Contractor shall, within three (3) business days of the return or destruction of PI, certify to EOHHS in writing that all PI has been returned or destroyed in accordance with this **Section 1.6** and neither the Contractor nor any of its subcontractors or agents retains any PI.

B. If the Contractor determines that returning or destroying PI is not feasible, the Contractor shall provide EOHHS written notification of the conditions that make return or destruction not feasible. If, based on the Contractor's representations, EOHHS concurs that return or destruction is not feasible, the Contractor shall extend all protections pertaining to PI set forth in this Agreement to all such PI and shall limit further uses and disclosures of such PI to those purposes that make its return or destruction not feasible, for as long as the Contractor (or any of its subcontractors) maintains any PI.

Exhibit 1 – PI Tracker

Report	Information Contained in Report (Including Time Period Covered)	Report Frequency
1. SUD-related raw claims extract	The SUD-related raw claims extract includes information for members currently or formerly enrolled in the Contractor, as described below: • Current members are enrolled in the Contractor on the date the data is pulled from MassHealth's Data Warehouse or other MassHealth data source to inform the report. • Former members were enrolled in the Contractor at some point during the 24 months prior to the day the data is pulled from MassHealth's Data Warehouse or other MassHealth data source to inform the report. Member-level information is provided including SUD-related medical claims, SUD-related pharmacy claims, and SUD-related MBHP encounter data. Data fields show member identifying information (e.g. Medicaid ID, date of birth); member plan and provider affiliations including provider identification and tax identification numbers; claim identifiers, type, and source; dates of service; admission and discharge information; patient status; bill information; price information including billed, paid, and allowed amounts; diagnoses, accident diagnoses, and present on admission indicators; procedure and revenue codes; DRGs; information on billing and servicing providers including provider identification numbers and tax identification numbers; claim status; quantity; prescription information including therapeutic class, dispense as written indicator, dosage, days' supply, refill quantity NDC code, GCN, brand versus generic indicator, and route of administration; and prescriber information. Information is included for the 24 months prior to the day the data is pulled from MassHealth's Data Warehouse or other MassHealth data source to inform the report. For members currently enrolled in the Contractor, information will be included for any time span the member was enrolled in MassHealth over the 24-month period. For members formerly enrolled in the Contractor at the time the data is pulled to inform the report, member information is included only for spans when the member was enrolled in MassHealth and enrolled in the Contractor.	Monthly

Exhibit 2

ACKNOWLEDGMENT REGARDING CONFIDENTIALITY OF PROTECTED INFORMATION

I, the undersigned, understand that in the course of my work for _____, (name or organization) relating to a contract with the Executive Office of Health and Human Services (EOHHS), I may have access to protected information- ("PI")-including protected health information, other personally identifiable information or security information--either provided by EOHHS or created or obtained on its behalf.

I understand that PI is confidential and access to, use of and disclosure of PI is regulated by federal and state law including, without limitation, the privacy and security regulations promulgated under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and M.G.L. c. 66A, and the terms of the EOHHS contract.

I recognize that the unauthorized access, use or disclosure of PI may cause serious harm to individuals. Unauthorized access, use, or disclosure of PI may also violate the terms of the EOHHS contract and/or federal or state law, which may result in civil or criminal penalty including, without limitation, fines and imprisonment.

Acknowledged and agreed:

Protected Information User's name (printed or typed): _____

Protected Information User's Signature: _____

Date: _____

Contractor: _____

APPENDIX I
TCOC BENCHMARKS

[RESERVED]

APPENDIX J
SUB-CAPITATION PROGRAM RATES FOR PRIMARY CARE ENTITIES

[RESERVED]

APPENDIX K
Contractor Information

Contractor Legal Name: Community Care Cooperative, Inc.

Contractor ACO Partner Name (if applicable):

Contractor ACO Name (if applicable):

Contractor Principal Offices Address: 75 Federal Street, 7th Floor, Boston, MA 02110

Contractor Recipient of Written Notices:

Christina Severin
Community Care Cooperative, Inc.
75 Federal Street, 7th Floor
Boston, MA 02110