

MASSHEALTH ONE CARE

MODEL CONTRACT

FOR ONE CARE PLANS

BY AND BETWEEN

THE EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES

AND

[TBD]

[TBD, 2025]

DOCUMENT #: 23EHSKAONECARESCOPROCURE

BID #: BD-23-1039-EHS01-ASHWA-84773

This Contract is by and between the Massachusetts Executive Office of Health and Human Services (“EOHHS”) and [TBD] (the Contractor). The Contractor's principal place of business is: [TBD]

WHEREAS, EOHHS oversees 11 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 One Care Plans on November 30, 2023, to solicit responses from One Care Plans to provide comprehensive health care coverage to eligible 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 eligible MassHealth Members in accordance with the terms and conditions of this Contract and in compliance with all federal and State laws and regulations, 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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1 Definition of Terms

- 1.1. **1915(c) Waivers or Home and Community Based Services Waivers (HCBS Waivers)** – A federally approved program operated under Section 1915(c) of the Social Security Act that authorizes the U.S. Secretary of Health and Human Services to grant waivers of certain Medicaid statutory requirements so that a state may furnish home and community services to certain Medicaid beneficiaries who need a level of care that is provided in a hospital, nursing facility, or Intermediate Care Facility operated by the Department of Developmental Services (DDS).
- 1.2. **Abuse** - Actions or inactions by Providers (including the Contractor) and/or Members that are inconsistent with sound fiscal, business, or medical practices, and that result in unnecessary cost to the MassHealth program, including, but not limited to practices that result in MassHealth reimbursement for services that are not Medically Necessary, or that fail to meet professionally recognized standards for health care.
- 1.3. **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/chair, get around inside the home, and manage incontinence.
- 1.4. **Actual Non-Service Expenditures** — The Contractor's actual amount incurred for non-service expenditures, including both administrative and care management costs, for Enrollees during the applicable calendar year. These costs will exclude start-up costs, defined as costs incurred by the Contractor prior to the start of the contract. Any reinsurance costs reflected here will be net reinsurance costs.
- 1.5. **Actual Service Expenditures** — The Contractor's actual amount paid for Covered Services (as referenced in **Section 2.7** and defined in **Appendix C**) delivered. Actual Service Expenditures shall be priced at the Contractor fee level and should include all payments to providers for Covered Services, including pay-for-performance payments, risk-sharing arrangements, or sub-capitation payments.
- 1.6. **Adult Community Crisis Stabilization (Adult CCS)** – Adult CCS is a community-based program that serves a medically necessary, less-restrictive alternative to inpatient psychiatric hospitalization when clinically appropriate and provides twenty-four (24) hour, short-term, staff-secure, safe, and structured crisis stabilization, and treatment services for individuals eighteen (18) years of age and older with mental health and/or substance use disorders. Stabilization and treatment include the capacity to provide induction onto and bridging for medications for the treatment of opioid use disorder (MOUD and withdrawal management for opioid use disorders (OUD) as clinically indicated. The Adult CCS program is an integrated part of the CBHC model.

- 1.7. **Adult Mobile Crisis Intervention (AMCI)** (formerly known as Emergency Services Program (ESP)) - AMCI provides adult community-based Behavioral Health crisis assessment, intervention, stabilization, and follow-up for up to three (3) days. AMCI services are available 24/7/365 and are co-located at the CBHC site. Services are provided as mobile responses to the client (including private residences), and provided via Telehealth to individuals aged 21 and older when requested by the Member or directed by the 24/7 BH Help Line and clinically appropriate. AMCIs operate Adult CCS programs with a preference for co-location of services. AMCI services must have capacity to accept adults voluntarily entering the facility via ambulance or law enforcement drop-off through an appropriate entrance.
- 1.8. **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.
- 1.9. **Adverse Action** – Any one of the following actions or inactions by the Contractor shall be considered an Adverse Action:
- 1.9.1. The failure to provide Covered Services in a timely manner in accordance with the accessibility standards in **Section 2.7**;
 - 1.9.2. The denial or limited authorization of a requested service, including the determination that a requested service is not a Covered Service;
 - 1.9.3. The reduction, suspension, or termination of a previously authorized service;
 - 1.9.4. The denial, in whole or in part, of payment for a service, where coverage of the requested service is at issue, provided that procedural denials for requested services do not constitute Adverse Actions, including but not limited to denials based on the following:
 - 1.9.4.1. Failure to follow prior authorization procedures;
 - 1.9.4.2. Failure to follow referral rules;
 - 1.9.4.3. Failure to file a timely claim;
 - 1.9.4.4. The failure to act within the timeframes in **Section 2.10.9.8** for making authorization decisions;
 - 1.9.4.5. The denial of an Enrollee's request to dispute a financial liability,
 - 1.9.4.6. The failure to act within the timeframes in **Section 2.13.4.4** for reviewing an Internal Appeal and issuing a decision; and

- 1.9.4.7. An adverse decision on an Integrated Organization Determination (as defined in 42 CFR § 422.561), to the extent not otherwise included in items (1)-(7).
- 1.10. **Aging Services Access Point (ASAP)** – An entity organized under Massachusetts General Law (M.G.L.) c.19A §-4B that contracts with the Executive Office of Elder Affairs to manage the Home Care Program in Massachusetts.
- 1.11. **Alternative Formats** – Formats for the provision of Enrollee information that enhance accessibility. Examples of Alternative Formats shall include, but not be limited to, Braille, large font, audio tape, video tape, American Sign Language video clips, and Enrollee Information read aloud to an Enrollee by an Enrollee services representative.
- 1.12. **Alternative Payment Methodologies** – 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 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.
- 1.13. **American Sign Language (ASL) Interpreters** – A specially trained professional whose job is to translate between people who do not share the same language or mode of communication. The purpose of providing an interpreter is to allow hearing, deaf, and hard of hearing individuals equal access to information and interactions.
- 1.14. **Appeal** – An Enrollee’s request for formal review of an Adverse Action of the Contractor in accordance with **Section 2.13**.
- 1.15. **Appeal Representative** – Any individual that the Contractor can document has been authorized by the Enrollee in writing to act on the Enrollee’s behalf with respect to all aspects of a Grievance or Appeal (whether internal or external). The Contractor shall allow an Enrollee to give a standing authorization to an Appeal Representative to act on behalf for all aspects of Grievances and Internal Appeals. The Enrollee must execute such a standing authorization in writing according to the Contractor’s procedures. The Enrollee may revoke such a standing authorization at any time.
- 1.16. **Appeals Coordinator** – A staff person designated by the Contractor to act as a liaison between the Contractor and the Board of Hearings.
- 1.17. **ASAM** – The American Society for Addiction Medicine, a professional society in the field of addiction medicine that sets standards, guidelines, and performance measures for the delivery of addiction treatment which includes

a continuum of five basic levels of care from Level 0.5 (early intervention) to Level 4.0 (medically managed intensive inpatient treatment). References to levels within the Contract with respect to Behavioral Health services are references to these ASAM levels.

- 1.18. **Authorized Representative** – A friend, family Member, relative, or other person chosen by a Member to help with some or all of the responsibilities of applying for or getting MassHealth benefits. This may include enrolling in and receiving services from a One Care Plan. An Authorized Representative may fill out an application or review form and other MassHealth eligibility forms, give MassHealth proof of information given on applications, review forms, and other MassHealth forms, reports changes in a Member's income, address, or other circumstances, and get copies of all MassHealth eligibility notices sent to the Member.
- 1.19. **Base Capitation Rate** – A fixed monthly fee paid prospectively by EOHHS to the Contractor for each Enrollee for all Covered Services actually and properly delivered to the Enrollees in accordance with and subject to the provisions of this Contract and all applicable federal and state laws, regulations, rules, billing instructions, and bulletins, as amended, prior to the application of any risk adjustment.
- 1.20. **Behavioral Health** – The promotion of emotional health, the prevention of mental illnesses and substance use disorders, and provision of treatments and services for mental and/or substance use disorders.
- 1.21. **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 for Behavioral Health crises.
- 1.22. **Behavioral Health Services** – Covered Services as set forth in detail in **Appendix C**, as applicable, of this Contract, that promote emotional health, prevent mental illnesses and substance use disorders, and treat mental health and/or substance use disorders.
- 1.23. **Benefit Coordination** – The function of coordinating benefit payments from other payers, for services delivered to an Enrollee, when such Enrollee is covered by another coverage source.
- 1.24. **Board of Hearings (BOH)** – The Board of Hearings within the EOHHS.
- 1.25. **BOH Appeal** – A written request to the BOH, made by an Enrollee or Appeal Representative to review the correctness of a Final Internal Appeal decision by the Contractor.

- 1.26. **Bureau of Special Investigations (BSI)** – A bureau within the Office of the State Auditor that is charged with the responsibility of investigating Member fraud within the Commonwealth’s public assistance programs, principally those administered by the Department of Transitional Assistance (DTA) and the EOHHS Office of Medicaid.
- 1.27. **Care Coordinator** – The Care Coordinator is an Enrollee’s primary partner to navigate the health plan, MassHealth, and Medicare complexities, a Care Coordinator serves as the primary point of contact for the Enrollee and the ICT, participates in the Enrollee’s Comprehensive Assessments, provides care planning and the coordination of services, and serves as an internal representative for Enrollee needs and preferences within the plan. A Clinical Care Manager may serve in the role of an Enrollee’s Care Coordinator when appropriate to meet the Enrollee’s needs. See **Section 2.6.1** for detailed requirements, qualifications, and responsibilities of a Care Coordinator.
- 1.28. **Centers for Medicare & Medicaid Services (CMS)** – The federal agency under the Department of Health and Human Services responsible for administering the Medicare and Medicaid programs under Titles XVIII and XIX of the Social Security Act.
- 1.29. **Centralized Enrollee Record (CER)** – Centralized and comprehensive documentation, containing information relevant to maintaining and promoting each Enrollee's general health and well-being, as well as clinical information concerning illnesses and chronic medical conditions. See **Section 2.15.5.6** for more information about the contents of the Centralized Enrollee Record.
- 1.30. **Certified Mental Health Peer Specialist (CPS)** – A person who has been trained by an agency approved by the Department of Mental Health (DMH) who is a self-identified person with lived experience of a mental health disorder, recovery, and wellness that can effectively share their experiences and serve as a mentor, advocate, or facilitator for a Member experiencing a mental health disorder.
- 1.31. **Chronic Homelessness** – A definition established by the U.S. Department of Housing and Urban Development (HUD) of a disabled individual who has been continuously homeless on the streets or in an emergency shelter or safe haven for twelve (12) months or longer, or has had four or more episodes of homelessness (on the streets, or in an emergency shelter, or safe haven) over a three (3) year period where the combined occasions must total at least twelve (12) months (occasions must be separated by a break of at least seven nights, stays in institution of fewer than ninety (90) days do not constitute a break). To meet the disabled part of the definition, the individual must have a diagnosable substance use disorder, serious and persistent mental illness, developmental disability, post-traumatic stress disorder, cognitive impairment resulting from a brain injury, or chronic physical illness, or disability, including the co-occurrence of two or more of those conditions.

- 1.32. **Claim** – A Provider’s bill for services, performed per Enrollee, by line item, including but not limited to services performed, units of service, and billing charges.
- 1.33. **Claim Attachment** – A supplemental document submitted in conjunction with a Claim that provides additional information that concurs with the services billed.
- 1.34. **Clean Claim** – A Claim that can be processed without obtaining additional information from the provider of the service or from a third party, with or without Claim Attachment(s). It may include a Claim with errors originating from the Contractor’s claims system. It may not include a Claim from a Provider who is under investigation for fraud or abuse, or a Claim under review for Medical Necessity.
- 1.35. **Clinical Care Management** – A set of activities and services provided by a Clinical Care Manager that comprise intensive monitoring, follow-up, care coordination, and clinical management of individuals with Complex Care Needs.
- 1.36. **Clinical Criteria** – Criteria used to determine the most clinically appropriate and necessary level of care (LOC) and intensity of services to ensure the provision of Medically Necessary Services.
- 1.37. **Clinical Care Manager** – A licensed registered nurse or other independently licensed behavioral health clinician (i.e., social worker, mental health counselor, alcohol or drug counselor, etc.), employed by the Contractor or Enrollee’s PCP and licensed to provide clinical care management, including intensive monitoring, follow-up, and care coordination, clinical management of Enrollees with Complex Care Needs, as further specified by EOHHS. A Clinical Care Manager may serve as an Enrollee’s Care Coordinator when the Enrollee requires or would benefit from Care Coordination from an individual with advanced or specialized expertise.
- 1.38. **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. CBHC services for adults are collectively referred to as the “adult component.” CBHCs include an Adult Mobile Crisis Intervention (AMCI) and Adult Crisis Stabilization (Adult CCS).
- 1.39. **Community Health Workers (CHWs)** – Public health workers who apply their unique understanding of the experience, language and/or culture of the populations they serve in order to carry out one or more of the following roles:

- Providing culturally appropriate health education, information, and outreach in community-based settings, such as homes, schools, clinics, shelters, local businesses and community centers;
- Bridging and/or culturally mediating between Enrollees, communities, and health and human services, including actively building individual and community capacity;
- Assisting Enrollees to access the services and community resources they need;
- Providing direct services, such as informal counseling, social support, care coordination and health screenings;
- Advocating for individual and community needs; and
- Assisting Enrollees to engage in wellness activities as well as chronic disease self- management.

CHWs are distinct from other health professionals because they are hired primarily for their understanding of the populations and communities they serve, spend a significant portion of time conducting outreach in the categories above, and have experience providing services in community settings. The Massachusetts Department of Public Health (DPH) has established criteria and training for individuals to become Certified Community Health Workers.

1.40. **Complex Care Need** – Enrollees with Complex Care Needs are minimally those individuals who meet any of the criteria below, the Contractor shall not limit such designation by an Enrollee’s assignment to a Rating Category:

- 1.40.1. Have LTSS and BH co-occurring conditions/needs, or needs in two (2) or more domains (i.e. physical, BH, functional, cognitive, and social),
- 1.40.2. Are in a Very High Needs Community Rating Category (C2B and C3B),
- 1.40.3. Have co-morbidities,
- 1.40.4. Have complex or high-risk presentations of a condition, functional limitation, or disease,
- 1.40.5. Have rare diseases that require additional specialized Care Coordination, or
- 1.40.6. Require highly individualized approaches to care and/or intense care management to prevent complications or increased severity of symptoms or conditions.

- 1.41. **Comprehensive Assessment** – A person-centered process used by the Contractor during at least one in-person meeting to document an Enrollee’s care needs, functional needs, accessibility needs, goals, and other characteristics, as described in **Section 2.5** of this contract.
- 1.42. **Consumer** – An Enrollee or Potential Enrollee, or the spouse, sibling, child, or unpaid primary caregiver of an Enrollee or Potential Enrollee.
- 1.43. **Continuing Services**– Covered Services that were previously authorized by the Contractor and are the subject of an internal Appeal or Board of Hearings (BOH) Appeal, if applicable, involving a decision by the Contractor to terminate, suspend, or reduce the previous authorization and which are provided by the Contractor pending the resolution of the internal Appeal or BOH Appeal, if applicable. In the event of the adverse integrated organization determination, the Enrollee must request to continue services (also referred to as continuation of benefits per §422.632) for the previously approved Medicare and/or Medicaid benefit(s) that the plan is terminating, suspending, or reducing.
- 1.44. **Contract** – The Contract between EOHHS and the Contractor awarded pursuant to EOHHS’ Request for Response (RFR).
- 1.45. **Contract Effective Date** – The date on which a Contract resulting from this procurement is effective, which may be as early as the date of Contract execution.
- 1.46. **Contract Management Team** – A group of EOHHS representatives responsible for overseeing the contract management functions outlined in **Section 2.3** of the Contract.
- 1.47. **Contract Operational Start Date** – The date on which a Contractor first provides Covered Services through a One Care Plan, which shall be January 1, 2026.
- 1.48. **Contract Year (CY)** – A twelve-month period commencing January 1, and ending December 31, unless otherwise specified by EOHHS.
- 1.49. **Contractor** – Any entity that enters into an agreement with EOHHS for the provision of services described in the Contract.
- 1.50. **Covered Services** – Those services referenced in **Section 2.7** of the contract and defined in **Appendix C**. For the avoidance of doubt, Covered Services shall not include any items or services for which payment is prohibited pursuant to 42 U.S.C. § 1396b(i)(16) and 42 U.S.C. § 1396b(i)(17).
- 1.51. **Critical Incident** - Any sudden or progressive development (event) that requires immediate attention and decisive action to prevent or minimize any

negative impact on the health and welfare of one or more MassHealth Members. Critical incidents may include but are not limited to:

- 1.51.1. Serious physical injury, including a self-inflicted injury and injuries where the cause or origin is unknown and where the Member requires medical treatment beyond basic first aid,
 - 1.51.2. Any serious communicable disease that is required to be reported to health authorities pursuant to state and/or local ordinances,
 - 1.51.3. Natural disaster such as fire, serious flooding, or incidents causing displacement,
 - 1.51.4. Exposure to hazardous material (including blood-borne pathogens),
 - 1.51.5. Medication error (requiring medical intervention),
 - 1.51.6. Mistreatment or allegation of mistreatment of a Member including abuse, neglect, emotional harm, sexual or financial exploitation, or any other mistreatment, whether perpetrated by staff, family Member, other caregiver, or Member to Member,
 - 1.51.7. Person missing from scheduled care,
 - 1.51.8. Significant property damage to the provider's premises,
 - 1.51.9. Suspected or alleged criminal activity occurring while the provider is providing care, and
 - 1.51.10. Death of a Member from non-natural cause, including by suicide, homicide, suspected drug overdose, or any other unexpected cause for death.
- 1.52. **Cultural and Linguistic Competence** – Competence, understanding, and awareness with respect to Culturally and Linguistically Appropriate Services.
- 1.53. **Cultural Competence** – Understanding those values, beliefs, and needs that are associated with an Enrollee's age, gender, gender identity, sexual orientation, or with their racial, ethnic, or religious background. Cultural Competence also includes a set of competencies which are required to ensure appropriate, culturally sensitive health care to persons with congenital or acquired disabilities.
- 1.54. **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>

- 1.55. **Deemed Eligibility** – The determination to continue to provide care for an individual who no longer meets the State eligibility criteria for enrollment into a One Care Plan, as long as the individual can reasonably be expected to regain One Care eligibility in accordance with the State criteria within a specified period of time.
- 1.56. **Default Enrollment** – An enrollment process that allows a Medicare Advantage (MA) organization, following approval by the state and CMS, to enroll – unless the Member chooses otherwise – a Member of an affiliated MassHealth health plan into its Medicare Dual Eligible Special Needs Plan (D-SNP) when that Member becomes newly eligible for Medicare. This process is only permissible in circumstances where the Member enrolls with the One Care plan offered by their MassHealth health plan upon receiving Medicare eligibility. The only default enrollment effective date possible is the date an individual is initially eligible for Medicare (i.e., when an individual has both Medicare Part A and Part B for the first time).
- 1.57. **Department of Mental Health (DMH) Community-based Services** – DMH non-acute mental health care services provided to DMH clients, such as ACCS, community aftercare, housing and support services, and non-acute residential services.
- 1.58. **Disability Culture** – A set of artifacts, beliefs, and expressions created by individuals with disabilities to describe their own life experiences from a social, political and personal dynamic. Disability Culture emphasizes and supports the human ideals of equality, self-direction and opportunity, and arises from a unified struggle for civil rights, personal independence and cultural respect. Disability Culture is continually evolving as it incorporates the distinct history and contemporary experience of “difference” that includes attributes such as race, ethnicity, gender, gender identity, age, and sexual orientation.
- 1.59. **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.
- 1.60. **Dual Eligible** – An adult between the ages of 21 to 64 at the time of enrollment, who is eligible for and enrolled in Medicare Parts A and B and eligible for and enrolled in MassHealth Standard or CommonHealth coverage. This includes Qualified Medicare Beneficiaries with full Medicaid (QMB Plus)

and Low-Income Medicare Beneficiaries with full Medicaid (SLMB Plus) aged 65 or older and with MassHealth Standard coverage.

- 1.61. **Effective Enrollment Date** – The first calendar day of the month following the receipt of Enrollee’s enrollment into a One Care Plan.
- 1.62. **Eligible Individual** – Persons aged 21 to 64 at the time of enrollment who are enrolled in Medicare Parts A and B and eligible for and receiving MassHealth Standard or CommonHealth and no other comprehensive private or public health coverage.
- 1.63. **Eligibility Redetermination** – The process by which MassHealth Members must complete certain forms and provide certain verifications in order to establish continued MassHealth eligibility. This process may be required annually, or in response to certain changes in the Member’s circumstances.
- 1.64. **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.
- 1.65. **Emergency Medical Condition** – A medical condition, whether physical or mental, that manifests itself by acute symptoms of sufficient severity, including severe pain, that, in the absence of prompt medical attention, could reasonably be expected by a prudent layperson, who possesses an average knowledge of health and medicine, to result in: one (1) placing the health of the individual (or with respect to a pregnant individual, the health of the pregnant individual or their unborn child) in serious jeopardy, two (2) serious impairment to bodily functions, or three (3) serious dysfunction of any bodily organ or part.
- 1.66. **Emergency Services** – Covered 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 42 C.F.R. §438.206©(1)(iii) and that are needed to evaluate or stabilize an Enrollee’s Emergency Medical Condition.
- 1.67. **Encounter Data** – A dataset provided by the Contractor that records every service provided to an Enrollee. This dataset shall be developed in the format specified by EOHHS and shall be updated electronically according to protocols and timetables established by EOHHS in accordance with **Appendix H**.
- 1.68. **Enrollee** – A Member enrolled in the Contractor’s Plan. A Member shall be considered an Enrollee beginning on the Effective Date of Enrollment in the Contractor’s Plan, including retroactive enrollment periods. A Member shall not be considered an Enrollee during any period following the Effective Date of Disenrollment from the Contractor’s Plan, including retroactive

disenrollment periods. An Enrollee also includes an individual who remains enrolled during a deeming period.

- 1.69. **Enrollee Communications** – Materials designed to communicate plan benefits, policies, processes and/or Enrollee rights to Enrollees. This includes pre-enrollment, post-enrollment, and operational materials.
- 1.70. **Enrollee Information** – Information about the Contractor for Enrollees that includes, but is not limited to, a Provider directory that meets the requirements of **Section 2.8.7**, and an Enrollee handbook that meets the requirements of **Section 2.12.5**, and an identification card.
- 1.71. **Enrollee Service Representative (ESR)** – An employee of the Contractor who assists Enrollees with questions and concerns.
- 1.72. **Executive Office of Health and Human Services (EOHHS)** – The single State agency that is responsible for the administration of the MassHealth program, pursuant to M.G.L. c. 118E, Titles XIX and XXI of the Social Security Act and other applicable laws and waivers.
- 1.73. **Federally-Qualified Health Center (FQHC)** – An entity that has been determined by CMS to satisfy the criteria set forth in 42 U.S.C. § 1396d (l)(2)(B).
- 1.74. **Fee-For-Service (FFS)** – A method of paying an established fee for a unit of health care service.
- 1.75. **Fiscal Intermediary** – An entity operating as a Fiscal Employer Agent (F/EA) under Section 3504 of IRS code, Revenue Procedure 70-6, and as modified by IRS Proposed Notice 2003-70 and contracting with EOHHS to perform Employer-Required Tasks and related Administrative Tasks connected to Self-directed PCA Services on behalf of Enrollees who chose Self-directed PCA Services including, but not limited to, issuing PCA checks and managing employer-required responsibilities such as purchasing workers' compensation insurance, and withholding, filing and paying required taxes.
- 1.76. **Flexible Benefits** - Items or services other than – or beyond the amount, duration, and scope of – Covered Services (defined in **Section 1** and listed in **Appendix C**). The Contractor may use the capitated payment to fund such items or services as specified in the Enrollee's Individualized Care Plan and appropriate to address the Enrollee's needs.
- 1.77. **Fraud** – An intentional deception or misrepresentation made by a person or corporation with the knowledge that the deception could result in some unauthorized benefit under the MassHealth program to the person, the corporation, or some other person or entity. It also includes any act that constitutes fraud under applicable federal or state health care fraud laws. Examples of provider fraud include improper coding, billing for services never

rendered, inflating bills for services and/or goods provided, and providers who engage in a pattern of providing and/or billing for medically unnecessary services. Examples of Enrollee fraud include improperly obtaining prescriptions for controlled substances and card sharing.

- 1.78. **Fully Integrated Dual Eligible Special Needs Plan (FIDE SNP)** – A managed care plan defined at 42 CFR 422.2 as a dual eligible special needs plan that:
- 1.78.1. Provides dual eligible individuals access to Medicare and Medicaid benefits under a single entity that holds both a Medicare Advantage contract with CMS and a Medicaid managed care organization contract under Section 1903(m) of the Act with the applicable State;
 - 1.78.2. Whose capitated contract with the State Medicaid agency provides coverage, consistent with State policy, of specified primary care, acute care, behavioral health, and Long-term Services and Supports, and provides coverage of nursing facility services for a period of at least 180 days during the plan year;
 - 1.78.3. That coordinates the delivery of covered Medicare and Medicaid services using aligned care management and specialty care network methods for high-risk beneficiaries; and
 - 1.78.4. That employs policies and procedures approved by CMS and the State to coordinate or integrate Enrollee communication materials, enrollment, communications, grievance and appeals, and quality improvement.
- 1.79. **Functional Status** – Measurement of the ability of individuals to perform Activities of Daily Living (ADLs) (for example, mobility, transfers, bathing, dressing, toileting, eating, and personal hygiene) and Instrumental Activities of Daily Living (IADLs) (for example, meal preparation, laundry, and grocery shopping).
- 1.80. **Gender-affirming Care** – A supportive form of healthcare consisting of an array of services that may include medical, surgical, mental health, and non-medical services for transgender and nonbinary people. Gender-affirming care is person-centered and treats individuals holistically, aligning their outward, physical traits with their gender identity.
- 1.81. **Grievance** – Any complaint or dispute, other than one that constitutes an Integrated Organization Determination, expressing dissatisfaction with any aspect of the Contractor or provider's operations, activities, or behavior, regardless of whether remedial action is requested.
- 1.81.1. A grievance may be submitted by an Enrollee or an Enrollee's Appeal Representative about any action or inaction by the Contractor other

than an Adverse Action. Possible subjects for Grievances include, but are not limited to, quality of care or services provided, aspects of interpersonal relationships such as rudeness of a Provider or employee of the Contractor, or failure to respect the Enrollee's rights regardless of whether remedial action is requested. Grievances include an Enrollee's right to dispute an extension of time proposed by the Contractor to make an authorization decision. For the purposes of this Contract grievances follow the rules of integrated grievances as defined in 42 CFR § 422.561. Grievance may also be referred to as complaint.

- 1.82. **Health Insurance Portability and Accountability Act of 1996 (HIPAA)** – Federal legislation (Pub. L. 104-191) enacted to improve the continuity of health insurance coverage in group and individual markets, combat waste, Fraud and Abuse in health insurance and health care delivery, simplify the administration of health insurance, and protect the confidentiality and security of individually identifiable health information
- 1.83. **Health Plan Management System (HPMS)** – A system that supports contract management for Medicare health plans and prescription drug plans and supports data and information exchanges between CMS and health plans. Current and prospective Medicare health plans submit applications, information about Provider Networks, plan benefit packages, formularies, and other information via HPMS.
- 1.84. **Healthcare Effectiveness Data and Information Set (HEDIS)** – A standardized set of health plan performance measures developed by the National Committee for Quality Assurance (NCQA) and utilized by EOHHS and other purchasers and insurers.
- 1.85. **Independent Living Center (ILC)** – A Consumer-controlled, community-based, cross-disability, nonresidential private nonprofit agency that is designed and operated within a local community by individuals with disabilities, and provides an array of independent living services. ILCs promote a philosophy of independent living, including a philosophy of Consumer control, peer support, self-help, self-determination, equal access, and individual and system advocacy.
- 1.86. **Independent Living Principles** – A philosophy predominant in Disability Culture which advocates for the availability of a wide range of services and options for maximizing self-reliance and self-determination in all of life's activities.
- 1.87. **Indian Enrollee** – An individual who is an Indian (as defined in Section 4.2.8 of the Indian Health Care Improvement Act of 1976 (25 U.S.C. 1603(c)) and is enrolled in the Contractor's One Care Plan.

- 1.88. **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.
- 1.89. **Individualized Care Plan (ICP)** – The plan of care developed by an Enrollee and an Enrollee’s Interdisciplinary Care Team. The plan of care outlines the scope, frequency, type, amount, and duration, of all Covered Services to be provided by the Contractor to the Enrollee as described in **Section 2.7** of this Contract.
- 1.90. **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.
- 1.91. **Interdisciplinary Care Team (ICT)** – A team consisting of at least the Enrollee, their PCP, a Behavioral Health clinician, if indicated, a Care Coordinator/Clinical Care Manager, an LTS Coordinator, and other individuals at the discretion of the Enrollee. The team is responsible for working with the Enrollee to develop, implement, and maintain their Individualized Care Plan (“care plan”).
- 1.92. **Justice Involvement** – Enrollees with Justice Involvement shall be those individuals released from a correctional institution within one (1) year, or who are under the supervision of the Massachusetts Probation Service or the Massachusetts Parole Board.
- 1.93. **Key Personnel** – Staff within the Contractor’s organization accountable for significant areas of the organization, or who have responsibility for the implementation and operation of major programmatic and administrative functions.
- 1.94. **Long-term Services and Supports (LTSS)** – A wide variety of services and supports that help people with disabilities 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.
- 1.95. **Long-term Supports (LTS) Coordinator** – An individual employed by a community-based organization (CBO) contracted by a Contractor to ensure that an independent resource is assigned to and available to the Enrollee to perform the responsibilities in **Section 2.7**, including assisting with the coordination of the Enrollee’s LTSS needs, community-based Behavioral

Health Needs, and providing expertise on community supports to the Enrollee and the Enrollee's care team.

- 1.96. **Marketing, Outreach, and Enrollee Communications** – Marketing, including the use of promotional materials, produced in any medium, targeted to potential Enrollees to promote the Contractor's program and the use of notification forms and materials to communicate with current Enrollees.
- 1.97. **MassHealth** – The Massachusetts Medicaid Program, the medical assistance and benefit programs administered by the Executive Office of Health and Human Services pursuant to Title XIX of the Social Security Act (42 USC 1396), M.G.L. c. 118E, and other applicable laws and regulations (Medicaid).
- 1.98. **MassHealth CommonHealth** – MassHealth coverage type as specified at 130 CMR 505.004 that offers health benefits to certain working and non-working disabled adults, including those over the age of twenty-one (21).
- 1.99. **MassHealth Standard** – MassHealth coverage type that offers a full range of health benefits to certain Eligible Individuals, including families, pregnant individuals, individuals with disabilities under age 65, and individuals aged 65 and older. For purposes of this Contract, MassHealth Standard Members means individuals aged 21 and older.
- 1.100. **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 Administrative Services for any program area or function that relates to the delivery or payment of Covered Services or Flexible Services including, but not limited to, behavioral health, claims processing, Care Management, Utilization Management or pharmacy benefits, including specialty pharmacy providers. Contracts with Material Subcontractors shall be referred to as Material Subcontracts. Material Subcontracts are distinct from Provider Contracts.
- 1.101. **Medicaid** – The program of medical assistance benefits under Title XIX of the Social Security Act.
- 1.102. **Medicaid Fraud Division (MFD)** – A division of the Massachusetts Office of the Attorney General that is dedicated to investigating cases of suspected Fraud or Abuse.
- 1.103. **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.
- 1.104. **Medicaid Waiver** – Generally, a waiver of existing law authorized under Section 1115(a), or 1915 of the Social Security Act.

1.105. **Medically Necessary or Medical Necessity** – Services shall be provided consistent with all Enrollee protections and benefits provided by Medicare and MassHealth, and that provide the Enrollee with coverage to at least the same extent, and with the cumulative effect, as provided by the combination of Medicare and MassHealth.

1.105.1.1. Per Medicare, Medically Necessary Services are those that are reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body Member, or otherwise medically necessary under 42 U.S.C. § 1395y.

1.105.1.2. In accordance with Medicaid law and regulations, services shall be provided in accordance with MassHealth regulations, including in accordance with 130 CMR 450.204. Medically Necessary services are those services:

1.105.1.2.1. That 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

1.105.1.2.2. 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.

1.105.1.2.3. Medically Necessary services shall be of a quality that meets professionally recognized standards of health care and shall be substantiated by records including evidence of such medical necessity and quality.

1.105.1.3. In addition, a service is Medically Necessary when:

1.105.1.3.1. It may attain, maintain, regain, improve, extend, or expand the Enrollee's health, function, functional capacity, overall capacity, or otherwise support the Enrollee's ability to do so, or

1.105.1.3.2. A delay, inaction, or a reduction in amount, duration, or scope, or type or frequency of a service may jeopardize the Enrollee's health, life, function, functional capacity, or overall capacity to maintain or improve health or function.

1.106. **Medicare** – Title XVIII of the Social Security Act, the federal health insurance program for people aged 65 or older, people under 65 with certain disabilities, and people with End Stage Renal Disease (ESRD) or Amyotrophic Lateral Sclerosis (ALS). Medicare Part A provides coverage of inpatient hospital

services and services of other institutional Providers, such as skilled nursing facilities and home health agencies. Medicare Part B provides supplementary medical insurance that covers physician services, outpatient services, some home health care, durable medical equipment, and laboratory services and supplies, generally for the diagnosis and treatment of illness or injury. Medicare Part C provides Medicare beneficiaries with the option of receiving Part A and Part B services through a private health plan. Medicare Part D provides outpatient prescription drug benefits.

- 1.107. **Medicare Advantage** – The Medicare managed care options that are authorized under Title XVIII as specified at Part C and 42 C.F.R. § 422.
- 1.108. **Minimum Data Set (MDS)** – A clinical screening system, mandated by federal law for use in nursing facilities, which assesses the key domains of function, health, and service use. MDS assessment forms include the MDS-HC for home care and the MDS 3.0 for nursing facility residents.
- 1.109. **Minimum Data Set-Home Care (MDS-HC)** – A clinical screening system using proprietary tools developed by interRAI Corporation, which assesses the key domains of function, health, and service use.
- 1.110. **Network Management** – The activities, strategies, policies and procedures, and other tools used by the Contractor in the development, administration, and maintenance of the collective group of health care providers under contract to deliver Covered Services.
- 1.111. **Network Provider** – An appropriately credentialed and licensed individual, facility, agency, institution, organization, or other entity that has an agreement with the Contractor or any Material Subcontractor, for the delivery of services covered under the Contract.
- 1.112. **Ombudsman** – A neutral entity that has been contracted by MassHealth to assist Enrollees and any other MassHealth Members (including their families, caregivers, representatives, and/or advocates) with information, issues, or concerns related to One Care or other MassHealth health plans, benefits, or services (may also be referred to as My Ombudsman). Ombudsman staff fulfill both individual and systemic advocacy roles.
- 1.113. **One Care** – A comprehensive managed care program implemented by EOHHS in collaboration with CMS for the purpose of delivering and coordinating all Medicare- and Medicaid-covered benefits for MassHealth Members eligible for both programs. Services are developed and delivered based on an Enrollee's person-centered assessment and care plan.
- 1.114. **One Care Implementation Council** – A consumer-led working committee that advises EOHHS on One Care and on related matters. The One Care Implementation Council holds a key role in monitoring access to health care and compliance with the Americans with Disabilities Act (ADA), tracking

quality of services, and promoting accountability and transparency. Also known as the “Implementation Council.”

- 1.115. **One Care Plan** – The Contractor.
- 1.116. **Person-centered** - Person-centered care and person-centered planning in One Care means providing Covered Services, flexible benefits, and coordination to an Enrollee to meet the individual’s needs and goals. Placed at the center of care and planning, the Enrollee and their needs, preferences, and goals provide direction and purpose for what and how medical, behavioral health, Long-term Services and Supports, and flexible benefits are provided, including to address social determinants of health and health equity. This is achieved by integrating available resources of the MassHealth and Medicare programs as defined in the Contract.
- 1.117. **Personal Assistance Services (PAS)** – Physical assistance, cueing, and/or monitoring with Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs) provided to an Enrollee by a PCA in accordance with the Enrollee’s Individualized Care Plan.
- 1.118. **Personal Care Attendant (PCA)** – A person who provides personal care to an Enrollee who requires assistance with Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs).
- 1.119. **Personal Care Management (PCM) Agency** – A public or private entity under contract with EOHHS to provide Personal Care Management Services.
- 1.120. **Personal Care Management (PCM) Services** – Services provided by a Personal Care Management (PCM) Agency to an Enrollee in accordance with the PCM Contract with EOHHS, including, but not limited to, those services described under 130 CMR 422.419(A). PCM Services include but are not limited to intake and orientation to instruct a new Consumer in the rules, policies, and procedures of the Self-directed PCA program, assessment of the Enrollee’s ability to manage Self-directed PCA Services independently, development and monitoring of Service Agreements, and provision of functional skills training to assist Consumers in developing the skills and resources to maximize the Enrollee’s ability to manage their Self-directed PCA Services.
- 1.121. **Post-stabilization Care Services** – Covered Services, related to an Emergency Medical Condition, whether physical or mental, that are provided after an Enrollee is stabilized in order to maintain the stabilized condition or, when covered pursuant to 42 CFR 438.114(e), to improve or resolve the Enrollee’s condition.
- 1.122. **Prevalent Languages** – EOHHS has determined the current Prevalent Languages spoken by MassHealth Enrollees are Spanish, English, Cambodian, Chinese, Haitian Creole, Laotian, Portuguese, Russian, and

Vietnamese. EOHHS may identify additional or different languages spoken by a significant percentage of Enrollees as Prevalent Languages at any time during the term of the Contract.

- 1.123. **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.
- 1.124. **Primary Care Provider (PCP)** – A practitioner of primary care selected by the Enrollee or assigned to the Enrollee by the One Care Plan and responsible for providing and coordinating the Enrollee's health care needs, including the initiation and monitoring of referrals for specialty services when required. PCPs for persons with disabilities, including but not limited to, persons with HIV/AIDS, may include practitioners who are board certified or eligible for certification in other relevant specialties. PCPs also include registered nurses or advanced practice nurses, who are licensed by the commonwealth and certified by a nationally recognized accrediting body, and physician assistants who are licensed by the Board of Registration of Physician Assistants.
- 1.125. **Privacy and Security Rules** – The standards for privacy of individually identifiable health information required by the Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191 (HIPAA), and the associated regulations (45 CFR parts 160 and 164, as currently drafted and subsequently amended).
- 1.126. **Program of All-Inclusive Care for the Elderly (PACE)** – A comprehensive service delivery and financing model that integrates medical and LTSS under dual capitation agreements with Medicare and Medicaid. The PACE program is limited to individuals aged fifty-five (55) and over who meet the nursing-facility level of care (LOC) criteria and reside in a PACE service area.
- 1.127. **Provider** – An individual, group, facility, agency, Institution, organization, or business that furnishes or has furnished medical services to Enrollees.
- 1.128. **Provider Contract** – An agreement between the Contractor and a Provider for the provision of services.
- 1.129. **Provider Network** – The collective group of Network Providers, including but not limited to primary care physicians, nurses, nurse practitioners, physician assistants, Care Coordinators, specialty providers, behavioral health providers, community and institutional long-term care providers, pharmacy providers, and acute providers employed by or under subcontract with the Contractor.

- 1.130. **Provider Preventable Conditions (PPC)** – As identified by EOHHS through bulletins or other written statements of policy, which may be amended from time to time, a condition that meets the definition of a “Health Care Acquired Condition” or an “Other Provider Preventable Condition” as defined by CMS in federal regulations at 42 C.F.R. § 447.26(b).
- 1.131. **Rating Categories** – The categories used by the MassHealth component of the capitation payment methodology, as described in **Section 4.1.2**.
- 1.132. **Readiness Review** – Prior to being eligible to accept One Care enrollments, each prospective Contractor selected to operate a One Care plan must undergo a Readiness Review. The Readiness Review evaluates each prospective Contractor’s ability to comply with the requirements specified in this Contract, including but not limited to, the ability to quickly and accurately process claims and enrollment information, accept and transition new Enrollees, and provide adequate access to all Medicare and Medicaid-covered Medically Necessary Services. EOHHS will use the results to inform its decision of whether the prospective Contractor is ready to operate a One Care plan. At a minimum, each Readiness Review includes a desk review and potentially a site visit to the prospective Contractor’s headquarters.
- 1.133. **Recovery Learning Community (RLC)** – Consumer-run networks of self-help/peer support, information and referral, advocacy, and training activities. Training in recovery concepts and tools, advocacy forums and social and recreational events are all part of what goes on in a Recovery Learning Community.
- 1.134. **Request for Responses (RFR)** – The Request for Responses for One Care Plans issued by EOHHS and the RFR from which this Contract resulted.
- 1.135. **Risk Adjusted Capitation Rate** – The Base Capitation Rate as adjusted by the blended risk score to reflect acuity of the Enrollees in accordance with **Section 4.2.3** of the Contract. The Blended Risk Adjusted Capitation Rate is calculated as follows:
- 1.135.1. **LTSS Portion of the Capitation Rate** - The percentage of the NHC rate for each region and rating category that is determined by the actuary to represent the costs impacted by the functional status of the Member.
 - 1.135.2. **Risk Adjusted Portion of the Capitation Rate** – The LTSS portion of the capitation rate multiplied by the final bounded plan-level rating category risk score.
 - 1.135.3. **Non-Risk Adjusted Portion of the Capitation Rate** - The percentage of the NHC capitation rate for each region and rating category that is determined by the actuary to represent the costs that are not impacted by the functional status of the Member. Specifically, this includes the

portion of the rate that is calculated by subtracting the LTSS portion of the rate from the NHC Base Capitation Rate for each rating category, including the medical expenses not related to LTSS services and all non-medical expenses.

- 1.135.4. **Blended Risk Adjusted Capitation Rate** – The sum of the Risk Adjusted Portion of the Capitation Rate and the Non-Risk Adjusted Portion of the Capitation Rate.
- 1.135.5. **Blended Risk Score** – The Blended Risk Adjusted Capitation Rate divided by the Base Capitation Rate for each NHC Region and Rating Category.
- 1.136. **Self-directed PCA** – A model of service delivery in which the Enrollee, or the Enrollee’s designated surrogate, is the employer of record, and has decision-making authority to hire, manage, schedule, and dismiss their PCA worker(s).
- 1.137. **Senior Care Options (SCO)** – A managed care program implemented by EOHHS in collaboration with CMS for the purpose of delivering and coordinating all Medicare and Medicaid covered benefits for eligible Massachusetts individuals managed by a SCO Plan using a person-centered model of care.
- 1.138. **Serious and Persistent Mental Illness (SPMI)** – A mental illness that includes a substantial disorder of thought, mood, perception, which grossly impairs judgment, behavior, capacity to recognize reality or the ability to meet the ordinary demands of life, and is the primary cause of a functional impairment that substantially interferes with or limits the performance of one or more major life activities, and is expected to do so in the succeeding year, and meets diagnostic criteria specified within the Diagnostic and Statistical Manual of Mental Disorders (5th ed., text revision) American Psychiatric Association, Washington, DC (2013), which indicates that the individual has a serious, long-term mental illness that is not based on symptoms primarily caused by: (a) developmental disorders usually first diagnosed in infancy, childhood or adolescence, such as mental retardation or pervasive developmental disorders, or (b) cognitive disorders, including delirium, dementia or amnesia, or (c) mental disorders due to a general medical condition not elsewhere classified, or (d) substance-related disorders.
- 1.139. **Serious Reportable Event (SRE)** – An event that occurs on premises covered by a hospital’s license that results in an adverse patient outcome, is clearly identifiable and measurable, usually, or reasonably preventable, and of a nature such that the risk of occurrence is significantly influenced by the policies and procedures of the hospital. An SRE is an event that is specified as such by the Department of Public Health (DPH) and identified by EOHHS.

- 1.140. **Service Agreement** – A written plan of services developed in conjunction with the Enrollee, as appropriate, that describes the responsibilities of parties as they relate to the management of the Enrollee’s Self-directed PCA Services.
- 1.141. **Service Area** – A geographic area, specified by EOHHS and as listed in **Appendix F** of the Contract, in which a Contractor has contracted with EOHHS to serve MassHealth Members.
- 1.142. **Service Request** – An Enrollee’s oral or written request of the Contractor to authorize and pay for a benefit or service. This request for services shall include Covered Services as referenced in **Section 2.7** and defined in **Appendix C**. Service Requests may also be referred to as: requests for Covered Services, requests for coverage decisions or requests for Integrated Organization Determinations.
- 1.143. **Solvency** – Standards for requirements on cash flow, net worth, cash reserves, working capital requirements, insolvency protection and reserves established by DOI.
- 1.144. **State** – The Commonwealth of Massachusetts.
- 1.145. **State Fair Hearing** – An Appeal filed for Medicaid services with the Board of Hearings.
- 1.146. **State Medicaid Agency Contract (SMAC)** - A set of requirements for all new and existing Medicare Advantage organizations seeking to offer a D-SNP.
- 1.147. **Surrogate** – An Enrollee’s legal guardian, family Member, or other person who has been identified in the Service Agreement with the Personal Care Management (PCM) agency that will be responsible for performing certain personal care attendant (PCA) management tasks that the Enrollee is unable to perform. The Surrogate must live in proximity to the Enrollee and be readily available to perform the PCA management tasks.
- 1.148. **Third Party Liability (TPL) Indicator Form** – Form supplied to inpatient hospitals by EOHHS that is used to notify the Contractor when the hospital discovers that an Enrollee has comprehensive insurance coverage other than Medicare or Medicaid.
- 1.149. **Total Adjusted Expenditures** – The sum of the Adjusted Service Expenditures and the Adjusted Non-Service Expenditures.
- 1.150. **Urgent Care** – Medical services required promptly to prevent impairment of health due to symptoms that do not constitute an Emergency Medical Condition, but that are the result of an unforeseen illness, injury, or condition for which medical services are immediately required. Urgent Care is appropriately provided in a clinic, physician's office, or in a hospital

emergency department if a clinic or physician's office is inaccessible. Urgent Care does not include Primary Care services or services provided to treat an Emergency Medical Condition.

- 1.151. **Utilization Management** – A process of evaluating and determining coverage for and appropriateness of Covered 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.
- 1.152. **Waste** - Misuse of funds or resources through excessive or nonessential expenditures.

2 Contractor Responsibilities

2.1. Compliance

2.1.1. The Contractor shall comply, to the satisfaction of EOHHS, with:

2.1.1.1. All provisions set forth in this Contract;

2.1.1.2. All applicable provisions of federal and State laws, regulations, guidance, waivers, including the implementation of a compliance plan;

2.1.1.3. Federal Medicaid Managed Care statutes and regulations, including all applicable provisions of 42 U.S.C. § 1396u-2 et seq. and 42 CFR 438 et seq. at all times during the term of this Contract;

2.1.1.4. Medicare Advantage requirements in Part C of Title XVIII, and 42 C.F.R. Part 422 and Part 423; and

2.1.1.5. All applicable bulletins issued by EOHHS.

2.1.2. Medicaid and Medicare Coordination and Integration

2.1.2.1. The Contractor shall employ policies and procedures approved by EOHHS to coordinate or integrate Member communication materials, enrollment, communications, Grievances and Appeals, Service Requests, Utilization Management, and quality improvement as further described in this Contract, including but not limited to **Sections 2.4, 2.6, 2.7, 2.10, 2.11, 2.12, 2.13, and 2.14.**

2.1.3. Conflict of Interest

2.1.3.1. Neither the Contractor nor any Material Subcontractor may, for the duration of the Contract, have any interest that will conflict, as determined by EOHHS with the performance of services under the Contract. Without limiting the generality of the foregoing, EOHHS requires that neither the Contractor nor any Material Subcontractor has any financial, legal, contractual, or other business interest in any entity performing health plan enrollment functions for EOHHS, the EOHHS customer service vendor, and Material Subcontractor(s), if any.

2.1.3.2. In accordance with 42 U.S.C. § 1396u 2(d)(3) and 42 C.F.R. § 438.58, EOHHS will implement safeguards against conflicts of interest on the part of its officers and employees who have responsibilities relating to the Contractor or any Material Subcontractors that are at least as effective as the safeguards

specified in Section 27 of the Office of Federal Procurement Policy (41 U.S.C. § 423).

2.2. Contract Readiness

2.2.1. Contract Readiness Review Requirements

2.2.1.1. EOHHS or its designee shall conduct a Readiness Review of the Contractor which shall be completed successfully prior to the Contract Operational Start Date.

2.2.2. EOHHS Readiness Review Responsibilities

2.2.2.1. EOHHS or its designee shall conduct a Readiness Review of the Contractor. This review shall be conducted prior to enrollment of eligible MassHealth Members into the Contractor's One Care Plan. EOHHS or its designee shall conduct the Readiness Review to verify the Contractor's assurances that the Contractor is ready and able to perform satisfactorily in each of the areas set forth in 42 CFR 438.66(d)(4) and to meet its obligations under the Contract.

2.2.2.2. EOHHS reserves the right to conduct additional readiness reviews, as determined appropriate by EOHHS, upon the implementation of changes in scope to this Contract and new programs or initiatives and/or Service Area expansions, as further specified by EOHHS.

2.2.2.3. The scope of the Readiness Review shall include, but is not limited to, a review of the following elements:

2.2.2.3.1. Operational and Administration:

2.2.2.3.1.1. Staffing, including Key Personnel and functions directly impacting Enrollees (e.g., adequacy of Enrollee Services staffing), in accordance with **Sections 2.3.1** and **5.3**;

2.2.2.3.1.2. Delegation and oversight of Contractor responsibilities, including but not limited to capabilities of Material Subcontractors in accordance with **Section 2.3.2.1.1.3**;

2.2.2.3.1.3. Internal Grievance and Appeal policies and procedures, in accordance with **Section 2.13**; and

2.2.2.3.1.4. Program integrity and compliance, including Fraud and Abuse and other program integrity requirements in accordance with **Section 2.3.6**.

2.2.2.3.2. Service Delivery:

- 2.2.2.3.2.1. Assessments and Care Planning, in accordance with **Section 2.5**;
- 2.2.2.3.2.2. Care Coordination, care management, and care model, in accordance with **Section 2.6**;
- 2.2.2.3.2.3. Reasonable accommodation capabilities, policies, and protocols;
- 2.2.2.3.2.4. Service Request intake, Prior Authorization, and Utilization Review, including to reflect the broader scope of Medical Necessity and the integration of Medicare and Medicaid Covered Services, in accordance with **Section 2.10**;
- 2.2.2.3.2.5. Quality improvement, including comprehensiveness of quality management/quality improvement strategies, in accordance with **Section 2.14**;
- 2.2.2.3.2.6. Content of Provider Contracts, including any Provider performance incentives, in accordance with **Section 2.8.2**; and
- 2.2.2.3.2.7. Network Provider composition and access, in accordance with **Section 2.9.1**.
- 2.2.2.3.3. Enrollment, Enrollee Services, and Marketing:
 - 2.2.2.3.3.1. Enrollment and Disenrollment functionality in accordance with **Section 2.4**;
 - 2.2.2.3.3.2. Enrollee Service capabilities (materials, processes, and infrastructure, e.g., call center capabilities), in accordance with **Section 2.11**;
 - 2.2.2.3.3.3. Communication materials; and
 - 2.2.2.3.3.4. Provider directory (or directories), in accordance with **Section 2.8.7**.
- 2.2.2.3.4. Financial Management:
 - 2.2.2.3.4.1. Financial reporting and monitoring; and
 - 2.2.2.3.4.2. Financial solvency, in accordance with **Section 2.16**.
- 2.2.2.3.5. Systems Management:
 - 2.2.2.3.5.1. Claims management; and

- 2.2.2.3.5.2. Encounter Data and enrollment information, as applicable, including but not limited to, at the request of EOHHS, a walk-through of any information systems, including but not limited to enrollment, claims payment system performance, interfacing and reporting capabilities and validity testing of Encounter Data, in accordance with **Section 2.15.2**, including IT testing and security assurances.
- 2.2.2.3.6. A review of other items specified in the Contract, including:
 - 2.2.2.3.6.1. Capabilities of Material Subcontractors;
 - 2.2.2.3.6.2. Compliance with EOHHS requirements for FIDE SNPs; and
 - 2.2.2.3.6.3. Data collection and reporting capabilities.
- 2.2.2.4. No individual shall be enrolled into the Contractor's One Care Plan 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.
- 2.2.2.5. EOHHS or its designee shall identify to the Contractor all areas where the Contractor is not ready and able to meet its obligations under the Contract and provide an opportunity for the Contractor to remedy all identified deficiencies prior to the Contract Operational Start Date.
- 2.2.2.6. EOHHS may, in its discretion, postpone the Contract Operational Start Date if the Contractor fails to satisfy all Readiness Review requirements. If, for any reason, the Contractor does not fully satisfy EOHHS that it is ready and able to perform its obligations under the Contract prior to the Contract Operational Start Date, and the Commonwealth does not agree to postpone the Contract Operational Start Date or extend the date for full compliance with the applicable Contract requirement, then EOHHS may terminate the Contract.
- 2.2.3. Contractor Readiness Review Responsibilities
 - 2.2.3.1. The Contractor shall demonstrate to EOHHS's satisfaction that the Contractor is ready and able to meet all Contract requirements identified in the Readiness Review prior to the Contract Operational Start Date, and prior to the Contractor engaging in marketing of its One Care Plan.
 - 2.2.3.2. At the request of EOHHS, the Contractor shall provide to EOHHS, or its designee, access to all information, materials, contracts, or

documentation pertaining to the provision of any service or function required under this Contract within five (5) business days of receiving the request.

- 2.2.3.3. The Contractor shall provide EOHHS or its designee with corrections requested by the Readiness Review report within ten (10) business days after receipt of the Readiness Review report.

2.3. Administration and Contract Management

2.3.1. Organization, Staffing, and Key Personnel

2.3.1.1. Structure and Governance

2.3.1.1.1. The Contractor shall:

- 2.3.1.1.1.1. Be located within the United States,
- 2.3.1.1.1.2. Not be an excluded individual or entity as described in 42 CFR 438.808(b),
- 2.3.1.1.1.3. Meet the definition of an MCO, as defined in 42 CFR 438.2.
 - 2.3.1.1.1.3.1. Meet the federal and EOHHS criteria to qualify as a Fully Integrated Dual Eligible Special Needs Plan (FIDE SNP)
- 2.3.1.1.1.4. Meet all application and contracting requirements established by CMS to be eligible to participate with Medicare as a Medicare Advantage Dual Eligible Special Needs Plan (D-SNP),
- 2.3.1.1.1.5. Hold a D-SNP contract with CMS to operate in the Service Area approved by EOHHS for One Care and described in **Appendix F**.

2.3.1.1.2. Governing Board

- 2.3.1.1.2.1. The Contractor's Governing Board shall include at least one MassHealth consumer or MassHealth consumer advocate as a voting Member.
- 2.3.1.1.2.2. 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.

2.3.1.1.3. Consumer Advisory Board

2.3.1.1.3.1. The Contractor shall operate a Consumer Advisory Board for its One Care plan, with a scope and purview specific to the One Care plan, and inclusive of both the Medicaid managed care entity and this Contract, and of the Medicare contracted D-SNP organization and Medicare D-SNP Contract.

2.3.1.1.3.2. Such Consumer Advisory Board shall meet both:

2.3.1.1.3.2.1. Medicaid managed care requirements for a Member Advisory Committee as described at 42 CFR 438.110, and

2.3.1.1.3.2.2. Medicare D-SNP requirements for an Enrollee Advisory Committee as described at 42 CFR 422.107(f).

2.3.1.1.3.3. The Consumer Advisory Board for the Contractor's One Care plan shall operate independently from any other Consumer Advisory Board. The Consumer Advisory Board shall be convened to solely focus on the Contractor's One Care plan.

2.3.1.1.3.4. Duties of the Consumer Advisory Board include, but are not limited to:

2.3.1.1.3.4.1. Providing regular feedback to the Contractor's Governing Board on issues of the Contractor's One Care Plan management, Enrollee care and services, and on other solicited input,

2.3.1.1.3.4.2. Identifying and advocating for preventive care practices to be utilized by the Contractor,

2.3.1.1.3.4.3. Being involved with the development and updating of cultural and linguistic policies and procedures, including those related to Quality Improvement, education, Contractor marketing materials and campaigns, and operational and cultural competency issues affecting groups who speak a primary language other than English; and

2.3.1.1.3.4.4. Providing input and advice on Member experience survey results, ways to improve access to covered services, coordination and integration of services, and health equity for Enrolled and specific

underserved sub-populations and other appropriate data and assessments, among other topics.

2.3.1.1.3.5. The Consumer Advisory Board shall be comprised of Enrollees, family members and other Enrollee caregivers

2.3.1.1.3.6. The composition of the Consumer Advisory Board shall reflect the diversity of the One Care eligible population, including individuals with various disabilities, with a Membership that:

2.3.1.1.3.6.1. Considers cultural, linguistic, racial, disability, sexual orientation, and gender identities, among others.

2.3.1.1.3.7. EOHHS reserves the right to review and approve Consumer Membership.

2.3.1.1.3.8. The Contractor shall proactively ensure:

2.3.1.1.3.8.1. Reasonable accommodations and interpreter services, as well as other resources, are provided as may be needed to support full participation by Enrollees, their family members, and caregivers in the Consumer Advisory Board, and

2.3.1.1.3.8.2. That the process and opportunity for joining the Consumer Advisory Board is publicized. Contractor shall conduct marketing and outreach to One Care Enrollees (or their family members or caregivers as applicable) to ensure Enrollees are aware of the opportunity to apply to join or otherwise participate.

2.3.1.1.3.9. The Contractor shall designate staff to actively engage with the Consumer Advisory Board activities and convenings, and to consider and reflect Board concerns and recommendations in the Contractor's One Care Plan policies and procedures, including the Contractor's accountable designee for Utilization Management as described in **Section 2.10.12** and the Contractor's Accessibility and Accommodations Officer described in **Section 2.10.8**.

2.3.1.1.3.10. The Contractor shall ensure that:

- 2.3.1.1.3.10.1. The Consumer Advisory Board meets at least quarterly throughout the Contract term.
- 2.3.1.1.3.10.2. The Consumer Advisory Board reports annually to the Contractor regarding the following:
 - 2.3.1.1.3.10.2.1. The dates for all meetings held within the reporting year;
 - 2.3.1.1.3.10.2.2. Names of Consumer Advisory Board Members invited, including identifying which invitees are actual Enrollees, family members, or caregivers;
 - 2.3.1.1.3.10.2.3. Names of Consumer Advisory Board Members in attendance, including identifying which attendees are actual Enrollees, family members, or caregivers;
 - 2.3.1.1.3.10.2.4. Meeting agenda; and
 - 2.3.1.1.3.10.2.5. Meeting minutes.
 - 2.3.1.1.3.10.2.6. The Consumer Advisory Board's reports are provided to EOHHS as requested.
- 2.3.1.1.3.11. The Contractor shall also include Ombudsman reports, as available, in quarterly updates to the Consumer Advisory Board.

2.3.1.2. Key Personnel and Other Staff

- 2.3.1.2.1. The Contractor shall have and identify to EOHHS Key Personnel and other staff as set forth in this **Section 2.3.1.2.**

2.3.1.2.2. Key Personnel Roles

- 2.3.1.2.2.1. The Contractor's One Care Executive Director, or similar title, 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.
- 2.3.1.2.2.2. The Contractor's Chief Medical Officers/Medical Director, who shall be a clinician licensed to practice in Massachusetts and shall oversee Contractor's Care Delivery and Care Management activities, all clinical initiatives including quality improvement activities,

including but not limited to clinical initiatives targeted to various subpopulations of Enrollees, Utilization Management programs, and the review of all appeals decisions that involve the denial of or modification of a requested Covered Service, and shall attend Medical Director meetings as described in this Contract and further directed by EOHHS.

- 2.3.1.2.2.3. The Contractor's Pharmacy Director, or similar title, who shall be responsible for the Contractor's activities related to pharmacy Covered Services and shall attend Pharmacy Director meetings as described in this Contract and further directed by EOHHS.
- 2.3.1.2.2.4. The Contractor's Behavioral Health Director, or similar title, who shall be responsible for Contractor's continuum of care and activities related to mental health and substance use disorder services and related Care Delivery and Care Management activities, and for all BH-related interaction with EOHHS, and shall attend Behavioral Health Director meetings as described in this Contract and further directed by EOHHS.
- 2.3.1.2.2.5. The Contractor's Long-term Services and Supports (LTSS) Director, or similar title, who shall be responsible for Contractor's continuum of care and activities related to LTSS and related Care Delivery and Care Management activities, and for all LTSS-related interaction with EOHHS.
- 2.3.1.2.2.6. 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.
- 2.3.1.2.2.7. The Contractor's Chief Operating Officer, who shall have primary responsibility for ensuring plan administrative and operation functions comply with the terms of this contract, including, but not limited to, **Sections 2.2 and 2.11.**
- 2.3.1.2.2.8. The Contractor's Chief Data Officer, who shall have primary responsibility for ensuring management and compliance of all activities under **Section 2.15 and Appendix B.**

- 2.3.1.2.2.9. The Contractor's Compliance Officer, who shall oversee Contractor's compliance activities including Contractor's Fraud and Abuse Prevention activities as described in this Contract and further specified by EOHHS, and shall attend related meetings with EOHHS regarding fraud and abuse,
- 2.3.1.2.2.10. The Contractor's Accessibility and Accommodations Officer, State Agency Liaison, and DMH and DDS Liaisons, as further described in **Section 2.3.1.2.3** below.
- 2.3.1.2.2.11. The One Care Legal Counsel, or similar title, who shall be the individual with responsibility for legal matters related to the Contractor's One Care plan and this Contract.
- 2.3.1.2.2.12. The Contractor's Ombudsman Liaison, or similar title, who shall liaise with the EOHHS' health plan Ombudsman, its contractors or its designees, to resolve issues raised by Enrollees or individuals authorized to advocate on behalf of an Enrollee.
- 2.3.1.2.2.13. The Contractor's designated 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.
 - 2.3.1.2.2.13.1. The Contractor shall designate a backup for the Key Contact in the event they are not available in an emergency due to vacation or illness.
- 2.3.1.2.2.14. The Contractor's designated Quality Key Contact, who shall oversee the Contractor's quality management and quality improvement activities under this Contract, including those described in **Section 2.14** and other quality activities as further specified by EOHHS.
- 2.3.1.2.2.15. The Contractor's designated Leadership Contact, who shall serve as the contact person for the Secretary of Health and Human Services, EOHHS' Assistant Secretary for MassHealth, and as a leadership or escalation point of contact for other MassHealth program staff.
- 2.3.1.2.2.16. The Contractor's Care Coordination Contact, who shall liaise with EOHHS on matters related to care coordination and Care Management, including through

LTS Coordinators and any Material Subcontractors to which such functions are delegated; and

2.3.1.2.2.17. Any other positions designated by EOHHS.

2.3.1.2.3. Requirements for Certain Key Personnel

2.3.1.2.3.1. Accessibility and Accommodations Officer

2.3.1.2.3.1.1. Responsibilities of the Accessibility and Accommodations Officer shall include, but may not be limited to:

- 2.3.1.2.3.1.1.1. Ensuring that the Contractor and its Providers comply with federal and state laws and regulations pertaining to persons with disabilities. Such requirement shall include monitoring, evaluating, and ensuring adequate access to Covered Services and Network Providers as described in **Section 2.7 and 2.9**, and that Network Providers provide physical access, communication access, accommodations, and accessible equipment for Enrollees.
- 2.3.1.2.3.1.1.2. Developing and maintaining written policies and procedures describing clear and simple processes for Enrollees to make, and for the Contractor to respond to, accessibility and accommodation requests as described in **Section 2.10.8**, including standing requests for all future notifications and communication, and using data resulting from these processes to evaluate and improve such policies and procedures as needed.
- 2.3.1.2.3.1.1.3. 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.
- 2.3.1.2.3.1.1.4. 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 escalations of all inquiries and Grievances related to issues of disabilities from Enrollees.

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

2.3.1.2.3.1.1.6. Upon request of EOHHS, participating in meetings or workgroups related to the needs and care of Enrollees with disabilities.

2.3.1.2.3.2. State Agency Liaison

2.3.1.2.3.2.1. The State Agency Liaison shall have the following responsibilities:

2.3.1.2.3.2.1.1. Work with designated EOHHS staff and the state agency leadership, including but not limited to for the Department of Mental Health (DMH), the Department of Developmental Services (DDS), the Department of Public Health (DPH) and the DPH Bureau of Substance Addiction Services (BSAS), Massachusetts Commission for the Blind (MCB), Massachusetts Commission for the Deaf and Hard of Hearing (MCDHH), Massachusetts Rehabilitation Commission (MRC), and the Executive Office of Elder Affairs (EOEA),

2.3.1.2.3.2.1.2. Be responsible for collaboration, communication, and coordination with state agencies as needed based on Enrollee affiliations, services, and other needs,

2.3.1.2.3.2.1.3. Establish and maintain contact with designated state agency staff and assist in the resolution of any problems or issues that may arise with an Enrollee affiliated with each such agency,

2.3.1.2.3.2.1.4. As requested by EOHHS, participate in regional informational and educational meetings with state agency staff and as

directed by EOHHS, individuals, caregivers, or other family Member(s),

- 2.3.1.2.3.2.1.5. As requested by EOHHS, provide advice and assistance to DDS, DMH, DPH, MRC, MCB, MCDHH, and other State agencies as may be needed, on individual cases regarding Covered Services and coordinating non-Covered Services provided by State agencies other than MassHealth; and
- 2.3.1.2.3.2.1.6. As requested by EOHHS, actively participate in any joint meetings or workgroups with State agencies, and
- 2.3.1.2.3.2.1.7. Coordinate Contractor's interaction with state agencies with which Enrollees may have an affiliation. Such Liaison shall act as or shall oversee a designated DMH liaison and a designated DDS liaison, as described in this **Section**.

2.3.1.2.3.3. DMH Liaison

- 2.3.1.2.3.3.1. The Contractor's DMH Liaison shall have experience working with individuals with significant behavioral health needs, and
- 2.3.1.2.3.3.2. The Contractor's DMH Liaison shall actively participate in the planning and management of services for Enrollees who are affiliated with DMH, including, but not limited to, adult community clinical services (ACCS) clients and Program for Assertive Community Treatment (PACT). This shall include, but not be limited to:
 - 2.3.1.2.3.3.2.1. 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,
 - 2.3.1.2.3.3.2.2. Upon request of DMH, or its designee, participating in regional informational and educational meetings with DMH staff and as directed by DMH, Enrollees' family members, and Peer Supports,

- 2.3.1.2.3.3.2.3. As requested by DMH, providing advice and assistance to DMH regional directors or case managers on individual cases regarding One Care Covered Services and coordinating non-covered services,
- 2.3.1.2.3.3.2.4. If requested by DMH, working with providers to coordinate Discharge Planning,
- 2.3.1.2.3.3.2.5. As requested by EOHHS, actively participating in any joint meetings or workgroups with State agencies and other MassHealth managed care organizations, including other One Care plans,
- 2.3.1.2.3.3.2.6. Assisting DMH caseworkers with obtaining Enrollee appointments for One Care Covered Services,
- 2.3.1.2.3.3.2.7. Coordinating and communicating with DMH regarding One Care Enrollees who are ACCS clients,
- 2.3.1.2.3.3.2.8. Coordinating and communicating with DMH, EOE, any other EOHHS employees, or their designee, regarding care coordination and transition planning of One Care Enrollees residing in SNFs who have a positive Level II PASRR screening, and
- 2.3.1.2.3.3.2.9. Performing other functions as requested by EOHHS necessary to comply with the requirements of this Contract.

2.3.1.2.3.4. DDS Liaison

- 2.3.1.2.3.4.1. Such liaison shall have experience working with individuals in need of services related to developmental or intellectual disability, and
- 2.3.1.2.3.4.2. Shall actively participate in the planning and management of services for individuals who are clients of DDS. This shall include, but not be limited to:
 - 2.3.1.2.3.4.2.1. Establishing and maintaining contact with designated DDS case managers, as identified by DDS, and assisting MassHealth and DDS in

resolving any problems or issues that may arise with a DDS affiliated Enrollee,

- 2.3.1.2.3.4.2.2. Upon request of DDS, participating in regional informational and educational meetings with DDS staff,
- 2.3.1.2.3.4.2.3. As requested by DDS, providing advice and assistance to regional directors or case managers on individual cases regarding Covered Services and coordinating non-covered Services,
- 2.3.1.2.3.4.2.4. If requested by DDS, working with providers to coordinate Discharge Planning,
- 2.3.1.2.3.4.2.5. As requested by EOHHS, actively participating in any joint meetings or workgroups with EOHHS agencies and MassHealth health plans, including other One Care plans,
- 2.3.1.2.3.4.2.6. Performing any functions to assist the Contractor in complying with the requirements of **Section 2.7**,
- 2.3.1.2.3.4.2.7. Assisting DDS caseworkers with obtaining Enrollee appointments in compliance with **Section 2.10.2**, and
- 2.3.1.2.3.4.2.8. Performing other functions necessary to comply with the requirements of this Contract.

2.3.1.2.4. Appointing Key Personnel

- 2.3.1.2.4.1. The Contractor shall appoint an individual to each of the roles listed in **Section 2.3.1.2**. The Contractor may appoint a single individual to more than one such role.
- 2.3.1.2.4.1. Key personnel shall be based in Massachusetts to ensure local control.
- 2.3.1.2.4.2. 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.
- 2.3.1.2.4.3. Key Personnel shall, for the duration of the Contract, be employees of the Contractor, shall not be Material

Subcontractors, and shall be assigned primarily to perform their job functions related to this Contract.

- 2.3.1.2.4.4. Contractor shall supply EOHHS with a Key Personnel and Contact list that contains the name, email address, and phone number for all Key Personnel and for any additional key contacts. Upon any changes in Key Personnel or key contacts, the Contractor shall supply EOHHS with an updated Key Personnel and Contact list no less than five (5) business days after such a change is made.
- 2.3.1.2.4.5. Contractor shall supply EOHHS with an organizational chart indicating where Key Personnel reside within the Contractor's corporate structure, their supervisors, and direct reports. The Contractor shall supply EOHHS with updates as changes in the corporate structure are made (See **Appendix A**).
- 2.3.1.2.4.6. The Contractor shall, when subsequently hiring, replacing, or appointing individuals to Key Personnel roles, notify EOHHS of such a change and provide the name(s) and resumes of such qualified individuals to EOHHS no less than five (5) business days after such a change is made.
- 2.3.1.2.4.7. 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 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. Failure to resolve the matter to EOHHS' satisfaction may result in an intermediate sanction and corrective action under **Section 5.5**.
- 2.3.1.2.4.8. The Contractor's local management team for Massachusetts, including Key Personnel described above shall have the necessary authority and accountability to carry out contractually necessary functions and responsibilities defined in this Contract. Any centralized functions shall have accountability to the Contractor's local management team for Massachusetts. Key Personnel and their staff working on the

Massachusetts One Care Plan shall be familiar with MassHealth, applicable state and federal regulations and requirements, the Massachusetts healthcare delivery system, the standards and practices of care in Massachusetts, and best practices in their area of responsibility.

- 2.3.1.2.4.9. The Contractor, and its Material Subcontractors as applicable, shall employ sufficient Massachusetts-based staffing and resources to carry out all functions and activities necessary to operate the One Care plan, and as otherwise required under this Contract. Such staff shall be familiar with MassHealth and with applicable State and federal regulations and requirements.

2.3.1.2.5. Organizational Structure

- 2.3.1.2.5.1. The Contractor shall maintain an organizational statement that describes the Contractor's philosophy, mission statement, operating history, location, organizational structure, ownership structure, and plans for future growth and development.
- 2.3.1.2.5.2. The Contractor shall establish, maintain, and describe the interdepartmental structures and processes to support the operation and management of its One Care Plan line of business in a manner that fosters integration of physical and behavioral health service provision. The provision of all services shall be based on prevailing clinical knowledge and the study of data on the efficacy of treatment when such data is available. The Contractor's Behavioral Health Services and activities should be person centered, and oriented to recovery and rehabilitation from behavioral health conditions.
- 2.3.1.2.5.3. On an annual basis, upon request, and on an ad hoc basis when changes occur or as directed by EOHHS, the Contractor shall submit to EOHHS an overall organizational chart that includes senior and mid-level managers for the organization, as well as any additional staff who engage with EOHHS or CMS.
- 2.3.1.2.5.4. The organizational chart shall include the organizational staffing for Behavioral Health Services and activities. If such Behavioral Health Services and activities are provided by a Material Subcontractor, the Contractor shall submit the organizational chart of the behavioral

health Material Subcontractor which clearly demonstrates the relationship with the Material Subcontractor and the Contractor's oversight of the Material Subcontractor.

- 2.3.1.2.5.5. For all organizational charts, the Contractor shall indicate any staff vacancies and provide a timeline for when such vacancies are anticipated to be filled.
- 2.3.1.2.5.6. For all employees, by functional area, the Contractor shall establish and maintain policies and procedures for managing staff retention and employee turnover. Such policies and procedures shall be provided to EOHHS upon request.
- 2.3.1.2.5.7. For Personnel described in **Section 2.3.1.2.** and any other key management positions, including the designated "key contact," the Contractor shall immediately notify EOHHS whenever the position becomes vacant and notify EOHHS when the position is filled and by whom.

2.3.2. Contract Management and Responsiveness to EOHHS

2.3.2.1. General

2.3.2.1.1. The Contractor shall:

- 2.3.2.1.1.1. Ensure its compliance with the terms of the Contract, including securing and coordinating resources necessary for such compliance;
- 2.3.2.1.1.2. Implement all action plans, strategies, and timelines, including but not limited to those described in the Contractor's response to the Request for Responses (RFR) and approved by EOHHS;
- 2.3.2.1.1.3. Oversee all activities by the Contractor's Material Subcontractors and Providers; and
- 2.3.2.1.1.4. Ensure that Enrollees receive written notice of any significant change in the manner in which services are rendered to Enrollees at least thirty (30) days before the intended effective date of the change, such as a retail pharmacy chain leaving the Provider Network.

2.3.2.1.2. The Contractor shall ensure and demonstrate appropriate responsiveness to EOHHS requests related to this Contract,

including ensuring availability of Contractor's staff with appropriate expertise to EOHHS upon request.

2.3.2.2. Contract Management and Performance Review Meetings

2.3.2.2.1. The Contractor shall attend regular Contract management and performance review meetings as directed by EOHHS.

2.3.2.2.2. The Contractor shall ensure that Key Personnel and other staff with appropriate expertise, as requested by EOHHS, attend such meetings.

2.3.2.2.3. 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:

2.3.2.2.3.1. Reports, in a form and format approved by EOHHS, related to the Contractor's performance under this Contract. Unless otherwise specified, such information shall be reported for Medicaid, for Medicare, and in aggregate. Information requested may include, but shall not be limited to measures such as:

2.3.2.2.3.1.1. Revenue, cost, and utilization data for Enrollees by Rating Category and category of service,

2.3.2.2.3.1.2. Performance reporting information,

2.3.2.2.3.1.3. Quality Measure performance,

2.3.2.2.3.1.4. Measures of Enrollee utilization across categories of service and other indicators of changes in patterns of care,

2.3.2.2.3.1.5. Denials and/or approvals of Service Requests by service category and type, including supporting information,

2.3.2.2.3.1.6. Internal Appeals and External Appeals for both Medicare and MassHealth, by service category and type, and disposition, timeliness, continuing services requests and actions, and implementation of appeals actions favorable to the Enrollee,

2.3.2.2.3.1.7. Drivers of financial, quality, or utilization performance, including but not limited to stratified utilization data by service categories, drug and procedure types, provider type,

- 2.3.2.2.3.1.8. Measures showing impact of Network Provider payments varying from MassHealth fee schedule payments and Original Medicare fee schedule payments,
- 2.3.2.2.3.1.9. Financial projections and models showing impact of certain actions specified by EOHHS,
- 2.3.2.2.3.1.10. Analysis related to completeness and validity of any data submissions made to EOHHS,
- 2.3.2.2.3.1.11. Opportunities the Contractor identifies to improve performance, and plans to improve such performance, including plans proposed to be implemented by the Contractor for Network Providers, Material Subcontractors, and other Material Subcontractors,
- 2.3.2.2.3.1.12. Changes in Contractor's staffing and organizational development,
- 2.3.2.2.3.1.13. Performance of Material Subcontractors including but not limited to any changes in or additions to Material Subcontractor relationships,
- 2.3.2.2.3.1.14. Health Equity data completion and disparities reduction metrics as further specified by EOHHS, and
- 2.3.2.2.3.1.15. Any other measures deemed relevant by the Contractor or requested by EOHHS.
- 2.3.2.2.3.2. Updates and analytic findings from any reviews requested by EOHHS, such as reviews of data irregularities, and
- 2.3.2.2.3.3. Updates on any action items and requested follow-ups from prior meetings or communications with EOHHS.
- 2.3.2.2.4. The Contractor shall, within two business days following each contract management or 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.
- 2.3.2.3. Timely Response to EOHHS Requests

- 2.3.2.3.1. The Contractor shall respond to all inquiries and requests made by EOHHS in time frames and formats specified by EOHHS, including requests for review, analysis, information, or other materials related to the Contractor's performance of this Contract. Such requests may include but are not limited to requests for:
- 2.3.2.3.1.1. Records from the Contractor's Health Information System, claims processing system, Encounter Data submission process, or other sources, to assist the Contractor and EOHHS in identifying and resolving issues and inconsistencies in the Contractor's data submissions to EOHHS,
 - 2.3.2.3.1.2. Analysis of utilization, timeliness of access to care, patterns of care, cost, and other characteristics to identify opportunities to improve the Contractor's performance on any cost, quality, Member experience, or outcome measures related to this Contract,
 - 2.3.2.3.1.3. Financial and data analytics, such as the Contractor's payment rates to Network Providers as a percent of MassHealth's fee schedules, Original Medicare fee schedules, or other benchmarks as requested by EOHHS,
 - 2.3.2.3.1.4. Individualized Care Plan and other documentation and supporting information in a form and format specified by EOHHS related to Enrollee case escalations, critical incidents, and service denials, including partial denials,
 - 2.3.2.3.1.5. Information regarding the Contractor's contracts and agreements with Medicare ACO Providers, MassHealth ACO Providers, and other Network Providers, including on payment, risk-sharing, performance, and incentive arrangements,
 - 2.3.2.3.1.6. Information regarding the payer revenue mix of the Contractor's Network Providers,
 - 2.3.2.3.1.7. Documentation and information related to the Contractor's care delivery, Care Management, or Material Subcontractor responsibilities, to assist EOHHS with understanding the Contractor's activities pursuant to these requirements,
 - 2.3.2.3.1.8. Information about the Contractor's Member protections activities, such as Grievances and Appeals,

2.3.2.3.1.9. Documentation and information related to the Contractor's program integrity activities as described in this Contract,

2.3.2.3.1.10. Documentation, analysis, and detail on the metrics evaluated in the Contractor's Quality Improvement performance and programming,

2.3.2.3.1.11. 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, and

2.3.2.3.1.12. Information about the Contractor's D-SNP, including but not limited to, the D-SNP's administration, operations, performance, quality, claims processing, and service authorization criteria.

2.3.2.3.2. 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 this Contract.

2.3.2.4. Performance Reporting

2.3.2.4.1. EOHHS may, at its discretion and at any time, identify certain Contract requirements and other performance and quality measures about which the Contractor shall report to EOHHS. If EOHHS is concerned with the Contractor's performance on such measures, the Contractor shall discuss such performance with EOHHS and, as further specified by EOHHS:

2.3.2.4.1.1. Provide EOHHS with an analysis as to why the Contractor's performance is at the level it reports, and

2.3.2.4.1.2. Provide EOHHS with, and implement as approved by EOHHS, a concrete plan for improving its performance.

2.3.2.5. Ad Hoc Meetings

2.3.2.5.1. The Contractor shall attend ad hoc meetings for the purposes of discussing this Contract via videoconference, at EOHHS' offices, or at another location determined by EOHHS, as requested by EOHHS.

2.3.2.5.2. The Contractor shall ensure that Key Personnel and other staff with appropriate expertise are present, including in person as

specified, at such meetings, as requested by EOHHS, including but not limited to Contractor's One Care Executive Director.

2.3.2.5.3. The Contractor shall prepare materials and information for such meetings as further directed by EOHHS.

2.3.2.6. Participation in EOHHS Efforts

2.3.2.6.1. As directed by EOHHS, the Contractor shall participate in any:

- 2.3.2.6.1.1. Efforts to promote the delivery of services in a Culturally and Linguistically Appropriate manner to all Enrollees, including those with limited English proficiency and diverse cultural and ethnic backgrounds, physical or mental disabilities, and regardless of gender, sexual orientation, or gender identity,
- 2.3.2.6.1.2. EOHHS activities related to Health Equity,
- 2.3.2.6.1.3. EOHHS activities related to Program Integrity,
- 2.3.2.6.1.4. Activities to verify or improve the accuracy, completeness, or usefulness of Contractor's data submissions to EOHHS, including but not limited to validation studies of such data,
- 2.3.2.6.1.5. Activities related to EOHHS' implementation and administration of its integrated care program efforts, including improving Medicare-Medicaid integration and the integration of physical health services, behavioral health services, oral health and Long-term Services and Supports,
- 2.3.2.6.1.6. One Care shared learning opportunities, joint performance management activities, and other meetings or initiatives by EOHHS to facilitate information sharing and identify best practices among integrated care plans. 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.
- 2.3.2.6.1.7. 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),

- 2.3.2.6.1.8. Enrollment, disenrollment, or attribution activities related to this Contract,
 - 2.3.2.6.1.9. Training programs, including training curricula and outcomes,
 - 2.3.2.6.1.10. Coordination with EOHHS, the Massachusetts Office of the Attorney General, and the Massachusetts Office of the State Auditor,
 - 2.3.2.6.1.11. Workgroups and councils, including but not limited to workgroups related to reporting or data submission specifications,
 - 2.3.2.6.1.12. Educational sessions for EOHHS staff, such as but not limited to trainings for EOHHS' Customer Service Team,
 - 2.3.2.6.1.13. Site visits and other reviews and assessments by EOHHS, and
 - 2.3.2.6.1.14. Any other activities related to this Contract.
 - 2.3.2.6.1.15. As directed by EOHHS, the Contractor shall comply with all applicable requirements resulting from EOHHS initiatives.
- 2.3.2.6.2. The Contractor shall participate in all statewide stakeholder and oversight meetings as requested by EOHHS.
- 2.3.2.7. Policies and Procedures for Core Functions
- 2.3.2.7.1. The Contractor shall develop, maintain, and provide to EOHHS upon request, policies and procedures for all core functions necessary to manage the One Care eligible and enrolled 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.
 - 2.3.2.7.2. These policies and procedures shall include, but are not limited to, the following topics:
 - 2.3.2.7.2.1. Response to violations of Enrollees' privacy rights by staff, Providers, or Material Subcontractors;
 - 2.3.2.7.2.2. Non-discrimination of Enrollees;

- 2.3.2.7.2.3. Non-restriction of Providers advising or advocating on an Enrollee's behalf;
- 2.3.2.7.2.4. Enrollee cooperation with those providing health care services;
- 2.3.2.7.2.5. Marketing activities that apply to the Contractor, Providers, and Material Subcontractors, including both Medicare and Medicaid activities, as well as the Contractor's procedures for monitoring these activities;
- 2.3.2.7.2.6. Cost-sharing by Enrollees;
- 2.3.2.7.2.7. Advance directives;
- 2.3.2.7.2.8. Assisting Enrollees in understanding their benefits and how to access them;
- 2.3.2.7.2.9. Access and availability standards;
- 2.3.2.7.2.10. Enrollee rights in accordance with **Appendix N** and in accordance with 42 CFR 438.100;
- 2.3.2.7.2.11. Enrollees' right to be free from restraint or seclusion used as a means of coercion or retaliation;
- 2.3.2.7.2.12. The provision of Culturally and Linguistically Appropriate Services;
- 2.3.2.7.2.13. Practice guidelines in quality measurement and improvement activities;
- 2.3.2.7.2.14. Compliance with Emergency Services and Post-stabilization Care Services requirements as identified in 42 CFR 438.114;
- 2.3.2.7.2.15. Procedures for tracking Appeals when Enrollees become aware of the Adverse Action, in the event that no notice had been sent;
- 2.3.2.7.2.16. Handling of inquiries and Grievances sent directly to EOHHS;
- 2.3.2.7.2.17. Process used to monitor Provider and Material Subcontractor implementation of amendments and improvements;
- 2.3.2.7.2.18. Retention of medical records;

- 2.3.2.7.2.19. Engagement and coordination with LTS Coordinators contracted from community-based organizations;
- 2.3.2.7.2.20. Care Management and Care Coordination;
- 2.3.2.7.2.21. In-person engagement for various assessment, care coordination and care planning activities;
- 2.3.2.7.2.22. Provision of services in an Enrollee's home;
- 2.3.2.7.2.23. Public health emergencies;
- 2.3.2.7.2.24. Risk stratification; and
- 2.3.2.7.2.25. Claims processing.

2.3.3. FIDE SNP Medicare Contract Requirements

- 2.3.3.1. The Contractor shall operate a Medicare Advantage dual eligible special needs plan for its One Care plan in Massachusetts under a unique CMS Medicare contract number ("H number"), subject to CMS approval, separate from all other Medicare Advantage contracts offered by the Contractor, as indicated in 42 CFR 422.107(e)(1)(i).
- 2.3.3.2. If the Contractor operates both a One Care plan and a SCO plan in Massachusetts, the Contractor shall operate the One Care plan and the SCO plan under separate unique CMS Medicare contract numbers ("H numbers"), subject to CMS approval.
- 2.3.3.3. The Contractor shall submit only one (1) Plan Benefit Package (PBP) to CMS for its One Care plan, unless otherwise approved in advance by EOHHS.
- 2.3.3.4. The Contractor shall submit to EOHHS information about its performance, model, benefits, risk scores, and other elements pertaining to the operation of its One Care Plan under a FIDE SNP model, as further described in this Contract. EOHHS may waive this requirement for any information sufficiently available to EOHHS through CMS' Health Plan Management System (HPMS), including in an acceptable form and format.

2.3.4. Service Area Expansion

- 2.3.4.1. The Contractor may request to expand its Service Area as follows:
 - 2.3.4.1.1. In the event the Contractor intends to pursue a Service Area Expansion (SAE), the Contractor shall submit a request in

writing to EOHHS for approval of its SAE request no later than 13 months (December 1 of the prior Calendar Year) prior to the Contract Year that the SAE would take effect. Such notification shall minimally include a list of any counties for which the Contractor is proposing to expand its Service Area, as well as its projected enrollment in each proposed new county for the Contract Year in which it first covers each such county. EOHHS may establish additional criteria for SAE proposals.

The Contractor may propose SAEs only for full county coverage.

- 2.3.4.2. EOHHS shall review the Contractor's request for SAE and provide the Contractor with a response (as described in **Section 2.3.4.3**) prior to the annual CMS deadline for submission of Medicare applications for SAEs;
 - 2.3.4.3. EOHHS may, in its sole discretion, grant in full, grant in part, or deny the Contractor's requested SAE, including for the purpose of limiting the total number of Plans operating in each County.
 - 2.3.4.4. The Contractor may submit a SAE request to CMS for its Medicare D-SNP only with EOHHS' prior approval, as described in **Section 2.3.4.1.1**.
 - 2.3.4.5. Upon request, the Contractor shall provide to EOHHS all documentation submitted to CMS regarding such SAE requests;
 - 2.3.4.6. In the event that EOHHS and CMS approve the Contractor's requested Service Area expansion, whether in full or in part, the Contractor and EOHHS shall amend **Appendix F** accordingly; and
 - 2.3.4.7. Prior to the Contractor accepting Enrollments in an expanded Service Area, the Contractor shall provide to EOHHS all information EOHHS deems necessary to complete a readiness review of network adequacy, staffing requirements, and related implementation requirements.
- 2.3.5. Material Subcontractors
- 2.3.5.1. 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.
 - 2.3.5.2. Prior to contracting with a Material Subcontractor, the Contractor shall evaluate the prospective Material Subcontractor's ability to perform the activities to be subcontracted.

- 2.3.5.3. 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 K**, using the template provided by EOHHS as may be modified by EOHHS from time-to-time.
- 2.3.5.3.1. For Material Subcontractors who are not pharmacy benefit managers or Behavioral Health Subcontractors, 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.
- 2.3.5.3.2. The Contractor shall submit such report for pharmacy benefit managers and Behavioral Health Subcontractors 90 calendar days prior to the date the Contractor expects to execute the Material Subcontract.
- 2.3.5.3.3. The Contractor shall provide EOHHS with any additional information requested by EOHHS in addition to the information required in the Material Subcontractor checklist report. For Material Subcontractors who are pharmacy benefit managers, the Contractor shall provide a network adequacy report at EOHHS' request.
- 2.3.5.4. The Contractor's contract, agreement, or other arrangement with a Material Subcontractor shall:
- 2.3.5.4.1. Be a written agreement;
- 2.3.5.4.2. Specify, and require compliance with, all applicable requirements of this Contract and the activities and reporting responsibilities the Material Subcontractor is obligated to provide;
- 2.3.5.4.3. Provide for imposing sanctions, including contract termination if the Material Subcontractor's performance is inadequate;
- 2.3.5.4.4. Require the Material Subcontractor to comply with all applicable Medicaid laws, regulations, and applicable sub-regulatory guidance, including but not limited to federally required disclosure requirements set forth in this Contract; and
- 2.3.5.4.5. 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 5.4**.

- 2.3.5.5. 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
- 2.3.5.6. The Material Subcontractor shall make its premises, facilities, staff, equipment, records, and systems available for the purposes of any audit, evaluation, or inspection described immediately above.
- 2.3.5.7. 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.
- 2.3.5.8. 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. The Contractor shall notify EOHHS of any corrective action within two (2) business days of issuing such action. Upon request, the Contractor shall provide EOHHS with a copy of the annual review and any corrective action plans developed as a result.
- 2.3.5.9. 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 Enrollee transition or related activities as described in **Section 2.3** and elsewhere in this Contract.
- 2.3.5.10. In accordance with **Appendix K**, 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.
- 2.3.5.11. 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.

- 2.3.5.12. The Contractor shall, pursuant to the Acts of 2014, c. 165, Section 188, file with EOHHS any contracts or subcontracts for the management and delivery of behavioral health services by specialty behavioral health organizations to Enrollees and EOHHS shall disclose such contracts upon request.

2.3.6. Program Integrity

2.3.6.1. General Provisions

2.3.6.1.1. The Contractor shall:

- 2.3.6.1.1.1. Comply with all applicable federal and state program integrity laws and regulations regarding Fraud, Waste, and Abuse, including but not limited to, the Social Security Act and 42 CFR Parts 438, 455, and 456.
- 2.3.6.1.1.2. Implement and maintain written internal controls, policies and procedures, and administrative and management arrangements or procedures designed to prevent, detect, reduce, investigate, correct and report known or suspected Fraud, Waste, and Abuse activities consistent with 42 CFR 438.608(a) and as further specified in this Contract.
- 2.3.6.1.1.3. In accordance with federal law, including but not limited to Section 6032 of the federal Deficit Reduction Act of 2005, make available written Fraud and Abuse policies to all employees. If the Contractor has an employee handbook, the Contractor shall include specific information about such Section 6032, the Contractor's policies, M.G.L. Ch. 12, Section 5J, and the rights of employees to be protected as whistleblowers.
- 2.3.6.1.1.4. Meet with EOHHS regularly and upon request to discuss Fraud, Waste, and Abuse, audits, overpayment issues, reporting issues, and best practices for program integrity requirements.
- 2.3.6.1.1.5. At EOHHS' discretion, implement certain program integrity requirements for providers, as specified by EOHHS, including but not limited to implementing

National Correct Coding Initiative edits or other CMS claims processing/provider reimbursement manuals, and mutually agreed upon best practices for program integrity requirements.

2.3.6.2. Compliance Plan

2.3.6.2.1. The Contractor shall, in accordance with 42 CFR 438.608(a)(1), have a compliance plan designed to guard against Fraud, Waste, and Abuse.

2.3.6.2.2. At a minimum, the Contractor's compliance plan shall include the following:

- 2.3.6.2.2.1. Written policies, procedures, and standards of conduct that articulate the Contractor's commitment to comply with all applicable federal and state laws regarding Fraud, Waste, and Abuse.
- 2.3.6.2.2.2. The designation of a compliance officer and a compliance committee, as described in 42 CFR 438.608, that is accountable to senior management.
- 2.3.6.2.2.3. Adequate Massachusetts-based staffing and resources to investigate incidents and develop and implement plans to assist the Contractor in preventing and detecting potential Fraud, Waste, and Abuse activities. Staff conducting program integrity activities for the Contractor shall be familiar with MassHealth and state and federal regulations on Fraud, Waste, and Abuse.
- 2.3.6.2.2.4. Effective training and education for the Contractor's employees, including but not limited to the Contractor's compliance officer and senior management.
- 2.3.6.2.2.5. Effective lines of communication between the compliance officer and the Contractor's employees, as well as between the compliance officer and EOHHS.
- 2.3.6.2.2.6. Enforcement of standards through well-publicized disciplinary guidelines.
- 2.3.6.2.2.7. Provision for internal monitoring and auditing as described in 42 CFR 438.608.
- 2.3.6.2.2.8. Provision for prompt response to detected offenses, and for development of corrective action initiatives, as well as the reporting of said offenses and corrective actions to

EOHHS as stated in this Contract and as further directed by EOHHS, and

2.3.6.2.2.9. Communication of suspected violations of state and federal law to EOHHS, consistent with the requirements of this **Section 2.3.6.2**.

2.3.6.2.3. The Contractor's compliance plan shall be in place by the Contract Operational Start Date and in a form and format specified by EOHHS. The Contractor shall provide EOHHS with its compliance plan in accordance with **Appendix A**, annually, and when otherwise requested. The Contractor shall make any modifications requested by EOHHS within thirty (30) calendar days of a request.

2.3.6.3. Anti-Fraud, Waste, and Abuse Plan

2.3.6.3.1. The Contractor shall have an anti-Fraud, Waste, and Abuse plan.

2.3.6.3.2. The Contractor's anti-Fraud, Waste, and Abuse plan shall, at a minimum:

2.3.6.3.2.1. Require reporting of suspected and confirmed Fraud, Waste, and Abuse consistent with this Contract.

2.3.6.3.2.2. Include a risk assessment of the Contractor's various Fraud, Waste, and Abuse and program integrity processes, a listing of the Contractor's top three vulnerable areas, and an outline of action plans in mitigating such risks.

2.3.6.3.2.2.1. The Contractor shall submit to EOHHS this risk assessment quarterly at EOHHS' request and immediately after a program integrity related action, including financial-related actions (such as overpayment, repayment, and fines).

2.3.6.3.2.2.2. With such submission, the Contractor shall provide details of such action and outline activities for employee education of federal and state laws and regulations related to Medicaid program integrity and the prevention of Fraud, Waste, and Abuse to ensure that all of its officers, directors, managers and employees know and understand the provisions of the Contractor's compliance plan and anti-Fraud, Waste, and Abuse plan.

- 2.3.6.3.2.3. Outline activities for Provider education of federal and state laws and regulations related to Medicaid program integrity and the prevention of Fraud, Waste, and Abuse, specifically related to identifying and educating targeted Providers with patterns of incorrect billing practices or overpayments,
- 2.3.6.3.2.4. Contain procedures designed to prevent and detect Fraud, Waste, and Abuse in the administration and delivery of services under this Contract, and
- 2.3.6.3.2.5. Include a description of the specific controls in place for prevention and detection of potential or suspected Fraud, Waste, and Abuse, such as:
 - 2.3.6.3.2.5.1. A list of automated pre-payment claims edits,
 - 2.3.6.3.2.5.2. A list of automated post-payment claims edits,
 - 2.3.6.3.2.5.3. A description of desk and onsite audits performed on post-processing review of claims,
 - 2.3.6.3.2.5.4. A list of reports of Provider profiling and credentialing used to aid program and payment integrity reviews,
 - 2.3.6.3.2.5.5. A list of surveillance and/or utilization management protocols used to safeguard against unnecessary or inappropriate use of Medicaid services, and
 - 2.3.6.3.2.5.6. A list of provisions in the Material Subcontractor and Provider Contracts that ensure the integrity of provider credentials.
- 2.3.6.3.2.6. The Contractor shall have its anti-Fraud, Waste, and Abuse plan in place by the Contract Operational Start Date and in a form and format specified by EOHHS. The Contractor shall provide EOHHS with its compliance plan in accordance with **Appendix A**, annually, and when otherwise requested. The Contractor shall make any modifications requested by EOHHS within thirty (30) calendar days of a request.

2.3.6.4. Overpayments

2.3.6.4.1. Reporting MassHealth Overpayments to EOHHS

- 2.3.6.4.1.1. This **Section 2.3.6.4** shall apply to overpayments for Medicaid-only services, this **Section 2.3.6.4** shall not apply to overpayments for Medicare covered services.
- 2.3.6.4.1.2. The Contractor shall report MassHealth overpayments to EOHHS using the following reports as specified below and in **Appendix A**,
 - 2.3.6.4.1.2.1. Notification of Provider Overpayments Report,
 - 2.3.6.4.1.2.2. Fraud and Abuse Notification Report,
 - 2.3.6.4.1.2.3. Summary of Provider Overpayments Report, and
 - 2.3.6.4.1.2.4. Self-Reported Disclosures Report.
- 2.3.6.4.1.3. In accordance with **Appendix A**, the Contractor shall submit to EOHHS the Notification of Provider Overpayments Report and Fraud and Abuse Notification Report no later than five (5) business days after the identification of the overpayment.
- 2.3.6.4.1.4. In accordance with **Appendix A**, the Contractor shall submit to EOHHS the Summary of Provider Overpayments Report as follows:
 - 2.3.6.4.1.4.1. The Contractor shall report all overpayments identified, including but not limited to those resulting from potential Fraud, as further specified by EOHHS,
 - 2.3.6.4.1.4.2. The Contractor shall, as further specified by EOHHS, report all overpayments identified during the Contract Year, regardless of dates of service, and all investigatory and recovery activity related to those overpayments. This report shall reflect all cumulative activity for the entire contract year plus six months after the end of the contract year,
 - 2.3.6.4.1.4.3. For any overpayments that remain unrecovered for more than six months after the end of the Contract Year, the Contractor shall continue to report all cumulative activity on such overpayments until all collection activity is completed.
- 2.3.6.4.2. Identifying and Recovering Overpayments:

2.3.6.4.2.1. If the Contractor identifies an overpayment prior to EOHHS:

2.3.6.4.2.1.1. The Contractor shall recover the overpayment and may retain any overpayments collected.

2.3.6.4.2.1.2. In the event the Contractor does not recover an overpayment first identified by the Contractor within one hundred and eighty (180) days after such identification, the Contractor shall provide justification in the Summary of Provider Overpayments report for any initial overpayment amounts identified but not recovered. EOHHS may, at its sole discretion, apply a Capitation Payment deduction equal to the amount of the overpayment identified but not collected in accordance with this **Section 2.3.6.4.2.**

2.3.6.4.2.2. If EOHHS identifies an overpayment prior to the Contractor that the Contractor did not identify and report to EOHHS in accordance with all applicable Contract requirements:

2.3.6.4.2.2.1. Within 90 days of EOHHS' notification of the overpayment, the Contractor shall investigate the associated claims and notify EOHHS as to whether the Contractor agrees with or disputes EOHHS's findings, in the Response to Overpayments Identified by EOHHS Report as specified in **Appendix A.**

2.3.6.4.2.2.2. If the Contractor disputes EOHHS's finding, the Contractor's response shall provide a detailed description of the reasons for the dispute, listing the claim(s) and amount of each overpayment in dispute.

2.3.6.4.2.2.3. If the Contractor agrees with EOHHS's finding:

2.3.6.4.2.2.3.1. The Contractor's response shall provide the amount of each overpayment agreed to.

2.3.6.4.2.2.3.2. The Contractor shall complete collections of such agreed-upon overpayments. The Contractor shall submit a report to EOHHS of such collections within ninety (90) days of the Contractor's response to EOHHS's notification,

in the Agreed Upon Overpayments Collection Report as specified in **Appendix A**.

- 2.3.6.4.2.2.4. In the event the Contractor recovers an agreed-upon overpayment first identified by EOHHS within ninety (90) days of the Contractor's response to EOHHS's notification, EOHHS may, at its sole discretion, apply a Capitation Payment deduction equal to 80% of the agreed-upon overpayment amount in accordance with this **Section 2.3.6.4.2**. The Contractor shall retain the remaining 20% of the agreed-upon overpayment amount collected. In the event EOHHS determines that there is a valid justification for any agreed-upon overpayment amounts that cannot be collected (e.g., MFD hold), this Capitation Payment deduction shall be calculated based on the amount collected instead of the initial agreed-upon overpayment amount.
- 2.3.6.4.2.2.5. In the event the Contractor does not recover an overpayment first identified by EOHHS within ninety (90) days of the Contractor's response to EOHHS's notification, without providing sufficient justification for any initial overpayment amounts identified but not recovered as determined by EOHHS, EOHHS may, at its sole discretion, apply a Capitation Payment deduction equal to the amount of the overpayment identified but not collected in accordance with this **Section 2.3.6.4.2**.
- 2.3.6.4.2.2.6. No Capitation Payment deductions shall apply to any amount of a recovery to be retained under the False Claims Act cases.
- 2.3.6.4.2.2.7. EOHHS shall calculate, following the end of the Contract Year, all Capitation Payment deductions for the prior Contract Year pursuant to this **Section 2.3.6.4.2**.
- 2.3.6.4.2.2.8. In the alternative to the above process, EOHHS may, in its discretion, recover the overpayment and may retain any overpayments collected.

2.3.6.4.3. Other Requirements Regarding Overpayments

- 2.3.6.4.3.1. The Contractor shall maintain and require its Providers to use a mechanism for the Provider to report when it has received an overpayment, to return the overpayment to the Contractor within sixty (60) calendar days of the identification of the overpayment, and to notify the Contractor in writing of the reason for the overpayment. The Contractor shall report any such notifications by its Providers to EOHHS in the Self-Reported Disclosures report.
- 2.3.6.4.3.2. The Contractor may not act to recoup improperly paid funds or withhold funds potentially due to a Provider when the issues, services or claims upon which the recoupment or withhold is based on the following:
 - 2.3.6.4.3.2.1. The improperly paid funds were recovered from the Provider by EOHHS, the federal government or their designees, as part of a criminal prosecution where the plan had no right of participation, or
 - 2.3.6.4.3.2.2. The improperly paid funds currently being investigated by EOHHS are the subject of pending federal or state litigation or investigation, or are being audited by EOHHS, the Office of the State Auditor, CMS, Office of the Inspector General, or any of their agents.

2.3.6.5. Suspected Fraud

2.3.6.5.1. Contractor Obligations

- 2.3.6.5.1.1. Report, within five (5) business days, in accordance with **Appendix A** and all other Contract requirements, 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 to EOHHS,
- 2.3.6.5.1.2. Notify EOHHS and receive EOHHS' approval to make such contact, prior to initiating contact with a Provider suspected of Fraud about the suspected activity,
- 2.3.6.5.1.3. Take no action on any claims which form the basis of a Fraud referral to EOHHS, including refraining from voiding or denying such claims, as well as refraining from any attempts to collect overpayments on such claims,

- 2.3.6.5.1.4. 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.
- 2.3.6.5.1.5. Suspend payments to Providers for which EOHHS determines there is a credible allegation of Fraud pursuant to 42 CFR 455.23, or as further directed by EOHHS, unless EOHHS identifies or approves the Contractor's request for a good cause exception as set forth in **Section 2.9.8.2.10**.
 - 2.3.6.5.1.5.1. As further directed by EOHHS, after the conclusion of a Fraud investigation that results in a verdict or settlement obtained by the Office of the Attorney General (AGO) Medicaid Fraud Division, the Contractor shall disburse to EOHHS any money the Contractor held in a payment suspension account connected to the investigation to account for the verdict or settlement.
 - 2.3.6.5.1.5.2. As further directed by EOHHS, if the amount of money the Contractor held in the payment suspension account exceeds the Provider's liability under the verdict or settlement, the Contractor shall release to the Provider the amount of money that exceeds the Provider's liability under the verdict or settlement.
 - 2.3.6.5.1.5.3. As further directed by EOHHS, if EOHHS determines the Contractor may receive a finders' fee performance incentive as described in **Section 4.7.3** below, the Contractor may retain any money in a payment suspension account necessary to satisfy all or part of the amount of such finders' fee performance incentive. If the Contractor is entitled to a finder's fee performance incentive in an amount greater than the amount held in a payment suspension account, EOHHS will pay the Contractor the difference between the amount of the performance incentive and the amount in the payment suspension account.
- 2.3.6.5.1.6. The Contractor and, where applicable, its Material 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.

2.3.6.5.2. Monetary Recoveries by the Office of the Attorney General's Medicaid Fraud Division

2.3.6.5.2.1. Except as otherwise provided within this **Section 2.3.6.5.2**, EOHHS shall retain all monetary recoveries made by MFD arising out of a verdict or settlement with Providers.

2.3.6.5.2.2. The Contractor shall receive a finders' fee performance incentive as follows:

2.3.6.5.2.2.1. To receive the finders' fee performance incentive, the Contractor shall satisfy, in EOHHS' determination, the following requirements as they relate to MFD's case against a Provider.

2.3.6.5.2.2.1.1. The Contractor made a fraud referral to EOHHS pursuant to **Section 2.3.6.5**;

2.3.6.5.2.2.1.2. The Contractor's fraud referral provided sufficient details regarding the Provider(s), conduct, and time period of the allegation(s) of Fraud at issue;

2.3.6.5.2.2.1.3. The Contractor attests, in a form and format specified by EOHHS, that the fraud referral arose out of the Contractor's own investigatory activity that led to the identification of the allegation(s) of fraud at issue;

2.3.6.5.2.2.1.4. The Contractor complies with all other obligations in **Section 4.7.3**;

2.3.6.5.2.2.1.5. The Contractor made its Fraud referral to EOHHS prior to MFD's investigation becoming public knowledge; and

2.3.6.5.2.2.1.6. The basis of the Contractor's Fraud referral – the specific Provider and allegedly fraudulent conduct – is the subject of a verdict or settlement achieved by MFD with a Provider that requires the Provider to pay EOHHS.

2.3.6.5.2.2.2. The amount of the finders' fee performance incentive, as determined by EOHHS, shall be as set forth in **Section 4.7.3**.

2.3.6.5.2.3. The Contractor shall abide by and adhere to any release of liability regarding a provider in any verdict or settlement signed by MFD or EOHHS.

2.3.6.6. Other Program Integrity Requirements

2.3.6.6.1. Prior to initiating an audit, investigation, review, recoupment, or withhold, or involuntarily termination of a Provider, the Contractor shall request from EOHHS deconfliction, cease all activity, and wait to receive permission from EOHHS to proceed. The Contractor shall wait until EOHHS either grants the deconfliction request or notifies the Contractor to continue to cease activity so as not to interfere in a law enforcement investigation or other law enforcement activities.

2.3.6.6.2. The Contractor shall notify EOHHS within two (2) business days after contact by the Medicaid Fraud Division, the Bureau of Special Investigations or any other investigative authorities conducting Fraud and Abuse investigations, unless specifically directed by the investigative authorities not to notify EOHHS. The Contractor, and where applicable any Material Subcontractors, shall cooperate fully with the Medical Fraud Division, Bureau of Special Investigations, and other agencies that conduct investigations, full cooperation includes, but is not limited to, timely exchange of information and strategies for addressing Fraud and Abuse, as well as allowing prompt direct access to information, free copies of documents, and other available information related to program violations, while maintaining the confidentiality of any investigation. The Contractor shall make knowledgeable employees available at no charge to support any investigation, court, or administrative proceeding.

2.3.6.6.3. The Contractor shall report promptly to EOHHS, in accordance with **Appendix A** and all other Contract requirements, when it receives information about an Enrollee's circumstances that may affect their MassHealth eligibility, including but not limited

to a change in the Enrollee's residence and the death of the Enrollee.

- 2.3.6.6.4. The Contractor shall report no later than five (5) business days to EOHHS, in accordance with **Appendix A** and all other Contract requirements, when it receives information about a Provider's circumstances that may affect its ability to participate in the Contractor's network or in MassHealth, including but not limited to the termination of the Provider's contract with the Contractor.
- 2.3.6.6.5. The Contractor shall verify, in accordance with other Contract requirements, through sampling, whether One Care Covered Services that were represented to be delivered by Providers were received by Enrollees. The Contractor shall report the identification of any overpayments related to One Care Covered Services that were represented to be delivered by Providers but not received by Enrollees in the following reports as set forth in **Appendix A**: Fraud and Abuse Notification, Notification of Provider Overpayments, and Summary of Provider Overpayments report.
- 2.3.6.6.6. The Contractor shall provide employees, as well as Material Subcontractors and agents, detailed information about the False Claims Act and other federal and state laws described in Section 1902(a)(68) of the Social Security Act, including whistleblower protections.
 - 2.3.6.6.6.1. The Contractor shall comply with all federal requirements for employee education about false claims laws under 42 U.S.C. §1396a(a)(68) if the Contractor received or made Medicaid payments in the amount of at least \$5 million during the prior Federal fiscal year.
 - 2.3.6.6.6.2. If the Contractor is subject to such federal requirements, the Contractor shall:
 - 2.3.6.6.6.2.1. On or before April 30th of each Contract Year, or such other date as specified by EOHHS, provide written certification, in accordance with **Appendix A** or in another form acceptable to EOHHS, and signed under the pains and penalties of perjury, of compliance with such federal requirements,
 - 2.3.6.6.6.2.2. Make available to EOHHS, upon request, a copy of all written policies implemented in accordance with 42 U.S.C. §1396a(a)(68), any employee

handbook, and such other information as EOHHS may deem necessary to determine compliance, and

2.3.6.6.3. Failure to comply with this **Section 2.3.6.6** may result in intermediate sanctions in accordance with **Section 5.3.14**

2.3.6.6.7. The Contractor shall designate a Fraud and Abuse prevention coordinator responsible for the following activities. Such coordinator may be the Contractor's compliance officer. The Fraud and Abuse prevention coordinator shall:

2.3.6.6.7.1. Assess and strengthen internal controls to ensure claims are submitted and payments properly made;

2.3.6.6.7.2. Develop and implement an automated reporting protocol within the claims processing system to identify billing patterns that may suggest Provider and Enrollee Fraud and shall, at a minimum, monitor for under-utilization or over-utilization of services;

2.3.6.6.7.3. Conduct regular reviews and audits of operations to guard against Fraud and Abuse;

2.3.6.6.7.4. Receive all referrals from employees, Enrollees, or Providers involving cases of suspected Fraud and Abuse and developing protocols to triage all referrals involving suspected Fraud and Abuse;

2.3.6.6.7.5. Educate employees, Providers, and Enrollees about Fraud and how to report it, including informing employees of their protections when reporting fraudulent activities per Mass. Gen. Laws Ch. 12, Section 5J; and

2.3.6.6.7.6. Establish mechanisms to receive, process, and effectively respond to complaints of suspected Fraud and Abuse from employees, Providers, and Enrollees, and report such information to EOHHS.

2.3.6.6.8. In accordance with M.G.L. Ch. 12, Section 5J, do not discriminate against an employee for reporting a fraudulent activity or for cooperating in any government or law enforcement authority's investigation or prosecution,

2.3.6.6.9. Upon a complaint of Fraud, Waste, or Abuse from any source or upon identifying any questionable practices, the Contractor shall

report the matter in writing to EOHHS within five (5) business days,

2.3.6.6.10. Make diligent efforts to recover improper payments or funds misspent due to fraudulent, wasteful, or abusive actions by the Contractor, its parent organization, its Providers, or its Material Subcontractors,

2.3.6.6.11. Require Providers to implement timely corrective actions related to program integrity matters as approved by EOHHS or terminate Provider Contracts, as appropriate,

2.3.6.6.12. In accordance with **Appendix A**, submit a Summary of Provider Overpayments report in a form and format, and at times, specified by EOHHS, and submit ad hoc reports related to program integrity matters as needed or as requested by EOHHS,

2.3.6.6.13. In accordance with **Appendix A**, have the CEO or CFO certify in writing to EOHHS that after a diligent inquiry, to the best of their knowledge and belief, the Contractor is in compliance with this Contract as it relates to program integrity requirements and has not been made aware of any instances of Fraud and Abuse other than those that have been reported by the Contractor in writing to EOHHS.

2.3.6.7. Screening Employees and Material Subcontractors

2.3.6.7.1. In addition to the requirements set forth in **Section 2.9.8**, the Contractor shall screen employees and Material Subcontractors by searching the Office of the Inspector General List of Excluded Individuals Entities and the other databases listed in **Appendix I** to determine if any such individuals or entities are excluded from participation in federal health care programs.

2.3.6.7.2. The Contractor shall conduct such screening upon initial hiring or contracting and on an ongoing monthly basis, or other frequency specified at **Appendix I**.

2.3.6.7.3. The Contractor shall notify EOHHS of any discovered exclusion of an employee or Material Subcontractor within two (2) business days of discovery.

2.3.6.7.4. The Contractor shall require its Providers to also comply with the requirements of this **Section 2.3.6.7** with respect to its own employees and Material Subcontractors.

2.3.6.8. Screening Providers

2.3.6.8.1. The Contractor shall screen Providers in accordance with the requirements set forth in **Section 2.9.8**.

2.3.7. Continuity of Operations Plan

2.3.7.1. The Contractor shall maintain a continuity of operations plan that addresses how the Contractor's, and Material Subcontractor's operations shall be maintained in the event of a natural disaster, terrorist attack, pandemic, or other event which leads to a significant disruption in operations due to staff absence and/or loss of utilities. The Contractor shall provide copies of such plan with EOHHS upon request and shall inform EOHHS whenever such plan shall be implemented.

2.4. Eligibility, Enrollment, and Initial Outreach

2.4.1. Eligible Populations

2.4.1.1. To be eligible to enroll in One Care, an individual shall:

2.4.1.1.1. Be 21 through 64 years of age at the time of enrollment;

2.4.1.1.2. Reside in the Commonwealth;

2.4.1.1.3. Be enrolled in Medicare Parts A and B and eligible for Part D, enrolled in MassHealth Standard or CommonHealth, have no other comprehensive private or public health insurance;

2.4.1.1.4. Not have presumptive eligibility;

2.4.1.1.5. Not be subject to a six-month deductible period under 130 CMR 520.028;

2.4.1.1.6. Not be a refugee described at 130 CMR 522.002; and

2.4.1.1.7. Not be excluded on the One Care Effective Enrollment Date for any reason described in **Section 2.4.2**.

2.4.1.2. Continued Enrollment at Age 65

2.4.1.2.1. Individuals who reach 65 years of age while enrolled in a One Care Plan may remain enrolled in the One Care Plan provided that those individuals continue to meet all other eligibility requirements described in **Section 2.4.1.1**.

2.4.2. Concurrent Exclusion Reasons

- 2.4.2.1. Individuals residing in an Intermediate Care Facility operated by the Massachusetts Department of Developmental Services (DDS) may not be enrolled in One Care.
 - 2.4.2.2. Individuals enrolled in 1915(c) waivers who meet the eligibility criteria for One Care may enroll in a One Care Plan, with One Care enrollment taking effect on the first day of the first month following the individual's disenrollment from the 1915(c) waiver.
 - 2.4.2.3. Individuals enrolled in PACE, another Medicare Advantage Plan, or a Medicare Part D Plan may enroll in a One Care Plan, with One Care enrollment taking effect on the first day of the first month following the individual's disenrollment from their PACE, Medicare Advantage, or Part D Plan.
- 2.4.3. Eligibility Verification
- 2.4.3.1. Prior to submitting an enrollment to EOHHS, the Contractor shall verify through EOHHS's electronic on-line Eligibility Verification System (EVS) that the MassHealth Member is eligible for MassHealth Standard or MassHealth CommonHealth, and otherwise meets One Care participation requirements, including eligibility for Medicare, as described in **Section 2.4.1**.
 - 2.4.3.2. If the Enrollee is covered under a different comprehensive healthcare product, including those operated by the Contractor (including commercial plans, and Qualified Health Plans offered through the Exchange), the Contractor shall promptly submit to EOHHS a completed Third-Party Liability (TPL) Indicator Form in accordance with EOHHS's specifications.
 - 2.4.3.3. The Contractor shall instruct and assist the Contractor's Providers in the process and need for verifying an Enrollee's MassHealth eligibility and enrollment prior to providing any service at each point of service, through EOHHS's Eligibility Verification System (EVS), provided, however, the Contractor and its Providers shall not require such verification prior to providing Emergency Services.
- 2.4.4. Eligibility and Enrollment Resources
- 2.4.4.1. The Contractor shall direct all inquiries about MassHealth eligibility coverage that the Contractor may receive from Enrollees or their representatives, as well as former or prospective Enrollees and their representatives, to the MassHealth customer service vendor as applicable. For inquiries received by phone, the Contractor shall make their best efforts to connect the caller to the MassHealth customer service line. For eligibility- related inquiries the Contractor

may receive through other media, or when the MassHealth customer service vendor is unreachable, the Contractor shall offer to connect the individual at another time, and/or otherwise assist the individual to successfully reach the MassHealth customer service line within a reasonable period of time. The Contractor shall document all measures the Contractor took to address the eligibility-related inquiries, including their efforts to connect the caller to the MassHealth customer service line. The Contractor shall make this information available to EOHHS upon request.

- 2.4.4.2. The Contractor shall direct all requests for individual Medicare insurance information, counseling, and assistance to the SHINE (Serving the Health Insurance Needs of Everyone) Program, the Massachusetts State Health Insurance Assistance Program (SHIP), SHINE is a free, nonbiased resource for individuals to understand the insurance options available to them, or to 1-800-Medicare.
- 2.4.4.3. The Contractor shall provide EOHHS with access to enrollment packages, Marketing materials, and educational materials to use as training materials and reference guides about One Care and the Contractor's Plan, and to be distributed by EOHHS's customer service vendor to Members upon request by EOHHS.
- 2.4.5. MassHealth Benefit Request and Eligibility Redetermination Assistance
 - 2.4.5.1. The Contractor shall:
 - 2.4.5.1.1. Actively track redetermination due dates, including with information provided by EOHHS;
 - 2.4.5.1.2. No later than thirty (30) days prior to the Enrollee's MassHealth redetermination date, contact the Enrollee and provide assistance (if required) to complete and return to MassHealth the redetermination form;
 - 2.4.5.1.3. Assertively support Enrollees to resolve redetermination requests with EOHHS;
 - 2.4.5.1.4. Make best efforts to proactively assist Enrollees to remain continuously enrolled in their One Care Plan when they are likely to be found eligible through a redetermination process;
 - 2.4.5.1.5. Make best efforts to help Enrollees avoid lapses in their MassHealth eligibility; and
 - 2.4.5.1.6. 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.

2.4.5.2. The Contractor shall assist Enrollees with completing eligibility redetermination activities as follows. The Contractor shall:

2.4.5.2.1. Explain to Enrollees the forms used to apply for MassHealth Benefits (e.g., ACA-3, SACA-2);

2.4.5.2.2. Assist MassHealth applicants in applying for MassHealth, including support completing and submitting MassHealth forms;

2.4.5.2.3. Provide assistance to Enrollees with the completion of the annual Eligibility Redetermination Verification form and other MassHealth Eligibility forms, including assistance with completing and submitting MassHealth forms, gathering necessary documentation, and addressing logistical barriers; and

2.4.5.2.4. Refer Enrollees to the MassHealth customer service center as needed or to other specific resources as directed by EOHHS.

2.4.6. Enrollment

2.4.6.1. Enrollment Processing

2.4.6.1.1. Enrollment and disenrollment shall be processed through the One Care Plan, consistent with the Effective Enrollment Date requirements outlined in **Section 2.4.6.2**, and the requirements for marketing, education, and enrollment activities described in **Section 2.12.1**.

2.4.6.1.2. The Contractor shall opt into the Medicare Online Enrollment Center (OEC) to receive Medicare Enrollment and Disenrollment requests for its One Care Plan, and shall maintain participation in the OEC throughout the Contract Term.

2.4.6.1.3. The Contractor shall:

2.4.6.1.3.1. Have a mechanism for sending and receiving timely information about all Enrollees, including confirmation of

the Effective Enrollment Date, from CMS and MassHealth systems.

- 2.4.6.1.3.2. Submit enrollment requests to EOHHS on behalf of MassHealth Members eligible for, and seeking to enroll in, the Contractor's One Care Plan.
- 2.4.6.1.3.3. Submit and receive aligned enrollment transactions to CMS or its designee for Medicare coverage through the Contractor's One Care Plan, in accordance with CMS requirements.
- 2.4.6.1.3.4. On each business day, obtain from EOHHS, via the HIPAA 834 Enrollment File, and process information pertaining to all enrollments in the Contractor's Plan, including the Effective Date of Enrollment.

2.4.6.2. Enrollment Policy

2.4.6.2.1. General

- 2.4.6.2.1.1. Enrollment in One Care is voluntary. The first Effective Enrollment Date under this Contract is scheduled for no earlier than January 1, 2026.
- 2.4.6.2.1.2. The Contractor shall submit clinical assessment information (MDS-HC or its successor, as described in **Section 2.5.1**) to EOHHS to assign an Enrollee to a different Rating Category.
- 2.4.6.2.1.3. Enrollments received, approved, processed, and confirmed via the MassHealth Medicaid Management Information System (MMIS) by the last business day of the month will be effective on the first calendar day of the following month.
- 2.4.6.2.1.4. The Contractor shall be responsible to provide or arrange, and to pay for all One Care Covered Services required to be provided by the Contractor to Enrollees under this Contract for each Enrollee as of 12:01 a.m. on the Effective Enrollment Date for the Enrollee, even if the Contractor is not notified of an Enrollee's enrollment into the Contractor's One Care Plan until after such Enrollee's Effective Enrollment Date. As specified by EOHHS, the Contractor's responsibilities under this **Section** continue until such time as provided in **Section 2.4.3**.

- 2.4.6.2.1.5. Enrollment in the Contractor's Plan shall occur at the sole discretion of the Member or EOHHS, except for Reinstatement as described in **Section 2.4.7**, to ensure Exclusively Aligned Enrollment as required in **Section 2.4.10**, or as described in **Section 2.4.9**.
- 2.4.6.2.1.6. Subject to the eligibility requirements set forth in 130 CMR 508 et seq. and in **Section 2.4.1** above, the Contractor shall accept for enrollment all eligible MassHealth Members seeking enrollment in the order in which they seek to join the Contractor's Plan or are assigned to the Contractor's Plan, without restriction.
- 2.4.6.2.1.7. The Contractor shall notify EOHHS of any third-party liability in accordance with **Section 2.17.8.1**.
- 2.4.6.2.1.8. The Contractor shall inform the Member that enrolling in One Care ends the Member's enrollment in their current PACE, a Medicare Advantage Plan that is not a One Care Plan, or a Medicare Part D Plan, prior to the effective date of their One Care Plan enrollment.
- 2.4.6.2.1.9. The Contractor shall accept for enrollment in the Contractor's Plan all eligible MassHealth Members seeking enrollment at any time without regard to income status, physical or mental condition (such as cognitive, intellectual, mobility, psychiatric, or sensory disabilities as further defined by EOHHS), age, sex, gender identity, sexual orientation, religion, creed, race, color, physical or mental disability, national origin, ancestry, pre-existing conditions, expected health status, or need for Covered Services.
- 2.4.6.2.1.10. The Contractor shall not interfere with the Enrollee's right to enroll or remain enrolled in its One Care Plan through threat, intimidation, pressure, or otherwise.
- 2.4.6.2.2. Member Consent
 - 2.4.6.2.2.1. The Contractor shall utilize integrated enrollment forms, modalities, and methods permitted pursuant 42 CFR 422 subpart V, to the Medicare Communication and Marketing Guidance and approved by EOHHS.
 - 2.4.6.2.2.2. The Contractor shall provide a range of methods (e.g., electronic submission, paper form submission, telephonic with signature, etc.) accessible to individuals with various

disabilities, functional needs, and accessibility needs for Members to use to Enroll into or Disenroll from the Contractor's One Care Plan.

- 2.4.6.2.2.3. The Contractor shall establish and execute policies and procedures that provide mechanisms by which an Enrollee can sign or otherwise convey agreement to Enroll in and Disenroll from the Contractor's One Care Plan.
- 2.4.6.2.2.4. The Contractor shall accept requests to Enroll in or Disenroll from the Contractor's One Care Plan from the MassHealth Member or their Authorized Representative via telephone but shall confirm Member consent by obtaining the Member's or their Authorized Representative's signature on an enrollment or disenrollment form, including an electronic form. The Contractor may use alternative means of consent only for Members who are not able to provide a signature as an accessibility accommodation.
- 2.4.6.2.2.5. Only the MassHealth Member or their Authorized Representative may make voluntary Enrollment or Disenrollment decisions and provide authorization (i.e., consent) for such actions.
- 2.4.6.2.2.6. The Contractor shall document Member consent to enroll into or disenroll from One Care in accordance with all applicable rules and guidance and as further directed by EOHHS.
- 2.4.6.2.2.7. The Contractor shall maintain records of all such Member consent and provide such records to EOHHS for review upon request.

2.4.7. Reinstatement

- 2.4.7.1. As directed by EOHHS, an Enrollee who becomes ineligible for MassHealth or whose coverage type changes such that they are no longer eligible for One Care, and who regains One Care eligibility no more than two (2) months after the change in eligibility, including One Care Enrollees aged sixty-five (65) or older shall be re-enrolled in the Contractor's Plan, effective on the first day of the first full month in which the Enrollee is eligible, unless the Enrollee requests or otherwise initiates a different enrollment option.
- 2.4.7.2. The following shall apply to an Enrollee who becomes ineligible for MassHealth or whose coverage type changes such that they are no

longer eligible for One Care and who regains One Care eligibility at least two (2) months and no more than twelve (12) months after the change in eligibility:

- 2.4.7.2.1. Enrollees aged sixty-five (65) and older, including Enrollees who turn sixty-five (65) during the period of disenrollment, may re-enroll in the Contractor's One Care Plan if they otherwise meet the One Care Participation requirements in **Section 2.4.1**; and
- 2.4.7.2.2. The Contractor shall notify all such Enrollees (including those aged sixty-four (64) and under) of their eligibility to re-enroll in the Contractor's One Care Plan within thirty (30) days of the Enrollee regaining One Care eligibility. The Contractor shall notify such Enrollees using at least two notification or communication methods; such methods shall be in accordance with the Enrollee's communication preferences, including any standing requests submitted per **Section 2.4.14.3.5**.

2.4.8. Deemed Eligibility

- 2.4.8.1. EOHHS may require the Contractor to offer a period of continued Deemed Eligibility due to loss of MassHealth eligibility, as directed by EOHHS.
- 2.4.8.2. As required by EOHHS, the Contractor shall provide continued enrollment and coverage to any Member experiencing a loss of MassHealth or Medicare eligibility that qualifies for Deemed Eligibility (MassHealth) or Deemed Enrollment (Medicare).
- 2.4.8.3. The Contractor shall maintain aligned Medicaid and Medicare enrollment periods for Enrollees during any Deemed Eligibility (MassHealth) or Deemed Enrollment (Medicare) period for a period of not less than 30 days. Such Deemed periods shall not be cancelled retroactively, unless approved by EOHHS.

2.4.9. Default Enrollment

- 2.4.9.1. Any Default Enrollment requests under Medicare regulation shall be approved in advance by EOHHS. EOHHS may revoke approval for a Contractor to conduct Default Enrollment at any time.

2.4.10. Aligning MassHealth and Medicare Coverage

- 2.4.10.1. In accordance with **Section 2.1**, prior to commencing the initial enrollment of MassHealth Members, the Contractor shall demonstrate to EOHHS that it has been designated by CMS as a

Medicare Advantage Special Needs Plan for persons dually eligible for Medicare and Medicaid and has Medicare Part D authority in each county approved by EOHHS to be served by the Contractor under this Contract.

2.4.10.2. The Contractor shall operate a One Care Plan that meets the requirements of a Medicare Advantage Fully Integrated Dual Eligible Special Needs Plan (FIDE SNP), and shall provide Exclusively Aligned Enrollment for Dual Eligible individuals as follows:

2.4.10.2.1. Eligible individuals choosing to participate in One Care shall enroll for both their Medicare and their MassHealth coverage through a single One Care Plan; and

2.4.10.2.2. Eligible individuals may not be enrolled in a One Care Plan for only their Medicare or their MassHealth coverage.

2.4.10.3. Individuals enrolled in Medicare but not eligible for MassHealth Standard or MassHealth CommonHealth (i.e., not a Dual Eligible) are not eligible to enroll in One Care, including in the Contractor's One Care D-SNP for their Medicare coverage.

2.4.10.4. The Contractor shall conduct enrollments and disenrollments for Dual Eligible individuals to always ensure the individual's MassHealth and Medicare enrollments are aligned and maintained with the same One Care Plan.

2.4.10.5. The legal entity holding a contract with CMS for the FIDE SNP covered under this Contract receives direct capitation from EOHHS to provide coverage of the Medicaid benefits described in **Appendix C**.

2.4.11. Medicare Special Election Period (SEP) Applicability

2.4.11.1. In the event that a Dual Eligible individual does not have an available Medicare SEP to allow a change in their Medicare enrollment for an effective date of the first calendar day of the following month, the Contractor shall hold the Medicaid enrollment or disenrollment transaction and shall submit it to MMIS no sooner than the first day of the month preceding the next available month in which a change in Medicare enrollment may be effective. The MassHealth and Medicare enrollment effective dates shall remain aligned when Medicare's SEP policy prevents a Medicare enrollment change.

2.4.12. Limiting or Suspending Enrollment

- 2.4.12.1. EOHHS may require the Contractor to suspend new Medicaid enrollments within six (6) months (or less) of the end date of the Contract unless the Contract is or is expected to be renewed or extended.
- 2.4.12.2. EOHHS may require the Contractor to suspend Medicaid enrollment as described in **Section 5.3.14**.
- 2.4.13. Disenrollment
 - 2.4.13.1. Disenrollment Processing
 - 2.4.13.1.1. The Contractor shall:
 - 2.4.13.1.1.1. Have a mechanism for sending and receiving timely information about all disenrollments from the Contractor's One Care Plan, including the effective date of disenrollment and the disenrollment reason code from CMS and MassHealth systems.
 - 2.4.13.1.1.2. Submit Disenrollment transactions and reason codes to EOHHS on behalf of Enrollees seeking to disenroll from the Contractor's One Care Plan.
 - 2.4.13.1.1.3. Submit and receive aligned disenrollment transactions to CMS or its designee to disenroll from Medicare coverage through the Contractor's One Care Plan, in accordance with CMS requirements.
 - 2.4.13.1.1.4. On each business day, obtain the HIPAA 834 Enrollment File from EOHHS and process information pertaining to all Enrollee disenrollments, including the Effective Date of Disenrollment and disenrollment reason code.
 - 2.4.13.1.1.5. At a minimum, continue to provide One Care Covered Services, and all other services required under this Contract, to Enrollees through 11:59 p.m. on the Effective Date of Disenrollment, and be responsible for ceasing the provision of Covered Services to an Enrollee upon the effective date of disenrollment, as specified by EOHHS.
 - 2.4.13.1.1.6. EOHHS shall review the Contractor's voluntary disenrollment rate, including as compared with other One Care Plans and other MassHealth FIDE SNPs, as an indicator of plan performance towards meeting Enrollee satisfaction.
 - 2.4.13.2. Disenrollment Policy

2.4.13.2.1.General

- 2.4.13.2.1.1. Disenrollments received by the Contractor and approved by EOHHS and CMS by the last business day of the month will be effective on the first calendar day of the following month.
- 2.4.13.2.1.2. For all disenrollments, the Contractor shall have processes in place to ensure continuity of services and to cooperate with EOHHS in the smooth transition of a disenrolled beneficiary to their subsequent Medicaid and/or Medicare coverage.
- 2.4.13.2.1.3. If the Enrollee transfers to another One Care Plan, SCO Plan, or PACE, the Contractor shall, with the Enrollees consent, in accordance with applicable laws and regulations, promptly transfer current Minimum Data Set Home Care (MDS HC) assessment (or successor tool, if applicable) information to the new MassHealth Plan, and
- 2.4.13.2.1.4. The Contractor shall:
 - 2.4.13.2.1.4.1. Not interfere with the Enrollee's right to disenroll through threat, intimidation, pressure, or otherwise,
 - 2.4.13.2.1.4.2. Not request the disenrollment of any Enrollee due to an adverse change in the Enrollee's health status or because of the Enrollee's utilization of treatment plan, medical services, diminished mental capacity, or uncooperative or disruptive behavior resulting from their special needs (except when the Enrollee's continued enrollment in the One Care Plan seriously impairs the One Care Plan's ability to furnish services to either the particular enrollee or other enrollees).
 - 2.4.13.2.1.4.3. Transfer Enrollee record information promptly to the new provider upon written request signed by the disenrolled Enrollee.
 - 2.4.13.2.1.4.4. Notify EOHHS if the Contractor becomes aware that an Enrollee has comprehensive insurance other than Medicare or Medicaid.

2.4.13.3. Voluntary Disenrollment

- 2.4.13.3.1. Subject to 42 C.F.R. § 422.66 and § 438.56, and subject to applicable eligibility requirements, Enrollees may elect to disenroll from their One Care Plan and enroll in a different One Care Plan, or another MassHealth program such as PACE or SCO, or to MassHealth FFS or other MassHealth State plan and/or waiver programs and either Original Medicare (FFS) or a Medicare Advantage Plan, including enrollment into a Part D Plan.
- 2.4.13.3.2. When an Enrollee meets participation requirements for their current One Care Plan but elects to enroll in a different Plan for their Medicaid coverage, Medicare coverage, or both, the disenrollment shall be considered voluntary.
- 2.4.13.3.3. All voluntary disenrollments shall meet the Member Consent requirements of **Section 2.4.13.3** above.
- 2.4.13.3.4. The Contractor shall document the Enrollee's reason for voluntary disenrollment and shall report to EOHHS such reasons in a form and format specified by EOHHS.
- 2.4.13.3.5. The Contractor shall not discontinue or suspend enrollment for Enrollees for any amount of time without 30 calendar days advance notice and the approval of EOHHS.
- 2.4.13.4. Qualifying Involuntary Disenrollment
 - 2.4.13.4.1. The Contractor may request that an Enrollee be involuntarily disenrolled for the following reasons only:
 - 2.4.13.4.1.1. Loss or downgrade of MassHealth eligibility
 - 2.4.13.4.1.2. Enrollee no longer meets One Care program participation requirements set forth in **Section 2.4.1**.
 - 2.4.13.4.1.3. Enrollee has confirmed to the Contractor that they have relocated out of the Service Area
 - 2.4.13.4.1.4. Fraud or abuse, which occurs when the Enrollee provides fraudulent information on an Enrollment form or the Enrollee willfully misuses or permits another person to misuse the Enrollee's ID card.
 - 2.4.13.4.2. Consistent with the requirements of **Appendix M**, the Contractor, may submit a written request, accompanied by supporting documentation, to EOHHS to disenroll an Enrollee, for cause, for the following reason:

2.4.13.4.2.1. When the Enrollee's continued enrollment seriously impairs the Contractor's ability to furnish services to either this Enrollee or other Enrollees, provided the Enrollee's behavior is determined to be unrelated to an adverse change in the Enrollee's health status, or because of the Enrollee's utilization of medical services, diminished mental capacity, or uncooperative or disruptive behavior resulting from their individual needs. Such requests shall be approved by EOHHS in advance, and the Contractor shall follow the procedures described in **Appendix M**.

2.4.13.4.3. For Involuntary Disenrollments related to MassHealth eligibility changes, Enrollment continues until the last day of the month in which the Enrollee's last Medicaid eligible day occurs or the Deemed Eligibility/Enrollment period ends, whichever is later.

2.4.14. Initial Enrollee Contact and Onboarding

2.4.14.1. The Contractor shall:

2.4.14.1.1. Except as otherwise permitted during Medicare open enrollment, provide an onboarding to Enrollees within thirty (30) days, either prior to or following the initial date of enrollment. The onboarding shall include:

2.4.14.1.1.1. Engage with the Enrollee to identify any immediate health or social needs (e.g., immediate connect an Enrollee with a dentist for urgent dental needs); and

2.4.14.1.1.2. Working with the Enrollee to schedule a Comprehensive Assessment (see **Section 2.5**).

2.4.14.2. Selection of a Primary Care Provider (PCP)

2.4.14.2.1. For Enrollees with a current non-network Primary Care Provider (PCP), making reasonable efforts to contract with their PCP (See **Section 2.8.3**).

2.4.14.2.2. For Enrollees with a current PCP that is not in network and refuses to become a Network Provider or enter into a single case non-network agreement where applicable (see **Section 2.8.2.2**), assist the Enrollee to choose a PCP. The Enrollee shall choose a new PCP by the end of the 90-day Continuity of Care period or after the Individualized Care Plan is developed. If the Enrollee has not chosen an in-network

PCP by that time, the Contractor shall choose one for the Enrollee.

2.4.14.2.3. For Enrollees without a current PCP identified at the time of enrollment, the Contractor shall assist the Enrollee to identify and choose a PCP with an open panel.

2.4.14.2.4. If an Enrollee does not identify a current PCP or select a PCP within ninety (90) days of enrollment, and the Contractor has made reasonable, unsuccessful attempts to engage the Enrollee in identifying or selecting a PCP, the Contractor shall assign a PCP to the Enrollee and notify the Enrollee of the assignment.

2.4.14.2.5. Provide materials, including those described in **Section 2.12.2**, and a welcome call to the Enrollee including, but not limited to the following:

2.4.14.2.5.1. Providing any pre-enrollment materials specified in **Section 2.4** that, due to a late month enrollment request, were not provided prior to the time of enrollment;

2.4.14.2.5.2. Making available any enrollment and onboarding materials upon request and with consent of the Enrollee to family members, significant informal caregivers, and designated representatives, as appropriate; and

2.4.14.2.5.3. For Enrollees for whom written materials are not appropriate, providing non written onboarding in a format such as telephone calls, home visits, video screenings, or group presentations.

2.4.14.3. Notify its Enrollees:

2.4.14.3.1. That translations of written information are available in Prevalent Languages per 42 CFR 422.2267(a),

2.4.14.3.2. That oral interpretation services are available for any language spoken by Enrollees and Eligible Individuals free of charge,

2.4.14.3.3. How Enrollees can access oral interpretation services,

2.4.14.3.4. How Enrollees can access alternate format materials described in **Section 2.12.5.5**, and

2.4.14.3.5. How Enrollees can make a standing request to receive all future notifications and communication in a specified

preferred language and/or Alternative Format per 42 CFR 422.2267(a).

- 2.4.14.3.6. Ensure that all onboarding materials are provided in a manner and format that may be easily understood, including providing written materials in Prevalent Languages and oral interpretation services when requested.

2.5. Assessments and Care Plans

2.5.1. Comprehensive Assessment

2.5.1.1. Frequency of Assessments

2.5.1.1.1. At Enrollment

- 2.5.1.1.1.1. The Contractor shall complete a Comprehensive Assessment within ninety (90) calendar days of each Enrollee's Effective Enrollment Date.
- 2.5.1.1.1.2. The Contractor shall make subsequent attempts beyond the ninety (90) days if the initial attempt to contact the Enrollee is unsuccessful. The Contractor shall incorporate the following into their policies and procedures for unreachable Enrollees:
 - 2.5.1.1.1.2.1. The Contractor shall submit a weekly no contact list to EOHHS outlining frequency and type of outreach efforts;
 - 2.5.1.1.1.2.2. The Contractor's Medical Director or designee shall review past and/or current claims utilization to find provider(s) and/or pharmacies connected to the Enrollee; and
 - 2.5.1.1.1.2.3. The Contractor shall notify EOHHS of Enrollees who remain unreachable after 180 days, have not actively participated in Care Coordination, Assessment and Care Planning, and who have no claims for physical and/or behavioral health treatment.
- 2.5.1.1.1.3. With the Member's consent, the Contractor may complete the assessment in advance of the Effective Enrollment Date for new One Care program Enrollees.
- 2.5.1.1.1.4. The Contractor is not required to conduct a new Comprehensive Assessment for individuals who were

enrolled in the Contractor's One Care Plan prior to January 1, 2026, and for whom that Comprehensive Assessment is still current.

2.5.1.1.2. Ongoing

2.5.1.1.2.1. The Contractor shall complete Comprehensive Assessments:

2.5.1.1.2.1.1. At least annually, and no later than 12 months from the date of initial Comprehensive Assessment,

2.5.1.1.2.1.2. More frequently as directed by a condition identified, or

2.5.1.1.2.1.3. Whenever an Enrollee experiences a major change that is:

2.5.1.1.2.1.3.1. Not temporary or episodic,

2.5.1.1.2.1.3.2. Impacts on more than one area of health status, and

2.5.1.1.2.1.3.3. Requires interdisciplinary review or revision of the Individualized Care Plan.

2.5.1.2. Approach

2.5.1.2.1. General

2.5.1.2.1.1. The Contractor shall perform Comprehensive Assessments for all Enrollees to collect pertinent medical and behavioral health history, and support needs to begin the development of an Enrollee's Individualized Care Plan.

2.5.1.2.1.2. The Enrollee shall be at the center of the Comprehensive Assessment process. The Contractor shall ensure that the Enrollee receives information about the Comprehensive Assessment, and any necessary assistance and accommodations to prepare for and fully participate in the Comprehensive Assessment, the right to initiate Service Requests, and how to request access to the Comprehensive Assessment results and documentation.

- 2.5.1.2.1.3. The Contractor shall complete the Comprehensive Assessment in a location that meets the needs of the Enrollee, including conducting home-based assessments as appropriate. With the Enrollee's consent the Contractor shall also gather information from the Enrollee's providers or other sources of support.
- 2.5.1.2.1.4. Using the information gathered from the Comprehensive Assessment, the contractor shall work with the Enrollee to develop an ICP (see **Section 2.5.3.1.2** below).
- 2.5.1.2.1.5. The Contractor shall record the findings of the Comprehensive Assessment results, which includes but is not limited to, all pertinent Enrollee reported information in the Centralized Enrollee Record.
- 2.5.1.2.2. Concurrent Assessment Requirements
 - 2.5.1.2.2.1. The Comprehensive Assessment as described in **Section 2.5.1** shall be conducted concurrently and clearly aligned and integrated with the assessment tool for rating category assignment (i.e., MDS-HC or its successor), as described in **Section 2.5.2**, in order to remove redundancies in the assessment process and to reduce burden on the Enrollee. Any elements represented in both assessments shall be completed by a qualified Registered Nurse as described in **Section 2.5.2.2.1**.
- 2.5.1.2.3. In-person/Face-to-Face Requirements
 - 2.5.1.2.3.1. The Comprehensive Assessment shall be informed by at least one (1) in-person meeting in a location preferred by the Enrollee, including but not limited to the following:
 - 2.5.1.2.3.1.1. Enrollee's home or an alternate location of their choosing;
 - 2.5.1.2.3.1.2. Enrollee's Primary Care Clinic; or
 - 2.5.1.2.3.1.3. Virtually (e.g., with video and audio or other alternatives approved by EOHHS).
 - 2.5.1.2.3.2. Subject to advance approval by EOHHS, the Contractor may have policies and procedures to use modalities other than in-person engagement (e.g., virtually with audio and video, or other alternatives approved by EOHHS) for Comprehensive Assessments in certain

cases, based on a particular Enrollee's need and current status.

- 2.5.1.2.3.3. The Contractor shall not have policies or procedures that rely on alternative modalities based on geographic location, travel time for an assessor, use of contracted vendors or staff not primarily located within Massachusetts, or to reduce costs.

2.5.1.2.4. Assessor Qualifications

- 2.5.1.2.4.1. The Comprehensive Assessment shall be conducted at a minimum by a Registered Nurse or equivalently trained health care professional.

2.5.1.3. Comprehensive Assessment Tool

- 2.5.1.3.1. The Comprehensive Assessment shall be conducted using an approved assessment tool and informed by at least one (1) in person meeting. The tool shall also cover expanded domains that may be relevant to the creation of each Enrollee's care plan.
- 2.5.1.3.2. The Contractor may develop its own tool to conduct the Comprehensive Assessment. All assessment tools shall be prior approved by EOHHS.
- 2.5.1.3.3. EOHHS reserves the right to specify which tool the Contractor shall use to conduct the Comprehensive Assessment.
- 2.5.1.3.4. Any changes the Contractor proposes to make to its Comprehensive Assessment tool shall be approved by EOHHS prior to use.
- 2.5.1.3.5. The Contractor shall complete a population analysis to inform any such changes proposed to its tool:
 - 2.5.1.3.5.1. The Contractor's proposed changes to the tool shall incorporate the results of this population analysis to ensure domains adequately capture the needs, problems, and conditions of the Contractor's Enrollees, and
 - 2.5.1.3.5.2. The Contractor shall submit the population analysis with its proposed changes to the tool to EOHHS for approval.
- 2.5.1.3.6. Required Domains

2.5.1.3.6.1. The Comprehensive Assessment tool shall include the following domains, which may be updated by EOHHS during the Contract period:

- 2.5.1.3.6.1.1. Enrollee's immediate needs, problems, or conditions using the Enrollee's own voice,
- 2.5.1.3.6.1.2. Health conditions of known prevalence among subpopulations, including but not limited to physical, emotional, mental health, substance use, cognitive, intellectual, low vision/blindness, deaf and hard of hearing, and oral health,
- 2.5.1.3.6.1.3. Specialized supports that may be needed, particularly for individuals who utilize the emergency department for a psychiatric or behavioral issue,
- 2.5.1.3.6.1.4. Current medications for all health conditions including but not limited to physical, emotional, mental health, substance use, cognitive, intellectual, low vision/blindness, deaf and hard of hearing, and oral health,
- 2.5.1.3.6.1.5. Immunizations or vaccines,
- 2.5.1.3.6.1.6. The ability of the individual to communicate their concerns or symptoms, including if the individual can verbalize issues and/or whether physical symptoms are manifested through behavior,
- 2.5.1.3.6.1.7. Functional Status, including ADL and IADL limitations and support needs, and what the Enrollee identifies as their strengths, weaknesses, interests, choices about daily routine, and any adaptive equipment, assistive technology, or durable medical equipment currently in use,
- 2.5.1.3.6.1.8. Accommodation/Accessibility Needs including but not limited to, in Housing, Accessing Health Care Services, Communication with Health Care Providers.
- 2.5.1.3.6.1.9. Health Literacy
- 2.5.1.3.6.1.10. Identification of the Enrollee's Race, Ethnicity, Language, Sexual Orientation, and Gender Identification (REL SOGI), including identifying

how these factors create barriers to or otherwise influence the Enrollee's needs, problems, conditions, and access to care,

- 2.5.1.3.6.1.11. Social needs and social determinants of health, including but not limited to transportation, housing, food security, social isolation/connections, work/vocational, financial security, interpersonal, and physical safety, including risk of abuse or neglect by family members or caregivers,
- 2.5.1.3.6.1.12. Current Providers, including Primary Care Providers, Behavioral Health Providers, Specialists, and Providers of Home and Community-based Services,
- 2.5.1.3.6.1.13. Personal goals, including health goals and activities enjoyed by the Enrollee and barriers to participating,
- 2.5.1.3.6.1.14. Cultural and ethnic orientation or personal beliefs towards the Enrollee's presenting problems that may influence the Enrollee's health care,
- 2.5.1.3.6.1.15. Specific communication needs and accommodations, such as language interpreters/translators, sign language interpreters, CART, written materials, and any other adaptations and supports necessary for the Enrollee to understand treatment options,
- 2.5.1.3.6.1.16. Involvement or affiliation with other Care Coordinators, care teams, or other State agencies, including current and past involvement, use of self-directed services through State agencies, and agency contacts,
- 2.5.1.3.6.1.17. Social supports, including informal supports/caregivers and the activities they perform for Enrollees, and a back-up plan for all supports provided,
- 2.5.1.3.6.1.18. Status of and access to preventive care, screenings, and wellness strategies, including for oral health, sexual and reproductive health and family planning, nutritional needs, exercise/activity, and other prevention strategies,

2.5.1.3.6.1.19. Advance Directive/guardianship, including health care proxy and power of attorney, and

2.5.1.3.6.1.20. Other domains and/or considerations as may be required by EOHHS.

2.5.1.3.6.2. To the extent not covered in the Contractor's Onboarding activities, at the time of the assessment, the assessor shall also confirm:

2.5.1.3.6.2.1. The Enrollee's preferences regarding Privacy, services, caregivers, and daily routine, and

2.5.1.3.6.2.2. The Enrollee's understanding of their rights, in accordance with **Appendix N**.

2.5.2. Assessment for Assignment to Rating Categories

2.5.2.1. General

2.5.2.1.1. For all Enrollees residing in the community, the Contractor shall complete and submit assessments as instructed by EOHHS to inform EOHHS' assignment of Enrollees to community rating categories and capitation payment.

2.5.2.1.2. The Contractor shall use the MDS-HC (or its successor) as the assessment tool, designated by EOHHS, for rating category assignment, as instructed by EOHHS, and as further as described in **Section 2.5.2**.

2.5.2.1.3. The MDS-HC assessment shall be completed in-person with the Enrollee, and whenever possible, in the Enrollee's residence.

2.5.2.1.4. EOHHS may require completion and submission of the MDS-HC for Enrollees in all community rating categories, including for all Enrollees designated as C1, during the Contract term.

2.5.2.2. Assessor Qualifications

2.5.2.2.1. The MDS-HC assessment shall be completed in-person with the Enrollee by a qualified Registered Nurse. The Contractor shall verify licensures for all RNs conducting MDS-HC assessments at least monthly.

2.5.2.2.2. The MDS-HC assessment shall be conducted concurrently with and incorporated into the Comprehensive Assessment

as appropriate and described in **Section 2.5.1** whenever both are due. When conducting the assessments concurrently, the process may be streamlined to avoid duplicative questions. Responses to Comprehensive Assessment elements may be applied to the MDS-HC, other than for assessing functional status, as long as the assessor meets the qualifications required for the MDS-HC assessment (see **Section 2.5.2.2.**).

2.5.2.2.3. The assessor may obtain additional information about Enrollees from other sources, including Case Managers, health care providers, an LTS Coordinator, and Enrollee medical records.

2.5.2.2.4. The Contractor shall cooperate with and participate in any and all requests from EOHHS for further information concerning any submitted MDS-HC assessment data or related information.

2.5.2.3. Frequency

2.5.2.3.1. Except as described in **Section 2.5.2.2.2.**, the Contractor shall conduct a new MDS-HC assessment no later than ninety (90) days following the Enrollee's Effective Enrollment Date into the Contractor's One Care plan. As further described in **Section 4.4**, EOHHS will provide retroactive reconciliation for changes in Rating Category assignment for new Enrollees for up to three (3) calendar months for timely assessments.

2.5.2.3.2. With the Member's consent, the Contractor may complete the assessment in advance of the Effective Enrollment Date for incoming One Care Enrollees.

2.5.2.3.3. For Enrollees assigned to the C1 Rating Category, the MDS HC shall be completed to change the Rating Category.

2.5.2.3.4. For Enrollees assigned to the C2 and the C3 Rating Categories, including C2A, C2B, C3A, and C3B, the MDS HC shall be completed within 90 days of the Enrollee's Effective Enrollment Date into One Care, and at least annually thereafter.

2.5.2.3.5. For Enrollees assigned to the C4 Rating Category, the MDS HC shall be completed:

2.5.2.3.5.1. Within thirty (30) days following the Enrollee's admission into a Transitional Living Program; and

2.5.2.3.5.2. Prior to the end of the month of discharge from a Transitional Living Program.

2.5.2.3.6. An Enrollee shall be assigned to the F1 Rating Category when the Enrollee's current residence is a long-term care facility, and such residence has lasted at least ninety (90) days.

2.5.2.4. Submission

2.5.2.4.1. Information collected on the MDS-HC or its successor shall be sent to MassHealth via the MDS-HC application in the Commonwealth's Virtual Gateway to ensure accurate assignment of Rating Categories.

2.5.2.4.2. The Contractor shall cooperate with and participate in any and all requests made by EOHHS for further information concerning any MDS-HC submission.

2.5.2.4.3. EOHHS reserves the right to make changes to this tool.

2.5.2.5. MassHealth Review

2.5.2.5.1. The Contractor shall have policies and procedures in place to submit rating category discrepancies to EOHHS for review.

2.5.2.5.2. EOHHS may audit the Contractor's assessment processes and tools at any time, including through case file and medical record review.

2.5.2.6. Enrollees in Facility Settings

2.5.2.6.1. Status Change Form (SC-1)

2.5.2.6.1.1. EOHHS uses the EOHHS Status Change form ("SC-1") to identify and designate the start and end dates for payment to a long-term care facility.

2.5.2.6.1.2. The SC-1 form shall be completed and submitted to EOHHS:

2.5.2.6.1.2.1. Upon an Enrollee's admission to or discharge from a long-term care facility; and

2.5.2.6.1.2.2. In the event of a facility closure, which shall be considered a discharge from the facility for

payment and rating category assignment purposes.

- 2.5.2.6.1.3. SC-1 forms are submitted to EOHHS by the long-term care facility. The Contractor shall ensure the SC-1 form is completed and submitted to EOHHS in a form, format, and timeframe specified by EOHHS when an Enrollee enters or leaves a facility and shall include requirements for timely submission of the SC-1 in its contracts with long-term care facilities.

2.5.2.6.2. Assessment Tool and Process for Enrollees Residing in a Nursing Facility

- 2.5.2.6.2.1. When an Enrollee is admitted into a Nursing Facility, including Enrollees who are residing in a Nursing Facility at the time of Enrollment, the Contractor shall ensure that the facility shall complete an MDS 3.0.
- 2.5.2.6.2.2. The Contractor shall ensure that the facility completes and submits the MDS 3.0 to EOHHS within fourteen (14) days of admission, and at least annually thereafter. The Contractor shall work with the Facility as needed to ensure timely submission.
- 2.5.2.6.2.3. The MDS 3.0 shall be conducted or coordinated by a Registered Nurse with the appropriate participation of health professionals.
- 2.5.2.6.2.4. The MDS 3.0 assessment shall be conducted in person with the Enrollee, include direct observation, and include communication with the Enrollee and direct care staff on all shifts.

2.5.3. Care Plan

2.5.3.1. General

- 2.5.3.1.1. The Contractor shall reach each Enrollee through Person Centered Planning in ongoing development of their Individualized Care Plan (ICP).
- 2.5.3.1.2. The ICP shall:
 - 2.5.3.1.2.1. Reflect the Enrollee's preferences and needs. The Contractor shall ensure that the Enrollee receives any necessary assistance and accommodations to prepare for and fully participate in the care planning process,

including the development of the ICP, and that the Enrollee receives clear information about:

- 2.5.3.1.2.1.1. Their health status, including functional limitations; and
- 2.5.3.1.2.1.2. How family members, caregivers, and social supports can be involved in the care planning as the Enrollee chooses.
- 2.5.3.1.2.2. Be developed by the Enrollee, their Care Coordinator/Clinical Care Manager, their LTS Coordinator if assigned, others identified by the Enrollee (and/or the Enrollee's representative, if applicable), and in consultation with any specialists caring for the Enrollee, in accordance with 42 C.F.R. 438.208(c)(3) and 42 C.F.R. 422.112(a)(6)(iii) and updated periodically to reflect changing needs identified by the Enrollee. The Enrollee shall be at the center of the care planning process.
- 2.5.3.1.2.3. Specify how services and care shall be integrated and coordinated among health care providers, and community and social services providers where relevant to the Enrollee's care.
- 2.5.3.1.2.4. The ICP shall include at least the following information:
 - 2.5.3.1.2.4.1. A prioritized list of Enrollee identified goals, concerns, and strengths using the Enrollee's own voice;
 - 2.5.3.1.2.4.2. The plan for addressing goals or concerns,
 - 2.5.3.1.2.4.3. The person(s) responsible for specific interventions;
 - 2.5.3.1.2.4.4. The due date for each intervention;
 - 2.5.3.1.2.4.5. The Enrollee's understanding of available services; and
 - 2.5.3.1.2.4.6. The Enrollee's desire to self-manage all or part of their care plan regardless of the severity of disability, and the Enrollee's understanding of their self-management responsibilities.

2.5.3.1.3. MassHealth reserves the right to audit and review Enrollee care plans.

2.5.3.2. Member Approval/Consent

2.5.3.2.1. The Contractor shall:

2.5.3.2.1.1. Inform an Enrollee of their right to approve the ICP;

2.5.3.2.1.2. Establish and execute policies and procedures that provide mechanisms by which an Enrollee can sign or otherwise convey approval of their ICP when it is developed and at the time of subsequent modifications to it;

2.5.3.2.1.3. Obtain Enrollee's or their representative's signature on the initial ICP and all subsequent revisions. Where the ICP is developed via telephone or videoconference, if the audio is recorded, the Contractor shall receive the Enrollee's consent for the audio recording. The Contractor shall also document when Enrollees or their representatives refuse to sign, including a clear explanation of the reason for the Enrollee's refusal;

2.5.3.2.1.4. Provide the Enrollee with access to their ICP;

2.5.3.2.1.5. 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 ICP;

2.5.3.2.1.6. Inform an Enrollee how to submit a Grievance or an Appeal; and

2.5.3.2.1.7. Inform an Enrollee how to contact the Ombudsman.

2.5.3.3. Service Requests

2.5.3.3.1. The Contractor shall:

2.5.3.3.1.1. Accept at any time from an Enrollee a Service Request or other request for a modification of the ICP.

2.5.3.3.1.2. Document all Service Requests and other requests for a modification of the ICP in the Enrollee's Centralized Enrollee Record.

2.5.3.3.1.3. Issue a timely service authorization decision (consistent with **Section 2.10.9.8**).

2.5.3.3.1.4. Provide proper notice to the Enrollee of the service authorization decision (consistent with **Section 2.10.9.7**), including Appeal rights.

2.5.3.3.1.5. Educate Enrollees about the process and timetable for Service Requests, including but not limited to how long the Plan may take to make a service authorization decision (consistent with **Section 2.10.9**):

2.5.3.3.1.5.1. During the initial welcome call; and

2.5.3.3.1.5.2. Before the annual review of the ICP.

2.5.3.3.1.6. Document the above education in the Enrollee's Centralized Enrollee Record.

2.5.3.4. Flexible Benefits

2.5.3.4.1. The ICP shall identify Flexible Benefits that may promote independent living or recovery, positively impact outcomes, or address access or other barriers to achieving goals in the ICP.

2.5.3.4.2. Flexible Benefits may be identified and requested in the ICP by the Enrollee, a Provider, or any Member of the Enrollee's ICT as part of Person-Centered Planning. Consistent with **Section 2.10.11**, One Care Plans the Contractors are encouraged to authorize Service Requests for Flexible Benefits in the ICP that add value, including by promoting independent living or recovery, positively impacting outcomes, or addressing barriers to achieving goals in the Enrollee's care plan.

2.5.3.5. Care Plan Linkage to Prior Authorization/Utilization Management

2.5.3.5.1. Service authorization requests may be identified and requested in the ICP by the Enrollee, the Care Coordinator, a Provider, or any Member of the Enrollee's ICT as part of Person-Centered Planning.

2.5.3.5.2. The Contractor shall have policies and procedures in place to ensure that the individuals making an authorization decision notify the Enrollee's Care Coordinator when a modification or denial are considered to confirm all applicable information is reflected in their review.

2.5.3.5.2.1. The Care Coordinator shall ensure all necessary supporting information is provided to the authorizing

reviewer, including the Enrollee's ICP, and any additional information from Providers or the Enrollee.

- 2.5.3.5.2.2. The authorizing reviewer shall review and consider all supporting information, including the cumulative effect of Medicare and Medicaid benefits, Medical Necessity as defined in this Contract, and value and outcomes as required in **Section 2.10.11**, prior to modifying or denying any service request identified on the ICP.

2.6. Care Coordination and Care Model

2.6.1. Care Coordination/Care Management

2.6.1.1. General

- 2.6.1.1.1. The Contractor shall offer care coordination to all Enrollees:

- 2.6.1.1.1.1. Through a Care Coordinator or a Clinical Care Manager (CCM) for medical and Behavioral Health Services, and

- 2.6.1.1.1.2. Through a Long-term Supports (LTS) Coordinator, contracted from a community-based organization, for LTSS.

- 2.6.1.1.2. The Contractor shall provide Enrollees with information on how to contact their coordinator(s). The Contractor shall ensure that communication with each Enrollee's designated coordinator(s) is in accordance with the Enrollee's communication preferences, including through mail, telephone, text, and other electronic means, and including any interpreter services and other technology to ensure effective communication for the Enrollee.

2.6.1.2. In-Person Care Coordination/Care Management Engagement

- 2.6.1.2.1. In-person visits shall be conducted by the Enrollee's Care Coordinator or Clinical Care Manager at least once per year in the following circumstances:

- 2.6.1.2.1.1. When an Enrollee is receiving in-home services and agrees to and is able to have a home visit.

- 2.6.1.2.1.2. For an Enrollee who indicates that face-to-face interaction is their preferred method of communication. Enrollees may choose to have face-to-face visits done in their home or in another appropriate location of their choice.

- 2.6.1.2.2. Enrollees for whom home visits are not possible or not preferred shall consistently receive active and effective communication via methods that are available to and preferred by them, including, but not limited to telephone, email, virtual video/audio meetings, and written correspondence. Assistive technologies for communication shall be provided as needed to support communication between the Care Coordinator and Enrollee. Enrollees shall not be disadvantaged in receiving quality care coordination based on their ability or preference regarding method of communication or need for communication accommodations.
- 2.6.1.3. The Contractor shall provide and perform both the Administrative and Clinical activities of Care Coordination and Care Management as required for each Enrollee, and as described in this **Section 2.6**.
- 2.6.1.4. Administrative Requirements
 - 2.6.1.4.1. The Contractor shall assign Care Coordinator or Clinical Care Manager staff that are appropriately trained, licensed, and credentialed to perform the required administrative activities described in this **Section**.
 - 2.6.1.4.2. Care Coordinators shall complete the following administrative activities as required for each Enrollee.
 - 2.6.1.4.2.1. Maintain open lines of communication with Enrollees, interact with Enrollees as needed based on Enrollee preferences and care recommendations
 - 2.6.1.4.2.2. Ensure Enrollees have an ICT composed of all people key to managing their care, communicate with and convene the ICT as needed, and encourage Enrollees to identify ICT Members.
 - 2.6.1.4.2.3. Ensure Enrollees have a current ICP on record,
 - 2.6.1.4.2.4. Maintain Enrollee records to ensure that health plan services (medical, BH, LTSS, social) are recorded and that requests for services are appropriately documented, submitted, tracked, and adjudicated.
 - 2.6.1.4.2.5. Ensure that appropriate mechanisms are in place to receive Enrollee input and Grievances, and secure communication among relevant parties.

- 2.6.1.4.2.6. Ensure Enrollees can get to appointments and make community connections.
- 2.6.1.4.2.7. Act as a first point of contact for Enrollees, including by assisting Enrollees with navigating health plan processes and interactions, help Enrollees get answers to questions and manage challenges in getting services.
- 2.6.1.4.2.8. Ensure ADA compliance of services provided.
- 2.6.1.4.2.9. Educate Enrollees on One Care's benefits/service options.
- 2.6.1.4.2.10. Help Enrollees find care in their preferred language, arrange for interpreter services as needed.
- 2.6.1.4.2.11. Facilitate communication and information exchange for the services the Enrollee receives from community and social support providers.
- 2.6.1.4.2.12. Help Enrollees identify and engage with community-based resources that support social engagement, recovery, social determinants of health (including addressing homelessness, food insecurity and other factors), wellness, and independent living.

2.6.1.5. Clinical Requirements

- 2.6.1.5.1. The Contractor shall assign Care Coordinator or Clinical Care Manager staff that are appropriately trained, licensed, and credentialed to perform the required clinical activities described in this Section.
- 2.6.1.5.2. Care Coordinators shall complete the following clinical activities as required for each Enrollee:
 - 2.6.1.5.2.1. Document and access Enrollees' care plans, healthcare needs, and goals.
 - 2.6.1.5.2.2. Arrange and ensure that appropriate assessments, evaluations, and in-home resources are available.
 - 2.6.1.5.2.3. Update care plans as Enrollees' needs change.
 - 2.6.1.5.2.4. Be available and accessible to Enrollees to help answer questions and get needs met, provide, or facilitate access to interventions, as necessary.

- 2.6.1.5.2.5. Facilitate Service Requests and interaction with providers, LTS Coordinators, and others to ensure adequate Service Request presentation to UM/PA entities and appropriate adjudication in consideration of the ICP.
- 2.6.1.5.2.6. Access health plan escalation processes if there are concerns about Enrollee needs and/or preferences being appropriately addressed.
- 2.6.1.5.2.7. Support safe transitions in care for Enrollees moving between settings, including for short-term and long-term stays.
- 2.6.1.5.2.8. Ensure post-hospitalization services are discussed with Enrollees and put into place (for both medical and BH conditions).
- 2.6.1.5.2.9. Assist Enrollees in connecting with recovery supports necessary to prevent hospitalization or re-hospitalization.
- 2.6.1.5.2.10. Follow-up within twenty-four (24) hours of an Enrollee's admission to an acute hospital, and coordination with the Enrollee and hospital staff to facilitate hospital discharges.
- 2.6.1.5.2.11. Provide Care Coordination/Care Management to Enrollees residing in a skilled nursing facility or nursing facility that has a positive PASRR level II screening.
- 2.6.1.5.2.12. Report concerns about abuse or neglect to the appropriate agency (i.e., Disabled Persons Protection Commission (DPPC) for adults with disabilities ages 21-59, Executive Office of Elder Affairs (EOEA) for adults ages 60 and over).
- 2.6.1.6. Additional Clinical Requirements for Enrollees with Complex Care Needs
 - 2.6.1.6.1. The Contractor shall assign Clinical Care Manager staff that are appropriately trained, licensed, and credentialed to perform the required clinical activities described in this **Section** for Enrollees with Complex Care Needs.
 - 2.6.1.6.1.1. Such assignment may be delegated to a Provider under agreement with the Contractor to assume Clinical Care Management responsibilities.

- 2.6.1.6.1.2. In addition to executing the Administrative requirements and Clinical requirements of care coordination, the Clinical Care Manager shall provide and/or coordinate Clinical Care Management for medical and Behavioral Health Services.
- 2.6.1.6.2. The Clinical Care Manager shall require one of the following levels of licensure and/or certification:
 - 2.6.1.6.2.1. A licensed registered nurse;
 - 2.6.1.6.2.2. A Licensed Independent Clinical Social Worker (LICSW);
 - 2.6.1.6.2.3. A Licensed Clinical Social Worker (LCSW) who is directly supervised by a LICSW;
 - 2.6.1.6.2.4. A Licensed Mental Health Counselor (LMHC);
 - 2.6.1.6.2.5. A Licensed Alcohol and Drug Counselor (LADC) I; or
 - 2.6.1.6.2.6. A Licensed Alcohol and Drug Counselor (LADC) II who is directly supervised by a LADC I; and
- 2.6.1.6.3. Shall be employed by the Contractor, the Enrollee's PCP, or a patient-centered medical home or health home provider.
- 2.6.1.6.4. The Clinical Care Manager shall provide Clinical Care Management, or a set of activities that comprise intensive monitoring, follow up, and Care Coordination and clinical management of Enrollees with Complex Care Needs, including but not limited to:
 - 2.6.1.6.4.1. Engagement of the Enrollee into Clinical Care Management;
 - 2.6.1.6.4.2. Assessment of the clinical risks and needs of each Enrollee;
 - 2.6.1.6.4.3. Medication review and reconciliation;
 - 2.6.1.6.4.4. Medication adjustment by protocol;
 - 2.6.1.6.4.5. Enhanced self- management training and support for complex clinical conditions, including coaching for family members if appropriate; and
 - 2.6.1.6.4.6. Frequent Enrollee contact, as appropriate.
- 2.6.1.7. Long-term Supports (LTS) Coordinator

- 2.6.1.7.1. The Contractor shall contract with multiple Community-Based Organizations (CBOs) for the LTS Coordinator role, including at least one (1) Independent Living Center (ILC), where geographically feasible in its Service Area.
- 2.6.1.7.2. LTS Coordinators may have specific knowledge or skill sets to serve certain Enrollees, such as individuals who are Deaf or hard of hearing, or individuals with behavioral health needs. Additional CBOs may include but are not limited to Recovery Learning Communities (RLCs), ASAPs, and other CBOs serving individuals with disabilities.
- 2.6.1.7.3. Enrollees over the age of sixty (60) shall be offered the option of receiving LTS Coordinator services through an ASAP.
- 2.6.1.7.4. The Contractor shall contract with an adequate number of CBOs to allow Enrollees a choice of at least two (2) LTS Coordinators, except that with EOHHS prior approval, Contractor may offer Enrollee only one (1) LTS Coordinator.
- 2.6.1.7.5. The Contractor shall not have a direct or indirect financial ownership interest in an entity that serves as a CBO that is contracted to provide LTS Coordinators. Providers of facility- or community-based LTS on a compensated basis by a One Care Plan may not function as LTS Coordinators, except if the Contractor obtains a waiver of this requirement from EOHHS. For the purpose of this provision, an organization compensated by the Contractor to provide only evaluation, assessment, coordination, skills training, peer supports, and Fiscal Intermediary services is not considered a provider of LTSS.
- 2.6.1.7.6. The Contractor shall provide the LTS Coordinator with secure electronic user access to the Centralized Enrollee Record.
- 2.6.1.7.7. The LTS Coordinator is responsible for the following activities:
 - 2.6.1.7.7.1. Representing the LTSS and/or recovery needs of the Enrollee, advocating for the Enrollee and providing education on LTSS and/or recovery needs to the ICT and the Enrollee;

- 2.6.1.7.7.2. As a Member of the ICT, participating in Comprehensive Assessments of the health and Functional Status of Enrollees with LTSS and/or recovery needs, and, at the Enrollee's direction, assisting in the development of the community-based services component of an ICP as necessary to improve or maintain Enrollee health and Functional Status;
- 2.6.1.7.7.3. Arranging and, with the agreement of the ICT, coordinating the authorization and the provision of appropriate community LTSS and resources;
- 2.6.1.7.7.4. Assisting Enrollees in accessing Personal Care Attendant Services;
- 2.6.1.7.7.5. Monitoring the appropriate provision and functional outcomes of community LTSS, according to the ICP, as deemed appropriate by the ICT;
- 2.6.1.7.7.6. Determining community-based alternatives to long-term care; and
- 2.6.1.7.7.7. Assessing appropriateness for facility-based LTSS, if indicated, including assessing any accommodation or access needs, including accessibility requirements and equipment needs.
- 2.6.1.7.8. The LTS Coordinator shall participate as a full Member of the ICT for all Enrollees with LTSS and/or recovery needs, at the discretion of the Enrollee. The Contractor shall provide information about the LTS Coordinator to all Enrollees and offer an LTS Coordinator to all Enrollees within ninety (90) days of each Enrollee's Effective Enrollment Date.
- 2.6.1.7.9. The Contractor shall make an LTS Coordinator available:
 - 2.6.1.7.9.1. During Comprehensive Assessments for all Enrollees in C3, including C3A and C3B, in C4, and in F1 Rating Categories, and for all Enrollees in any Rating Category who request it;
 - 2.6.1.7.9.2. At any other time at an Enrollee's request;
 - 2.6.1.7.9.3. When the need for community-based LTSS is identified by the Enrollee or ICT;
 - 2.6.1.7.9.4. If the Enrollee is receiving targeted case management, is receiving rehabilitation services provided by the

Department of Mental Health, or has an affiliation with any State agency; or

- 2.6.1.7.9.5. In the event of a contemplated admission to or discharge from a nursing facility, psychiatric hospital, or other long-term care facility; and
- 2.6.1.7.9.6. Before, during, and following transitions between settings of care, including short-term and long-term hospital and institutional stays.
- 2.6.1.7.10. If the Contractor has not contacted the Enrollees within 120 days of their initial enrollment as described in **Section 2.5.1.1.1.2**. The Contractor shall assess and ensure adequate capacity of contracted LTS Coordinators to support participation in Comprehensive Assessments and other activities as described in **Section 2.5** and as directed by EOHHS.
- 2.6.1.7.11. The LTS Coordinator shall assist in identifying a more appropriate LTS Coordinator if, after a Comprehensive Assessment, it is determined that the Enrollee has specific needs outside of the LTS Coordinator's expertise.
- 2.6.1.7.12. The Contractor shall establish written qualifications for the LTS Coordinator that include, at a minimum:
 - 2.6.1.7.12.1. Bachelor's degree in social work or human services, or at least two years working in a human service field with the population eligible for One Care;
 - 2.6.1.7.12.2. Completion of person-centered planning and person-centered direction training;
 - 2.6.1.7.12.3. Experience working with people with disabilities, behavioral health needs, or elders in need of LTSS;
 - 2.6.1.7.12.4. Knowledge of the home and community-based service system and how to access and arrange for services;
 - 2.6.1.7.12.5. Experience conducting LTSS needs assessments and monitoring LTSS delivery;
 - 2.6.1.7.12.6. Cultural competency and the ability to provide informed advocacy;

2.6.1.7.12.7. Ability to write an ICP and communicate effectively, both verbally and in writing across complicated service and support systems; and

2.6.1.7.12.8. Meet all requirements of their CBO employer.

2.6.1.7.13. The Contractor shall work with the Implementation Council, the Contractor's Consumer advisory board, and other stakeholders in the community to identify and implement best practices for promoting effective LTS Coordinator engagement.

2.6.2. Interdisciplinary Care Team

2.6.2.1. The Contractor shall arrange for each Enrollee, in a manner that respects the needs and preferences of the Enrollee, the formation and operation of an ICT. The Contractor shall ensure that each Enrollee's care is integrated and coordinated within the framework of an ICT and that each ICT Member has a defined role appropriate to their licensure and relationship with the Enrollee. The Enrollee shall be encouraged to identify individuals they would like to participate on the ICT.

2.6.2.2. The ICT shall consist of at least the following staff:

2.6.2.2.1. PCP;

2.6.2.2.2. Behavioral Health Provider, if indicated;

2.6.2.2.3. Care Coordinator or Clinical Care Manager, as indicated; and

2.6.2.2.4. LTS Coordinator, if indicated, as specified in **Section 2.6.1.7.8.**

2.6.2.3. As appropriate and at the discretion of the Enrollee, the ICT also may include any or all of the following participants:

2.6.2.3.1. Registered nurse;

2.6.2.3.2. Specialist clinician(s);

2.6.2.3.3. Other professional and support disciplines including social workers, Community Health Workers, Certified Mental Health Peer Specialists, and qualified peers;

2.6.2.3.4. Family members and social supports;

- 2.6.2.3.5. Other informal caregivers;
 - 2.6.2.3.6. Advocates; and
 - 2.6.2.3.7. State agency or other case managers and other state agency clinical staff.
- 2.6.2.4. The Contractor shall establish and communicate to Enrollees clear processes for Enrollees to request changes in ICT Members, including but not limited to changes to their Care Coordinator or Clinical Care Manager, and LTS Coordinator.
- 2.6.2.5. The Contractor shall:
- 2.6.2.5.1. Recruit, select, train, manage, and employ or contract with appropriate and qualified personnel, including PCPs, behavioral health clinicians, Care Coordinators and LTS Coordinators, and shall maintain staffing levels necessary to perform its responsibilities under the Contract;
 - 2.6.2.5.2. Document that all Members of the ICT have participated in required training on the person-centered planning processes, cultural competence, accessibility and accommodations, independent living and recovery, and wellness principles;
 - 2.6.2.5.3. Ensure that the ICT is accessible to the Enrollee, including by providing alternatives to office visits, including, as appropriate, home visits, email and telephone contact;
 - 2.6.2.5.4. Ensure care team meetings are held periodically and shall monitor the provision of services provided for Enrollees;
 - 2.6.2.5.5. Ensure Contractor-employed and Provider ICT participants are appropriately resourced and compensated for care coordination and integration activities accomplished through Enrollee ICTs; and
 - 2.6.2.5.6. Have a mechanism to identify Enrollees that need a course of treatment or regular care monitoring, to allow Enrollees direct access to a specialist(s) (for example, through a standing referral or an approved number of visits) as appropriate for the Enrollee's condition and identified needs.
- 2.6.2.6. The ICT shall:
- 2.6.2.6.1. With the Enrollee and/or the Enrollee's designated representative, if any, and with all appropriate ICT Members,

including the Enrollee, develop an ICP, that reflects treatment goals (medical, functional, behavioral, and social) and measures progress and success in meeting those goals (see **Section 2.5.3.1.2**) and the roles of each ICT Member in supporting treatment goals;

- 2.6.2.6.2. On an ongoing basis, consult with and advise acute, specialty, LTSS, and Behavioral Health Providers about care plans and clinically appropriate interventions;
 - 2.6.2.6.3. With the assistance of the Care Coordinator and/or LTS Coordinator as appropriate, promote independent functioning of the Enrollee and provide services in the most appropriate, least restrictive environment using Independent Living Principles and recovery principles;
 - 2.6.2.6.4. Document and comply with Advance Directives about the Enrollee's wishes for future treatment and health care decisions;
 - 2.6.2.6.5. Assist in the designation of a health care proxy, if the Enrollee wants one;
 - 2.6.2.6.6. Maintain the Centralized Enrollee Record, including but not limited to appropriate and timely entries about the care provided, diagnoses determined, medications prescribed, and treatment plans developed and designate the physical location of the record for each Enrollee (see **Section 2.15.5.6**); and
 - 2.6.2.6.7. Communicate with the Enrollee, and, in accordance with the Enrollee's preferences, the Enrollee's family members and significant caregivers, if any, about the Enrollee's medical, social, and psychological needs.
- 2.6.2.7. Beyond supporting ICTs, the Contractor may also use qualified peers and nonmedical staff (e.g., Community Health Workers, Certified Mental Health Peer Specialist) to support and connect Enrollees with community-based resources. The Contractor shall have written protocols for:
- 2.6.2.7.1. Generating or receiving referrals or requests for services from Enrollees and for recording and tracking the results of referrals and requests for services from Enrollees;
 - 2.6.2.7.2. Providing or arranging for second opinions, whether in or non-network at no cost to the Enrollee;

- 2.6.2.7.3. Sharing clinical data and ICT information, including management of medications;
- 2.6.2.7.4. Determining conditions and circumstances under which specialty services shall be provided;
- 2.6.2.7.5. Tracking and coordination of Enrollee transfers from one setting to another (for example, hospital to home and nursing home to adult day health) and ensuring the provision of necessary new or Continuing Services and supports to minimize unnecessary complications related to care setting transitions;
- 2.6.2.7.6. Obtaining and sharing individual medical and care planning information among the Enrollee's caregivers, and with EOHHS for quality management and evaluation purposes; and
- 2.6.2.7.7. Integrating into the ICT care planning process and the ICP, as appropriate, hospice services that may be received by an Enrollee from a hospice provider.

2.6.3. Care Transitions and Discharge Planning Requirements

2.6.3.1. General

- 2.6.3.1.1. For purposes of this Section, transitions of care shall include transitions across facility and community settings, typically referred to as discharges and admissions, including:
 - 2.6.3.1.1.1. Inpatient discharge or transition, including but not limited to discharge from an acute inpatient hospital, nursing facility, chronic disease and rehabilitation hospital, psychiatric inpatient hospital, or substance use disorder hospital, collectively referred to as "inpatient discharge;"
 - 2.6.3.1.1.2. Discharge from a twenty-four (24) hour diversionary setting, Emergency Department (ED), or any other change in treatment setting;
 - 2.6.3.1.1.3. Admissions, including an Enrollee entering an inpatient setting or a different residential treatment setting, a twenty-four (24) -hour diversionary service setting, an ED, and other setting changes in which an Enrollee receives ongoing support services or treatment.

- 2.6.3.1.2. Where appropriate, the Contractor shall encourage its providers to adopt of evidence-based health at home models;
- 2.6.3.1.3. The Contractor shall ensure that the Care Coordinator is informed about in a timely manner and engaged in any care transition involving the Enrollee;
- 2.6.3.1.4. Prior to a transition in care, the Contractor shall ensure that the ICT, including the Care Coordinator assists in the development of an appropriate discharge or transition plan, including on-site presence in acute settings if appropriate;
- 2.6.3.1.5. For Enrollees who require new or changing LTSS supports, the Contractor shall ensure that the Enrollee's LTS Coordinator is present at or otherwise participates in discharge planning meetings, in accordance with **Section 2.6.4**, as appropriate;
- 2.6.3.1.6. The Contractor shall develop, implement, and maintain written protocols and operational capabilities to ensure an appropriate two-way exchange of information about the Enrollee to facilitate effective transitions for Enrollees as necessary. Such information shall include:
 - 2.6.3.1.6.1. Primary diagnoses and major health problems;
 - 2.6.3.1.6.2. A plan of care or treatment plan that includes Enrollee goals and preferences, diagnosis and treatment plan, and community care/service plan (if applicable);
 - 2.6.3.1.6.3. An Enrollee's Advance Directives, and power of attorney;
 - 2.6.3.1.6.4. Emergency plan and contact number and person;
 - 2.6.3.1.6.5. Reconciled medication list;
 - 2.6.3.1.6.6. Identification of, and contact information for, transferring clinician/institution;
 - 2.6.3.1.6.7. An Enrollee's cognitive and Functional Status;
 - 2.6.3.1.6.8. Follow-up appointment schedule with contact information;
 - 2.6.3.1.6.9. Formal and informal caregiver status and contact information; and

2.6.3.1.6.10. Designated community-based care provider, long-term services, and social services as appropriate.

2.6.3.1.7. The Contractor shall develop, implement, and maintain written protocols for facilitating timely and effective Care Transitions between settings, including with all Network Hospitals and Nursing Facilities. Such protocols shall include elements such as but not limited to the following:

- 2.6.3.1.7.1. Event notification written 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, 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, Behavioral Health provider if any, LTSS provider (e.g., Personal Care Attendant) if any, Care Coordinator, and LTS Coordinator, if any;
- 2.6.3.1.7.2. Discharge Planning activities occurring at the time of admission;
- 2.6.3.1.7.3. Prioritizing return to an appropriate home or community-based setting rather than a facility setting whenever possible, including proactive planning to identify and mitigate barriers to effectively supporting an Enrollee to return to and remain in their home, and make best efforts to ensure a smooth transition to the next service or to the community;
- 2.6.3.1.7.4. 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;
- 2.6.3.1.7.5. Inclusion of the Enrollee's Behavioral Health provider, if any, and LTSS providers (e.g., Personal Care Attendant) if any in Discharge Planning and follow-up;
- 2.6.3.1.7.6. Identification of the Enrollee's State agency affiliation, release of information, and coordination with any State agency representative assigned to the Enrollee;
- 2.6.3.1.7.7. Identification of non-clinical supports and the role they serve in the Enrollee's treatment and after care plans;

- 2.6.3.1.7.8. Include protocols for documenting all efforts related to Care Transitions and Discharge Planning in the Enrollee's medical record, including the Enrollee's active participation, goals, and preferences;
- 2.6.3.1.7.9. Scheduling of discharge/aftercare appointments in accordance with the access and availability standards;
- 2.6.3.1.7.10. Referral to and care coordination with post-acute and outpatient providers as needed, including community-based support services providers;
- 2.6.3.1.7.11. Telephonic or other follow-up with Enrollees within forty-eight (48) hours of an inpatient encounter;
- 2.6.3.1.7.12. Culturally and linguistically competent post-discharge education regarding symptoms that may indicate additional health problems or a deteriorating condition;
- 2.6.3.1.7.13. Patient-centered self-management support and relevant information specific to the Enrollee's condition and any ongoing risks; and
- 2.6.3.1.7.14. Home visits post-discharge as required by the Enrollee.

2.6.3.2. Follow-up Requirements Post-Discharge

- 2.6.3.2.1. Within seven (7) calendar days following an Enrollee's emergency department (ED) discharge, seven (7) calendar days following 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 follows up with the Enrollee face-to-face or via telehealth (e.g., telephone or videoconference, or as further specified by EOHHS), and at a minimum:
 - 2.6.3.2.1.1. Discusses with the Enrollee, and with the Enrollee's consent, updates the Enrollee's Care Plan; and
 - 2.6.3.2.1.2. Coordinates clinical services, in-home or community-based services, and other supports for the Enrollee, as needed.
- 2.6.3.2.2. 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 an appropriately licensed and credentialed individual, such as a registered

nurse (RN) or a licensed practical nurse (LPN) under the oversight and supervision of an RN:

- 2.6.3.2.2.1. Reviews the updated Care Plan, if applicable.
 - 2.6.3.2.2.2. Conducts a formal Medication Reconciliation that includes a comprehensive Medication Review and provides Medication Management as needed, including ensuring that Enrollees who require medication monitoring shall have access to such services within seven (7) business days of discharge from a behavioral health inpatient setting,
 - 2.6.3.2.2.3. Documents a discussion with the Enrollee and the Enrollee's ICT plans to better support the Enrollee to prevent future admissions or re-admissions, as appropriate.
 - 2.6.3.2.2.4. The Contractor shall ensure the Care Coordinator monitors and updates ICT Members on the Enrollee's status following transitions in care.
 - 2.6.3.2.2.5. The Contractor shall ensure that the Care Coordinator assists Enrollees in accessing supports to which they are referred following a transition of care.
 - 2.6.3.2.2.6. Assurance that inpatient and twenty-four (24) hour diversionary Behavioral Health Providers provide a discharge plan following any behavioral health admission to ICT Members.
- 2.6.3.3. Discharge Planning for Enrollees Experiencing or At Risk of Homelessness
- 2.6.3.3.1. The Contractor shall, as further directed by EOHHS, including but not limited to in Managed Care Entity Bulletins, implement policies and procedures that ensure timely, appropriate, and comprehensive Discharge Planning for Enrollees experiencing homelessness or Enrollees at risk of homelessness. Such policies and procedures shall be consistent with federal and state privacy laws and regulations and shall be incorporated into the Contractor's protocols for Care Transitions with all Network Hospitals.
 - 2.6.3.3.2. In addition to the requirements above in **Section 2.6.3.2**, ensure that Discharge Planning activities include the following as further specified by EOHHS:

- 2.6.3.3.2.1. The hospital shall contact the Contractor at the time of admission in order to collaborate in identifying resources to assist with the Enrollee's housing situation.
 - 2.6.3.3.2.2. At the time of admission, and as part of its general Discharge Planning processes, the hospital shall assess each admitted Enrollee's current housing situation.
 - 2.6.3.3.2.3. The hospital shall invite and encourage participation in Discharge Planning, as appropriate, by the Enrollee, the Enrollee's family, providers, Community Partner, Care Coordinators, shelter staff, and any other supports identified by the Enrollee.
 - 2.6.3.3.2.4. For any Enrollee who is a client of the Department of Mental Health (DMH), the Department of Developmental Services (DDS), the Massachusetts Rehabilitation Commission (MRC), or the Executive Office of Elder Affairs (EOEA), the hospital shall invite and encourage designated staff from each such agency to participate in such Enrollee's discharge planning activities.
 - 2.6.3.3.2.5. For any Enrollee that is not a client of DMH, DDS, MRC, or EOEA, the hospital shall determine whether the Enrollee may be eligible to receive services from some or all of those agencies and offer to assist in submitting an application to DMH, DDS, MRC, or EOEA as appropriate.
 - 2.6.3.3.2.6. The hospital shall determine whether the Enrollee has any substance use disorder, as further specified by EOHHS. For any such Covered Individual, the Provider must contact the Massachusetts Substance Use Helpline (800) 327-5050), the statewide, public resource for finding substance use treatment, recovery options, and assistance with problem gambling, or successor Helplines as identified by EOHHS. The Helpline's trained specialists will help the Enrollee understand the available treatment services and their options.
- 2.6.3.3.3. Ensure that Discharge Planning activities include the following assessment of options for discharge as further specified by EOHHS:
- 2.6.3.3.3.1. The hospital shall ensure that discharge planning staff are aware of and utilizes available community resources to assist with Discharge Planning.

- 2.6.3.3.3.2. For any Enrollee with skilled care needs, who needs assistance with activities of daily living, or whose behavioral health condition would impact the health and safety of individuals residing in the shelter, the hospital shall make all reasonable efforts to prevent discharges to emergency shelters. For such Enrollees, the hospital shall seek placement in more appropriate settings, such as DMH community-based programs or nursing facilities.
- 2.6.3.3.3.3. For any Enrollee who was experiencing homelessness prior to admission and is expected to remain in the hospital for fewer than 14 days, the hospital shall contact the appropriate emergency shelter to discuss the Enrollee's housing options following discharge, as further specified by EOHHS.
- 2.6.3.3.3.4. For any Enrollee for whom discharge to an emergency shelter or specific placement cannot be secured, the hospital shall provide additional supports and track discharges of such Enrollees as further specified by EOHHS.
- 2.6.3.3.4. For the purposes of this **Section**, Enrollees experiencing homelessness shall be any Enrollee who lacks a fixed, regular, and adequate nighttime residence and who:
 - 2.6.3.3.4.1. 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;
 - 2.6.3.3.4.2. 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
 - 2.6.3.3.4.3. Is chronically homeless as defined by the US Department of Housing and Urban Development and in **Section 1.31** of this contract.
- 2.6.4. Coordinating Care and Services with Federal, State, and Community Agencies
 - 2.6.4.1. General

2.6.4.1.1. The Contractor shall implement a systematic process for coordinating care and creating linkages between Enrollees and organizations that provide services not covered, including but not limited to:

- 2.6.4.1.1.1. State agencies, including e.g., the Department of Developmental Services (DDS), Department of Mental Health (DMH), Department of Public Health (DPH) and DPH's Bureau of Substance Addiction Services (DPH/BSAS), Massachusetts Commission for the Blind (MCB), Massachusetts Commission for the Deaf and Hard of Hearing (MCDHH), Massachusetts Rehabilitation Commission, and the Executive Office of Elder Affairs (EOEA);
- 2.6.4.1.1.2. Social service agencies;
- 2.6.4.1.1.3. Community-based mental health and substance use disorder programs;
- 2.6.4.1.1.4. Consumer, civic, and religious organizations; and
- 2.6.4.1.1.5. Federal agencies (e.g., the Department of Veterans Affairs, Housing and Urban Development, and the Social Security Administration).

2.6.4.2. Requirements

2.6.4.2.1. The systematic process and associated linkages shall provide for:

- 2.6.4.2.1.1. Sharing information and generating, receiving, and tracking referrals;
- 2.6.4.2.1.2. Obtaining and recording consent from Enrollees to share individual Enrollee medical information where necessary; and
- 2.6.4.2.1.3. Ongoing coordination efforts (for example, regularly scheduled meetings, newsletters, and jointly community-based projects).

2.6.4.2.2. The Contractor shall designate a State Agency Liaison as described in **Section 2.3**.

2.6.4.3. Department of Mental Health (DMH)

2.6.4.3.1. The Contractor shall ensure that services are provided to Enrollees with DMH affiliation as follows:

2.6.4.3.1.1. Ensure that the ICT communicates with the DMH caseworker(s) assigned to Enrollees and informs them of the services provided through the Contractor's plan;

2.6.4.3.1.2. Ensure that for all DMH clients, a release of information is requested to be used to inform the agency of the Enrollee's current status;

2.6.4.3.1.3. Ensure that for all DMH clients, the ICP specifies all Behavioral Health Services required during any acute Behavioral Health Inpatient Services stay, identifies discharge plans and, when appropriate, indicates the need for DMH Community-based Services or continuing inpatient psychiatric care as part of the ICP; and

2.6.4.3.1.4. Designate a DMH Liaison as described in **Section 2.3**.

2.6.4.4. Department of Developmental Services (DDS)

2.6.4.4.1. The Contractor shall ensure that services are provided to Enrollees with DDS affiliation as follows:

2.6.4.4.1.1. Ensure that the ICT communicates with the DDS caseworker(s) assigned to Enrollees and inform them of the services provided through the Contractor's Plan; and

2.6.4.4.1.2. Designate a DDS Liaison as described in **Section 2.3**.

2.6.4.5. Ombudsman

2.6.4.5.1. The Contractor shall support Enrollee access to, and work with, the Ombudsman to address Enrollee requests for information, issues, or concerns related to One Care, including:

2.6.4.5.1.1. Educating Enrollees about the availability of Ombudsman services:

2.6.4.5.1.1.1. On the Contractor's website;

2.6.4.5.1.1.2. When Enrollees receive the Member Welcome package;

2.6.4.5.1.1.3. At the time of the annual Comprehensive Assessment; and

2.6.4.5.1.1.4. When Enrollees – or their family members or representatives – contact One Care plan staff, including Member services and provider staff, with a Grievance, or Appeal.

2.6.4.5.1.2. Communicating and cooperating with Ombudsman staff as needed for them to investigate and resolve Enrollee requests for information, issues, or concerns related to One Care, including by:

2.6.4.5.1.2.1. Designating a staff person as the Contractor's Ombudsman liaison as described in **Section 2.3**;

2.6.4.5.1.2.2. Providing Ombudsman staff with access to records needed to investigate and resolve Enrollee Grievances (with the Enrollee's approval); and

2.6.4.5.1.2.3. Ensuring ongoing communication and cooperation of Plan staff with Ombudsman staff in working to investigate and resolve Enrollee Grievances, including updates on progress made towards resolution, until such time as the Grievances have been resolved.

2.6.5. Continuity of Care

2.6.5.1. For all services other than Part D drugs, the Contractor shall develop policies and procedures to ensure continuity of care for all Enrollees into the Contractor's One Care Plan for whichever is the longer of:

2.6.5.1.1. A period of up to ninety (90) days following the Effective Enrollment Date, unless the Comprehensive Assessment and the ICP are completed (developed and reviewed with the Enrollee, including any changes in providers, services, or medications) sooner and the Enrollee agrees to the shorter time period; or

2.6.5.1.2. Until the Comprehensive Assessment and ICP are complete (developed and reviewed with the Enrollee, including any changes in providers, services, or medications).

2.6.5.2. Continuity of Care policies shall apply any time an individual enrolls into the Contractor's One Care Plan, including for Members enrolling from other One Care plans or MassHealth health plans, or PACE.

- 2.6.5.3. Such policies and procedures shall be consistent with 42 C.F.R. § 438.62(b)(1) and 42 C.F.R. § 422.112(b) and for the purpose of:
- 2.6.5.3.1. Minimizing the disruption of care and ensuring uninterrupted access to Medically Necessary services;
 - 2.6.5.3.2. Ensuring that the Enrollee is established with any new service Providers, as indicated by the ICP, so that no gap in ongoing services occurs;
 - 2.6.5.3.3. For an Enrollee that has not transitioned to the Contractor's Network Providers at the conclusion of the 90-day continuity of care period, the Contractor shall make best efforts to provide uninterrupted care beyond the 90-day period and shall establish policies and procedures to this effect. Such policies and procedures shall include, but not be limited to, honoring authorizations from the Enrollee's previous plan until the Contractor issues new authorizations for Medically Necessary services; paying non-network providers for services until such Enrollees have been transitioned to a Network Provider; and other measures as further specified by EOHHS;
 - 2.6.5.3.4. Intaking and honoring prior authorizations at the time of enrollment that have been issued by MassHealth or its designee, by another One Care plan, MassHealth health plan, or PACE Organization, and by Medicare until the ICP is complete and any new or updated authorizations have been issued;
 - 2.6.5.3.5. Preventing gaps and disruptions in LTSS and ongoing support services, such as PCA, routines such as attending a particular day program; and
 - 2.6.5.3.6. Ensuring that Providers are able to confirm or obtain any authorization, if needed, as well as payment for any such services from the Contractor.
- 2.6.5.4. In addition to general Continuity of Care policies for all Enrollees, the Contractor shall have specific policies and procedures at a minimum for the Enrollees who, at the time of their Enrollment:
- 2.6.5.4.1. Are pregnant;
 - 2.6.5.4.2. Have significant health care needs or complex medical conditions;
 - 2.6.5.4.3. Have autism spectrum disorder (ASD);

- 2.6.5.4.4. Are receiving ongoing services such as dialysis, home health, chemotherapy and /or radiation therapy;
- 2.6.5.4.5. Are hospitalized, in a nursing facility, or in a residential service setting;
- 2.6.5.4.6. Are receiving behavioral health treatment or substance use disorder treatment;
- 2.6.5.4.7. Are receiving ongoing supports for ADLs and/or IADLs; or
- 2.6.5.4.8. Have received prior authorization for One Care Covered Services including but not limited to:
 - 2.6.5.4.8.1. Scheduled and unscheduled inpatient care (medical and Behavioral Health), outpatient procedures, and admission to a nursing facility;
 - 2.6.5.4.8.2. Out-of-area specialty services;
 - 2.6.5.4.8.3. Durable medical equipment (DME) or prosthetics, orthotics, and supplies, Physical therapy (PT), occupational therapy (OT), or speech therapy (ST);
 - 2.6.5.4.8.4. PCA and other LTSS;
 - 2.6.5.4.8.5. Oral health care and procedures; and
 - 2.6.5.4.8.6. Other medically necessary services.
- 2.6.5.5. The contractor shall have specific policies and procedures for:
 - 2.6.5.5.1. Identifying and communicating with Enrollees for whom Continuity of Care is required in accordance with this **Section**, and those Enrollees' providers (including but not limited to Network Providers);
 - 2.6.5.5.2. Facilitating continuity of care so that Enrollees may continue to see their current providers (including but not limited to Network Providers) for Medically Necessary Behavioral Health Covered Services for at least ninety (90) days from the Enrollee's Effective Enrollment Date;
 - 2.6.5.5.3. Ensuring that Enrollees currently receiving inpatient care (medical, Behavioral Health, post-acute or custodial care) from a hospital or nursing facility, including non-Network hospitals and non-network nursing facilities, at the time of their Enrollment may continue to receive such care from

such hospital or nursing facility as long as such care is Medically Necessary. The Contractor shall make best efforts to contact such facility to ensure such Continuity of Care; and

- 2.6.5.5.4. Ensuring Enrollees with upcoming appointments, ongoing treatments or services, prior authorizations, and services previously authorized by another One Care plan, other MassHealth health plan, PACE Organization, Medicare plan, or a commercial carrier may continue to seek and receive such care from providers (including non-Network) with whom they have an existing relationship for such care.
- 2.6.5.6. The Contractor shall ensure such continuity by providing new authorization or extending existing authorization, if necessary, for the duration of such prior authorizations and prior approvals, without regard to Medical Necessity criteria, for at least the required 90-day period.
- 2.6.5.7. If the Contractor chooses to modify or terminate a prior authorization and prior approval, then the Contractor shall treat such modification or termination as an Adverse Action and follow the appeal rights policy and procedures, including notification to the Enrollee and the Enrollee's provider in question,
- 2.6.5.8. The Contractor shall have the ability to:
 - 2.6.5.8.1. Accept and utilize medical records, claims histories, and prior authorizations from an Enrollee's previous One Care plan, other MassHealth health plan, PACE Organization, MassHealth, MassHealth FFS providers, Medicare, or a commercial carrier.
 - 2.6.5.8.2. Accept the transfer of all administrative documentation, as directed by EOHHS,
- 2.6.5.9. For pregnant Enrollees, the Contractor shall:
 - 2.6.5.9.1. Ensure that the Enrollee may choose to remain with their current provider of obstetrical and gynecological services, even if such provider is not in the Contractor's Provider Network,
 - 2.6.5.9.2. Cover all Medically Necessary obstetrical and gynecological services through delivery of the child, as well as immediate post-partum care and the follow-up appointments within the first six weeks of delivery, even if the provider of such services is not in the Contractor's Provider Network, and

- 2.6.5.9.3. However, if a pregnant Enrollee would like to select a new Provider of obstetrician and gynecological services within the Contractor's Provider Network, such Enrollee may do so.
- 2.6.5.10. For Enrollees affiliated with other state agencies, the Contractor shall ensure coordination and consultation with such agencies as described in **Section 2.6.4, 2.7 and 5.3.8**.
- 2.6.5.11. As directed by EOHHS, the Contractor shall participate in any other activities determined necessary by EOHHS to ensure the continuity of care for Enrollees.
- 2.6.5.12. Continuity of PCA Services for Enrollees at Disenrollment
 - 2.6.5.12.1. Upon the disenrollment of an Enrollee who receives PCA services, in addition to any other continuity of care requirements imposed by law, regulation, or this Contract, the Contractor shall comply with EOHHS-prescribed continuity of PCA service procedures.
- 2.6.6. Enrollees with Special Health Care Needs
 - 2.6.6.1. Enrollees including, at a minimum, those who have or are at increased risk to have chronic physical, developmental, or behavioral health condition(s); require an amount or type of services beyond those typically required for individuals of similar age; and may receive these services from an array of public and/or private providers across health, education, and social systems of care.
 - 2.6.6.2. In accordance with 42 CFR 438.208(c), Enrollees with Special Health Care Needs have access to care coordination as part of the One Care Plan's Care Model, including having assessments as described in **Section 2.5.1**, engagement in person-centered care planning as described in **Section 2.5.3.**, care coordination as described in **Section 2.6.1**, and direct access to specialists as described in **Section 2.6.2.5.6**. Assessment of the quality and appropriateness of care furnished to such individuals occurs through the Contractor's Quality Improvement Activities described in **Section 2.14.3**.
- 2.6.7. FIDE SNP Model of Care
 - 2.6.7.1. In accordance with Section 1859(f)(7) of the Social Security Act, the Contractor's Model of Care as approved by the National Committee for Quality Assurance (NCQA) for its One Care Plan shall comply with all EOHHS requirements described in this **Section**. These EOHHS requirements are in addition to all existing Medicare

Advantage Special Needs Plan Model of Care requirements outlined in 42 CFR §422.101(f) and Chapter 5 of the Medicare Managed Care Manual.

- 2.6.7.2. The Contractor's model of care shall support EOHHS' goals to ensure all Enrollees have access to equitable, high-quality care and to provide Care Coordination or Care Management services that are responsive to Enrollees needs and risks, which may change over time. In addition, the Contractor's model of care shall prioritize the goal of Enrollees maintaining their independence in the community through continuity of care and seamless transitions for Enrollees across the full continuum of physical health, behavioral health, pharmacy, LTSS, and social service needs.
- 2.6.7.3. The Contractor's Model of Care shall include the following required elements:
 - 2.6.7.3.1. Provide the full scope of Care Coordination and Care Management services for all Members, as defined in **Section 2.6** of the Contract.
 - 2.6.7.3.2. Include how the Comprehensive Assessments, the MDS-HC and LOC tools are coordinated with or used as the Health Risk Assessment (HRA). In addition, describe Comprehensive Assessments, individualized care planning, and Interdisciplinary Care Team involvement for all Enrollees, as defined in **Section 2.6** of the contract.
 - 2.6.7.3.3. Integrate physical health, behavioral health, pharmacy, oral health, LTSS, HCBS, and social service needs into the Contractor's approach to the provision of services.
 - 2.6.7.3.4. Specify how the Contractor confirms LTSS services restart at the time of discharge from a twenty-four (24) hour care setting.
 - 2.6.7.3.5. Ensure a comprehensive set of covered services are provided, including Flexible Benefits as specified in the Member's Individualized Care Plan. The provision of Covered Services shall be in accordance with Medical Necessity as holistically described in this Contract, and without any predetermined limits, unless specifically stated in **Section 2.7**.
 - 2.6.7.3.6. Be responsive to the Member's needs, goals, and preferences, and take into account the Member's health, safety, and welfare.

- 2.6.7.3.7. Include staff and provider network training (in conjunction with EOHHS whenever possible) on the model of care to ensure Enrollees receive person-centered, culturally competent care through trained providers, and
- 2.6.7.3.8. Include processes and systems of care that engage Enrollees and family members in person-centered, culturally competent care, and ensure seamless transitions between levels of care and care settings, addressing all barriers to accessing appropriate services to support optimal Enrollee health and outcomes.
- 2.6.7.4. The Contractor shall submit to EOHHS the Model of Care (MOC) required under Social Security Act Section 1859(f)(7), including care management roles and responsibilities of each Member of the ICT. The Contractor shall submit to EOHHS the MOC at the same time as the Contractor is submitting the MOC to CMS and NCQA for review. In addition, the Contractor shall submit the MOC to EOHHS annually, notifying EOHHS of any changes made to the MOC. Finally, the Contractor shall submit the MOC score and all summary-level performance reporting exchanged with CMS or NCQA, within five (5) business days of exchange with CMS or NCQA.

2.7. Covered Services and Care Delivery

2.7.1. General

- 2.7.1.1. The Contractor shall provide a benefit package that includes the comprehensive set of Covered Services referenced in **Section 2.7.2** (Medical Necessity) and listed in **Appendix C, Exhibits 1, 2, and 3**. The Contractor shall authorize, arrange, integrate, and coordinate the provision of all Covered Services for its Enrollees. Covered Services shall be available to all Enrollees, as authorized by the Contractor. Covered Services shall be managed and coordinated by the Contractor through the Interdisciplinary Care Team (ICT) (see **Section 2.6.2**).
- 2.7.1.2. The Contractor shall provide the full range of Covered Services. If Medicare or MassHealth provides more expansive services for a particular condition, type of illness, or diagnosis, the One Care Plan shall provide the most expansive set of services required by either program, including the cumulative effect as provided by the combination of Medicare and MassHealth. The Contractor may not limit or deny services to Enrollees based on either Medicare or MassHealth providing a more limited amount, duration, type, frequency, or scope of services than the other program.

- 2.7.1.3. The Contractor shall provide all Covered Services in an amount, duration, type, frequency, and scope that is no less than the amount, duration, type, frequency, and scope for the same services provided under MassHealth fee for service.
- 2.7.1.4. The provision of Covered Services shall be in accordance with medical necessity and without any predetermined limits, unless specifically stated (see **Section 2.7.2**), and shall be provided as set forth in 42 C.F.R. Parts 440, 434, and 438.
- 2.7.1.5. The Contractor shall ensure that all Covered Services are sufficient in amount, duration, and scope, as well as type and frequency, to reasonably achieve the purpose for which the services are furnished.
- 2.7.1.6. As described in **Appendix C, Exhibits 1, 2, and 3**, Covered Services include:
 - 2.7.1.6.1. All services provided under Medicare Part A, Part B, and Part D, in that the Contractor's Medicare Contract provides primary coverage of Medicare services, and this Medicaid Contract provides secondary coverage for Medicare primary services, which includes Medicaid payment of Medicare cost-sharing and eligible individuals' Medicaid benefits, which may exceed or complement Medicare primary benefits in amount, duration, or scope, as well as type and frequency.
 - 2.7.1.6.2. All Medicaid services listed and defined in **Appendix C, Exhibits 1, 2, and 3**.
 - 2.7.1.6.3. Pharmacy products that are covered by MassHealth, which are not covered under Medicare Part D, including over-the-counter drugs and prescription vitamins and minerals specified in the MassHealth Drug List. Contractors are encouraged to offer a broader drug formulary than Part D and MassHealth minimum requirements.
- 2.7.1.7. Additions to Medicaid required services enacted through legislative or judicial change, including midyear updates, will not require a Contract revision or agreement by all parties prior to the Contractor offering providing or arranging for the service to Enrollees.
- 2.7.1.8. Medicaid payment of Medicare cost-sharing.
 - 2.7.1.8.1. Medically Necessary nursing facility services no more restrictive than the State plan nursing facility benefit, including stays in excess of 180 days as Medically Necessary.

- 2.7.1.8.2. In addition to the Covered Services described above, One Care Plans shall use Flexible Benefits, as specified in the Enrollee's Individualized Care Plan and appropriate to address the Enrollee's needs.
- 2.7.1.8.3. EOHHS may require the Contractor to cover certain items or services as Medicare Supplemental Services.
- 2.7.1.8.4. The Contractor shall offer to Enrollees any additional non-medical programs and services available to a majority of the Contractor's commercial population, if any, on the same terms and conditions on which those programs and services are offered to the commercial population, unless otherwise agreed upon in writing by EOHHS and the Contractor, such as health club discounts, diet workshops, and health seminars.

2.7.2. Medical Necessity

2.7.2.1. The Contractor shall:

- 2.7.2.1.1. Authorize, arrange, coordinate, and provide timely to Enrollees all Medically Necessary Covered Services as described in **Section 2.7.2**, in accordance with the requirements of this Contract, including **Section 1.105**; and
- 2.7.2.1.2. The Contractor shall develop and implement policies and procedures to ensure that all Medically Necessary Services are provided to Enrollees based on their individual health care and functional needs and consistent with **Appendix C**. Such policies and procedures, including any updates to existing policies and procedures, shall be submitted to the EOHHS for review upon request.

2.7.2.2. The Contractor shall not:

- 2.7.2.2.1. Arbitrarily deny or reduce the amount, duration, or scope, or type or frequency, of a required Covered Service solely because of diagnosis, type of illness, or condition of the Enrollee; and
- 2.7.2.2.2. Deny authorization for a Covered Service that the Enrollee or the provider demonstrates is Medically Necessary.
- 2.7.2.3. The Contractor may place appropriate limits on a Covered Service on the basis of Medical Necessity, or for the purpose of utilization management, provided that the furnished services can reasonably

be expected to achieve their purpose. The Contractor's Medical Necessity guidelines shall, at a minimum, be:

- 2.7.2.3.1. Developed with input from practicing physicians in the Contractor's Service Area.
- 2.7.2.3.2. Developed in accordance with standards adopted by national accreditation organizations.
- 2.7.2.3.3. Updated as new treatments, applications, and technologies are adopted as generally accepted professional medical practice.
- 2.7.2.3.4. Be evidence based, if practicable; and
- 2.7.2.3.5. Be applied in a manner that considers the individual health care and functional needs of the Enrollee.
- 2.7.2.4. Medicare and MassHealth coverage and benefits, including how such benefits would be provided to an Eligible Individual with MassHealth Standard in MassHealth FFS, including MassHealth Dental services purchased through a TPA, shall be the minimum standard for coverage and benefits the Contractor shall provide to its Enrollees. Limits in either Medicare or MassHealth shall not be construed to limit the amount, duration, or scope, or type or frequency of benefits the Contractor shall provide to Enrollees in accordance with this Contract, unless otherwise specified herein.
- 2.7.2.5. The Contractor's Medical Necessity criteria shall not limit a Covered Service to either the Medicare or the MassHealth criteria when the combination or cumulative effect of such Medicare and MassHealth coverage would result in an increased minimum amount, duration, or scope, or type or frequency.
- 2.7.2.6. The Contractor's Medical Necessity guidelines, program specifications, and service components for all Covered Services shall, at a minimum, be submitted to EOHHS for approval no later than sixty (60) days prior to any change, except as specified by EOHHS.
- 2.7.3. Cost-sharing for Covered Services
 - 2.7.3.1. Enrollee cost-sharing is not permitted in One Care.
 - 2.7.3.2. The Contractor shall not charge Medicare Part C premiums for its One Care Plan.

- 2.7.3.3. Enrollee Contribution to Care Amounts for Enrollees residing in a nursing facility as described in **Section 4.2.7** shall not be considered cost-sharing for purposes of this Section.
- 2.7.3.4. MassHealth premiums that individuals pay to EOHHS to establish and maintain MassHealth eligibility shall not be considered cost-sharing for purposes of this **Section 2.7.3**.
- 2.7.3.5. In its Medicare D-SNP Bid, the Contractor shall apply Medicare LIS payments to Enrollee Medicare co-insurance costs for Medicare Part D before applying Medicare Rebate dollars to reduce Enrollee cost-sharing.
- 2.7.4. Limitations on Covered Services
 - 2.7.4.1. The following services and benefits shall be limited as covered services:
 - 2.7.4.1.1. Termination of pregnancy may be provided only as allowed by applicable State and federal law and regulation (42 C.F.R. Part 441, Subpart E).
 - 2.7.4.1.2. Sterilization services may be provided only as allowed by State and federal law (see 42 C.F.R. Part 441, Subpart F).
- 2.7.5. Primary Care
 - 2.7.5.1. Primary Care Providers (PCP)
 - 2.7.5.1.1. The PCP shall:
 - 2.7.5.1.1.1. Provide primary medical services, including acute and preventive care;
 - 2.7.5.1.1.2. Refer the Enrollee, in coordination with the ICT and in accordance with the Contractor's policies, to Covered Service providers, as medically appropriate; and
 - 2.7.5.1.1.3. Engage with and provide direction to the ICT, together with the Care Coordinator, and if indicated, with the Behavioral Health Provider.
- 2.7.6. Pharmacy Management
 - 2.7.6.1. General
 - 2.7.6.1.1. The Contractor shall manage its pharmacy program, including all pharmacy products as described in **Appendix**

C, in accordance with EOHHS requirements in this Contract. For any pharmacy products and activities outside the scope of Part D, EOHHS requirements solely apply [<https://www.mass.gov/doc/pharmacy-regulations/download>].

2.7.6.2. Management and Support

2.7.6.2.1. The Contractor shall:

- 2.7.6.2.1.1. Dedicate a clinical pharmacist to oversee the program and shall provide additional pharmacy staffing as necessary to support the provisions of this Contract.
- 2.7.6.2.1.2. Establish and maintain a call center to answer questions and provide support to pharmacy Providers and to prescribers.
- 2.7.6.2.1.3. If the Contractor uses a pharmacy benefit manager (PBM) to assist with the Contractor's prescription drug management program, the Contractor shall follow all requirements with respect to Material Subcontractors set forth in this Contract, including but not limited to those set forth in **Section 2.3**.

2.7.6.3. Drug Coverage

2.7.6.3.1. The Contractor shall:

- 2.7.6.3.1.1. As described in **Appendix C**, cover all prescription drugs, Non-Drug Pharmacy Products, and over-the-counter drugs uniformly with how EOHHS covers such drugs and products for MassHealth fee-for-service Members as set forth in the MassHealth Drug List, and any updates thereto in the timeframe specified by EOHHS, including but not limited to the drugs and products themselves and any utilization management and authorization requirements for such drugs and products.
- 2.7.6.3.1.2. Operate and maintain a National Council for Prescription Drug Programs (NCPDP)-compliant, on-line pharmacy claims processing system. Such system shall allow for:
 - 2.7.6.3.1.2.1. Financial, eligibility, and clinical editing of claims;
 - 2.7.6.3.1.2.2. Messaging to pharmacies;
 - 2.7.6.3.1.2.3. Downtime and recovery processes;

2.7.6.3.1.2.4. Electronic prescribing;

2.7.6.3.1.2.5. Electronic prior authorization.

2.7.6.3.1.3. Having a separate BIN, PCN, and group number combination for each of Medicare primary claims and MassHealth claims to differentiate them from commercial claims. The Contractor shall notify EOHHS of this BIN, PCN, and group number combination changes as set forth in **Appendix A**.

2.7.6.3.1.4. The Contractor shall provide outpatient drugs pursuant to this **Section 2.7** in accordance with Section 1927 of the Social Security Act and 42 CFR 438.3(s), including but not limited to complying with all applicable requirements related to coverage, drug utilization data, drug utilization review program activities and prior authorization policies.

2.7.6.3.1.5. Integrate medical claims information to make pharmacy prior authorization decisions at the point of sale.

2.7.6.4. Clinical Management

2.7.6.4.1. The Contractor shall:

2.7.6.4.1.1. Have appropriate processes in place to clinically manage all prescription drugs, over-the-counter drugs, and Non-Drug Pharmacy Products consistent with **Section 2.7** and the MassHealth Drug List, unless otherwise specified by EOHHS.

2.7.6.4.1.2. Provide electronic access to the MassHealth Drug List by linking the MassHealth Drug List on the Contractor's website.

2.7.7. Health Promotion and Wellness Activities

2.7.7.1. The Contractor shall provide a range of health promotion and wellness informational activities for Enrollees, their family members, and other significant informal caregivers. The focus and content of this information shall be relevant to the specific health status needs and high-risk behaviors in the Enrollee population. Interpreter services shall be available for Enrollees who are not proficient in English. Examples of health promotion and prevention seminar topics include, but are not limited to the following:

2.7.7.1.1. Chronic condition self-management;

- 2.7.7.1.2. Smoking cessation;
- 2.7.7.1.3. Nutrition; and
- 2.7.7.1.4. Prevention and treatment of substance use disorder.

2.7.7.2. Whenever possible and appropriate, the Contractor shall use Community Health Workers to provide health promotion and wellness information to Enrollees, including as described in **Sections 2.7.11 and 2.10.5.**

2.7.8. Behavioral Health

2.7.8.1. Continuum of Behavioral Health Care

- 2.7.8.1.1. The Contractor shall offer a continuum of behavioral health care as defined in **Appendix C** that is coordinated with PCPs, ICTs, or other Members of the care team, as appropriate.

2.7.8.2. Coordination of Medication

- 2.7.8.2.1. Prescriptions for any psychotropic medications shall be evaluated for interactions with the medications already prescribed for the Enrollee.

2.7.8.3. Behavioral Health Responsibilities

- 2.7.8.3.1. The Contractor shall manage the provision of all Behavioral Health services. When services for Emergency Medical Conditions are needed, the Enrollee may seek care from any qualified behavioral health Provider.
- 2.7.8.3.2. The care management protocol for Enrollees shall ensure appropriate access to all behavioral health covered services in **Appendix C** in all settings, including those listed in **Appendix G.**
- 2.7.8.3.3. For Enrollees who require Behavioral Health Services, the Behavioral Health Provider shall:
 - 2.7.8.3.3.1. With the Enrollee and the Enrollee's designated representative, if any, develop the behavioral health portion of the ICP for each Enrollee in accordance with accepted clinical practice;
 - 2.7.8.3.3.2. With the input of the PCP or ICT, as appropriate, determine clinically appropriate interventions on an on-

going basis, with the goal of promoting the independent functioning of the Enrollee;

2.7.8.3.3. With Enrollee consent and per Enrollee preferences documented in the Comprehensive Assessment, make appropriate and timely entries into the CER about the behavioral health assessment, diagnosis determined, medications prescribed, if any, and ICP developed. As stated in **Section 2.15.5.6.2.7**, psychotherapeutic session notes shall not be recorded in the CER; and

2.7.8.3.4. Obtain authorization as appropriate, for any non-emergency services, except when authorization is specifically not required under this Contract.

2.7.8.4. Services for Enrollees with Serious and Persistent Mental Illness

2.7.8.4.1. The Contractor shall ensure that Enrollees with serious and persistent mental illness have access to services in keeping with the recovery principles. For such Enrollees, a qualified behavioral health clinician (see **Section 2.6.2.2.2**) shall be part of the ICT. As necessary, care coordination with the DMH and its contracted programs that serve the Enrollee shall be provided.

2.7.8.4.2. The Contractor and providers shall comply with the Mental Health Parity and Addiction Equity Act of 2008, including the requirements that treatment limitations applicable to mental health or substance use disorder benefits are no more restrictive than the predominant treatment limitations applied to substantially all medical and surgical benefits covered by the plan (or coverage), and there are no separate treatment limitations that are applicable only with respect to mental health or substance use disorder benefits.

2.7.8.4.3. The Contractor shall maintain a structured process for identifying and addressing complex behavioral health needs at all levels of care and in all residential settings. Qualified behavioral health Providers shall proactively coordinate and follow Enrollee progress through the continuum of care.

2.7.8.4.4. The Contractor shall implement all Current Procedural Terminology (CPT) evaluation and management codes for behavioral health services as most recently adopted by the American Medical Association and CMS.

2.7.8.5. Substance Use Disorder Services

2.7.8.5.1. “In accordance with Section 1004 of the Substance Use Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act, also referred to as the SUPPORT for Patients and Communities Act or the SUPPORT Act, and consistent with other applicable Contract requirements, the Contractor shall have in place the following with respect to its drug utilization review (DUR) program in a manner compliant with the requirements set forth in such act:

2.7.8.5.1.1. Safety edits, including but not limited to, as further directed by EOHHS:

2.7.8.5.1.1.1. Having safety edits in place that include prior authorization when the accumulated daily morphine equivalents for an individual exceeds the maximum amount allowed by the state, quantity limits, early refill rules, duplicate and overlap restrictions; and

2.7.8.5.1.1.2. Implementing a safety edit for concurrent chronic use of opioids and benzodiazepines and review automated processes.

2.7.8.5.1.2. A program to monitor antipsychotic medications, including but not limited to, as further directed by EOHHS:

2.7.8.5.1.2.1. Having a method to monitor and report on concurrent chronic use of opioids and antipsychotics;

2.7.8.5.1.2.2. Fraud and abuse identification requirements, including but not limited to, having a process that identifies potential fraud or abuse by Enrollees, health care providers, and pharmacies;

2.7.8.5.1.2.3. Any required claims review automated processes; and

2.7.8.5.1.2.4. Retrospective reviews on opioid prescriptions to address duplicate fill and early fill alerts, quantity limits, dosage limits, and morphine milligram equivalents limitations.

2.7.9. Emergency, Urgent, and 24/7 Provider Access

2.7.9.1. Twenty-four (24) Hour Service Access

- 2.7.9.1.1. The Contractor shall follow Federal and State regulations about twenty-four (24) hour service in accordance with 42 C.F.R. § 438.206(c)(1)(iii) and 42 C.F.R. § 422.112(a)(7)(ii), making Covered Services available twenty-four (24) hours a day, seven (7) days a week when medically necessary.
- 2.7.9.1.2. The Contractor shall ensure access to twenty-four (24) hour Emergency Services for all Enrollees, whether they reside in institutions or in the community through the Contractor's Provider Network. The Contractor shall:
 - 2.7.9.1.2.1. Have a process established to notify the PCP (or the designated covering physician) and other appropriate physical health, LTSS, or BH providers, and any additional ICT Members of an Emergency Medical Condition within one business day after the Contractor is notified by the provider. If the Contractor is not notified by the provider within ten (10) calendar days of the Enrollee's presentation for Emergency Services, the Contractor may not refuse to cover Emergency Services;
 - 2.7.9.1.2.2. Have a process to notify the PCP and other appropriate physical health, LTSS, or BH providers, and any additional ICT Members of required Urgent Care within twenty-four (24) hours of the Contractor being notified;
 - 2.7.9.1.2.3. Record summary information about Emergency Medical Conditions and Urgent Care services in the Centralized Enrollee Record no more than 18 hours after the PCP or ICT is notified, and a full report of the services provided within two business days;
 - 2.7.9.1.2.4. If the Contractor's network is unable to provide necessary medical services to an Enrollee, the Contractor shall adequately and timely cover these services for the Enrollee for as long as the Contractor's network is unable to provide them. This shall be done within sixty (60) calendar days after the claim has been submitted. The Contractor shall ensure that cost to the Enrollee is no greater than it would be if the services were furnished within the network and Enrollees are afforded all protections against balance billing by providers.
- 2.7.9.1.3. When an Enrollee is involved with one or more EOHHS agency the Contractor shall notify such agencies of an Enrollee's admission to an inpatient facility within one (1)

business day of the facility's admission notification with respect to such Enrollee.

- 2.7.9.1.4. The Contractor shall authorize other non-network services to promote access and continuity of care.

2.7.9.2. Emergency and Post-stabilization Care Coverage

- 2.7.9.2.1. The Contractor's Provider Network shall comply with the Emergency Medical Treatment and Labor Act (EMTALA), which requires:

- 2.7.9.2.1.1. Qualified hospital medical personnel provide appropriate medical screening examinations to any individual who "comes to the emergency department," as defined in 42 C.F.R. § 489.24(b);

- 2.7.9.2.1.2. As applicable, provide individuals stabilizing treatment or, if the hospital lacks the capability or capacity to provide stabilizing treatment, conduct appropriate transfers;

- 2.7.9.2.1.3. The Contractor's contracts with its providers shall clearly state the provider's EMTALA obligations and shall not create any conflicts with hospital actions required to comply with EMTALA.

- 2.7.9.2.2. The Contractor shall cover and pay for Emergency Services and any services obtained for Emergency Medical Conditions in accordance with 42 C.F.R. § 438.114(c) and Massachusetts General Laws chapter 118E, Section 17A.

- 2.7.9.2.3. The Contractor shall cover and pay for Emergency Services regardless of whether the provider that furnishes the services has a contract with the Contractor.

- 2.7.9.2.4. The Contractor shall not deny payment for treatment obtained when an Enrollee had an Emergency Medical Condition, including cases in which the absence of immediate medical attention would not have had the outcomes specified in 42 C.F.R §§ 438.114(a) of the definition of emergency medical condition.

- 2.7.9.2.5. The Contractor shall ensure that the Enrollee is not billed for the difference, if any, between such rate and the non-contracted provider's charges.

- 2.7.9.2.6. The Contractor shall not deny payment for treatment of an Emergency Medical Condition if a representative of the

Contractor instructed the Enrollee to seek Emergency Services.

- 2.7.9.2.7. The Contractor shall not limit what constitutes an Emergency Medical Condition based on lists of diagnoses or symptoms.
- 2.7.9.2.8. The Contractor shall require providers to notify the Enrollee's PCP of an Enrollee's screening and treatment but may not refuse to cover Emergency Services based on their failure to do so.
- 2.7.9.2.9. The Contractor shall ensure that an Enrollee who has an Emergency Medical Condition is not held liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the Enrollee.
- 2.7.9.2.10. The attending emergency physician, or the provider treating the Enrollee for an Emergency Medical Condition, is responsible for determining when the Enrollee is sufficiently stabilized for transfer or discharge, and that determination is binding on the Contractor responsible for coverage and payment.
- 2.7.9.2.11. The Contractor shall cover and pay for post stabilization Care Services in accordance with 42 C.F.R. § 438.114(e) and M.G.L. c. 118E, § 17A.

2.7.9.3. Comparable FFS Payment for Non-Network Providers

- 2.7.9.3.1. To the extent non-network Medicare payment provisions apply to the Contractor for activities described in **Section 2.7.9.1** and **2.7.9.2** above, the Contractor shall be advised that for a Provider of a Medicare Service serving a Dual Eligible Individual with Original Medicare and MassHealth FFS, the amount such Provider would receive would be limited to the MassHealth FFS fee schedule when such fee schedule is less than the applicable Medicare fee schedule.

2.7.9.4. 24/7 Clinical Advice Line

- 2.7.9.4.1. The Contractor shall provide a twenty-four (24) hours-per-day, seven (7) days-per-week toll-free telephone system with access to a registered nurse or similarly licensed and qualified skilled health care professional who:
 - 2.7.9.4.1.1. Has immediate access to the Centralized Enrollee Record;

- 2.7.9.4.1.2. Is able to respond to Enrollee questions about health or medical concerns;
- 2.7.9.4.1.3. Has the experience and knowledge to provide clinical triage;
- 2.7.9.4.1.4. Is able to provide options other than waiting until business hours or going to the emergency room; and
- 2.7.9.4.1.5. Is able to provide access to oral interpretation services available as needed, free-of-charge.

2.7.10. Long-term Services and Supports (LTSS)

2.7.10.1. LTSS Delivery System

- 2.7.10.1.1. In delivering the Covered Services defined in **Appendix C** that relate to LTSS, the Contractor shall demonstrate the capacity to provide coordination of care and expert care management through the ICT. The Contractor shall ensure that:
 - 2.7.10.1.1.1. The LTS Coordinator executes the responsibilities described in **Section 2.6.1.7.7**;
 - 2.7.10.1.1.2. The Care Coordinator and LTS Coordinator, as part of the ICT, participate in determinations of appropriateness for institutional and community long-term care services; and
 - 2.7.10.1.1.3. The measurement of the Functional Status of Enrollees is performed in Assessments as specified in **Section 2.5.2**. Reports will be produced in accordance with **Appendix A**.
- 2.7.10.1.2. The Contractor shall have a process in place to alert and engage the Enrollee's Care Coordinator (internal or contracted) of any determination that a requested Long-term Service or Support would be denied or partially denied as the result of prior authorization, utilization management, or other evaluation. This engagement with the Enrollee's Care Coordinator shall occur before a final denial, partial denial, or reduction action is effectuated, except where a request for expedited service authorization has been made as described in **Section 2.10.9.8.2** and it is not possible to alert and engage the Care Coordinator in advance due to timeliness requirements. In this circumstance, the Care Coordinator shall be alerted and engaged regarding any denial or partial

denial immediately after the determination and notification to the Member is made.

2.7.10.2. Continuum of Long-term Care

2.7.10.2.1. The Contractor shall arrange and pay for:

2.7.10.2.1.1. Community alternatives to institutional care,

2.7.10.2.1.2. Other transitional, respite, and support services to maintain Enrollees safely in the community, based on assessment by the Contractor of Functional Status, Functional need, and cost effectiveness of the services being requested,

2.7.10.2.1.3. Nursing facility services for both short-term and long-term stays as described in **Appendix C** for Enrollees who;

2.7.10.2.1.3.1. Meet applicable screening requirements in accordance with 130 CMR Chapter 456 and Chapters 515 through 524,

2.7.10.2.1.3.2. Desire such services (See **Appendix A** for reporting requirements), and

2.7.10.2.1.3.3. For whom the Contractor has no community service package appropriate and available to meet the Enrollee's medical needs

2.7.10.2.1.4. Other institutional services as determined by the ICT.

2.7.10.3. Pre-Admission Screening and Resident Review (PASRR) Evaluation

2.7.10.3.1. The Contractor shall comply with federal regulations requiring referral of nursing facility eligible Enrollees, as appropriate, for PASRR evaluation for mental illness and developmental disability treatment pursuant to the Omnibus Budget Reconciliation Act of 1987, as amended, and 42 CFR 483.100 through 483.138. Among other things, the Contractor shall not pay for nursing facility services rendered to an Enrollee during a period in which the nursing facility has failed to comply with PASRR with respect to that Enrollee. In any instance in which the Contractor denies payment in accordance with this **Section**, in addition to any prohibitions on balance-billing set forth in this Contract (including **Section 5.1.10**), the Contractor shall ensure that

the Provider does not attempt to bill the Enrollee for such services.

2.7.11. Community Health Workers

2.7.11.1. Consistent with the Enrollee's ICP, the Contractor may employ or contract with Community Health Workers under the supervision of the ICT to provide:

- 2.7.11.1.1. Wellness coaching to engage the Enrollee in prevention activities such as smoking cessation, exercise, diet, and obtaining health screenings;
- 2.7.11.1.2. Evidence based practices and techniques for chronic disease self-management;
- 2.7.11.1.3. Qualified peer support for Enrollees with mental health and/or substance use disorders to assist such Enrollees in their recovery, and for Enrollees with physical disabilities to assist such Enrollees in the pursuit of independent living; and
- 2.7.11.1.4. Community supports for newly housed Enrollees who are experiencing homelessness, have recently experienced homelessness, or are at risk of homelessness.

2.7.11.2. Community Health Workers shall be available and appropriate for the populations served, such as for Enrollees who are Deaf or hard of hearing.

2.7.12. Additional Requirements

- 2.7.12.1. The Contractor shall deliver preventive health care services including, but not limited to, cancer screenings and appropriate follow-up treatment to Enrollees, other screenings or services as specified in guidelines set by EOHHS or, where there are no EOHHS guidelines, in accordance with nationally accepted standards of practice.
- 2.7.12.2. The Contractor shall provide systems and mechanisms designed to make Enrollees' medical history and treatment information available, within applicable legal limitations, at the various sites where the same Enrollee may be seen for care, especially for Enrollees identified as homeless. While establishing fully integrated delivery systems, the Contractor shall respect the Privacy of Enrollees. The Contractor shall comply with **Section 5.2** regarding compliance with laws and regulations relating to confidentiality and Privacy.

2.8. Provider Network, Contracts, and Related Responsibilities

2.8.1. Provider Network

2.8.1.1. General

- 2.8.1.1.1. The Contractor shall maintain and monitor a Provider Network sufficient to provide all Enrollees, including those with limited English proficiency or physical or mental disabilities, with meaningful access to the full range of Covered Services, including Behavioral Health, Oral Health, LTSS, Additional Community-based Services, other specialty services, and all other services required in 42 C.F.R. §§422.112, 423.120, and 438.206(b)(1) and under this Contract (see Covered Services in **Appendix C**). As further directed by EOHHS, the Contractor shall maintain information about its Provider Network with respect to the above requirement and provide EOHHS with such information upon request.
- 2.8.1.1.2. The Provider Network shall be comprised of a sufficient number of appropriately credentialed, licensed, or otherwise qualified Providers to meet the requirements of this Contract, including all entities listed in **Appendix G**.
 - 2.8.1.1.2.1. When directed by EOHHS, such Providers shall be enrolled with EOHHS as specified by EOHHS in accordance with 42 CFR 438.602(b),
 - 2.8.1.1.2.2. The Contractor shall comply with 42 CFR 438.602(b)(2) and therefore may execute Provider Contracts for up to 120 days pending the outcome of EOHHS' enrollment process but shall terminate a Provider Network immediately upon notification from EOHHS that the Network Provider cannot be enrolled, or the expiration of a single one hundred and twenty (120) day period without enrollment of the provider. The Contractor shall notify affected Enrollees of the termination.
 - 2.8.1.1.2.3. The Contractor shall notify EOHHS of any significant Provider Network changes immediately, with the goal of providing notice to EOHHS at least sixty (60) days prior to the effective date of any such change.
- 2.8.1.1.3. The Contractor shall comply with the requirements specified in 42 C.F.R. § 438.214, which includes selection and retention of providers, credentialing and recredentialing requirements, and nondiscrimination.

- 2.8.1.1.4. The Contractor shall make best efforts to ensure that SDO-certified businesses and organizations are represented in the Provider Network. The Contractor shall submit annually the appropriate certification checklist on its efforts to contract with SDO-certified entities (see **Appendix A**).
- 2.8.1.1.5. In establishing and maintaining the Provider Network, the Contractor shall consider the following:
 - 2.8.1.1.5.1. The anticipated number of Enrollees;
 - 2.8.1.1.5.2. The expected utilization of services, taking into consideration the cultural and ethnic diversity, demographic characteristics, communication requirements, and health care needs of specific populations enrolled with the Contractor;
 - 2.8.1.1.5.3. The numbers and types (in terms of training, experience, and specialization) of providers required to furnish the Covered Services;
 - 2.8.1.1.5.4. The number of Network Providers who are not accepting new patients; and
 - 2.8.1.1.5.5. The geographic location of providers and Enrollees, considering distance, travel time, the means of transportation ordinarily used by Enrollees, and whether the location provides physical access for Enrollees with disabilities.
- 2.8.1.1.6. The Contractor shall demonstrate through reports specified in **Appendix A** that its provider network offers an appropriate range of preventive, primary care, specialty services, behavioral health, community-based services, oral health, and LTSS that is sufficient in number, mix, geographic distribution, and competencies to adequately meet the needs of the anticipated number of Enrollees in its Service Area, as described in **Section 2.9**.
- 2.8.1.1.7. The Contractor shall not establish selection policies and procedures for providers that discriminate against providers that serve high risk populations or specialize in conditions that require costly treatment.
- 2.8.1.1.8. The Contractor shall ensure that the Provider Network provides Enrollees with direct access to a reproductive and gynecological health specialist, including an obstetrician or gynecologist, within the Provider Network for Covered

Services necessary to provide routine and preventive health care services. This shall include contracting with, and offering eligible Enrollees, reproductive and gynecological health specialists as PCPs.

- 2.8.1.1.9. The Contractor's Provider Network shall include freestanding birth centers licensed by the Commonwealth of Massachusetts Department of Public Health.
- 2.8.1.1.10. At the Enrollee's request, the Contractor shall provide for a second opinion from a qualified health care professional within the Provider Network or arrange for the Enrollee to obtain one outside the Provider Network, at no cost to the Enrollee.
- 2.8.1.1.11. The Contractor may use different reimbursement amounts for different specialties and for different practitioners in the same specialty.
- 2.8.1.1.12. The Contractor shall demonstrate to EOHHS, including through submission of reports as may be requested by EOHHS, use of Alternative Payment Methodologies that will advance the delivery system innovations inherent in the Commonwealth's integrated care plans, incentivize quality care, health equity, and improve health outcomes for Enrollees. The Contractor shall comply with the requirements of M.G.L. Chapter 224, Section 261 of the Acts of the 2012. Notwithstanding the foregoing, nothing herein shall be construed to conflict with the requirements of 42 U.S.C. 1395w 111, Sec. 1860D 11(i).
- 2.8.1.1.13. The Contractor shall ensure that its Network Providers and Material Subcontractors meet all current and future state and federal eligibility criteria, (e.g., not contract with providers excluded from participation in Federal health care programs under either Section 1128 or Section 1128A of the Social Security Act and implementing regulations at 42 C.F.R. Part 1001 et. Seq) and submit standard and ad hoc reporting requirements, and any other applicable rules and/or regulations related to this Contract.
- 2.8.1.1.14. As directed by EOHHS, the Contractor shall comply with any moratorium, numerical cap, or other limit on enrolling new Providers or suppliers imposed by EOHHS or the U.S. Department of Health and Human Services.

2.8.1.2. Required State Agency Providers

- 2.8.1.2.1. The Contractor shall contract with all inpatient hospitals, outpatient hospitals, and community mental health centers that are operated by DMH and DPH in **Appendix G**.
- 2.8.1.2.2. Additionally, as further specified by EOHHS, the Contractor shall include in its Provider Network the state agency providers set forth in **Appendix G, Exhibit 3** identified as providing Acute Treatment Services (ATS) and Clinical Stabilization Services (CSS) as described in **Appendix C, Exhibit 2**.
- 2.8.1.2.3. The Contractor shall not require the state agency providers described in this **Section 2.8.1.2** to indemnify the Contractor, to hold a license, or to maintain liability insurance.
- 2.8.1.2.4. If required by EOHHS, the Contractor shall include in its Provider Network or pay as non-network providers, other state agency providers as set forth in **Appendix G**.
- 2.8.1.3. Non-Network Access
 - 2.8.1.3.1. The Contractor shall ensure that best efforts are made to contact and contract with non-network providers, including, within the first ninety (90) days of an Enrollee's Membership in the Contractor's One Care Plan, such providers and prescribers which are providing services to Enrollees during the initial continuity of care period, and provide them with information on becoming credentialed, in-Network Providers. If the provider does not join the network, or if the Enrollee does not select a new in Network Provider by the end of the ninety (90) day period or after the Individualized Care Plan is developed, the Contractor shall choose one for the Enrollee.
 - 2.8.1.3.2. The Contractor shall not deny authorization of Medically Necessary Services due to insufficient appropriate in-network access to such services.
 - 2.8.1.3.3. If the Contractor's network is unable to provide necessary medical services covered under the Contract to a particular Enrollee, the Contractor shall adequately and timely cover these services non-network for the Enrollee, for as long as the Contractor is unable to provide them. No cost-sharing is allowed in this circumstance.
 - 2.8.1.3.4. The Contractor shall maintain and utilize protocols to address situations when the Provider Network is unable to provide an Enrollee with appropriate access to Covered

Services or medical diagnostic equipment due to lack of a qualified Network Provider or medical diagnostic equipment within reasonable travel time of the Enrollee's residence as defined in **Section 2.10** or that is not otherwise accessible to the Enrollee. The Contractor's protocols shall ensure best efforts to resolve an Enrollee's access to care need, whether through single case agreements, contracting with new providers, fully covering access to a non-network provider, or through other methods. The Contractor's protocols shall ensure, at a minimum, the following:

- 2.8.1.3.4.1. If the Contractor is unable to provide a particular Covered Service or medical diagnostic equipment through its Provider Network, it will be adequately covered in a timely way non-network;
- 2.8.1.3.4.2. When accessing a non-network provider, the Enrollee is able to obtain the same service or to access a provider with the same type of training, experience, and specialization as within the Provider Network;
- 2.8.1.3.4.3. That non-network providers shall coordinate with the Contractor with respect to payment, ensuring that the cost to the Enrollee is no greater than it would be if the services were furnished through the Provider Network;
- 2.8.1.3.4.4. That the particular service will be provided by the most qualified and clinically appropriate provider available;
- 2.8.1.3.4.5. That the provider will be located within the shortest travel time of the Enrollee's residence, taking into account the availability of public transportation to the location;
- 2.8.1.3.4.6. That the provider will be informed of their obligations under state or federal law to have the ability, either directly or through a skilled medical interpreter, to communicate with the Enrollee in their primary language;
- 2.8.1.3.4.7. That the only Provider available to the Enrollee in the Provider Network does not, because of moral or religious objections, decline to provide the service the Enrollee seeks;
- 2.8.1.3.4.8. That consideration is given for a non-network option in instances in which the Enrollee's Provider(s) determines that the Enrollee needs a service and that the Enrollee would be subjected to unnecessary risk if the Enrollee received those services separately and not all of the

related services are available within the Provider Network;

2.8.1.3.4.9. That the Contractor cover services furnished in another state in accordance with 42 CFR 431.52(b) and 130 CMR 450.109; and

2.8.1.3.4.10. That the Contractor complies with **Section 2.7**.

2.8.1.3.5. The Contractor shall report on its use of non-network providers to meet Enrollee's necessary medical service needs as required in **Appendix A**.

2.8.1.3.6. If the Contractor declines to include individuals or groups of providers in its Provider Network, the Contractor shall give the affected providers written notice of the reason for its decision.

2.8.1.3.7. The Provider Network shall be responsive to the linguistic, cultural, and other individual needs of any Enrollee, person experiencing homelessness, transgender or gender-diverse persons, or other special populations served by the Contractor by, at a minimum, including the capacity to communicate with Enrollees in languages other than English, communicate with individuals who are Deaf, hard of hearing or deaf blind.

2.8.1.4. Additional Provider Network Requirements for Behavioral Health Services

2.8.1.4.1. The Contractor shall ensure that its Behavioral Health Provider Network includes an adequate number of Providers with experience and expertise in various specialty areas described below. In addition to ensuring its Network includes Behavioral Health Providers who can address all Diagnostic and Statistical Manual of Mental Disorders Fifth Edition (DSM 5) (or current version as applicable) diagnostic needs as described in the most recent publication, the Contractor shall ensure that its Behavioral Health Provider Network has expertise in at least the following:

2.8.1.4.1.1. Co-Occurring Disorders;

2.8.1.4.1.2. Serious and persistent mental illness;

2.8.1.4.1.3. Physical disabilities and chronic illness;

- 2.8.1.4.1.4. Deaf and hard of hearing and blind or visually impaired;
- 2.8.1.4.1.5. HIV/AIDS;
- 2.8.1.4.1.6. Homelessness;
- 2.8.1.4.1.7. Post-traumatic stress disorder;
- 2.8.1.4.1.8. Fire-setting behaviors;
- 2.8.1.4.1.9. Sex-offending behaviors;
- 2.8.1.4.1.10. Substance use disorders;
- 2.8.1.4.1.11. Eating Disorders;
- 2.8.1.4.1.12. Gender dysphoria; and
- 2.8.1.4.1.13. Criminal justice involvement.
- 2.8.1.4.2. The Contractor shall allow independently practicing clinicians with the following licenses to apply to become Network Providers: Licensed Independent Clinical Social Worker (LICSW), Licensed Alcohol and Drug Counselors 1 (LADC1), Licensed Marriage and Family Therapist (LMFT), Licensed Mental Health Counselor (LMHC) and Licensed Psychologist;
- 2.8.1.4.3. The Contractor shall permit Enrollees to self-refer to any Network Provider of their choice for Medically Necessary Behavioral Health Services and to change Behavioral Health Providers at any time;
- 2.8.1.4.4. The Contractor shall require all Providers to provide an Enrollee's clinical information to other Providers, as necessary, to ensure proper coordination and behavioral health treatment of Enrollees who express suicidal or homicidal ideation or intent, consistent with state law;
- 2.8.1.4.5. For Behavioral Health Inpatient and twenty-four (24) hour Diversionary Services, the Contractor shall:
 - 2.8.1.4.5.1. Ensure that all Behavioral Health Inpatient and twenty-four (24)hour Diversionary Services Provider Contracts require the Behavioral Health Inpatient and twenty-four (24) hour Diversionary Services Provider accept for admission or treatment all Enrollees for whom the

Contractor has determined admission or treatment is Medically Necessary, regardless of clinical presentation, as long as a bed is available in an age appropriate unit;

- 2.8.1.4.5.2. Promote continuity of care for Enrollees who are readmitted to Behavioral Health Inpatient and twenty-four (24) hour Diversionary Services by offering them readmission to the same Provider when there is a bed available in that facility;
- 2.8.1.4.5.3. Require Behavioral Health Inpatient and twenty-four (24)hour Diversionary Services Providers to coordinate treatment and Discharge Planning with the state agencies (e.g., DMH, DDS) with which the Enrollee has an affiliation, and that in no such case shall Providers discharge patients who are homeless or who have unstable housing without a plan for housing;
- 2.8.1.4.5.4. Ensure that all Behavioral Health Inpatient and twenty-four (24) hour Diversionary Services Providers have:
 - 2.8.1.4.5.4.1. Human rights and restraint and seclusion protocols that are consistent with the DMH's Human Rights and Restraint Seclusion Policy and regulations and include training of the Provider's staff and education for Enrollees regarding human rights.
 - 2.8.1.4.5.4.2. A human rights officer, who shall be overseen by a human rights committee, and who shall provide written materials to Enrollees regarding their human rights, DMH's Human Rights and Restraint and Seclusion Policy and with applicable DMH regulations and requirements.
- 2.8.1.4.5.5. Require that Behavioral Health Inpatient and twenty-four (24) hour Diversionary Services Providers coordinate with all contracted CBHCs in the Contractor's Service Area(s), including procedures to credential and grant admitting privileges to AMCI Provider psychiatrists, if necessary;
- 2.8.1.4.5.6. As needed, participate in or convene regular meetings and conduct ad hoc communication on clinical and administrative issues with CBHCs to enhance the continuity of care for Enrollees; and

2.8.1.4.6. As directed by EOHHS, the Contractor shall contract with a network of Providers to provide Behavioral Health Emergency Screening, Community Behavioral Health Centers (CBHCs), and Adult Mobile Crisis Intervention Services.

2.8.1.5. CBHC Contracts

2.8.1.5.1. The Contractor shall:

2.8.1.5.1.1. Execute and maintain contracts with the CBHCs identified in **Appendix G, Exhibit 1**, as updated by EOHHS from time to time, to provide all CBHC services, including AMCI services as set forth in **Appendix C**, as applicable, to this Contract;

2.8.1.5.1.2. Implement CBHC performance specifications as specified by EOHHS, and ensure compliance with such specifications;

2.8.1.5.1.3. Not require CBHCs to obtain prior authorization for any services provided by CBHCs;

2.8.1.5.1.4. Provide payment for services provided by such CBHCs to Enrollees; and

2.8.1.5.1.5. As directed by EOHHS, take all steps and perform all activities necessary to execute contracts with CBHCs and support the successful implementation and operations of the CBHC program, including, without limitation, participation in meetings and workgroups, the development and implementation of new Enrollee access to AMCI provide by CBHCs.

2.8.1.5.2. Enrollee Access to Behavioral Health AMCI Provided by CBHCs

2.8.1.5.2.1. The Contractor shall:

2.8.1.5.2.1.1. Establish policies and procedures to make best efforts to ensure that all Enrollees receive AMCI provided by a CBHC or hospital ED-based crisis evaluation services prior to hospital admissions for Inpatient Mental Health Services to ensure that Enrollees have been evaluated for diversion or referral to the least restrictive appropriate treatment setting;

- 2.8.1.5.2.1.2. Permit Enrollees access to Behavioral Health Services provided by CBHCs through direct self-referral, the BH Help Line, the Contractor's toll-free telephone line, or referral by family members or guardians, individual practitioners, PCPs, or community agencies or hospital emergency departments;
- 2.8.1.5.2.1.3. Require that the response time for face-to-face crisis evaluations by CBHCs does not exceed one (1) hour from notification by telephone from the referring party or from the time of presentation by the Enrollee; and
- 2.8.1.5.2.1.4. Have policies and procedures to monitor Enrollee access to CBHCs and, as requested by EOHHS and in accordance with **Appendix A**, report, in a form and format as specified by EOHHS, about such access.
- 2.8.1.5.2.1.5. If needed, authorize Medically Necessary BH Covered Services within twenty-four (24) hours following a AMCI encounter.

2.8.1.5.3. CBHC Policies and Procedures

2.8.1.5.3.1. The Contractor shall:

- 2.8.1.5.3.1.1. In coordination with EOHHS' reporting and oversight, have policies and procedures to monitor CBHCs' performance with respect to established diversion and inpatient admission rates;
- 2.8.1.5.3.1.2. Have policies and procedures to monitor the CBHCs' performance with respect to diverting encounters with Enrollees from hospital emergency departments to the CBHCs' community-based locations or other community settings;
- 2.8.1.5.3.1.3. At the direction of EOHHS, identify and implement strategies to maximize utilization of community-based diversion services and reduce unnecessary psychiatric hospitalization, in a manner that is consistent with Medical Necessity criteria. Such strategies shall support Providers in shifting utilization from hospital EDs to community-based settings;

- 2.8.1.5.3.1.4. Have policies and procedures regarding the circumstances under which CBHCs shall contact the Contractor for assistance in securing an inpatient or twenty-four (24) hour Diversionary Service placement. Such policies and procedures shall include that if a CBHC requests the Contractor's assistance in locating a facility that has the capacity to timely admit the Enrollee, the Contractor shall contact Network Providers to identify such a facility or, if no appropriate Network Provider has such capacity, shall contact non-network Providers to identify such a facility;
- 2.8.1.5.3.1.5. At the direction of EOHHS, participate in development of policies and procedures to ensure collaboration between CBHCs, Network Providers, and DMH area and site offices in the geographic area they serve;
- 2.8.1.5.3.1.6. Have a plan in place to direct Enrollees to the least intensive but clinically appropriate service;
- 2.8.1.5.3.1.7. Have a process to ensure placement for Enrollees who require Behavioral Health Inpatient Services when no inpatient beds are available, including coordination with DMH's Expedited Psychiatric Inpatient Admissions (EPIA) Team when applicable;
- 2.8.1.5.3.1.8. Utilize standardized documents such as risk management/safety plans as identified by EOHHS;
- 2.8.1.5.3.1.9. Convene meetings to address clinical and administrative issues with CBHCs and to enhance the coordination of care for Enrollees;
- 2.8.1.5.3.1.10. Attend statewide meetings regarding CBHCs and services provided by CBHCs, as convened by EOHHS and/or EOHHS' Behavioral Health contractor;
- 2.8.1.5.3.1.11. Ensure that contracted CBHCs utilize, as is necessary, the statewide Massachusetts Behavioral Health Access website or other required tracking method; and

2.8.1.5.3.1.12. Ensure that, upon request of a court clinician conducting a psychiatric evaluation pursuant to M.G.L. c. 123 § 12(e):

2.8.1.5.3.1.12.1. CBHCs provide Crisis Assessment and Intervention to Enrollees, identify to the court clinician appropriate diversions from inpatient hospitalization, and assist court clinicians to develop any plan to utilize such diversions, and

2.8.1.5.3.1.12.2. If the court orders the admission of an individual under M.G.L. c. 123 § 12(e), and the CBHC determines that such admission is Medically Necessary, the CBHC conducts a search for an available bed, making best efforts to locate such a bed for the individual by 4:00 p.m. on the day of the issuance of such commitment order.

2.8.1.5.4. Medication for Opioid Use Disorder (MOUD) Services

2.8.1.5.4.1. The Contractor shall ensure that Enrollees have access to MOUD Services, including initiation and continuation of MOUD, and ensure that Enrollees receive assistance in accessing such services.

2.8.1.5.4.2. The Contractor shall include in its Provider Network, qualified Providers to deliver MOUD Services, by at a minimum, as further directed by EOHHS, and in accordance with all other applicable Contract requirements, offering Network Provider agreements at a reasonable rate of payment to:

2.8.1.5.4.2.1. All Office Based Opioid Treatment (OBOT) providers as specified by EOHHS;

2.8.1.5.4.2.2. All Opioid Treatment Program (OTP) providers as specified by EOHHS.

2.8.1.5.4.3. The Contractor shall ensure that all such Providers of MOUD Services coordinate and integrate care with Enrollees' PCP and other Providers in response to Enrollees' needs.

2.8.1.5.4.4. As further directed by EOHHS, the Contractor shall ensure Enrollees may receive MOUD Services through qualified PCPs in the Provider Network.

- 2.8.1.5.4.5. The Contractor shall not require an authorization or referral for MOUD Services, unless otherwise directed by EOHHS.

2.8.2. Provider Contracts

2.8.2.1. General

- 2.8.2.1.1. The Contractor shall maintain all Provider Contracts and other agreements and subcontracts relating to this Contract, including agreements with non-network providers, in writing. All such agreements and subcontracts shall fulfill all applicable requirements of 42 CFR Part 438 and shall contain all relevant provisions of this Contract appropriate to the subcontracted service or activity. Without limiting the generality of the foregoing, the Contractor shall ensure that all Provider Contracts and contracts with non-network providers include the following provision: “Providers shall not seek or accept payment from any Enrollee for any Covered Service rendered, nor shall Providers have any claim against or seek payment from EOHHS for any Covered Service rendered to an Enrollee. Instead, Providers shall look solely to the [Contractor’s name] for payment with respect to Covered Services rendered to Enrollees. Furthermore, Providers shall not maintain any action at law or in equity against any Enrollee or EOHHS to collect any sums that are owed by the [Contractor’s name] under the Contract for any reason, even in the event that the [Contractor’s name] fails to pay for or becomes insolvent or otherwise breaches the terms and conditions of the Contract (where “Contract” refers to the agreement between the Contractor and any Network Providers and non-Network Providers).” The Provider Contracts shall further state that this requirement shall survive the termination of the contract for services rendered prior to the termination of the contract, regardless of the cause of the termination.
- 2.8.2.1.2. The Contractor shall actively monitor the quality of care provided to Enrollees under any Provider Contracts and any other subcontracts.
- 2.8.2.1.3. The Contractor shall educate providers through a variety of means including, but not limited to, provider alerts or similar written issuances, about their legal obligations under State and Federal law to communicate with individuals with limited English proficiency, including the provision of interpreter services, and the resources available to help providers

comply with those obligations. All such written communications shall be subject to review at EOHHS' discretion.

- 2.8.2.1.4. Require a National Provider Identifier on all claims and provider applications.
- 2.8.2.1.5. The Contractor shall not include in its Provider Contracts any provision that directly prohibits or indirectly, through incentives or other means, limits or discourages Network Providers from participating as Network or non-network Providers in any provider network other than the Contractor's Provider Network(s).
- 2.8.2.1.6. With respect to all Provider Contracts, comply with 42 CFR 438.214, including complying with any additional requirements as specified by EOHHS.

2.8.2.2. Additional Standards for Provider Contracts and Other Agreements with Providers

- 2.8.2.2.1. All such Provider Contracts and agreements, including single case agreements, with non-network providers shall:
 - 2.8.2.2.1.1. Be in writing;
 - 2.8.2.2.1.2. Contain, at a minimum, the provisions described in this **Section**; and
 - 2.8.2.2.1.3. Comply with all applicable provisions of this Contract.
- 2.8.2.2.2. The Contractor shall ensure that all Provider Contracts prohibit Providers from:
 - 2.8.2.2.2.1. Billing Enrollees for missed appointments or refusing to provide services to Enrollees who have missed appointments. Such Provider Contracts shall require Providers to work with Enrollees and the Contractor to assist Enrollees in keeping their appointments;
 - 2.8.2.2.2.2. Billing patients for charges for Covered Services;
 - 2.8.2.2.2.3. Refusing to provide services to an Enrollee because the Enrollee has an outstanding debt with the Provider from a time prior to the Enrollee becoming a Member; and

- 2.8.2.2.2.4. Closing or otherwise limiting their acceptance of Enrollees as patients unless the same limitations apply to all commercially insured enrollees.

2.8.2.3. Cultural and Linguistic Competence

- 2.8.2.3.1. The Contractor and their Network Providers shall participate in any EOHHS efforts to promote the delivery of services in a culturally competent manner to all Enrollees that is sensitive to age, gender, gender identity, sexual orientation, cultural, linguistic, racial, ethnic, and religious backgrounds, and congenital or acquired disabilities.
- 2.8.2.3.2. The Contractor shall ensure that they contract with multilingual Network Providers to the extent that such capacity exists in the Contractor's Service Area and ensure that all Network Providers understand and comply with their obligations under State or Federal law to assist Enrollees with skilled medical interpreters and identify the resources that are available to assist Network Providers to meet these obligations.
- 2.8.2.3.3. The Contractor shall ensure that Network Providers and interpreters/translators, either in person or through video relay technology, are available for those who are Deaf or hard of hearing.
- 2.8.2.3.4. The Contractor shall ensure that its Network Providers have a strong understanding of disability culture, Substance Use Disorder recovery culture, and LTSS.

2.8.2.4. Provider Low Claims Volume

- 2.8.2.4.1. The Contractor shall identify Primary Care, Specialty, and BH Network Providers included in the Contractor's Provider Directory who have not submitted at least two claims for BH Covered Services to Enrollees in the past 12 (twelve) months, and report on such Providers to EOHHS as specified in **Appendix A**. EOHHS may require the Contractor to determine if Enrollees have meaningful access to these Providers, and if such Providers should remain in the Contractor's Provider Directory.
- 2.8.2.4.2. Contractor shall identify and contact by August 31, 2025, and annually thereafter all Providers who billed fewer than fifty services in the previous Contract Year to determine capacity and to assist them with expanding their reach and to assist and encourage them to provide services to a more

Members. Contractor shall document these efforts. Contractor shall report a list of such Providers to EOHHS by provider type and geographic location, as described in **Appendix A**. Contractor shall examine and describe in its report to EOHHS the extent to which Members have meaningful access to these Dental Providers in the Network, whether these Dental Providers status in Provider Directory as accepting new patients should change, and whether these Dental Provider should remain in the Network access metrics.

2.8.3. Additional Responsibilities for Certain Providers

2.8.3.1. Primary Care Providers (PCPs)

2.8.3.1.1. The Contractor shall ensure contracts with each PCP require the PCP to:

2.8.3.1.1.1. Share clinical data on Enrollees with the Contractor, including but not limited to data to support the Quality Measure reporting requirements described in **Appendix A**, subject to all applicable laws and regulations, as further specified by EOHHS;

2.8.3.1.1.2. Observe and comply with all applicable Enrollee rights and protections in this Contract;

2.8.3.1.1.3. Provide care to Enrollees in accordance with the requirements described in **Section 2.7**, and otherwise assist the Contractor with meeting the requirements of this Contract, including documenting information in an Enrollee's medical record,

2.8.3.1.1.4. Perform, at a minimum, the following activities:

2.8.3.1.1.4.1. Supervising, coordinating, and providing care to each assigned Enrollee;

2.8.3.1.1.4.2. Initiating referrals for Medically Necessary specialty care for which the Contractor requires referrals. The Contractor shall require its PCPs to refer Enrollees to Network Providers or, if the PCP refers the Enrollee to a non-network provider, to confirm with the Contractor that the contractor shall cover the Enrollee seeing that non-network provider and also inform the Enrollee to speak with the Contractor before seeing that non-network provider;

- 2.8.3.1.1.4.3. Ensuring that Enrollees who are identified as requiring Behavioral Health Services are offered referrals for Behavioral Health Services, when clinically appropriate;
- 2.8.3.1.1.4.4. Maintaining continuity of care for each assigned Enrollee; and
- 2.8.3.1.1.4.5. Maintaining the Enrollee's medical record, including documentation of all services provided to the Enrollee by the PCP, as well as any specialty services provided to the Enrollee.

2.8.3.1.1.5. State the Provider may only be terminated for cause.

2.8.3.1.2. The Contractor may develop, implement, and maintain alternative payment methodologies for PCPs and/or Primary Care Practices. Such alternative payment methodologies may be for individual network PCPs or for practices, pods, or other groupings of network PCPs. Such alternative payment methodologies shall:

- 2.8.3.1.2.1. Be subject to review by EOHHS;
- 2.8.3.1.2.2. Be implemented in accordance with any guidance or requirements issued by EOHHS; and
- 2.8.3.1.2.3. Shift financial incentives away from volume-based, fee-for-service delivery for PCPs.

2.8.3.1.3. The Contractor shall establish and implement policies and procedures to monitor PCP activities and to ensure that PCPs are adequately notified of, and receive documentation regarding, specialty services provided to assigned Enrollees by specialty physicians.

2.8.3.2. Network Hospitals

2.8.3.2.1. The Contractor shall develop, implement, and maintain protocols with each Network hospital that support the coordination of Enrollees' care, including as required in **Section 2.8.3.**

2.8.3.2.2. The Contractor shall ensure that any agreement the Contractor holds with a hospital includes, at a minimum, the following requirements:

2.8.3.2.2.1. Emergency Department (ED) Services:

- 2.8.3.2.2.1.1. The hospital shall notify the Enrollee's PCP, and/or ICT within one business day of the Enrollee's presentation at a hospital's ED. Notification may include a secure electronic notification of the visit;
- 2.8.3.2.2.1.2. The hospital shall offer ED-based Behavioral Health crisis evaluation services to all Members presenting with a behavioral health crisis in the ED;
- 2.8.3.2.2.1.3. The hospital shall offer substance use evaluations, treatment, and notification in the ED in accordance with M.G.L. c. 111, s. 51½ and M.G.L. c. 111, s. 25J½ and all applicable regulations.
- 2.8.3.2.2.2. Notification of Inpatient Admission and Discharge Planning Activities
 - 2.8.3.2.2.2.1. The hospital shall notify the Enrollee's PCP, and/or Care Team within one business day of the Enrollee's inpatient admission. Notification may include a secure electronic notification of the visit. EOHHS may specify the form and format for such notification.
 - 2.8.3.2.2.2.2. The hospital, when possible, shall begin Discharge Planning on the first day of the Enrollee's inpatient admission.
 - 2.8.3.2.2.2.3. In addition to satisfying all other requirements for Discharge Planning:
 - 2.8.3.2.2.2.3.1. The hospital shall ensure that the hospital's discharge summary is sent to the Enrollee's PCP, and/or Care Team within two business days of the discharge. The discharge summary shall include a copy of the hospital's discharge instructions that were provided to the Enrollee and include details on the Enrollee's diagnosis and treatment.
 - 2.8.3.2.2.2.3.2. The hospital shall notify the Enrollee's PCP and the Contractor in order to ensure that appropriate parties are included in Discharge Planning. Such parties may include care coordinators, case managers, caregivers, and other critical supports for the Enrollee.

2.8.3.2.2.3.3. The hospital shall document in the Enrollee's medical record all actions taken to satisfy the notification and Discharge Planning requirements set forth in **Section 2.6.3**.

2.8.3.2.2.3. A hospital with a DMH-licensed inpatient psychiatric unit shall accept into its DMH-licensed inpatient psychiatric unit all referrals of Enrollees that meet the established admission criteria of the inpatient unit.

2.8.3.2.2.4. The Contractor shall coordinate with DMH for any admissions to and discharges from DMH operated inpatient units.

2.8.3.2.2.5. The hospital shall report all available DMH-licensed beds into the Massachusetts Behavioral Health Access website at a minimum three times per day, 7 days per week. Such updates shall occur, at a minimum, between 8am-10am, 12pm-2pm, and 6pm-8pm, or at a time and frequency specified by EOHHS.

2.8.4. Administratively Necessary Day (AND) Status Data

2.8.4.1. As directed by EOHHS, the Contractor shall collect and report data to EOHHS regarding Enrollees on Administratively Necessary Days (AND) status in a twenty-four (24) hour level of care. The Contractor shall report to EOHHS Member-level reporting on a daily basis through the Massachusetts Behavioral Health Access (MABHA) website, as further specified by EOHHS, and additional information on an ad hoc basis in a form, format, and frequency specified by EOHHS.

2.8.5. Provider Payments

2.8.5.1. Timely Payment to Providers

2.8.5.1.1. The Contractor shall make payment on a timely basis to Providers for Covered Services furnished to Enrollees, in accordance with 42 USC 1396u-2(f) and 42 CFR 447.46. Unless otherwise provided for and mutually agreed to in a contract between the Contractor and a Provider that has been reviewed and approved by EOHHS, the Contractor shall:

2.8.5.1.1.1. Pay 90% of all Clean Claims for Covered Services from Providers within 30 days from the date the Contractor receives the Clean Claim;

- 2.8.5.1.1.2. Pay 99% of all Clean Claims from Providers within 60 days from the date the Contractor receives the Clean Claim;
 - 2.8.5.1.1.3. Submit a Claims Processing report in accordance with **Appendix A**; and
 - 2.8.5.1.1.4. For the purposes of this **Section**, the day the Contractor receives the Clean Claim is the date indicated by the date stamp on the claim and the day the Contractor pays the Clean Claim is the date of the check or other form of payment.
- 2.8.5.2. The Contractor shall not implement any incentive plan that includes a specific payment to a Provider as an inducement to deny, reduce, delay, or limit specific, Medically Necessary Services.
- 2.8.5.2.1. The Provider shall not profit from the provision of Covered Services that are not Medically Necessary or medically appropriate.
 - 2.8.5.2.2. The Contractor shall not profit from denial or withholding of Covered Services that are Medically Necessary or medically appropriate.
 - 2.8.5.2.3. Nothing in this **Section** shall be construed to prohibit Provider Contracts that contain incentive plans that involve general payments such as capitation payments or shared risk agreements that are made with respect to physicians or physician groups or which are made with respect to groups of Enrollees if such agreements, which impose risk on such physicians or physician groups for the costs of medical care, services and equipment provided or authorized by another physician or health care provider, comply with **Section 2.8.5.5.2**.
- 2.8.5.3. EOHHS may, in its discretion, direct the Contractor to establish payment rates for Providers of certain types of services in its Provider Network. EOHHS may require that such payment rates be:
- 2.8.5.3.1. No greater than a certain percentage of the Original Medicare (FFS) rate, or another payment rate specified by EOHHS;
 - 2.8.5.3.2. No less than a certain percentage of the MassHealth FFS rate or another payment rate specified by EOHHS;

- 2.8.5.3.3. EOHHS may approve exemptions from such requirements, such as to allow for implementation of an alternative payment methodology.
- 2.8.5.4. The Contractor shall ensure Provider payments are consistent with the provisions set forth in **Section 2.8.2** regarding Provider Contracts.
- 2.8.5.5. Non-Payment and Reporting
 - 2.8.5.5.1. Non-Payment and Reporting of Serious Reportable Events
 - 2.8.5.5.1.1. The Contractor shall work collaboratively with EOHHS to develop and implement a process for ensuring non-payment or recovery of payment for services when “Serious Reportable Events” (SREs) (a/k/a “Never Events”), as defined by this Contract, occur. The Contractor’s standards for non-payment or recovery of payment shall be, to the extent feasible, consistent with the minimum standards for non-payment for such events developed by EOHHS and provided to Contractors via regulation and administrative bulletins.
 - 2.8.5.5.1.2. The Contractor shall notify EOHHS of SREs, in accordance with **Appendix A** and with guidelines issued by the Department of Public Health.
 - 2.8.5.5.1.3. The Contractor shall provide, at a frequency and format specified by EOHHS a summary of SREs in accordance with **Appendix A**. Such summary shall include the resolution of each SRE, if any, and any next steps to be taken with respect to each SRE.
 - 2.8.5.5.2. Non-Payment and Reporting of Provider Preventable Conditions
 - 2.8.5.5.2.1. The Contractor shall take such action as is necessary in order for EOHHS to comply with and implement all Federal and State laws, regulations, policy guidance, and MassHealth policies and procedures relating to the identification, reporting, and non-payment of provider preventable conditions, including 42 U.S.C. 1396b-1 and regulations promulgated thereunder.
 - 2.8.5.5.2.2. In accordance with 42 CFR 438.3(g), the Contractor shall:

- 2.8.5.5.2.2.1. As a condition of payment, comply with the requirements mandating Provider identification of Provider-Preventable Conditions, as well as the prohibition against payment for Provider-Preventable Conditions as set forth in 42 CFR 434.6(a)(12) and 447.26, and
- 2.8.5.5.2.2.2. Report all identified Provider-Preventable Conditions in a form and format and frequency specified by EOHHS, including but not limited to any reporting requirements specified in accordance with **Appendix A**.
- 2.8.5.5.2.3. The Contractor shall develop and implement policies and procedures for the identification, reporting, and non-payment of Provider Preventable Conditions. Such policies and procedures shall be consistent with federal law, including but not limited to 42 C.F.R. § 434.6(a)(12), 42 C.F.R. § 438.3(g), and 42 C.F.R. § 447.26, and guidance and be consistent with EOHHS policies, procedures, and guidance on Provider Preventable Conditions. The Contractor's policies and procedures shall also be consistent with the following:
 - 2.8.5.5.2.3.1. The Contractor shall not pay a provider for a Provider Preventable Condition.
 - 2.8.5.5.2.3.2. The Contractor shall require, as a condition of payment from the Contractor, that all providers comply with reporting requirements on Provider Preventable Conditions as described at 42 C.F.R. § 447.26(d) and as may be specified by the Contractor and/or EOHHS.
 - 2.8.5.5.2.3.3. The Contractor shall not impose any reduction in payment for a Provider Preventable Condition when the condition defined as a Provider Preventable Condition for a particular Enrollee existed prior to the provider's initiation of treatment for that Enrollee.
 - 2.8.5.5.2.3.4. A Contractor may limit reductions in provider payments to the extent that the following apply:
 - 2.8.5.5.2.3.4.1. The identified Provider Preventable Condition would otherwise result in an increase in payment.

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

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

2.8.5.5.3. Non-Payment and Reporting of Preventable Hospital Readmissions

2.8.5.5.3.1. As directed by EOHHS, the Contractor shall develop and implement a process for ensuring non-payment or recovery of payment for preventable hospital readmissions. Such process shall be, to the extent feasible, consistent with minimum standards and processes developed by EOHHS.

2.8.6. Critical Access Hospitals

2.8.6.1. To the extent necessary to comply with the Commonwealth's statutory requirements set forth in Section 253 of Chapter 224 of the Acts of 2012, the Contractor shall ensure its payments to any licensed hospital facility operating in the Commonwealth that has been designated as a critical access hospital under 42 U.S.C. 1395i4 are paid at an amount equal to at least one hundred one percent (101%) of allowable costs under the Contractor's One Care Plan, as determined by utilizing the Medicare cost based reimbursement methodology, for both inpatient and outpatient services.

2.8.7. Provider Directory

2.8.7.1. The Contractor shall maintain a searchable Provider directory (or directories) as further specified by EOHHS. Such directory (or directories) shall include PCPs, BH Providers, LTSS Providers, hospitals, specialists, sub-specialists, pharmacies, including a listing of statewide emergency rooms and Crisis Services providers, including CBHCs, that is made available in Prevalent Languages and Alternative Formats, upon request, and includes, at a minimum, the following information:

2.8.7.1.1. For PCPs, Behavioral Health Providers, LTSS Providers, hospitals, pharmacies, and specialists:

2.8.7.1.1.1. Alphabetical Provider list, including any specialty and group affiliation as appropriate;

- 2.8.7.1.1.2. Geographic list of Providers by town;
- 2.8.7.1.1.3. Office address and telephone numbers for each Provider, as well as website URL as appropriate;
- 2.8.7.1.1.4. Office hours for each Provider;
- 2.8.7.1.1.5. The Provider's Cultural and Linguistic Competence and capabilities, including languages spoken by Provider or by skilled medical interpreter at site, including ASL, and whether the Provider has completed cultural competence training;
- 2.8.7.1.1.6. Whether or not the Provider's office or facility has accommodations for people with physical disabilities, including offices, exam rooms, and equipment;
- 2.8.7.1.1.7. PCPs with open and closed panels, where open panel refers to those accepting any new patient, and closed panel refers to those that are limited to the current patients only;
- 2.8.7.1.2. For Behavioral Health Providers, required information also includes qualifications and licensing information, and special experience, skills, and training (i.e., trauma, geriatrics, LGBTQ+, substance use); and
- 2.8.7.1.3. For Long-Term Services and Supports Providers, required information also includes a list of all services provided by the organization or ASAP (i.e., Home Health, Adult Foster Care, Personal Care Management, etc.).
- 2.8.7.1.4. For pharmacies:
 - 2.8.7.1.4.1. Alphabetical listing of the pharmacy chains included in the Contractor's network;
 - 2.8.7.1.4.2. Alphabetical listing of independent pharmacies, including addresses and phone numbers; and
 - 2.8.7.1.4.3. Instructions for the Enrollee to contact the Contractor's toll-free Enrollee Services telephone line for assistance in finding a convenient pharmacy.
- 2.8.7.1.5. For Dental Health:
 - 2.8.7.1.5.1. Develop a current directory of all Dental Providers in Active Status. The directory of all Dental Providers in

Active Status shall be available to Members via the Customer Web Portal and via EOHHS hosted website, and shall allow for multiple search capabilities as approved by EOHHS; and County-specific sections shall be made available in hard copy to Customers, upon request. The Contractor's online Dental Provider directory shall be populated against Contractor's online data systems. The Contractor shall ensure the Dental Provider directory includes, at a minimum, the following information:

- 2.8.7.1.5.1.1. Dental Provider's name;
- 2.8.7.1.5.1.2. Practice site address(es) including ZIP code and County;
- 2.8.7.1.5.1.3. Dental Provider's area(s) of specialty;
- 2.8.7.1.5.1.4. Age category of Members seen (adult only);
- 2.8.7.1.5.1.5. Dental practice status: open (accepting new Members) or closed (not accepting new Members);
- 2.8.7.1.5.1.6. Dental Provider's telephone number;
- 2.8.7.1.5.1.7. Dental Provider's or practice's internet address, if applicable;
- 2.8.7.1.5.1.8. Dental Provider's office hours;
- 2.8.7.1.5.1.9. Languages spoken;
- 2.8.7.1.5.1.10. Whether or not the Dental Provider's office has accommodations for people with physical or cognitive disabilities, including offices, exam rooms, and equipment;
- 2.8.7.1.5.1.11. Whether the Dental Provider has any advanced training or experience in serving persons with physical or cognitive disabilities and, if applicable, a brief description of this training and/or experience; and
- 2.8.7.1.5.1.12. Any other practical information about the Dental Provider.

- 2.8.7.1.5.2. Update the Dental Provider directory at least monthly with any new information obtained through credentialing and re-credentialing of Dental Providers, as detailed in this **Section 2.8.7.1.5**; outreach by Provider Relations Representatives or other outreach to Providers, as detailed in **Section 3.3**; secret shopper surveys, as detailed in **Section 2.10.7** and ; disenrollment notifications as detailed in **Section 2.4.13**; and information collected to develop the Dental Provider Network Administration Reports detailed in **Appendix P**.
- 2.8.7.1.5.3. Contractor shall maintain accurate provider directory data. EOHHS may, at the sole discretion of EOHHS, conduct periodic audits within 30 days of February 1, 2026, and annually thereafter, and within 30 days of August 1, 2026, and annually thereafter, to verify the accuracy of Contractor's provider directory data. Contractor shall maintain an accuracy rate of at least 80% in regard to the listed status (i.e., Active or Inactive) of each Dental Provider.
- 2.8.7.1.5.4. Contractor shall maintain complete provider directory data. EOHHS may, at the sole discretion of EOHHS, conduct periodic audits, within 30 days of February 1, 2026, and annually thereafter, and within 30 days of August 1, 2026, and annually thereafter, to verify the completeness of Contractor's provider directory data. Contractor shall ensure that no more than 20% of required information, as detailed in this **Section 2.8.7**, is missing.

2.9. Network Management

2.9.1. General Requirements

- 2.9.1.1. The Contractor shall develop and implement a strategy to manage the Provider Network with a focus on access to services and quality. The management strategy shall:
 - 2.9.1.1.1. Incorporate the principles of rehabilitation and recovery for Behavioral Health Services, the Independent Living Principles, Cultural and Linguistic Competence, integration, and cost effectiveness;
 - 2.9.1.1.2. Address all providers;
 - 2.9.1.1.3. Include a system for utilizing Network Provider profiling and benchmarking data to identify and manage outliers;

- 2.9.1.1.4. Include a system for the Contractor and Network Providers to identify and establish improvement goals and periodic measurements to track Network Providers' progress toward those improvement goals; and
 - 2.9.1.1.5. Include conducting announced and unannounced on-site visits to Network providers for quality management and quality improvement purposes, and for assessing meaningful compliance with ADA requirements.
- 2.9.1.2. The Contractor shall:
- 2.9.1.2.1. Ensure the Provider Network provides adequate access to all Covered Services; and
 - 2.9.1.2.2. Ensure that all providers are appropriately credentialed, maintain current licenses, are currently accepting and treating patients and have appropriate locations to provide the Covered Services.
 - 2.9.1.2.3. Establish and conduct an ongoing process for enrolling in their Provider Network any willing and qualified provider that meets the Contractor's requirements and with whom mutually acceptable provider Contract terms, including with respect to rates, are reached.
 - 2.9.1.2.4. Operate a toll-free pharmacy technical help call center or make available call support to respond to inquiries from pharmacies and providers regarding the Enrollee's prescription drug benefit. This requirement can be accommodated with on-call staff pharmacists or by contracting with the Contractor's pharmacy benefit manager during non-business hours as long as the below performance and competency standards are met. The call center shall:
 - 2.9.1.2.4.1. Respond competently to inquiries regarding claims processing, benefit coverage, claims submission, and claims payment.
 - 2.9.1.2.4.2. Operate or be available during the entire period in which the Contractor's network pharmacies in its plans' Service Areas are open, (e.g., contractors whose pharmacy networks include twenty-four (24) hour pharmacies must operate their pharmacy technical help call center twenty-four (24) hours a day as well).
 - 2.9.1.2.4.3. Meet the following operating standards:

- 2.9.1.2.4.3.1. Average hold time shall not exceed two (2) minutes, with the average hold time defined as the time spent on hold by the caller following the interactive voice response system, touch tone response system, or recorded greeting and before reaching a live person.
- 2.9.1.2.4.3.2. Eighty (80) percent of incoming calls answered within thirty (30) seconds.
- 2.9.1.2.4.3.3. Disconnect rate of all incoming calls not to exceed five (5) percent.
- 2.9.1.2.5. Maintain and distribute a provider manual(s), which includes specific information about Covered Services, non-Covered Services, and other requirements of the Contract relevant to provider responsibilities. The Contractor shall submit an updated provider manual(s) to EOHHS annually and document all changes, or updates made to the provider manual(s). Such updated provider manual(s) shall be distributed to providers annually and made available to providers on the Contractor's website. The provider manual(s) shall include, but not be limited to, the following information/requirements:
 - 2.9.1.2.5.1. Enrollee rights and the requirement that Enrollees must be allowed to exercise such rights without having their treatment adversely affected;
 - 2.9.1.2.5.2. Provider responsibilities as a Member of the ICT;
 - 2.9.1.2.5.3. That Enrollees may file a Grievance with the Contractor if the provider violates any Enrollee rights and the steps the Contractor may take to address any such Grievances;
 - 2.9.1.2.5.4. Enrollee privacy matters;
 - 2.9.1.2.5.5. That Providers shall make interpreter services available to Enrollees, that Providers shall not allow family members or other caregivers to serve as the interpreter except in instances of an emergency or if the provider will have to deny care, and that if the Provider allows a family Member or other caregiver to serve as the interpreter the Provider shall document it in the record as well as the reason an interpreter was not available;
 - 2.9.1.2.5.6. The Provider's obligation to accept and treat all Enrollees regardless of race/ethnicity, age, English proficiency,

gender identity, sexual orientation, health status, or disability;

- 2.9.1.2.5.7. General rules of provider-Enrollee Communications;
- 2.9.1.2.5.8. Covered Services lists;
- 2.9.1.2.5.9. The Provider's obligation to make Enrollees aware of available clinical options and all available care options;
- 2.9.1.2.5.10. Permissible provider marketing activities;
- 2.9.1.2.5.11. That Providers may not charge Enrollees or the Contractor for any service that (a) is not a Medically Necessary Covered Service or non-covered service, (b) for which there may be other Covered Services or non-Covered Services that are available to meet the Enrollee's needs, and (c) where the provider did not explain items (a) and (b) , that the Enrollee will not be liable to pay the provider for the provision of any such services. The provider shall be required to document compliance with this provision;
- 2.9.1.2.5.12. Information on Advance Directives, as defined in 42 C.F.R. § 489.100, and pursuant to 42 C.F.R. § 422.128, 130 CMR 450.112, and 42 CFR 438.3(j);
- 2.9.1.2.5.13. The Contractor's authority to audit the presence of Advance Directives in medical records;
- 2.9.1.2.5.14. Services that need PCP referrals or prior authorization by the Contractor;
- 2.9.1.2.5.15. Full explanation of new Enrollee's right to the initial continuity-of-care period;
- 2.9.1.2.5.16. Enrollee rights to access and correct medical records information;
- 2.9.1.2.5.17. The process through which the Contractor communicates updates to policies (for providers and Material Subcontractors);
- 2.9.1.2.5.18. The process and timelines for rendering decisions on service authorizations and frequency of concurrent reviews;

- 2.9.1.2.5.19. Protocols for transitioning Enrollees from one Behavioral Health Provider to another;
- 2.9.1.2.5.20. Protocols for communication and coordination between Members of the Enrollee's ICT, including access to electronic health records or care management portals;
- 2.9.1.2.5.21. Coordination between Behavioral Health Providers and PCPs;
- 2.9.1.2.5.22. Coordination between Behavioral Health Providers and State agencies, including but not limited to Department of Developmental Services (DDS), Department of Mental Health (DMH), Department of Transitional Assistance (DTA), Department of Corrections (DOC), Probation and Parole;
- 2.9.1.2.5.23. Provider responsibility for submission of Notification of Birth forms;
- 2.9.1.2.5.24. Steps a provider shall take to request disenrollment of an Enrollee from their panel;
- 2.9.1.2.5.25. Information on the Contractor's administrative Appeals process;
- 2.9.1.2.5.26. Information on the Contractor's process for an internal Appeal following an Adverse Action, including an Enrollee's right to use a provider as an Appeal representative; and
- 2.9.1.2.5.27. Information on the policy against balance billing.
- 2.9.1.2.6. Maintain a protocol that shall facilitate communication to and from providers and the Contractor;
- 2.9.1.2.7. Except when required by law or authorized by EOHHS, make best efforts to ensure that providers receive thirty (30) days advance notice in writing of policy and procedure changes and maintain a process to provide education and training for providers regarding any changes that may be implemented prior to the policy and procedure changes taking effect;
- 2.9.1.2.8. Work in collaboration with providers to actively improve the quality of care provided to Enrollees, consistent with the Quality Improvement Goals and all other requirements of this Contract; and

2.9.1.2.9. Collect data from providers in a standardized format to the extent feasible and appropriate, including secure information exchanges and technologies utilized for State Medicaid quality improvement and care coordination efforts, consistent with 42 CFR 438.242(b)(3)(iii).

2.9.1.3. Responsiveness to Provider Requests to Enter into Agreement with the Contractor.

2.9.1.3.1. The Contractor shall develop and maintain, and provide to EOHHS for review, policies, and procedures regarding its responsiveness to provider requests to enter into agreements with the Contractor to provide services to an Enrollee, including but not limited to Provider Contracts and single case agreements. Such policies and procedures shall include, but may not be limited to, how the Contractor:

2.9.1.3.2. Acknowledges receipt of the request, including whether such acknowledgement is in writing or in another manner; and

2.9.1.3.3. Provides a reasonable estimate as to the time it will take for the Contractor to make a decision with respect to such request, including whether such estimate takes into account the Enrollee's health condition.

2.9.2. Primary Care Provider (PCP) Network

2.9.2.1. The Contractor shall report to EOHHS, in accordance with **Appendix A**, the following:

2.9.2.1.1. A geographic access report for PCPs demonstrating access by geography; and

2.9.2.1.2. A PCP-to-Enrollee ratio report showing open and closed PCPs per number of Enrollees.

2.9.2.2. The Contractor shall make best efforts to ensure that PCP turnover does not exceed seven (7%) percent annually. The Contractor shall monitor and annually report to EOHHS the number and rate of PCP turnover separately for those PCPs who leave the Contractor's Plan voluntarily and those PCPs who are terminated by the Contractor. If the Contractor's annual PCP turnover rate exceeds seven (7%) percent, the Contractor shall submit an explanation for the turnover rate to EOHHS. EOHHS may subsequently request a business plan addressing the turnover rate for EOHHS review and approval.

2.9.2.3. The Contractor shall monitor Enrollees' voluntary changes in PCPs to identify Enrollees with multiple and frequent changes in PCPs in

order to address opportunities for Enrollee education about the benefits of developing a consistent, long-term patient doctor relationship with one's PCP, and to recommend to the PCP that a screen for the need for any Behavioral Health Services may be indicated, including situations where the Contractor suspects drug seeking behavior.

- 2.9.2.4. The Contractor shall provide access to appropriate PCPs in accordance with **Section 2.8.7.1**. An appropriate PCP is defined as a PCP who:
 - 2.9.2.4.1. Has qualifications and expertise commensurate with the health care needs of the Enrollee; and
 - 2.9.2.4.2. Has the ability to communicate with the Enrollee in a linguistically appropriate and culturally sensitive manner.
- 2.9.2.5. The Contractor shall provide access to PCPs with open panels in accordance with **Section 2.10.4**.
- 2.9.3. Behavioral Health Network Requirements
 - 2.9.3.1. Substance Use Disorder Treatment Providers
 - 2.9.3.1.1. To the extent permitted by law, the Contractor shall require all substance use disorder treatment providers to submit to DPH/BSAS the data required by DPH.
 - 2.9.3.1.2. The Contractor shall require all substance use disorder treatment providers to track, by referral source:
 - 2.9.3.1.2.1. All referrals for services;
 - 2.9.3.1.2.2. The outcome of each referral (i.e., admission, etc.); and
 - 2.9.3.1.2.3. If the substance use disorder treatment provider refuses to accept a referral, the reason for the refusal.
 - 2.9.3.2. The Contractor shall implement a unified Network Management strategy that ensures access to the continuum of care for Behavioral Health, consistent with the Behavioral Health requirements in **Section 2.7** and **2.8**. The network shall include, at a minimum, access to:
 - 2.9.3.2.1. All Behavioral Health Services listed in **Appendix C**;
 - 2.9.3.2.2. MassHealth Community Behavioral Health Centers (CBHCs) listed in **Appendix G, Exhibit 1**;

- 2.9.3.2.3. State-Operated Community Mental health Centers (SOCMHCs) listed in **Appendix G, Exhibit 2**;
 - 2.9.3.2.4. Hospitals Operated by DMH in **Appendix G, Exhibit 4**; and
 - 2.9.3.2.5. Covered Services in **Appendix C, Exhibit 2**.
- 2.9.3.3. The Contractor shall refer cases to the SOCMHCs in a manner that is consistent with the policies and procedures for Network referrals generally. See **Appendix G**, for a list of SOCMHCs, which may be updated by EOHHS from time to time.
 - 2.9.3.4. The Contractor shall require Hospitals with DMH-licensed beds in its Provider Network to comply with the Department of Mental Health Inpatient Licensing Division Clinical Competencies/ Operational Standards that follow, as they appear in [DMH Licensing Division Bulletin #19-01](#) (or any amended or successor bulletin), when delivering Inpatient Mental Health Services in those DMH-licensed beds to specialty populations.
 - 2.9.3.5. The Contractor shall require all hospitals in its Provider Network, including those that do not have DMH-licensed beds, to have the capability to treat, in accordance with professionally recognized standards of medical care, all individuals admitted to any unit or bed within the hospital who present with co-occurring behavioral conditions, including, but not limited to, individuals with co-occurring Substance Use Disorders (SUD), Autism Spectrum Disorder and Intellectual and Developmental Disabilities (ASD/ID/DD), and/or individuals who present with a high-level of psychiatric acuity, including severe behavior and assault risk.
 - 2.9.3.6. The Contractor shall work collaboratively with EOHHS and EOHHS's BH Vendor to support the CBHC program, as further specified by EOHHS.
 - 2.9.3.7. Community Support Program for Homeless Individuals (CSP-HI)
 - 2.9.3.7.1. Subject to the Medical Necessity requirements set forth in 130 CMR 450.204 and **Section 1**, other Contract requirements, and applicable statutory and regulatory requirements, and in at least the minimum amount, duration, and scope described in 130 CMR 461.403, under CSP-HI the Contractor shall provide CSP services as set forth in **Appendix C** to eligible Enrollees who meet the following criteria:
 - 2.9.3.7.1.1. Homeless Enrollees who meet the definition of Chronic Homelessness in **Section 1.31**; or

- 2.9.3.7.1.2. Homeless Enrollees who do not meet the Chronic Homeless definition but who are also high utilizers of MassHealth services as defined by MassHealth.

2.9.3.7.2. The Contractor shall:

- 2.9.3.7.2.1. Authorize, arrange, coordinate, and provide CSP-HI services as set forth in **Appendix C** to Enrollees who meet the criteria under this **Section 2.9.3.7**;
- 2.9.3.7.2.2. Actively communicate with CSP-HI providers regarding the provision of CSP-HI services to Enrollees, including coordinating care to ensure that Enrollees' needs are met;
- 2.9.3.7.2.3. Require that Network Providers of CSP-HI have demonstrated experience and employed staff as further specified by EOHHS and in 130 CMR 461.000 including Homelessness experience and expertise;
- 2.9.3.7.2.4. Develop Performance Specifications for the delivery of CSP-HI as specified by EOHHS and submit such Performance Specifications to EOHHS as well as any updates to the specifications as they occur;
- 2.9.3.7.2.5. Pay CSP-HI Providers a daily rate. Once the Enrollee has obtained housing, continue to pay CSP-HI Providers the daily rate until such a time as the Contractor determines that CSP-HI is no longer medically necessary;
- 2.9.3.7.2.6. Ensure that rates paid for CSP-HI services are reflective of the current market rate and are sufficient to ensure network adequacy. The Contractor shall ensure providers comply with billing requirements specified by EOHHS, including but not limited to using codes specified by EOHHS;
- 2.9.3.7.2.7. Designate a single point of contact for CSP-HI to provide information to CSP-HI providers and EOHHS as further specified by EOHHS. This single point of contact shall be the same contract designated for CSP-TPP as described in **Section 2.9.3.7**; and
- 2.9.3.7.2.8. Collect and maintain written documentation that the Enrollees receiving CSP-HI meet the definitions under **Section 2.9.3.7**, and as further specified by EOHHS.

2.9.3.8. Community Support Program for Justice Involvement (CSP-JI)

- 2.9.3.8.1. The Contractor shall ensure access to CSP-JI,
- 2.9.3.8.2. Subject to the Medical Necessity requirements under 130 CMR 450.204 and in **Section 1**, other Contract requirements, and applicable statutory and regulatory requirements and in at least the minimum amount, duration, and scope described in 130 CMR 461.403, the Contractor shall provide CSP services as set forth in **Appendix C, Exhibit 2**, to individuals with Justice Involvement as described in this Section.
- 2.9.3.8.3. The Contractor shall authorize, arrange, coordinate, and provide CSP services as set forth in **Appendix C, Exhibit 2**, to Enrollees with Justice Involvement that consist of intensive, and individualized support delivered face-to-face or via telehealth, as further specified by EOHHS, which shall include:
 - 2.9.3.8.3.1. Assisting in enhancing daily living skills;
 - 2.9.3.8.3.2. Providing service coordination and linkages;
 - 2.9.3.8.3.3. Assisting with obtaining benefits, housing, and healthcare;
 - 2.9.3.8.3.4. Developing a safety plan,
 - 2.9.3.8.3.5. Providing prevention and intervention; and
 - 2.9.3.8.3.6. Fostering empowerment and recovery, including linkages to peer support and self-help groups.
- 2.9.3.8.4. The Contractor shall, as further directed by EOHHS, with respect to CSP-JI;
 - 2.9.3.8.4.1. Actively communicate with CSP-JI providers regarding the provision of CSP-JI services, including coordinating care to ensure that individuals' needs are met;
 - 2.9.3.8.4.2. Ensure that network providers of CSP-JI have demonstrated experience and engage in specialized training;
 - 2.9.3.8.4.3. Report to EOHHS about its network providers of CSP-JI in accordance with **Appendix A**; and

- 2.9.3.8.4.4. Designate a single point of contact for CSP-JI to provide information to CSP-JI providers and EOHHS as further specified by EOHHS.
- 2.9.3.8.5. When directed by EOHHS, the Contractor shall maintain agreements with Behavioral Health Supports for individuals with Justice Involvement providers, as further specified by EOHHS.
- 2.9.3.9. Community Support Program Tenancy Preservation Program (CSP-TPP)
 - 2.9.3.9.1. Subject to the Medical Necessity requirements under 130 CMR 450.204 and in **Section 1**, other Contract requirements, and applicable statutory and regulatory requirements, and in at least the minimum amount, duration, and scope described in 130 CMR 461.403, the Contractor shall provide CSP-TPP services as set forth in **Appendix C** to Covered Individuals who are at risk of homelessness. For the purposes of this **Section** “at risk of homelessness” is defined as a Covered Individual who:
 - 2.9.3.9.1.1. 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;
 - 2.9.3.9.1.2. Is facing eviction, e.g., the process of obtaining a court order to remove a tenant and other occupants from a rental property including serving either a Notice to Quit or a request for temporary, preliminary, permanent relief. Eviction may also refer to any instance in which such relief has been granted.
 - 2.9.3.9.2. The Contractor shall:
 - 2.9.3.9.2.1. Authorize, arrange, coordinate, and provide CSP-TPP services as set forth in **Appendix C** to Covered Individuals who meet the criteria under **Section 2.9.3.9.1**.
 - 2.9.3.9.2.2. Actively communicate with CSP-TPP providers regarding the provision of CSP-TPP services to Covered Individuals, including coordinating care to ensure that Covered Individuals’ needs are met;

- 2.9.3.9.2.3. Require the Network Providers of CSP-TPP have demonstrated experience and employed staff as further specified by EOHHS and in 130 CMR 461.000;
- 2.9.3.9.2.4. Develop Performance Specifications for the delivery of CSP-TPP as specified by EOHHS and submit such Performance Specifications to EOHHS as well as any updates to the specifications as they occur;
- 2.9.3.9.2.5. Pay CSP-TPP Providers a daily rate and continue to pay CSP-TPP Providers the daily rate until such a time as the Contractor determines that CSP-TPP is no longer medically necessary;
- 2.9.3.9.2.6. Ensure that rates paid for CSP-TPP services are reflective of the current market rate and are sufficient to ensure network adequacy. The Contractor shall ensure providers comply with billing requirements specified by EOHHS, including but not limited to using codes specified by EOHHS;
- 2.9.3.9.2.7. Designate a single point of contact for CSP-TPP to provide information to CSP-TPP providers and EOHHS as further specified by EOHHS. This single point of contact shall be the same contact designated for CSP-HI as described in **Section 2.9.3.7**; and
- 2.9.3.9.2.8. Collect and maintain written documentation that the Enrollees receiving CSP-TPP meet the definitions under **Section 2.9.3.9.1** as further specified by EOHHS.

2.9.3.10. The Contractor shall incorporate DMH's Infection Control Competencies/Standards, as set forth in Attachments A and B to DMH Licensing Bulletin 20-05R, or successor guidance, in its contracts with DMH-licensed providers of Inpatient Mental Health Services. The Contractor shall review such facility's compliance with the applicable DMH requirements as part of the Contractor's program integrity efforts pursuant to **Section 2.3.6**. The Contractor shall promptly report any noncompliance with the applicable DMH standards to EOHHS and shall treat such noncompliance in accordance with the Contractor's program integrity activities pursuant to **Section 2.3.6**.

2.9.4. Long-term Services and Supports Provider Network

2.9.4.1. General

- 2.9.4.1.1. The Contractor's Provider Network shall offer a selection of nursing facility and community LTSS providers that meets Enrollee needs and preferences and satisfies the time and distance requirements in **Section 2.10.4**.
- 2.9.4.1.2. The Contractor shall maintain a network that ensures timely discharge from the hospital and admission to a nursing facility for enrollees when an admission to a nursing facility is medically necessary because the enrollee cannot be safely supported in the community.

2.9.4.2. Personal Assistance Services Network

- 2.9.4.2.1. The Contractor shall meet Personal Assistance Services (PAS) network requirements, including for intake and orientation, skills training, development of Service Agreements, and assessment of the Enrollee's ability to manage Self-directed PCA Services independently.
- 2.9.4.2.2. The Contractor shall contract with Personal Care Management (PCM) Agencies that are under contract with EOHHS to provide PCM Services to Enrollees accessing Self-directed PCA Services.
- 2.9.4.2.3. Enrollees who are authorized to receive Self-directed PCA Services at the time of enrollment shall be granted the option of continuing to receive their PCM Services through their current PCM provider, to ensure continuity of Self-directed PCA Services.
- 2.9.4.2.4. Enrollees who are not authorized to receive Self-directed PCA Services at the time of enrollment should be offered a choice of at least two PCM Agencies, at least one of which shall be an Independent Living Center (ILC) operating as a PCM where geographically feasible. Enrollees over the age of sixty (60) shall be offered the option of receiving PCM Services through an ASAP operating as a PCM.

2.9.4.3. Personal Assistance Services Evaluations

- 2.9.4.3.1. The Contractor shall ensure that PAS evaluations are done in a timely manner to ensure appropriateness and continuity of services.
- 2.9.4.3.2. The Contractor may contract with PCM Agencies under contract with EOHHS to perform evaluations for PAS.

- 2.9.4.3.3. If the Contractor does not contract with ILCs for PAS evaluations, the Contractor shall provide and require training for their PAS evaluators on the Independent Living Principles.

2.9.4.4. Promoting Self-Direction of Services

- 2.9.4.4.1. The Contractor shall provide education, choice, and needed supports to promote self-direction of PAS by Enrollees and shall inform Enrollees that they may identify a surrogate to help them if they choose Self-directed PCA Services.
- 2.9.4.4.2. The Contractor shall pay for services rendered by the PCA hired by the Enrollee if the PCA meets MassHealth requirements in 130 CMR 422 and has completed the required Fiscal Intermediary paperwork. The Contractor shall pay the Fiscal Intermediary the PCA rate as set by EOHHS under 101 CMR 309.00, which includes both the PCA collective bargaining wage, payment for employer required taxes, and workers' compensation insurance.
- 2.9.4.4.3. The Contractor shall contract with the Fiscal Intermediary under contract with EOHHS to support Enrollees in fulfilling their employer required obligations related to the payment of PCAs.

2.9.4.5. PAS for Enrollees who do not choose Self-directed PCA:

- 2.9.4.5.1. The Contractor shall provide Enrollees who do not choose Self-directed PCA, or who are not able to find a surrogate to assist them to self-direct, with the option of having their PAS provided by an agency. The Contractor shall contract with such agencies and provide Enrollees with the choice of at least two PAS agency providers, except that with EOHHS prior approval, Contractor may offer Enrollee only one PAS agency provider. Services provided by PAS agency providers shall be person-centered and the Enrollee shall have a choice of the schedule for PCAs and of who provides PAS.
- 2.9.4.5.2. The Contractor shall provide PAS to Enrollees who need such assistance for the purposes of cueing and monitoring, including for Enrollees who do not need hands-on assistance, as described in **Appendix C, Exhibit 3**.
- 2.9.4.5.3. For Enrollees receiving PCA services that are disenrolling from the Contractor, the Contractor shall include provisions

in its contracts with PCM agencies requiring compliance with EOHHS' continuity of PCA services procedures (see **Section 2.6.5**).

2.9.4.6. Personal Assistance Overtime

2.9.4.6.1. The Contractor shall include provisions in its contracts with its PCM Agencies requiring that the PCM Agencies instruct Enrollees regarding appropriate utilization of PCA overtime requiring authorization pursuant to 130 CMR 422.418(C), in accordance with 130 CMR 422.421(B)(1)(b)(5). The Contractor shall require such PCM Agency to agree to:

- 2.9.4.6.1.1. Attend trainings as directed by EOHHS;
- 2.9.4.6.1.2. Comply with reporting requirements for PCA services as directed by EOHHS;
- 2.9.4.6.1.3. Respond to Enrollee inquiries regarding overtime management and overtime approval requests;
- 2.9.4.6.1.4. Educate Enrollees that do or may need to schedule PCAs for more than 50 hours per week regarding the scheduling requirements pursuant to 130 CMR 422.420(A)(5)(b) and 130 CMR 422.418(C) and the potential consequences pursuant to 130 CMR 422.420(B)(5);
- 2.9.4.6.1.5. Assist Enrollees that do or may need to schedule PCAs to work more than 50 hours per week by working with those Enrollees to identify additional resources to enable such Enrollees to hire additional PCAs to meet the scheduling requirements;
- 2.9.4.6.1.6. Provide an overtime approval request form for Enrollees who request it, provide related instruction in completing the form to request overtime approval, and work with Enrollees to obtain Enrollee and PCA signatures;
- 2.9.4.6.1.7. Review and submit completed overtime approval request forms within one business day of receipt of said forms to MassHealth in a manner prescribed by MassHealth and maintain the original and related documents, if any, in the Enrollee's file;
- 2.9.4.6.1.8. Communicate MassHealth's decisions regarding overtime approval requests within one business day to Enrollees and to the Contractor;

- 2.9.4.6.1.9. Assist Enrollees who are denied overtime approval requests, or Enrollees who are approved for a short-term continuity of care overtime approval requests, by:
 - 2.9.4.6.1.9.1. Working with the Enrollee to identify additional resources to enable Enrollee to hire additional PCAs;
 - 2.9.4.6.1.9.2. Working and communicating with the FI regarding overtime approval requests and decisions;
 - 2.9.4.6.1.9.3. Working and communicating with the Contractor regarding the statuses of Enrollees who have been approved to schedule overtime, Enrollees who have not been approved to schedule overtime but who have applied for an overtime approval, and Enrollees who are not in compliance with the MassHealth overtime scheduling requirements pursuant to 130 CMR 422; and
 - 2.9.4.6.1.9.4. Informing Enrollees about their appeal rights with the MassHealth Board of Hearings pursuant to 130 CMR 610.
- 2.9.4.6.1.10. Receive and maintain lists provided by the Fiscal Intermediary that identify Enrollees who employ PCAs that work more than 50 hours per week; and
- 2.9.4.6.1.11. Prioritize the list of existing Enrollees who employ PCAs that work more than 50 hours per week and contact such Enrollees in order of priority to identify and assess each Enrollee's need for scheduling one or more PCAs for overtime.
- 2.9.4.6.2. The Contractor shall collect from its PCM Agencies, and provide to EOHHS upon request, reports as directed by EOHHS. Such reports may include, but are not limited to, the following information:
 - 2.9.4.6.2.1. The number of overtime approval requests received; and
 - 2.9.4.6.2.2. The number of overtime approval requests submitted to MassHealth.
- 2.9.4.7. Responsibilities Related to PCAs Employed by the Contractor's Enrollees

2.9.4.7.1. The Contractor shall implement a mechanism for receiving, investigating, and responding to Grievances, whether formal or informal, alleging non-payment of wages owed to PCAs employed by one or more of the Contractor's Enrollees.

2.9.4.7.2. In addition to any other indemnity provision within this Contract, the Contractor shall indemnify and hold harmless EOHHS and the Commonwealth from and against any and all liability, loss, damage, costs, or expenses, which EOHHS or the Commonwealth may sustain, incur, or be required to pay, arising out of or in connection with any Grievance or lawsuit related to the payment of wages to a PCA employed by one or more of the Contractor's Enrollees, regardless of whether such Grievance asserts violations of the Federal Fair Labor Standards Act (29 U.S.C. § 201, et seq.), the Commonwealth's Wage Act (M.G.L. c. 149, § 148), or any other federal or state law or regulation, provided that:

2.9.4.7.2.1. The Contractor is notified of any claims within a reasonable time from when EOHHS becomes aware of the claim; and

2.9.4.7.2.2. The Contractor is afforded an opportunity to participate in the defense of such claims.

2.9.5. Sexual and Reproductive Health/Family Planning Provider Network

2.9.5.1. The Contractor shall not restrict the choice of the provider from whom the Enrollee may receive family planning services and supplies. The Contractor shall provide or arrange family planning services as follows:

2.9.5.1.1. Ensure that all Enrollees are made aware that family planning services are available to the Enrollee through any MassHealth family planning provider, and that all Enrollees do not need authorization in order to receive such services;

2.9.5.1.2. Provide all Enrollees with sufficient information and assistance on the process and available providers for accessing family planning services in and out of the One Care Plan network;

2.9.5.1.3. Provide all Enrollees who seek family planning services from the Contractor with services including, but not limited to:

2.9.5.1.3.1. All methods of contraception, including sterilization, vasectomy, and emergency contraception;

- 2.9.5.1.3.2. Counseling regarding HIV, pre-exposure prophylaxis (PrEP) for HIV, post-exposure prophylaxis (PEP) for HIV, sexually transmitted diseases, including vaccinations to prevent sexually transmitted diseases, and risk reduction practices; and
- 2.9.5.1.3.3. Options counseling for pregnant Enrollees, including referrals for the following: prenatal care, foster care or adoption, and pregnancy termination;
- 2.9.5.1.4. Maintain sufficient family planning Providers to ensure timely access to family planning services.
- 2.9.5.1.5. Provide or arrange prenatal and postpartum services to pregnant Enrollees, in accordance with guidelines set by EOHHS or, where there are no EOHHS guidelines, in accordance with nationally accepted standards of practice.
- 2.9.6. Gender-affirming Care Provider Network
 - 2.9.6.1. Execute and maintain contracts with Gender-affirming care (GAC) Providers identified in **Appendix G, Exhibit 6** of this Contract, as updated by EOHHS from time to time, to provide all GAC services, including GAC services as set forth in **Appendix C**, as applicable. The Contractor shall:
 - 2.9.6.1.1. Ensure that all Enrollees are made aware that Gender-affirming care services are available to Enrollees through any MassHealth Gender-affirming care provider;
 - 2.9.6.1.2. Provide all Enrollees with sufficient information and assistance on the process and available providers for accessing Gender-affirming care services both in the Plan's network and out of the Plan's network;
 - 2.9.6.1.3. Ensure that the Contractor has policies and procedures in place for Enrollees seeking appropriate referrals to a non-network PCP, or other licensed professionals, to provide overall care, including, but not limited to, ongoing monitoring for hormone replacement therapy appropriate to Enrollees' gender goals;
 - 2.9.6.1.4. Ensure that the Contractor has policies and procedures in place for Enrollees seeking appropriate referrals to a non-network licensed, qualified behavioral health provider for Gender-affirming care services;

- 2.9.6.1.5. Utilize the MassHealth Guidelines for Medical Necessity Determinations for Gender Affirming Surgery;
- 2.9.6.1.6. Provide all Enrollees who seek Gender-affirming care services with Gender-affirming care services including, but not limited to:
 - 2.9.6.1.6.1. Feminizing Gender-Affirming Surgeries, when deemed medically necessary, including, but not limited to: Penectomy, Clitoroplasty, Colovaginoplasty, Vulvoplasty, Labiaplasty, Orchiectomy, Electrolysis or laser hair removal performed by a licensed qualified professional for the removal of hair on a skin graft donor site before its use in genital gender-affirming surgery;
 - 2.9.6.1.6.2. Masculinizing Gender-Affirming Surgeries, when deemed medically necessary, including, but not limited to: Hysterectomy, Salpingo-oophorectomy, Vulvectomy, Vaginectomy, Urethroplasty, Metoidioplasty (micropenis) or phalloplasty (allows coital ability and standing micturition), Scrotoplasty with insertion of testicular prosthesis, Electrolysis or laser hair removal performed by a licensed qualified professional for the removal of hair on a skin graft donor site before its use in genital gender-affirming surgery;
 - 2.9.6.1.6.3. Additional Feminizing and Masculinizing Gender-Affirming Surgeries, when deemed medically necessary, including: Blepharoplasty, Brow Lift, Cheek Augmentation, Forehead Contouring and Reduction, Genioplasty, Hairline Advancement, Lateral Canthopexy, Lip Lift, Lysis Intranasal Synechia, Osteoplasty, Rhinoplasty and Septoplasty, Suction-Assisted Lipectomy, Tracheoplasty; and
 - 2.9.6.1.6.4. Ensure that the authorization procedures established for Gender Affirming Speech Therapy provide for the first thirty-five (35) visits during a 12-month period without prior approval.

2.9.7. Dental Provider Network

- 2.9.7.1. Contractor shall, by August 31, 2025, and annually thereafter, contact all offices that treated Members with disabilities, including IDD, during the previous Contract Year, determine each of those offices' capacity to treat Enrollees with disabilities, including IDD, and encourage each of those offices to treat additional Enrollees by

providing training on how best to treat Enrollees with disabilities, including IDD.

- 2.9.7.2. The Contractor shall create and submit to EOHHS for approval Enrollees with disabilities, including IDD, Member Care Access Plan to expand Network capacity for Enrollees with disabilities, including IDD. This plan shall include, at minimum:
 - 2.9.7.2.1. Meeting monthly with a representative from a Provider group, to be designated by EOHHS, that specializes in treatment for Enrollees with disabilities, including IDD.
 - 2.9.7.2.2. The goal of these monthly meetings shall be to identify opportunities to connect Enrollees to dental care and to create Network capacity for Enrollees with disabilities, including IDD individuals.
 - 2.9.7.2.3. The Contractor shall document these efforts and update its provider directory.
 - 2.9.7.2.4. The Contractor shall ensure that Enrollee Services will have a referral list to utilize if an Enrollee should need placement.
- 2.9.7.3. The Contractor shall make best efforts to contract with Mobile Providers. The Contractor shall outreach to any non-network Mobile Providers at least annually to attempt to contract with them.
- 2.9.8. Provider Credentialing, Screening, and Board Certification
 - 2.9.8.1. General Provider Credentialing.
 - 2.9.8.1.1. The Contractor shall implement written policies and procedures that comply with the requirements of 42 C.F.R. §§ 422.504(i)(4)(iv) and 438.214(b) regarding the selection, retention and exclusion of providers and meet, at a minimum, the requirements below.
 - 2.9.8.1.2. The Contractor shall submit such policies and procedures annually to EOHHS, if amended, and shall demonstrate to EOHHS, by reporting annually that all providers within the Contractor's Provider Network are credentialed according to such policies and procedures. The Contractor shall:
 - 2.9.8.1.2.1. Designate a person/ people at the Contractor's organization who are responsible for provider credentialing and re-credentialing.

- 2.9.8.1.2.2. Maintain appropriate, documented processes for the credentialing and re-credentialing of physician providers and all other licensed or certified providers (e.g. RNs, PAs, and LICSWs) who participate in the Contractor's Provider Network. At a minimum, the scope and structure of the processes shall be consistent with recognized managed care industry standards such as those provided by the National Committee for Quality Assurance (NCQA) and relevant State regulations, including regulations issued by the Board of Registration in Medicine (BORIM) at 243 CMR 3.13. Such processes must also be consistent with any uniform credentialing policies specified by EOHHS addressing acute, primary and Behavioral Health Providers, including but not limited to substance use disorder providers, and any other EOHHS-specified providers.
- 2.9.8.1.2.3. Ensure that all providers are credentialed prior to becoming Network Providers and that a site visit is conducted in accordance with recognized managed care industry standards and relevant federal regulations.
- 2.9.8.1.2.4. Maintain a documented re-credentialing process that:
 - 2.9.8.1.2.4.1. Shall occur at least every three years (thirty-six months) and shall take into consideration various forms of data including, but not limited to, Grievances, results of quality reviews utilization management information, and Enrollee satisfaction surveys.
 - 2.9.8.1.2.4.2. Requires that physician providers and other licensed and certified professional providers, including Behavioral Health Providers, maintain current knowledge, ability, and expertise in their practice area(s) by requiring them, at a minimum, to conform with recognized managed care industry standards such as those provided by NCQA and relevant State regulations, when obtaining Continuing Medical Education (CME) credits or continuing Education Units (CEUs) and participating in other training opportunities, as appropriate. Such processes must also be consistent with any uniform re-credentialing policies specified by EOHHS addressing acute, primary, and Behavioral Health Providers, including but not limited to substance use disorder

providers, and any other EOHHS-specified providers.

- 2.9.8.1.3. The Contractor shall, upon notice from EOHHS, not authorize any providers terminated or suspended from participation in MassHealth, Medicare or from another state's Medicaid program, to treat Enrollees and shall deny payment to such providers for services provided.

2.9.8.2. Provider Screening and Monitoring

- 2.9.8.2.1. The Contractor shall monitor providers and prospective providers by monitoring all of the databases described in **Appendix I**, at the frequency described in **Appendix I** as follows:

- 2.9.8.2.1.1. The Contractor shall search the databases in **Appendix I** for individual providers, provider entities, and owners, agents, and managing employees of providers at the time of enrollment and re-enrollment, credentialing and recredentialing, and revalidation.

- 2.9.8.2.1.2. The Contractor shall evaluate the ability of existing providers, provider entities, and owners, agents, and managing employees of providers to participate by searching newly identified excluded and sanctioned individuals and entities reported as described in **Appendix I**.

- 2.9.8.2.2. The Contractor shall identify the appropriate individuals to search and evaluate pursuant to this **Section 2.9.8.2** by using, at a minimum, the federally required disclosures form provided by EOHHS.

- 2.9.8.2.3. The Contractor shall submit a monthly Excluded provider Monitoring Report to EOHHS, as described in **Appendix A**, which demonstrates the Contractor's compliance with this **Section 2.9.8.2**. At the request of EOHHS, the Contractor shall provide additional information demonstrating to EOHHS' satisfaction that the Contractor complied with the requirements of this **Section 2.9.8.2**, which may include, but shall not be limited to computer screen shots from the databases set forth in **Appendix I**.

- 2.9.8.2.4. The Contractor shall develop and maintain policies and procedures to implement the requirements as set forth in this

Section 2.9.8.2 and to comply with 42 C.F.R. § 438.608(a)(1).

- 2.9.8.2.5. If a provider is terminated or suspended from MassHealth, Medicare, or another state's Medicaid program or is the subject of a State or federal licensing action, the Contractor shall terminate, suspend, or decline a provider from its Provider Network as appropriate.
- 2.9.8.2.6. The Contractor shall notify EOHHS, through its Contract Manager, when it terminates, suspends, or declines a provider from its Provider Network because of fraud, integrity, or quality.
- 2.9.8.2.7. Consistent with 42 C.F.R. §438.608(d), the Contractor shall develop and maintain policies and procedures that support a process for the recoupment of overpayments to providers including those providers identified as excluded by appearing on any exclusion or debarment database including those at **Appendix I**. The Contractor shall maintain documentation to support the date and activities by which recoupment efforts are established for claims paid after the date indicated in the exclusion database. At a minimum, the Contractor shall document recoupment efforts including outreach to the Provider, voiding claims, and establishing a recoupment account; and
- 2.9.8.2.8. On an annual basis, the Contractor shall submit to EOHHS a certification checklist that it has implemented the actions necessary to comply with this **Section 2.9.8.2**.
- 2.9.8.2.9. This **Section 2.9.8.2** does not preclude the Contractor from suspending or terminating providers for cause prior to the ultimate suspension and termination from participation in MassHealth, Medicare, or another state's Medicaid program.
- 2.9.8.2.10. The Contractor shall not employ or contract with, or otherwise pay for any items or services (other than an emergency item or service, not including items or services furnished in an emergency room of a hospital) furnished, directed or prescribed under the plan by any individual or entity during any period when the individual or entity has been excluded from participation under title V, XVIII, XIX, or XX, or Sections 1128, 1128A, or 1842(j) of the Social Security Act, or that has been terminated from participation under Medicare or another state's Medicaid program, except as permitted under 42 C.F.R. §1001.1801 and 1001.1901,

furnished at the medical direction or on the prescription of a physician, during the period when such physician is excluded from participation under title V, XVIII, XIX, or XX pursuant to Section 1128, 1128A, 1156, or 1842(j)(2) and when the person furnishing such item or service knew, or had reason to know, of the exclusion (after a reasonable time period after reasonable notice has been furnished to the person), furnished by an individual or entity to whom the State has failed to suspend payments during any period when there is a pending investigation of a credible allegation of fraud against the individual or entity, unless the State determines there is good cause not to suspend such payments, and furnished by an individual or entity that is included on the preclusion list, as defined in 42 C.F.R. § 422.2.

- 2.9.8.2.10.1. Federal financial participation is not available for any amounts paid to the Contractor if the Contractor could be excluded from participation in Medicare or Medicaid under Section 1128(b)(8)(B) of the Social Security Act or for any of the reasons listed in 42 C.F.R. § 431.55(h).
- 2.9.8.2.11. The Contractor shall not pay for an item or service with respect to any amount expended for which funds may not be used under the Assisted Suicide Funding Restriction Act of 1997.
- 2.9.8.2.12. The Contractor shall ensure that no credentialed provider engages in any practice with respect to any Enrollee that constitutes unlawful discrimination under any other State or federal law or regulation, including, but not limited to, practices that violate the provisions of 45 C.F.R. Part 80, 45 C.F.R. Part 84, and 45 C.F.R. Part 90,
- 2.9.8.2.13. The Contractor shall search for the names of and not contract with parties disclosed during the credentialing process in the databases in **Appendix I** in accordance with the Contractor's obligations set forth in **Section 2.9** and the MassHealth exclusion list, and parties that have been terminated from participation under Medicare or another state's Medicaid program.
- 2.9.8.2.14. The Contractor shall obtain disclosures from all Network Providers and applicants in accordance with 42 C.F.R. 455 Subpart B and 42 C.F.R. 1002.3, including but not limited to obtaining such information through provider enrollment forms and credentialing and recredentialing packages, and

maintain such disclosed information in a manner which can be periodically searched by the Contractor for exclusions and provided to EOHHS in accordance with this Contract, including this **Section 2.9** and relevant State and federal laws and regulations, and

- 2.9.8.2.15. The Contractor shall notify EOHHS when a provider fails credentialing or re-credentialing because of a program integrity reason, and shall provide related and relevant information to EOHHS as required by EOHHS or State or federal laws, rules, or regulations.

2.9.8.3. Board Certification Requirements

- 2.9.8.3.1. The Contractor shall maintain a policy with respect to Board Certification for PCPs and specialty physicians that ensures that the percentage of board-certified PCPs and specialty physicians participating in the Provider Network, at a minimum, is approximately equivalent to the community average for PCPs and specialty physicians in the Contractor's Service Area. Specifically, the policy shall:

- 2.9.8.3.1.1. Require that all applicant physicians be board certified in their practicing medical specialty, or are in the process of achieving initial certification as a condition for participation, except as otherwise set forth in below,
- 2.9.8.3.1.2. Except as otherwise set forth below, require that all participating physicians achieve board certification in a time frame relevant to the guidelines established by their respective medical specialty boards, as applicable,
- 2.9.8.3.1.3. If necessary to ensure adequate access, the Contractor may contract with providers who have training consistent with board eligibility but are not board certified. In such circumstances, the Contractor shall submit to EOHHS for review and approval, on a case-by-case basis, documentation describing the access need that the Contractor is trying to address, and
- 2.9.8.3.1.4. Provide a mechanism to monitor participating physician compliance with the Contractor's board certification requirements, including, but not limited to, participating physicians who do not achieve board certification within the applicable time frames.

2.9.8.4. Behavioral Health Provider Credentialing

2.9.8.4.1. In addition to those requirements described above, the Contractor shall comply with the requirements of 42 C.F.R. § 438.214 regarding selection, retention and exclusion of Behavioral Health Providers. The Contractor shall:

2.9.8.4.1.1. Implement the Behavioral Health Credentialing Criteria as prior approved by EOHHS,

2.9.8.4.1.2. Meet or exceed all of the requirements of this Contract with regard to Behavioral Health Credentialing Criteria and Behavioral Health Clinical Criteria,

2.9.8.4.1.3. For Behavioral Health Providers treating substance use disorders, the Contractor shall require these providers to report to it on CEU trainings they have participated in on substance use disorder,

2.9.8.4.1.4. For a Behavioral Health Services Provider that is a hospital that provides Behavioral Health Inpatient Services, the Contractor shall ensure that such hospital has a human rights protocol that is consistent with the Department of Mental Health requirements to this Contract and includes training of the Behavioral Health Provider's staff and education for Enrollees regarding human rights, and

2.9.8.4.1.5. For a Behavioral Health Services Provider that is a hospital that provides Behavioral Health Inpatient Services, the Contractor shall ensure that such hospital has a human rights officer who shall be overseen by a human rights committee and shall provide written materials to Enrollees regarding their human rights.

2.9.9. Provider Profiling

2.9.9.1. The Contractor shall conduct profiling activities for PCPs, Behavioral Health Providers, community-based providers, LTSS providers, dental providers, vision providers and, as directed by EOHHS, specialty providers, at least annually. As part of its quality activities, the Contractor shall document the methodology it uses to identify which and how many providers to profile and to identify measures to use for profiling such providers.

2.9.9.2. Provider profiling activities shall include, but are not limited to:

2.9.9.2.1. Developing Provider specific reports that include a multidimensional assessment of a provider's performance using clinical, administrative, and Enrollee satisfaction

indicators of care that are accurate, measurable, and relevant to the enrolled population;

- 2.9.9.2.2. Establishing provider, group, or regional benchmarks for areas profiled, where applicable, including Contractor specific benchmarks, if any;
- 2.9.9.2.3. Providing feedback to providers regarding the results of their performance and the overall performance of the Provider Network; and
- 2.9.9.2.4. Designing and implementing quality improvement plans for providers who receive a relatively high denial rate for prospective, concurrent, or retrospective service authorization requests, including referral of these providers to the Network Management staff for education and technical assistance and reporting results annually to EOHHS.

2.9.9.3. The Contractor shall use the results of its provider profiling activities to identify areas of improvement for providers, and/or groups of providers. The Contractor shall:

- 2.9.9.3.1. Establish Provider specific quality improvement goals for priority areas in which a Provider or Providers do not meet established Contractor standards or improvement goals;
- 2.9.9.3.2. Develop and implement incentives, which may include financial and nonfinancial incentives, to motivate Providers to improve performance on profiled measures;
- 2.9.9.3.3. Conduct onsite visits to Network Providers for quality improvement purposes; and
- 2.9.9.3.4. At least annually, measure progress on the Provider Network and individual providers' progress, or lack of progress, towards meeting such improvement goals.

2.9.9.4. The Contractor shall maintain regular, systematic reports, in a form and format approved by EOHHS, of the abovementioned Provider profiling activities and related Quality Improvement activities pursuant to **Section 2.14.3**. Moreover, the Contractor shall submit to EOHHS, upon request, such reports or information that would be contained therein. The Contractor shall also submit summary results of such provider profiling and related Quality Improvement activities as a component of its annual evaluation of the QM/QI program.

2.9.10. Provider Education and Training

2.9.10.1. General

2.9.10.1.1. The Contractor shall:

- 2.9.10.1.1.1. Inform its Provider Network about its Covered Services and service delivery model;
- 2.9.10.1.1.2. Educate its Provider Network about its responsibilities for the integration and coordination of Covered Services;
- 2.9.10.1.1.3. Provide information about Grievances and Appeals policies, including about procedures and timeframes, to all providers and Material Subcontractors, per 42 C.F.R. § 438.414;
- 2.9.10.1.1.4. Inform its Provider Network about its quality improvement efforts and the Providers' role in such a program;
- 2.9.10.1.1.5. Inform its Provider Network about its policies and procedures, especially regarding in and non-network referrals, and ADA compliance, accessibility, and accommodations requirements, including as described in **Section 2.10.1.1.4**;
- 2.9.10.1.1.6. Develop and provide education to its Provider Network on Enrollee engagement roles, Utilization Management or Service Authorization roles, the availability and range of services, including behavioral health, community-based services, oral health, and LTSS services, available to meet Enrollee needs and the process for making Service Requests; and
- 2.9.10.1.1.7. How providers access and collaborate with care coordination staff, including by leveraging the Centralized Enrollee Record.

2.9.10.2. Quality Improvement Education and Training

- 2.9.10.2.1. In collaboration with, and as further directed by EOHHS, the Contractor shall develop and implement quality improvement activities directed at:
 - 2.9.10.2.1.1. Ensuring LTSS needs and goals are assessed, identified, and appropriately integrated with the other services provided and goals listed in the ICP.

2.9.10.2.1.2. With respect to behavioral health screening, developing and distributing Provider communications that shall give Providers information that describes:

2.9.10.2.1.2.1. The standardized behavioral health screening tools approved by EOHHS,

2.9.10.2.1.2.2. The Behavioral Health Services which are available when Medically Necessary including, but not limited to, Diversionary Services currently available and how Enrollees can access those services,

2.9.10.2.1.2.3. How and where to make referrals for follow up behavioral health clinical and LTSS assessments and services if such referrals are necessary in the judgment of the PCP,

2.9.10.2.1.3. Assisting EOHHS to improve tracking of delivered screenings, positive screenings and utilization of services by PCPs or Behavioral Health Providers following a behavioral health screening,

2.9.10.2.1.4. Improving ICT function and impact, particularly integration between primary care and behavioral health,

2.9.10.2.1.5. Promoting the development of primary care practices that operate with the capabilities of a patient-centered medical home or health home.

2.9.10.3. Continuing Education

2.9.10.3.1. The Contractor shall provide education and training for all PCPs to familiarize PCPs with the use of mental health and substance use disorder screening tools, instruments, and procedures for adults so that PCPs proactively identify behavioral health service needs at the earliest point in time and offer Enrollees referrals to Behavioral Health Services when clinically appropriate.

2.9.10.3.2. The Contractor shall provide education and training as needed for all PCPs to familiarize PCPs with the principles of disability competent care, and to improve care, access and accommodations for persons with disabilities.

2.9.10.3.3. EOHHS may provide learning collaboratives for Contractor staff and providers, which may include webinars, online courses, in-person sessions and other activities.

2.10. Enrollee Access to Services

2.10.1. General

2.10.1.1. The Contractor shall provide services to Enrollees as follows:

- 2.10.1.1.1. Authorize, arrange, coordinate and provide to Enrollees all Medically Necessary Covered Services as specified in **Section 2.7.2** and **Appendix C**, in accordance with the requirements of the Contract.
- 2.10.1.1.2. Offer and ensure adequate choice, accessibility, and availability to Covered Services for all Enrollees, and to primary, specialty, acute care, behavioral health, Long-term Services and Support, and oral health providers that meet EOHHS standards as provided in **Section 2.7**.
- 2.10.1.1.3. All such services shall be obtainable and available to Enrollees in a timely manner.
 - 2.10.1.1.3.1. Obtainability shall be defined as the extent to which the Enrollee is able to receive services at the time they are needed. Receiving service refers to both telephone, video, or other real-time access and ease of scheduling an appointment.
 - 2.10.1.1.3.2. Availability shall be defined as the extent to which the Contractor geographically distributes practitioners of the appropriate type and number to meet the needs of its Enrollees.
- 2.10.1.1.4. Reasonably accommodate persons and ensure that the programs and services are as accessible (including physical and geographic access) to an individual with disabilities (including an individual with diverse linguistic and Cultural Competence needs) as they are to an individual without disabilities. The Contractor and its Material Subcontractors shall comply with all State and federal laws and regulations governing accessibility and accommodations, including the Americans with Disabilities Act (ADA) (28 C.F.R. § 35.130), Section 504 of the Rehabilitation Act of 1973 (29 U.S.C. § 794), Massachusetts Public Accommodations Law (M.G.L. c. 272 s. 92A, 98, and 98A), and regulations promulgated by the Massachusetts Architectural Access Board at 521 CMR 1.00 et seq. The Contractor shall maintain capacity to deliver services in a manner that accommodates the needs of its Enrollees.

- 2.10.1.1.5. Ensure access to Covered Services in accordance with State and federal laws for persons with disabilities by ensuring that Network Providers are aware of and comply with such laws so that physical and communication barriers do not inhibit Enrollees from obtaining services under the Contract.

2.10.2. Timely Access (Obtainability)

- 2.10.2.1. The Contractor's Provider Network shall ensure, through its Provider Network, that Enrollees have access to and can get Covered services as described in this **Section 2.10.2.**

2.10.2.2. Emergency Services

- 2.10.2.2.1. Immediately upon Enrollee presentation at the service delivery site, including non-network and out-of-area facilities;
- 2.10.2.2.2. In accordance with 42 U.S.C. §1396u-2(b)(2) and 42 CFR 434.30, coverage for Emergency Services to Enrollees twenty-four (24) hours a day and seven days a week without regard to prior authorization or the Emergency Service Provider's contractual relationship with the Contractor; and
- 2.10.2.2.3. Adult Mobile Crisis Intervention shall be available within 60 minutes of the time of the Enrollee's readiness to receive such an assessment.

2.10.2.3. Primary Care, Urgent Care, and Specialty Care

- 2.10.2.3.1. Primary Care shall be available:

- 2.10.2.3.1.1. Within forty-eight (48) hours of the Enrollee's request for Urgent Care;

- 2.10.2.3.1.2. Within ten (10) calendar days of the Enrollee's request for Non-Urgent Symptomatic Care; and

- 2.10.2.3.1.3. Within forty-five (45) calendar days of the Enrollee's request for Non-Symptomatic Care.

- 2.10.2.3.1.4. Primary Care or Urgent Care shall be available during extended hours to reduce avoidable inpatient admissions and emergency department visits, as further specified by EOHHS.

- 2.10.2.3.2. Specialty care shall be available:

2.10.2.3.2.1. Within forty-eight (48) hours of the Enrollee's request for Urgent Care;

2.10.2.3.2.2. Within thirty (30) calendar days of the Enrollee's request for Non-Urgent Symptomatic Care; and

2.10.2.3.2.3. Within sixty (60) calendar days for Non-Symptomatic Care.

2.10.2.4. Behavioral Health Services

2.10.2.4.1. Services shall be available within the following timeframes to Enrollees for Behavioral Health Services other than emergency services (as described above), or Mobile Crisis Intervention Services:

2.10.2.4.1.1. Urgent Care shall be available within 48 hours for services that are not Emergency Services or routine services.

2.10.2.4.1.2. All other Behavioral Health Services: within fourteen (14) calendar days.

2.10.2.4.1.3. For services described in the inpatient or twenty-four (24) Hour Diversionary Services Discharge Plan:

2.10.2.4.1.3.1. Non twenty-four (24) Hour Diversionary Services – within two (2) calendar days of discharge;

2.10.2.4.1.3.2. Medication Management, including to review and refill medications – within fourteen (14) calendar days of discharge; and

2.10.2.4.1.3.3. Other outpatient services – within seven (7) calendar days of discharge.

2.10.2.5. Long-term Services and Supports (LTSS)

2.10.2.5.1. The Contractor's Provider Network shall ensure a selection of providers of community-based LTSS and nursing facilities that meets Enrollees' needs and preferences and satisfies the proximity requirements of this Contract.

2.10.2.5.2. If admission to a nursing facility is medically necessary because an Enrollee cannot be safely supported in the community, the Enrollee shall be admitted to a nursing facility within five (5) business days from the date the Enrollee is eligible to be discharged from a hospital.

2.10.3. Availability

2.10.3.1. The Contractor shall execute and maintain written contracts with Providers to ensure that Enrollees have access to Covered Services within a reasonable distance and travel time from the Enrollee's residence, as provided in **Section 2.10.4**. In determining compliance with this section and **Section 2.10.4**, the Contractor shall take into account only Providers meeting the requirements of **Section 2.10.2**.

2.10.3.2. Primary Care Providers

2.10.3.2.1. The Contractor shall develop and maintain a network of Primary Care Providers that ensures PCP coverage and availability throughout its Service Area twenty-four (24) hours a day, seven (7) days a week.

2.10.3.2.2. The Contractor shall include in its Network and provide access to a sufficient number of appropriate PCPs to meet time and distance requirements set forth in accordance with **Section 2.10.4 and Section 2.9.2**. An appropriate PCP is defined as a PCP who:

2.10.3.2.2.1. Is open at least 20 hours per week;

2.10.3.2.2.2. Has qualifications and expertise commensurate with the health care needs of the Enrollee; and

2.10.3.2.2.3. Has the ability to communicate with the Enrollee in a linguistically appropriate and culturally sensitive manner.

2.10.3.2.3. The Contractor shall provide access to PCPs with open panels in accordance with **Section 2.4.14**.

2.10.3.2.4. The Contractor shall promptly notify EOHHS of any County in its Service Area about which it has near-future concerns, or in which it sees upcoming obstacles in meeting the time and distance requirements for any County, including Network Adequacy requirements established by CMS for Medicare.

2.10.3.3. Other Physical Health Specialty Providers

2.10.3.3.1. The Contractor shall include in its Network and provide access to a sufficient number of specialty Providers to meet time and distance requirements set forth in accordance with **Section 2.10.2 and Section 2.10.4**.

2.10.3.4. Behavioral Health Services (as listed in **Appendix C**)

2.10.3.4.1. The Contractor shall include in its Network and provide access to a sufficient number of Behavioral Health Providers to meet time and distance requirements set forth in accordance with **Section 2.10.2 and Section 2.10.4.**

2.10.3.4.2. In addition to these standards, the Contractor shall include in its Network the Providers set forth in **Appendix G, Exhibit 1** as indicated in **Section 2.8.**

2.10.4. Proximity Access Requirements

2.10.4.1. For Medicare pharmacy providers, the Contractor shall adhere to the time, distance and minimum number as required in 42 C.F.R. §423.120; and

2.10.4.2. For all non-pharmacy providers, the Contractor shall demonstrate annually that its provider network meets the stricter of the following standards, as applicable:

2.10.4.2.1. Adhere to CMS's most current Medicare Advantage network adequacy criteria, including time and distance standards, as they apply to the Contractor's service area; and

2.10.4.2.2. EOHHS standards specified below;

2.10.4.2.2.1. Enrollees shall have a choice of at least two (2) PCPs within the applicable time and distance standards;

2.10.4.2.2.2. Enrollees shall have a choice of two (2) hospitals within the applicable Medicare Advantage time and distance standards, except that if only one (1) hospital is located within a County, the second hospital may be within a fifty (50) mile radius of the Enrollee's ZIP code of residence;

2.10.4.2.2.3. Enrollees shall have a choice of two (2) nursing facilities within the applicable Medicare Advantage time and distance standards, except that if only one (1) nursing facility is located within a County, the second nursing facility may be within a fifty (50) mile radius of the Enrollee's ZIP code of residence; and

2.10.4.2.2.4. If admission to a nursing facility is medically necessary because an enrollee cannot be safely supported in the community, Enrollees shall be admitted to a nursing facility within five (5) business days from the date the Enrollee is eligible to be discharged from a hospital.

- 2.10.4.2.2.5. The Contractor shall demonstrate annually that its Provider Network has sufficient providers to ensure that each Enrollee has a choice of at least two (2) outpatient and diversionary Behavioral Health Providers and two (2) community LTSS providers per Covered Service as referenced in **Section 2.7** and defined in **Appendix C** that are either within a fifteen (15) mile radius or thirty (30) minutes from the Enrollee's ZIP code of residence, except that with EOHHS prior approval, the Contractor may offer Enrollee only one community LTSS provider per Covered Service.
- 2.10.4.2.2.6. At least 90% of Enrollees in each of the Contractor's Service Areas shall have access to Providers in accordance with the time and distance standards in **Section 2.10.4**. If no time or distance is indicated, the Contractor shall have at least two Providers located anywhere in the Commonwealth.
- 2.10.4.2.3. EOHHS reserves the right to update these standards.
- 2.10.4.2.4. In determining compliance with the time and distance standards, the Contractor shall take into account only:
 - 2.10.4.2.4.1. Providers with open panels (i.e. accepting new patients);
 - 2.10.4.2.4.2. Providers serving current One Care Enrollees that would be in the Contractor's One Care Plan Network for the applicable coverage period, such Enrollees do not need additional open panel capacity for the particular service or provider type being evaluated for such Enrollees; and
 - 2.10.4.2.4.3. Realistic transportation modes for Enrollees in the Service Areas (e.g., walking, public transportation, private or hired vehicle, etc.), including considering various accessibility needs.
- 2.10.4.2.5. The Contractor shall report to EOHHS annually in accordance with **Appendix A**, the following:
 - 2.10.4.2.5.1. A specialist-to-Enrollee ratio report showing the number of each specialist by specialty type per the number of Enrollees;
 - 2.10.4.2.5.2. As specified by EOHHS, a geographic access report for high volume specialty provider types based on utilization, demonstrating access by geography as specified in **Appendix A**; and

2.10.4.2.5.3. The time between the day an enrollee is eligible to be discharged from a hospital to the day the enrollee is admitted to a nursing facility.

2.10.4.2.6. The Contractor shall provide to EOHHS, in accordance with the timeframes and other requirements specified by EOHHS all reports, data or other information EOHHS determines necessary for compliance with 42 C.F.R. § 438.207(d). Such information shall include a certification, in a form and format specified by EOHHS, attesting that the Contractor satisfies all Contract requirements regarding network adequacy, as well as any supporting documentation specified by EOHHS.

2.10.4.2.7. The Contractor shall have mechanisms in place to ensure compliance with timely access requirements pursuant to 42 C.F.R § 438.206 and **Section 2.10.2** of this Contract, including monitoring providers regularly to ensure compliance and taking corrective action if there has been a failure to comply.

2.10.4.3. Dental Access

2.10.4.3.1. The Contractor shall meet the Access Standards (as defined below), Travel Times (as defined below), Appointment Accessibility Standards (as defined below), and Wait Times (as defined below) for general, orthodontic and oral surgery practitioners by the Contract Implementation Date and thereafter throughout the life of the Contract except as described below:

2.10.4.3.1.1. Orthodontists and oral surgeons for Members residing in Barnstable, Berkshire, Dukes, Franklin, Hampden, and Hampshire counties, and on Nantucket Island;

2.10.4.3.1.2. General practitioners for Members residing in Barnstable; Berkshire, Dukes, Franklin, Hampden, and Hampshire counties and on Nantucket Island;

2.10.4.3.1.3. Orthodontists for Members residing in Berkshire County; and

2.10.4.3.1.4. Oral surgeons for Members residing in Barnstable; Berkshire, Dukes, Franklin, Hampden, and Hampshire counties, and on Nantucket Island.

2.10.4.3.2. In addition, the Contractor shall maintain, throughout the life of the Contract, an average over each Contract Year of at least 99% of the total number of Access Points (as defined in

Appendix P) that exist as of the Contract Operational Start Date.

- 2.10.4.3.3. The Contractor shall monitor its compliance with these requirements and shall provide annual reports to EOHHS not later than 60 days after the end of each Contract Year regarding its compliance with these requirements (or otherwise upon EOHHS request), and shall promptly notify EOHHS at any point when there are fewer than 99% of Current Access Points for any of the specified provider types, or the provider to Member ratio or percentage of Members with access, or the percentage of Members with access to care within Wait Time maximums fall below the specified ratio or percentage for any of the specified provider types.

2.10.5. Cultural and Linguistic Access

- 2.10.5.1.1. The Contractor shall have the capacity to meet the needs of the various linguistic groups in its Service Area. The following shall be available:

2.10.5.1.1.1. Multilingual Providers: The provision of care, including twenty--four (24) hour telephone access and scheduling appointments, by providers who are fluent in both English and the language spoken by the Enrollee, or through translation services performed by individuals who are:

2.10.5.1.1.1.1. Trained to translate in a medical setting;

2.10.5.1.1.1.2. Fluent in English;

2.10.5.1.1.1.3. Fluent in the Enrollee's language, and

2.10.5.1.1.1.4. Linguistically appropriate pharmacy, specialty, behavioral health, and LTSS.

2.10.5.1.1.1.5. For non-English speaking Enrollees, a choice of at least two PCPs, and at least two Behavioral Health Providers within each Behavioral Health Covered Service category set forth in **Appendix C**, in the Prevalent Languages in the Service Area provided that such provider capacity exists within the Service Area.

- 2.10.5.1.1.2. The Contractor shall provide culturally competent services, including by:

- 2.10.5.1.1.2.1. Ensuring that Network Providers are responsive to the linguistic, cultural, ethnic, or other individual needs of all Enrollees, homeless individuals, and other sub-populations served under the Contract,;
- 2.10.5.1.1.2.2. Identifying 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;
- 2.10.5.1.1.2.3. Participating in the state's efforts to promote the delivery of services in a culturally competent manner to all enrollees, including those with limited English proficiency and diverse cultural and ethnic backgrounds, various disabilities, and chronic medical conditions, and regardless of gender, sexual orientation, or gender identity; and
- 2.10.5.1.1.2.4. Employing or contracting with Community Health Workers, or contracting with provider organizations employing CHWs, to connect with Enrollees through shared cultural, linguistic, and lived experience, to perform outreach, health literacy education, health coaching, and other support activities appropriate to the CHW's training and skill sets.

2.10.6. Direct Access to Specialists

- 2.10.6.1. The Contractor shall have a mechanism to identify Enrollees that need a course of treatment or regular care monitoring, to allow Enrollees direct access to a specialist(s) (for example, through a standing referral or an approved number of visits) as appropriate for the Enrollee's condition and identified needs.

2.10.7. Additional Requirements

- 2.10.7.1. The Contractor shall demonstrate the capacity to deliver or arrange for the delivery of scheduled and unscheduled services in the Enrollee's place of residence when office visits are unsafe or inappropriate for the Enrollee's clinical status. Service sites shall include, but not be limited to the Enrollee's private residence, a nursing or assisted living facility, and adult day programs.
- 2.10.7.2. The Contractor shall ensure that Network Providers offer hours of operation that are no less than the hours of operation offered to commercial Enrollees or MassHealth Fee For Service if the

provider serves only Enrollees or other persons eligible for MassHealth.

- 2.10.7.3. The Contractor shall meet the EOHHS standards for network adequacy, as applicable, including access and availability, provided, however, the Contractor may request an exception to the EOHHS standards set forth in this **Section 2.10** by submitting a written request to EOHHS. Such request shall include alternative standards that are equal to, or more permissive than, the usual and customary community standards applicable in Massachusetts for accessing care. Upon approval by EOHHS, the Contractor shall notify Enrollees in writing of such alternative access standards.
- 2.10.7.4. The Contractor shall have a system in place to monitor, verify, and document meeting access and availability, including appointment scheduling standards and wait times.
 - 2.10.7.4.1. Such system shall include “secret shopper” activities, as further specified by EOHHS.
 - 2.10.7.4.2. The Contractor shall use statistically valid sampling methods for monitoring compliance with the appointment/access standards specified above in **Section 2.10.2** and shall promptly address any access deficiencies. Annually, in accordance with **Appendix A**, the Contractor shall evaluate and report to EOHHS Network-wide compliance with the access standards specified in **Section 2.10.2**.
- 2.10.7.5. The Contractor shall evaluate and report on its compliance with the access and availability standards and on its "secret shopper" and other verification activities as requested by EOHHS. The Contractor shall ensure all information submitted in such reports are up-to-date, accurate, and complete, including but not limited to information contained in any Provider directories and Provider lists.
- 2.10.7.6. The Contractor shall develop and submit by May 1, 2025, to EOHHS for Approval a Network Access Monitoring and Dental Caseload Capacity Plan including, at minimum, the following elements:
 - 2.10.7.6.1. A description of network access monitoring activities to be conducted at least quarterly to ensure that Contract’s access requirements are met:
 - 2.10.7.6.1.1. Monitoring activities shall include a Secret Shopper program wherein the Contractor selects a representative, statistically valid sample of Dental Provider practices and

assigns staff to call, posing as MassHealth Members, and ask to make an appointment;

2.10.7.6.1.2. Secret Shoppers shall record whether the information listed on the Provider Directory for each Provider is correct, with a focus on the Provider's Accepting Patients Status; and

2.10.7.6.1.3. Secret Shoppers shall record Wait Times.

2.10.7.6.2. Applying the EOHHS-Approved methodology, electronically track and report on a cumulative basis to EOHHS monthly, quarterly and annually the number of Dental Providers who close their practice to accepting new Members. The Contractor shall include the following details for each such Provider: name, address, County, service type (individual Dental Provider or group), specialty and effective date as MassHealth Provider.

2.10.7.6.3. A proposed format for reporting on the findings of monitoring activities to EOHHS within 30 days of the end of the quarter, including how the Contractor intends to address issues identified as part of these activities.

2.10.7.6.4. Quarterly (with each quarter's data compared to the previous quarter), on February 28, May 31, August 31 and November 30 (or if any such date is not a Business Day, the next Business Day) of each Contract year, report to EOHHS:

2.10.7.6.5. Findings from network access monitoring activities and how the Contractor intends to address issues identified as part of these activities;

2.10.7.6.5.1. The ratio of Dental Providers to Members for each County;

2.10.7.6.5.2. Average distance a Member must travel;

2.10.7.6.5.3. Number of Members with paid services; and

2.10.7.6.5.4. The number of new Dental Providers who have limited their caseload upon joining if data is available.

2.10.7.6.5.5. Each quarter this report shall include a written narrative identifying the Counties that are the most affected by new limits to caseload given the pre-existing Provider/Member ratio and travel distance and a description of recruitment efforts planned for the communities/Counties that show a

10% or greater increase in Dental Provider-to-Member ratio or average travel distance.

- 2.10.7.7. When a PCP or any medical, behavioral health or LTSS provider is terminated from the Contractor's One Care Plan or leaves the network for any reason, the Contractor shall make a good faith effort to give written notification of termination of such provider, within fifteen (15) days after receipt or issuance of the termination notice, to each Enrollee who received their care from, or was seen on a regular basis by, the terminated PCP or any other medical, behavioral or LTSS provider. For terminations of PCPs, the Contractor shall also report the termination to EOHHS and provide assistance to the Enrollee in selecting a new PCP within fifteen (15) calendar days. For Enrollees who are receiving treatment for a chronic or ongoing medical condition or LTSS, the Contractor shall ensure that there is no disruption in services provided to the Enrollee.
- 2.10.7.8. When the Food and Drug Administration (FDA) determines a drug to be unsafe, the Contractor shall remove it from the formulary immediately. The Contractor shall make a good faith effort to give written notification of removal of this drug from the formulary and the reason for its removal, within five (5) days after the removal, to each Enrollee with a current or previous prescription for the drug. The Contractor shall also make a good faith effort to call, within three (3) calendar days, each Enrollee with a current or previous prescription for the drug. A good faith effort shall involve no fewer than three phone call attempts at different times of the day and days of the week including on weekends.
- 2.10.7.9. 72-Hour Medication Supply
- 2.10.7.9.1. If a pharmacist cannot bill the Contractor at the time an Enrollee presents the pharmacy provider with a prescription for a MassHealth covered medication and in accordance with 130 CMR 406.414(c), and the pharmacy provider charges MassHealth for a onetime seventy-two (72) hour supply of prescribed medications, the Contractor shall reimburse MassHealth for any such sums. EOHHS shall perform quarterly onetime medication supply reconciliations as follows. EOHHS shall:
- 2.10.7.9.2. Calculate all claims paid by EOHHS for one time seventy-two (72) hour supplies of prescribed medications provided to Enrollees each quarter; and

- 2.10.7.9.3. Deduct the amount of such claims paid from a future capitation payment to the Contractor after written notification to the Contractor of the amount and timing of such deduction.

2.10.8. Accessibility and Accommodations

- 2.10.8.1. The Contractor shall identify to EOHHS the Accessibility and Accommodations Officer, i.e., the individual in its organization who is responsible for accessibility and accommodations compliance related to the Contract's One Care Plan, and for evaluating and ensuring adequate access to Covered Services and Network Providers for all Enrollees as described in this **Section 2.10.8**. The Accessibility and Accommodations Officer shall also be responsible for:

- 2.10.8.1.1. Monitoring the processes described in **Section 2.10.8.2** and **Section 2.10.8.3** and shall use data produced pursuant to **Section 2.10.8.3.1.11** to evaluate and improve such processes, policies, and procedures as needed; and
- 2.10.8.1.2. Shall participate in the Contractor's One Care Consumer Advisory Board;

2.10.8.2. Processes to Overcome Barriers

- 2.10.8.2.1. The Contractor shall have written policies and procedures to assure compliance, including ensuring that physical, communication, and programmatic barriers do not inhibit individuals with disabilities and/or with diverse ethnic and cultural backgrounds from obtaining all Covered Services from the Contractor by:
 - 2.10.8.2.1.1. Providing flexibility in scheduling to accommodate the needs of Enrollees;
 - 2.10.8.2.1.2. Ensuring that Enrollees are provided with reasonable accommodations to ensure effective communication, including auxiliary aids and services, which shall be made available upon request of the potential enrollee or enrollee at no cost and that Enrollees can make standing requests for reasonable accommodations. Reasonable accommodations will depend on the particular needs of the individual and include:
 - 2.10.8.2.1.2.1. Providing large print (at least eighteen (18)-point font) or Braille of all written materials to individuals with visual impairments, as requested;

- 2.10.8.2.1.2.2. Ensuring that all written materials are available in formats compatible with optical recognition software;
- 2.10.8.2.1.2.3. Reading notices and other written materials to individuals upon request;
- 2.10.8.2.1.2.4. Assisting individuals in filling out forms over the telephone;
- 2.10.8.2.1.2.5. Ensuring effective communication to and from Enrollees in accordance with their communication preferences, including through email, telephone, text, and other electronic means;
- 2.10.8.2.1.2.6. Ensuring effective communication to and from individuals who are Deaf or hard of hearing, or who have disabilities impacting their speech or communication needs, by using these individuals' preferred modes of communication access through email, text, telephone, and other electronic means, and through services and technologies such as TTY, Video Relay Services (VRS), computer-aided transcription services, telephone handset amplifiers, assistive listening systems, closed caption decoders, videotext displays, qualified interpreters (including ASL interpreters), and other auxiliary aids and services;
- 2.10.8.2.1.2.7. Providing interpreters or translators for Enrollees whose primary language is not English;
- 2.10.8.2.1.2.8. Providing accessible equipment such as exam tables, weight scales, and diagnostic equipment; and
- 2.10.8.2.1.2.9. Providing individualized forms of assistance;
- 2.10.8.2.1.3. Ensuring safe and appropriate physical access to buildings, services, and equipment;
- 2.10.8.2.1.4. Conducting annual independent survey or site review of facilities for both physical and programmatic accessibility, documenting any deficiencies in compliance, and monitoring correction of deficiencies to ensure compliance with the applicable State and federal laws

and regulations governing accessibility and accommodations; and

- 2.10.8.2.1.5. Developing, executing, and annually updating a work plan to achieve and maintain accessibility and accommodations compliance and submit the work plan in a form and format as specified in **Appendix A**.

2.10.8.3. Processing Enrollee Requests

- 2.10.8.3.1. The Contractor shall have written policies and procedures to ensure clear processes for Enrollees to make, and for the Contractor to respond to, accessibility and accommodation requests, which shall depend on the particular needs of the Enrollee, including:

- 2.10.8.3.1.1. How Enrollees shall be informed of such processes;

- 2.10.8.3.1.2. How Enrollees may make a request for accessibility or accommodations to their Provider or the Contractor,

- 2.10.8.3.1.3. How Enrollees may make standing requests for continued accessibility or accommodations to their Provider or One Care Plan;

- 2.10.8.3.1.4. Accepting and documenting all such requests, including in the Enrollee's Centralized Enrollee Record;

- 2.10.8.3.1.5. Policies and procedures for evaluating such requests;

- 2.10.8.3.1.6. Internal escalation procedures for evaluating and resolving requests;

- 2.10.8.3.1.7. Responding timely to all such requests, including communicating the outcome to the Enrollee;

- 2.10.8.3.1.8. Documenting the approved action in the Enrollee's Centralized Enrollee Record;

- 2.10.8.3.1.9. Communicating approved actions to the Enrollee's Providers, Material Subcontractors, or others as appropriate for implementation;

- 2.10.8.3.1.10. Procedures for Enrollees to escalate a request to the Accessibility and Accommodations Officer or their designee; and

2.10.8.3.1.11. Tracking and reporting on accessibility and accommodations requests, their status, and their outcomes.

2.10.9. Authorization of Services

2.10.9.1. In accordance with 42 C.F.R. § 438.210, the Contractor shall authorize services as follows:

2.10.9.1.1. For the processing of Service Requests for initial and continuing authorizations of services, the Contractor shall:

2.10.9.1.1.1. Have in place and follow written policies and procedures.

2.10.9.1.1.2. Ensure that its service authorization processes use the expanded definition of Medical Necessity in **Section 1** of this Contract.

2.10.9.1.1.3. Have in place procedures to allow Enrollees, authorized representatives, One Care Plan Care Coordinators or designees, and providers to initiate requests for provisions of services.

2.10.9.1.1.4. Have policies and procedures to ensure Service Requests are processed in accordance with the required timelines outlined in **Section 2.10.9.8**.

2.10.9.1.1.5. Have in effect mechanisms to ensure the consistent application of review criteria for authorization decisions.

2.10.9.1.1.6. Authorize services to reflect a Member's assessment and their ICP.

2.10.9.1.1.7. Have in place an authorization process for the covered Long-term Services and Supports (LTSS) referenced in **Section 2.7** and defined in **Appendix C**.

2.10.9.1.1.8. Consult with the Enrollee and requesting provider when appropriate.

2.10.9.2. In evaluating requests for LTSS, the Contractor shall consider continuity of care. If a service, level of service, or equipment has been part of the Enrollee's life routine over an extended period and is integral to their overall care and independence structure, any denial or reduction in amount, duration, frequency, or scope of that service/equipment/supply must be supported in the ICP to ensure that such changes will not cause diminished ability for independent

living and be consistent with the overall goals and needs of the enrollee as expressed in the ICP.

- 2.10.9.3. The Contractor shall ensure that a PCP and a Behavioral Health Provider are available twenty--four (24) hours a day for timely authorization of all Medically Necessary Services and to coordinate transfer of stabilized Enrollees in the emergency department, if necessary. Such individuals shall be familiar with the Massachusetts delivery system, standards and practices of care in Massachusetts, and best practices in the types of services they authorize. The Contractor's guidelines for Medically Necessary Services shall comport with the definition of Medically Necessary Services as described in **Section 1** and with **Section 2.7.2** and shall, at a minimum, be no more restrictive than the cumulative effect of the combined Medicare and Medicaid scopes of services.
- 2.10.9.4. Any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope, as well as type or frequency, that is less than requested shall be made by a health care professional who has appropriate clinical expertise in treating the Enrollee's medical condition, performing the procedure, or providing the treatment, and who is familiar with the Massachusetts delivery system, the standards and practices of care in Massachusetts, and best practices in the types of services they authorize. In addition to the foregoing requirements, Behavioral Health Services denials shall be rendered by board-certified or board eligible psychiatrists or by a clinician licensed with the same or similar specialty as the Behavioral Health Services being denied, except in cases of denials of service for psychological testing, which shall be rendered by a qualified psychologist.
- 2.10.9.5. The Contractor shall assure that all Behavioral Health authorization and utilization management activities are in compliance with 42 U.S.C. § 1396u2(b)(8). The Contractor shall comply with the requirements for demonstrating parity for both cost-sharing (copayments) and treatment limitations between mental health and substance use disorder and medical/surgical inpatient, outpatient and pharmacy benefits. The Contractor shall participate in any EOHHS efforts to standardize utilization management policies and procedures.
- 2.10.9.6. The Contractor shall authorize PAS to meet Enrollees' needs for assistance with ADLs and IADLs. The Contractor may consider the Enrollee's need for physical assistance as well as cueing or monitoring in order for the Enrollee to perform an ADL or IADL. Authorizations shall consider the medical and independent living needs of the Enrollee.

2.10.9.7. The Contractor shall notify the requesting provider, either orally or in writing, and give the Enrollee or authorized representative written notice of any decision by the Contractor to deny a service authorization request, or to authorize a service in an amount, duration, or scope, as well as type or frequency, that is less than requested. The written notice shall meet the requirements of 42 C.F.R. § 438.404 and **Section 2.13.4.3**, and shall:

- 2.10.9.7.1. Be produced in a manner, format, and language that can be easily understood,
- 2.10.9.7.2. Be made available in Prevalent Languages, upon request, including a standing request in the Enrollee's Centralized Enrollee Record,
- 2.10.9.7.3. Include information, in the most commonly used languages about how to request translation services, Alternative Formats, and the availability of auxiliary aids and services.
- 2.10.9.7.4. Be documented in the Enrollee's Centralized Enrollee Record.

2.10.9.8. Authorization Timeframes

2.10.9.8.1. The Contractor shall make authorization decisions in the following timeframes:

2.10.9.8.1.1. For standard authorization decisions, provide notice as expeditiously as the Enrollee's health condition requires and no later than fourteen (14) calendar days after receipt of the request for service, with a possible extension not to exceed fourteen (14) additional calendar days. Such extension shall only be allowed if:

2.10.9.8.1.1.1. The Enrollee, authorized representative, or the provider requests an extension; or

2.10.9.8.1.1.2. The Contractor can justify (to the satisfaction of EOHHS) that:

2.10.9.8.1.1.2.1. The extension is in the Enrollee's interest; and

2.10.9.8.1.1.2.2. There is a need for additional information where:

2.10.9.8.1.1.2.2.1. There is a reasonable likelihood that receipt of such information would lead to approval of the request, if received; and

2.10.9.8.1.1.2.2. Such outstanding information is reasonably expected to be received within fourteen (14) calendar days.

2.10.9.8.2. For expedited service authorization decisions, where the provider indicates or the Contractor determines that following the standard timeframe in **Section 2.10.9.8.1.1** above could seriously jeopardize the Enrollee's life or health or ability to attain, maintain, or regain maximum function, the Contractor shall make a decision and provide notice as expeditiously as the Enrollee's health condition requires and no later than seventy-two (72) hours after receipt of the request for service, with a possible extension not to exceed fourteen (14) additional calendar days. Such extension shall only be allowed if:

2.10.9.8.2.1. The Enrollee or the provider requests an extension, or the Contractor can justify (to EOHHS) that:

2.10.9.8.2.1.1. The extension is in the Enrollee's interest, and

2.10.9.8.2.1.2. There is a need for additional information where:

2.10.9.8.2.1.2.1. There is a reasonable likelihood that receipt of such information would lead to approval of the request, if received, and

2.10.9.8.2.1.2.2. Such outstanding information is reasonably expected to be received within fourteen (14) calendar days.

2.10.9.8.3. When a service authorization decision is not reached within the applicable timeframe for either standard or expedited requests:

2.10.9.8.3.1. The Contractor shall give Notice of an extension the date that the time frame expires. Any failure by the Contractor to provide timely notice of a service authorization decision in a timely manner may be subject to a corrective action plan or intermediate sanctions in accordance with **Section 5.3**.

2.10.9.8.3.2. Any extension of the required time frame for authorization decisions shall be documented in the Enrollee's Centralized Enrollee Record.

2.10.9.8.3.3. When the service authorization decision requested is for a service previously authorized for the Enrollee or that

the Enrollee is receiving at the time of the request for authorization, the Contractor shall authorize or extend authorization of the service:

2.10.9.8.3.3.1. For the duration of extended time frame; and

2.10.9.8.3.3.2. Until the resolution of and in accordance with all advance notice and applicable Appeal actions that apply for a termination of service.

2.10.9.8.4. In accordance with 42 C.F.R. §§ 438.6(h) and 422.208, compensation to individuals or entities that conduct Utilization Management activities for the One Care Plan shall not be structured so as to provide incentives for the individual or entity to deny, limit, or discontinue Medically Necessary Services to any Enrollee.

2.10.10. Services Not Subject to Prior Approval

2.10.10.1. The Contractor shall not require prior approval for the following services:

2.10.10.1.1. Any services for Emergency Medical Conditions as defined in 42 C.F.R 422.113(b)(1) and 438.114(a) (which includes emergency Behavioral Health care);

2.10.10.1.2. Any Inpatient Mental Health services as set forth in **Appendix C**. The Contractor shall require Providers of Inpatient Mental Health services to provide the Contractor, within seventy-two (72) hours of an Enrollee's admission, with notification of admission of an Enrollment and an initial treatment plan for such Enrollee;

2.10.10.1.3. Urgent Care sought outside of the Service Area;

2.10.10.1.4. Urgent Care under unusual or extraordinary circumstances provided in the Service Area when the contracted medical provider is unavailable or inaccessible;

2.10.10.1.5. Family planning services;

2.10.10.1.6. Out of area renal dialysis services;

2.10.10.1.7. Dental services that MassHealth or its TPA exclude from Prior Authorization, as specified in 130 CMR 420 and in Subchapter 6 of MassHealth's Dental Manual;

- 2.10.10.1.8. Outpatient Services for covered substance use disorder treatment services;
- 2.10.10.1.9. The following Behavioral Health Outpatient Services, as defined in **Appendix C, Exhibit 2**: Outpatient Couples/Family Treatment, Group Treatment, Individual Treatment, and Ambulatory Detoxification (Level 2.d);
- 2.10.10.1.10. Structured Outpatient Addiction Program (SOAP), as defined in **Appendix C, Exhibit 2**;
- 2.10.10.1.11. Intensive Outpatient Program (IOP), as defined in **Appendix C, Exhibit 2**; and
- 2.10.10.1.12. Partial Hospitalization (PHP), as defined in **Appendix C, Exhibit 2**;
- 2.10.10.1.13. American Society of Addiction Level 2.5, with short-term day or evening mental health programming available seven (7) days per week;
- 2.10.10.1.14. Clinically Managed Population Specific High Intensity Residential Services (ASAM Level 3.3), as defined in **Appendix C, Exhibit 2**;
- 2.10.10.1.15. Transitional Support Services (TSS) for Substance Use Disorders, Population Specific High Intensity Residential Services, and Residential Rehabilitation Services (RRS) (ASAM Level 3.1), as defined in **Appendix C**;
- 2.10.10.1.16. Additional SUD Treatment Services in accordance with **Section 2.9.3.1**;
- 2.10.10.1.17. The initiation or re-initiation of a buprenorphine/naloxone prescription of 32 mg/day or less, for either brand formulations (e.g., Suboxone™, Zubsolv™, Bunavail™) or generic formulations, provided, however, that the Contractor may have a preferred formulation. The Contractor may establish review protocols for continuing prescriptions. Notwithstanding the foregoing, the Contractor may implement prior authorization for buprenorphine (Subutex™) and limit coverage to pregnant or lactating individuals and individuals allergic to naloxone, provided such limitations are clinically appropriate.”;
- 2.10.10.1.18. Inpatient Substance Use Disorder Services (ASAM Level 4);

- 2.10.10.1.19. Acute Treatment Services (ATS) for Substance Use Disorders (ASAM Level 3.7). Medical necessity shall be determined by the treating clinician in consultation with the Covered Individual;
- 2.10.10.1.20. Clinical Stabilization Services for Substance Use Disorders (ASAM Level 3.5). Medical necessity shall be determined by the treating clinician in consultation with the Member;
- 2.10.10.1.21. Recovery Coach; and
- 2.10.10.1.22. Recovery Support Navigator.
- 2.10.11. Value and Outcomes in Service Authorization and Utilization Management
 - 2.10.11.1. The Contractor's approach to service authorizations and Utilization Management, including for the services described in **Appendix C, Exhibits 1, 2, and 3**, shall consider value, including how, as part of the Enrollee's ICP, the services:
 - 2.10.11.1.1. Contribute to the health, independent living, and quality outcomes of the Enrollee, and
 - 2.10.11.1.2. Support the Enrollee's connection to, and ability to, participate in their community, and reduce social isolation
 - 2.10.11.1.3. Improves or extends the Enrollee's overall capacity and/or function (e.g., such as by enabling Enrollee to allocate energy consistent with their goals and priorities or addressing related barriers and challenges).
 - 2.10.11.2. Authorization of services and Utilization Management policies and procedures shall incorporate:
 - 2.10.11.2.1. Consideration of expected individual outcomes, e.g., whether services as part of the ICP would:
 - 2.10.11.2.1.1. Meet the particular needs of the Enrollee,
 - 2.10.11.2.1.2. Support the Enrollee's ability to live independently and participate in their home life and their community, and
 - 2.10.11.2.1.3. Use preventive approaches and proactive strategies to shift utilization from acute care and other facility settings to community settings, including diverting from, preventing, or avoiding stays or visits in facility settings, hospitals, or emergency departments.

- 2.10.11.2.2. Individualized clinical standards for Members with medical or Behavioral Health conditions, environmental circumstances, social determinant of health needs, and/or accessibility or communication needs for which population-based clinical standards are not appropriate or are insufficient.
- 2.10.11.3. Authorization of services and Utilization Management policies and procedures shall encourage proactive, preventive strategies to prevent and avoid the need for acute care,
- 2.10.11.4. The Contractor's One Care Plan shall connect Enrollees to community organizations that can provide additional resources and support for Enrollees, and authorize accessibility, communication, and transportation services as needed to provide access to this additional support, and
- 2.10.11.5. The Contractor shall measure and report on its effectiveness in improving outcomes for its Enrollees as described in this **Section 2.10.11**, including as part of EOHHS' quality measurement approach and requirements.
- 2.10.12. Utilization Management
 - 2.10.12.1. The Contractor shall maintain a utilization management plan and procedures consistent with the following:
 - 2.10.12.1.1. Staffing of all Utilization Management activities shall include, but not be limited to, a medical director, or medical director's designee. The Contractor shall also have a medical director's designee for behavioral health Utilization Management.
 - 2.10.12.1.2. The Contractor's accountable designee(s) and staff conducting Utilization Management activities applied to the One Care Plan shall be credentialed in Massachusetts, and shall be familiar with the Massachusetts delivery system, the standards and practices of care in Massachusetts, and best practices for service delivery, and shall be accountable to the One Care Plan's local management team in Massachusetts.
 - 2.10.12.1.3. Such accountable designee for Utilization Management shall participate in the One Care Plan's Consumer Advisory Board.
 - 2.10.12.1.4. All of the Contractor's Utilization Management team members, including the accountable designees, shall:

- 2.10.12.1.4.1. Be in compliance with all federal, State, and local professional licensing requirements;
- 2.10.12.1.4.2. Include representatives from appropriate specialty areas. Such specialty areas shall include, at a minimum, cardiology, epidemiology, OB/GYN, psychiatry, substance use disorders (e.g., addictionology), mental health and Gender-affirming care;
- 2.10.12.1.4.3. Not have had any disciplinary actions or other type of sanction ever taken against them, in any state or territory, by the relevant professional licensing or oversight board or the Medicare and Medicaid programs; and
- 2.10.12.1.4.4. Not have any sanctions relating to their professional practice including, but not limited to, malpractice actions resulting in entry of judgment against them, unless otherwise agreed to by EOHHS.
- 2.10.12.1.5. In addition to the requirements set forth in **Section 2.10.9** the medical director's designee for Behavioral Health utilization management shall also:
 - 2.10.12.1.5.1. Be board-certified or board-eligible in psychiatry;
 - 2.10.12.1.5.2. Be available twenty-four (24) hours per day, seven days a week for consultation and decision-making with the Contractor's clinical staff and providers; and
 - 2.10.12.1.5.3. Meet the requirements, and ensure its staff meet the requirements, set forth in **Section 2.10.12.5**.
- 2.10.12.2. The Contractor shall have policies and procedures in place to ensure that the clinical staff coordinating and authorizing Gender-affirming care services, including, but not limited to, hormone replacement therapy, behavioral health care, and gender affirming surgeries, have experience or training in care for transgender or gender diverse individuals.
- 2.10.12.3. The Contractor shall have in place policies and procedures that include at a minimum the elements listed below. The Contractor shall submit such policies and procedures to EOHHS upon request.
 - 2.10.12.3.1. Routinely assess the effectiveness and the efficiency of the utilization management program;
 - 2.10.12.3.2. Evaluate the appropriate use of medical technologies, including medical procedures, diagnostic procedures and

technology, Behavioral Health treatments, pharmacy formularies and devices;

- 2.10.12.3.3. Target areas of suspected inappropriate service utilization;
 - 2.10.12.3.4. Detect over- and under-utilization;
 - 2.10.12.3.5. Routinely generate provider profiles regarding utilization patterns and compliance with utilization review criteria and policies;
 - 2.10.12.3.6. Compare Enrollee and provider utilization with norms for comparable individuals and Network Providers;
 - 2.10.12.3.7. Routinely monitor inpatient admissions, emergency department use, ancillary, out-of-area services, and out-of-network services, as well as Behavioral Health inpatient and outpatient services, diversionary services, and Mobile Crisis Intervention Services;
 - 2.10.12.3.8. Ensure that treatment and discharge planning are addressed at the time of authorization and concurrent review, and that the treatment planning includes coordination with the PCP, other providers, and other supports identified by the Enrollee as appropriate;
 - 2.10.12.3.9. Conduct retrospective reviews of the medical records of selected cases to assess the medical necessity, clinical appropriateness of care, and the duration and level of care,
 - 2.10.12.3.10. Refer suspected cases of provider or Enrollee fraud or abuse to EOHHS;
 - 2.10.12.3.11. Address processes through which the Contractor monitors issues around services access and quality identified by the One Care Plan, EOHHS, Enrollees, and providers, including the tracking of these issues and resolutions over time; and
 - 2.10.12.3.12. Are communicated, accessible, and understandable to internal and external individuals, and entities, as appropriate.
- 2.10.12.4. The Contractor's utilization management activities shall include:
- 2.10.12.4.1. Referrals and coordination of Covered Services;
 - 2.10.12.4.2. Authorization of Covered Services, including modification or denial of requests for such services;

- 2.10.12.4.3. Assisting care teams and providers to effectively provide inpatient Discharge Planning;
- 2.10.12.4.4. Behavioral Health treatment and discharge planning;
- 2.10.12.4.5. Monitoring and assuring the appropriate utilization of specialty services, including Behavioral Health Services;
- 2.10.12.4.6. Providing training and supervision to the Contractor's utilization management clinical staff and Providers on:
 - 2.10.12.4.6.1. The standard application of medical necessity criteria and utilization management policies and procedures to ensure that staff maintain and improve their clinical skills;
 - 2.10.12.4.6.2. Utilization management policies, practices and data reported to the One Care Plan to ensure that it is standardized across all providers within the One Care Plan's Provider Network;
 - 2.10.12.4.6.3. The consistent application and implementation of the Contractor's clinical criteria and guidelines including the Behavioral Health clinical criteria approved by EOHHS;
 - 2.10.12.4.6.4. Monitoring and assessing all Behavioral Health Services and outcomes measurement, using any standardized clinical outcomes measurement tools to support utilization management activities;
 - 2.10.12.4.6.5. The Contractor's Behavioral Health Services Provider Contracts shall stipulate that the Contractor may access, collect, and analyze such behavioral health assessment and outcomes data for quality management and Network Management purposes; and
 - 2.10.12.4.6.6. Care management programs.
- 2.10.12.5. The Contractor shall ensure that clinicians conducting utilization management who are coordinating Behavioral Health Services, and making Behavioral Health service authorization decisions, have training and experience in the specific area of Behavioral Health service for which they are coordinating and authorizing Behavioral Health Services. The Contractor shall ensure the following:
 - 2.10.12.5.1. That the clinician coordinating and authorizing mental health services shall be a clinician with experience and training in mental health services and recovery principles;

- 2.10.12.5.2. That the clinician coordinating and authorizing substance use disorders shall be a clinician with experience and training in substance use disorders; and
- 2.10.12.5.3. That the clinician coordinating and authorizing services for Enrollees with co-occurring disorders shall have experience and training in co-occurring disorders.
- 2.10.12.6. The Contractor shall have policies and procedures for its approach to retrospective utilization review of providers. Such approach shall include a system to identify utilization patterns of all providers by significant data elements and established outlier criteria for all services.
- 2.10.12.7. The Contractor shall have policies and procedures for conducting retrospective and peer reviews of a sample of providers to ensure that the services furnished by providers were provided to Enrollees, were appropriate and medically necessary or otherwise indicated in the Enrollee's care plan and evaluated in accordance with **Section 2.10.11** and were authorized and billed in accordance with the One Care Plan's requirements.
- 2.10.12.8. The Contractor shall have policies and procedures for conducting monthly reviews of a random sample of no fewer than five hundred (500) Enrollees to ensure that such Enrollees received the services for which providers billed with respect to such Enrollees and shall report the results of such review to EOHHS as requested.
- 2.10.12.9. The Contractor shall monitor and ensure that all Utilization Management activities provided by a Material Subcontractor comply with all provisions of this Contract.
- 2.10.12.10. The Contractor shall participate in any workgroups, task forces, and meetings related to Utilization Management and best practices, as requested by EOHHS. The Contractor shall review and align its Utilization Management policies and procedures to align with any recommendations of such group.
- 2.10.12.11. The Contractor shall submit an annual report of Enrollees who have been enrolled in the Contractor's Plan for one year or more with no utilization. The report shall include an explanation of outreach activities to engage these Enrollees (see **Appendix A**).
- 2.10.12.12. If utilization management review activities are performed for Acute Treatment Services (ASAM level 3.7) or Clinical Stabilization Services for Substance Use Disorders (ASAM level 3.5), such activities shall comply with Section 10H of Chapter 118E of the

General Laws. For ASAM level 3.5, specify that such activities may be performed no earlier than day 7 of the provision of such services, including but not limited to discussions about coordination of care and discussions of treatment plans. The Contractor may not make any utilization management review decisions that impose any restriction or deny any future Medically Necessary Clinical Stabilization Services for Substance Use Disorders (Level 3.5) unless an Enrollee has received at least 14 consecutive days of Clinical Stabilization Services for Substance Use Disorders (Level 3.5). Any such decisions shall follow the requirements set forth in **Section 2.13** regarding the transmission of adverse determination notifications to Enrollees and clinicians and processes for internal and external Appeals of the Contractor's decisions.

- 2.10.12.13. The Contractor shall not impose concurrent review and deny coverage for ATS based on utilization review; however, the Contractor may contact providers of ATS to discuss coordination of care, treatment plans, and after care.
- 2.10.12.14. The Contractor shall not establish utilization management strategies that require Enrollees to 'fail-first' or participate in 'step therapy' as a condition of providing coverage for injectable naltrexone (Vivitrol™). The Contractor shall cover Vivitrol™ as a pharmacy and medical benefit. If the Contractor covers Vivitrol™ as a specialty pharmacy benefit, the Contractor shall allow Enrollees to do a first-fill at any pharmacy, not just at specialty pharmacies. First fill is defined as a new start or a re-initiation of therapy.
- 2.10.12.15. To the extent that an Enrollee receives naltrexone in a provider setting that is billable under the medical benefit rather than under the pharmacy benefit, then the Contractor shall cover the naltrexone as a medical benefit.
- 2.10.12.16. The Contractor shall ensure that the authorization procedures established for Recovery Coach services allow for at least the first 90 days to occur without prior approval, provided however that the Contractor may establish notification or registration procedures during the first 90 days of Recovery Coach services as specified by EOHHS. Ensure that authorization procedures established for Recovery Coach services allow for the Member to access at least 90 units over a 90-day period, where 1 unit is equal to 1 day.
- 2.10.12.17. The Contractor shall ensure that the authorization procedures established for RRS allow for at least the first 90 days to occur without prior approval, provided however that the Contractor may establish notification or registration procedures during the first 90 days of RRS.

- 2.10.12.18. The Contractor shall ensure that the authorization procedures established for Recovery Support Navigator allow for at least the first ninety (90) days to occur without prior approval, provided however that the Contractor may establish notification or registration procedures during the first 90 days of Recovery Support Navigator services as further specified by EOHHS. Ensure that authorization procedures established for Recovery Support Navigator allow for the Member to access at least 180 units over a 90-day period, where 1 unit is equal to 15 minutes.
- 2.10.13. Behavioral Health Service Authorization Policies and Procedures
- 2.10.13.1. The Contractor shall review and update annually, at a minimum, the clinical criteria definitions and program specifications for each One Care Behavioral Health Covered Service. The Contractor shall submit any modifications to EOHHS annually for review and approval. In its review and update process, the Contractor shall consult with its clinical staff or medical consultants outside of the Contractor's organization, or both, who are familiar with standards and practices of mental health and substance use disorder treatment in Massachusetts and best practices in these treatment areas.
- 2.10.13.2. The Contractor shall review and update annually and submit for EOHHS approval, at a minimum, its Behavioral Health Services authorization policies, and procedures.
- 2.10.13.3. The Contractor shall develop and maintain Behavioral Health Inpatient Services and Diversionary Services authorization policies and procedures, which shall, at a minimum, contain the following requirements:
- 2.10.13.3.1. If prior authorization is required for any Behavioral Health Inpatient Services admission or Diversionary Service, assure the availability of such prior authorization twenty-four (24) hours a day, seven (7) days a week;
- 2.10.13.3.2. A plan and a system in place to direct Enrollees to the least intensive but clinically appropriate service;
- 2.10.13.3.3. For all Behavioral Health emergency inpatient admissions, ensure:
- 2.10.13.3.3.1. A system to provide an initial authorization and communicate the initial authorized length of stay to the Enrollee, facility, and attending physician for all Behavioral Health emergency inpatient admissions verbally within thirty (30) minutes, and within two (2)

hours for non-emergency inpatient authorization and in writing within twenty-four (24) hours of admission; and

2.10.13.3.3.2. Policies and procedures to ensure compliance by the Contractor and any of the Contractor's Material Subcontractors with the above **Section 2.10.13.3.3.1.**

2.10.13.3.4. Processes to ensure placement for Enrollees who require Behavioral Health Inpatient Services when no inpatient beds are available, including methods and places of care to be utilized while Enrollee is awaiting an inpatient bed;

2.10.13.3.5. A system to concurrently review Behavioral Health Inpatient Services to monitor Medical Necessity for the need for continued stay, and achievement of Behavioral Health Inpatient Services treatment goals;

2.10.13.3.6. Verification and authorization of all adjustments to Behavioral Health Inpatient Services treatment plans and Diversionary Services treatment plans;

2.10.13.3.7. Processes to ensure that treatment and discharge needs are addressed at the time of authorization and concurrent review, and that the treatment planning includes coordination with the PCP, other Members of the care team, and other providers, such as community-based mental health services providers, as appropriate;

2.10.13.3.8. Retrospective reviews of the medical records of selected Behavioral Health Inpatient Services admissions and twenty-four (24) hour Diversionary Services cases to assess the Medical Necessity, clinical appropriateness of care, and the duration and level of care; and

2.10.13.3.9. Monitor the rates of authorization, diversion, modification and denial at the service level for each such service, and for reporting to EOHHS in accordance with **Appendix A.**

2.10.13.4. The Contractor shall develop and maintain Behavioral Health Outpatient Services policies and procedures which shall include, but are not limited to, the following:

2.10.13.4.1. Policies and procedures to automatically authorize at least twelve (12) Behavioral Health Outpatient Services;

2.10.13.4.2. Policies and procedures for the authorization of all Behavioral Health Outpatient Services beyond the initial twelve (12) Outpatient Services;

- 2.10.13.4.3. Policies and procedures to authorize Behavioral Health Outpatient Services based upon Behavioral Health Clinical Criteria;
- 2.10.13.4.4. Policies and procedures based upon Behavioral Health Clinical Criteria, to review and approve or deny all requests for Behavioral Health Outpatient Services based on Clinical Criteria.
- 2.10.13.4.5. A plan and system in place to direct Enrollees to the least intensive clinically appropriate service.
- 2.10.13.4.6. For Outpatient Services, Outpatient Day Services, and non-twenty-four (24) hour Diversionary Services, the Contractor shall make a decision no later than 14 calendar days following receipt of the request and shall mail a written notice to both the Enrollees and the Network Provider on the next business day after the decision is made or provide an electronic notification of allowed.
- 2.10.13.4.7. The Contractor shall develop and maintain SUD Services policies and procedures which shall include, but not be limited to, the following:
 - 2.10.13.4.7.1. Require that Providers providing Clinical Stabilization Services for Substance Use Disorders (Level 3.5) and ATS shall provide the Contractor, within 48 hours of a Covered Individual's admission, with notification of admission of a Covered Individual and an initial treatment plan for such Covered Individual. The Contractor may establish the manner and method of such notification but may not require the provider to submit any information other than the name of the Covered Individual, information regarding the Covered Individual's coverage with the Contractor, and the provider's initial treatment plan. The Contractor may not use failure to provide such notice as the basis for denying claims for services provided.
 - 2.10.13.4.7.2. Allow for at least the first 90 days of Residential Rehabilitation Services for a Covered Individual to occur without prior approval, provided however that the Contractor may establish notification or registration procedures during the first 90 days of Residential Rehabilitation Services. The Contractor shall submit for EOHHS's approval the Contractor's authorization and

concurrent review procedures for Residential Rehabilitation Services.

2.10.14. Authorizations of LTSS and Community-based Services

2.10.14.1. At a minimum, the Contractor's authorizations of LTSS listed in **Appendix C, Exhibit 1**, shall be no more limiting than MassHealth FFS authorization criteria for those Covered Services.

2.10.14.2. The Contractor shall develop authorization criteria and a process for authorizing the Additional Community-based Services listed in **Appendix C, Exhibit 3** that considers the Enrollee's entire ICP. The Contractor has the discretion to authorize such services in a determined amount, duration and scope for an Enrollee if the Contractor determines that such authorization would provide sufficient value to the Enrollee's care. Value shall be determined in light of the full range of services included in the ICP, considering how the services contribute to the health and independent living of the Enrollee in the least restrictive setting and with reduced reliance on emergency department use, acute inpatient care and institutional long-term care.

2.10.14.3. The Contractor has discretion to cover other community-based services not listed in **Appendix C** if the Contractor determines that such authorization would provide sufficient value to the Enrollee's care, considering the Enrollee's entire ICP. Value shall be determined in light of the full range of services included in the ICP, considering how the services contribute to the health and independent living of the Enrollee in the least restrictive setting and with reduced reliance on emergency department use, acute inpatient care, and institutional long-term- care.

2.10.15. Notification of Birth and Coverage of Newborns

2.10.15.1. The Contractor shall:

2.10.15.1.1. Facilitate immediate transfer of newborns to the MassHealth eligibility process. The contractor shall not be responsible for costs associated with newborns on or after the date of birth as they will be retroactively enrolled in the MassHealth program effective the date of birth as soon as practicable.

2.10.15.1.2. For all births to Enrollees, require the provider that delivered the newborn, such as the hospital, to submit a properly completed Notification of Birth (NoB) form to MassHealth's NoB unit. Such form shall be submitted by the provider to MassHealth within thirty (30) calendar days of the newborn's

date of birth. The Contractor shall include such requirement in its provider Contracts.

- 2.10.15.1.3. Collaborate with EOHHS to establish a smooth and efficient process for reporting all newborns.

2.11. Enrollee Services

2.11.1. Enrollee Services Department

2.11.1.1. The Contractor shall:

- 2.11.1.1.1. Maintain an Enrollee services department to assist Enrollees, Enrollees' family members or guardians, and other interested parties in learning about and obtaining services under this Contract;
- 2.11.1.1.2. Maintain employment standards and requirements (e.g., education, training, and experience) for Enrollee services department staff and provide a sufficient number of staff to meet defined performance objectives;
- 2.11.1.1.3. Ensure that Enrollee services department staff have access to:
 - 2.11.1.1.3.1. The Contractor's Enrollee database;
 - 2.11.1.1.3.2. EOHHS's Eligibility Verification System (EVS); and
 - 2.11.1.1.3.3. An electronic provider directory that includes, but is not limited to, the information specified in **Section 2.8.7** of this Contract.
- 2.11.1.1.4. Employ Enrollee Services Representatives (ESRs) trained to answer Enrollee inquiries and concerns from Enrollees and Eligible MassHealth Members. Call center hours shall be consistent with the standards set forth in 42 C.F.R. § 422.111(h)(1) and 423.128(d)(1) as well as the following requirements:
 - 2.11.1.1.4.1. Be trained to answer Enrollee inquiries and concerns from Enrollees and prospective Enrollees;
 - 2.11.1.1.4.2. Be trained in the use of TTY, Video Relay services, remote interpreting services, how to provide accessible PDF materials, and other Alternative Formats;

- 2.11.1.1.4.3. Be capable of speaking directly with, or arranging for an interpreter to speak with, Enrollees in their primary language, including ASL, or through an alternative language device or telephone translation service;
- 2.11.1.1.4.4. Inform callers that interpreter services are free;
- 2.11.1.1.4.5. Make oral interpretation services available free of charge to Enrollees in all non-English languages spoken by Enrollees, including American Sign Language (ASL);
- 2.11.1.1.4.6. Maintain the availability of services, such as TTY services, computer aided transcription services; telephone handset amplifiers, assistive listening systems, closed caption decoders, videotext displays and qualified interpreters and other services for Deaf and hard of hearing Enrollees;
- 2.11.1.1.4.7. Demonstrate sensitivity to culture, including disability culture and the Independent Living Principles;
- 2.11.1.1.4.8. Provide assistance to Enrollees with cognitive impairments, for example, provide written materials in simple, clear language at a reading level of grade six (6) and below, and individualized guidance from Enrollee Services Representatives to ensure materials are understood; and
- 2.11.1.1.4.9. Provide reasonable accommodations needed to assure effective communication and provide Enrollees with a means to identify their disability to the One Care Plan.
- 2.11.1.1.5. Ensure that ESRs make available to Enrollees and Eligible Enrollees, upon request, information concerning the following:
 - 2.11.1.1.5.1. The identity, locations, qualifications, accessibility, and availability of providers;
 - 2.11.1.1.5.2. Enrollees' rights and responsibilities,
 - 2.11.1.1.5.3. The procedures available to an Enrollee and provider(s) to challenge or Appeal the failure of the Contractor to provide a Covered Service and to Appeal any Adverse Action (denials);
 - 2.11.1.1.5.4. How to access oral interpretation services and written materials in Prevalent Languages and Alternative

Formats and the availability of auxiliary aids and services;

2.11.1.1.5.5. Information on all Covered Services and other available services or resources (e.g., State agency services) either directly or through referral or authorization;

2.11.1.1.5.6. The procedures for an Enrollee to change plans or to disenroll from the Contractor; and

2.11.1.1.5.7. Additional information that may be required by Enrollees and Eligible Enrollees to understand the requirements and benefits of the One Care Plan.

2.11.2. Enrollee Service Call Center

2.11.2.1. Hours of Operation

2.11.2.1.1. The Contractor shall operate a call center and toll-free Enrollee services telephone line consistent with the standards set forth in 42 C.F.R. § 422.111(h)(1) and 423.128(d)(1).

2.11.2.1.2. The Contractor may use alternative call center technologies on Saturdays, Sundays, and Federal holidays except New Year's Day. On New Year's Day, the Contractor shall operate a call center with ESRs available during normal business hours.

2.11.2.2. Responsiveness Standards

2.11.2.2.1. The Contractor shall ensure ESRs are available during normal business hours daily. The Contractor shall ensure responsiveness in accordance with the following standards:

2.11.2.2.1.1. Answer 90% of all Enrollee telephone calls within 30 seconds and be able to provide reports indicating compliance with this requirement upon request of EOHHS. The Contractor shall have a process to measure the time from which the telephone is answered to the point at which an Enrollee reaches an ESR capable of responding to the Enrollee's question.

2.11.2.2.1.2. Limit average hold time to two (2) minutes. The hold time is defined as the time spent on hold by callers following the interactive voice response (IVR) system, touch-tone response system, or recorded greeting, before reaching a live person; and

- 2.11.2.2.1.3. Limit the disconnect rate of all incoming calls to five (5)%. The disconnect rate is defined as the number of calls unexpectedly dropped divided by the total number of calls made to the customer call center.

2.11.2.3. Customer Service Requirements

- 2.11.2.3.1. The Contractor shall ensure that its ESRs who are assigned to respond to One Care-specific inquiries:

- 2.11.2.3.1.1. Understand and have a working knowledge of MassHealth, Medicare, and the terms of the Contract between EOHHS and the Contractor, including the Covered Services as referenced in **Section 2.7** and defined in **Appendix C**;
- 2.11.2.3.1.2. Answer Enrollee inquiries, including those related to enrollment status and accessing care,
- 2.11.2.3.1.3. Are trained in Grievances, Internal Appeals, Medicare IRE, and Medicaid BOH Appeals processes and procedures, as specified in **Section 2.13**, and are available to Enrollees to discuss and provide assistance with resolving Enrollee Grievances and submitting Appeals;
- 2.11.2.3.1.4. Refer Enrollee inquiries that are of a clinical nature, but non-behavioral health, to clinical staff with the appropriate clinical expertise to adequately respond;
- 2.11.2.3.1.5. Refer Enrollee inquiries related to Behavioral Health to the Contractor's behavioral health clinical staff except where said inquiries are solely administrative in content. For the purposes of this **Section 2.11.2**, examples of administrative inquiries shall include requests for general information regarding particular Behavioral Health Providers such as their participation as Network Providers, their address or their hours of operation, and shall exclude any questions that require judgment by a Behavioral Health clinical professional to provide an adequate response; and
- 2.11.2.3.1.6. Refer Enrollee inquiries about Long-term Services and Supports, independent living supports, and community-based versus facility-based services to a LTS Coordinator, and actively support Enrollees to access LTS Coordinators.

2.11.3. Coverage Determinations and Appeals Call Center Requirements

2.11.3.1. The Contractor shall operate a toll-free call center with live customer service representatives available to respond to providers or Enrollees for information related to requests for coverage under Medicare or Medicaid, and Medicare and Medicaid Appeals (including requests for Medicare exceptions and prior authorizations).

2.11.3.2. The Contractor shall provide, via its toll-free call centers, opportunities for Enrollees to request for Medicare and Medicaid covered benefits and services, including Medicare coverage determinations and redeterminations.

2.11.3.3. The call center shall operate consistent with the standards set forth in 42 C.F.R. § 422.111(h)(1) and 423.128(d)(1). The Contractor shall accept requests for Medicare or Medicaid coverage, including Medicare coverage determinations /redeterminations, outside of normal business hours, but is not required to have live customer service representatives available to accept such requests outside normal business hours. Voicemail may be used outside of normal business hours provided the message:

2.11.3.3.1. Indicates that the mailbox is secure;

2.11.3.3.2. Lists the information that must be provided so the case can be worked (e.g., provider identification, beneficiary identification, type of request (coverage determination or Appeal), physician support for an exception request, and whether the Member is making an expedited or standard request);

2.11.3.3.3. For coverage determination calls (including exceptions requests), articulates and follows a process for resolution within twenty-four (24) hours of call for expedited requests and seventy-two (72) hours for standard requests; and

2.11.3.3.4. For Appeals calls, articulates and follows a process for resolution within seventy-two (72) hours for expedited Appeal requests and thirty (30) calendar days for standard Appeal requests.

2.12. Marketing, Outreach, and Enrollee Communications Standards

2.12.1. General Requirements

2.12.1.1. The Contractor is subject to rules governing marketing and Enrollee Communications as specified under Section 1851(h) of the Social

Security Act, 42 C.F.R. §422.111, §422.2260 et. seq., §423.120(b) and (c), §423.128, §423.2260 et. seq., and § 438.10, and §438.104, the Medicare Communications and Marketing Guidelines as updated from time to time. Additionally, the Contractor shall comply with the following requirements and restrictions. EOHHS may add additional requirements and restrictions related to marketing at its discretion.

2.12.1.2. In conducting marketing, education, and enrollment activities, the Contractor shall:

- 2.12.1.2.1. Permit only One Care Plan employees (or “employed agents”) to market and enroll Members with the Contractor. The Contractor’s employed agents shall not be paid referral fees, on a contingency basis, or other volume-based compensation for enrollments into the Contractor. The Contractor shall not contract with or permit any third-party Agents or Independent Agents/Brokers to market to or enroll Members in a One Care plan, unless it receives advance written permission from EOHHS and EOHHS approves the contract.
- 2.12.1.2.2. Comply with the information requirements of 42 CFR 438.104 and 42 CFR 438.10 to ensure that, before enrolling, the individual receives from the Contractor accurate oral and written information they need to make an informed decision on whether or not to enroll. This information shall be presented in a language or format that is accessible to the individual.
- 2.12.1.2.3. Ensure that marketing materials are accurate and not misleading, and do not defraud Enrollees, potential Enrollees, or MassHealth.
- 2.12.1.2.4. Make available to EOHHS, upon request, current schedules of all educational events conducted by the Contractor to provide information to Enrollees or Eligible MassHealth Members,
- 2.12.1.2.5. Convene all educational, marketing, sales, and enrollment events at sites that are:
 - 2.12.1.2.5.1. Within the Contractor’s Service Area,
 - 2.12.1.2.5.2. Physically accessible to Enrollees and Eligible MassHealth Members, including persons with disabilities and/or functional limitations,

- 2.12.1.2.5.3. Physically accessible to and easy to reach for persons using public transportation.
- 2.12.1.2.6. Distribute and/or publish Marketing Materials throughout the Contractor's Service Area(s) 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:
 - 2.12.1.2.6.1. To only a portion of the Contractor's Service Area(s); or
 - 2.12.1.2.6.2. Where the campaign relates to a local event (such as a health fair), to a single Provider (such as a hospital or clinic); and
 - 2.12.1.2.6.3. Provide EOHHS with a copy of all press releases pertaining to the Contractor's MassHealth line of business for prior review and approval.
- 2.12.1.3. The Contractor may convene or appear at a health fair or community activity sponsored by the Contractor provided that the Contractor shall notify all MassHealth-contracted One Care plans, PACE Organizations, and SCO plans within the geographic region of their ability to participate. Such notification shall be in writing and shall be made as soon as reasonably possible prior to the date of the event. If other MassHealth-contracted health plans choose to participate in a Contractor's sponsored event, they shall contribute to the costs of such event as a condition of participation, provided costs are reasonably apportioned among the MassHealth-contracted health plans. The Contractor may conduct or participate in Marketing at Contractor or non-Contractor sponsored health fairs and other community activities only if:
 - 2.12.1.3.1. Any Marketing Materials the Contractor distributes have been pre-approved by EOHHS; and
 - 2.12.1.3.2. Any free samples and gifts offered by the Contractor are only of a nominal value and are available to all attendees of the health fair or other community activity regardless of their intent to enroll in the Contractor's Plan.
- 2.12.1.4. The Contractor may participate in Health Benefit Fairs sponsored by EOHHS. Such Health Benefit Fairs will be held in accordance with **Section 3.3**.
- 2.12.1.5. Under no conditions shall a Contractor use MassHealth's Member data base or a Provider's patient/customer database to identify and market its plan to MassHealth beneficiaries, unless otherwise

specified or approved by EOHHS. The Contractor shall not share or sell Enrollee lists or Enrollee data with other persons or organizations for any purpose other than performance of the Contractor's obligations pursuant to this Contract.

- 2.12.1.6. The Contractor shall not market to or otherwise encourage One Care plan Enrollees who will remain eligible for One Care at age 65 to disenroll from One Care and enroll in SCO.
- 2.12.1.7. The Contractor shall not offer financial or other incentives, including private insurance, to induce Enrollees or Eligible MassHealth Members to enroll with the Contractor or to refer a friend, neighbor, or other person to enroll with the Contractor. The Contractor shall not directly or indirectly conduct door-to-door, telephone, email, texting, or other unsolicited contacts (with the exception of direct mail, which is permissible), nor shall Contractor employees or agents present themselves unannounced at an Enrollee's place of residence for marketing or "educational" purposes. Calls made by the Contractor to Dual Eligible individuals enrolled in the Contractor's other product lines, are not considered unsolicited direct contact and are permissible.
- 2.12.1.8. The Contractor shall not use any Marketing, Outreach, or Enrollee Communications materials that contain any assertion or statement (whether written or oral) that suggest or imply that
 - 2.12.1.8.1. The recipient shall enroll with the Contractor in order to obtain benefits or in order not to lose benefits, or the Contractor is endorsed by CMS, Medicare, Medicaid, the Federal government, EOHHS, or similar entity.
- 2.12.1.9. Annually, the Contractor shall present its marketing plan to EOHHS for review and approval.
- 2.12.2. Communications Materials
 - 2.12.2.1. The Contractor's Marketing, Outreach, and Enrollee Communications materials shall be:
 - 2.12.2.1.1. Made available in Alternative Formats, upon request and as needed to assure effective communication for blind and vision impaired Enrollees;
 - 2.12.2.1.2. Provided in a manner, format, and language that may be easily understood by persons with limited English proficiency, or for those with developmental disabilities or cognitive impairments, as required under 45 C.F.R. Part 92.101;

- 2.12.2.1.3. Translated into Prevalent Languages in the Service Area;
- 2.12.2.1.4. Sent in Spanish to Members whose primary language is known to be Spanish, if the materials are pre-enrollment or enrollment materials; and
- 2.12.2.1.5. Mailed with Spanish, Cambodian, Chinese, Haitian Creole, Laotian, Portuguese, Russian, Vietnamese, French, Italian, Hindi, Greek, Korean, Polish, Arabic, and Gujarati taglines that alert Enrollees to the availability of language assistance services, free of charge, and how those services can be obtained.
- 2.12.2.2. As applicable, mailed with a non-discrimination notice or statement, consistent with the requirements of 45 C.F.R. Part 92.
Developed utilizing definitions as specified by EOHHS and CMS, consistent with 42 C.F.R. § 438.10(c)(4)(i).
- 2.12.3. Submission, Review, and Approval
 - 2.12.3.1. The Contractor shall receive prior approval from EOHHS of all marketing and Enrollee Communications materials prior to use.
 - 2.12.3.2. EOHHS may conduct additional types of review of Contractor Marketing, Outreach, and Enrollee Communications activities, including, but not limited to:
 - 2.12.3.2.1. Review of on-site marketing facilities, products, and activities during regularly scheduled Contract compliance monitoring visits or during unannounced visits;
 - 2.12.3.2.2. Random review of actual Marketing, Outreach, and Enrollee Communications pieces as they are used in the marketplace;
 - 2.12.3.2.3. “For cause” review of materials and activities when Grievances are made by any source, and EOHHS determines it is appropriate to investigate;
 - 2.12.3.2.4. “Secret shopper” activities where EOHHS requests Contractor materials, such as enrollment packets.
 - 2.12.3.3. All marketing and Enrollee Communications materials used and submitted for review for the Contractor’s One Care Plan shall be tailored for use for the Massachusetts One Care Plan. For example, marketing material should not refer Enrollees to “your state’s health department” but should instead be created specifically for

Massachusetts (i.e., refer to the Massachusetts Department of Public Health).

2.12.4. Beginning of Marketing, Outreach, and Enrollee Communications Activity

2.12.4.1. The Contractor shall not begin Marketing, Outreach, and Enrollee Communications activities to new Enrollees more than ninety (90) days prior to the effective date of enrollment for the following Contract year (e.g., if the effective date of enrollment is January 1, 2024, Marketing, Outreach and Enrollee Communications activities may not be until October 3, 2023).

2.12.5. Requirements for Dissemination of Marketing, Outreach, and Enrollee Communications Materials

2.12.5.1. The Contractor shall provide new Enrollees with the following materials which, with the exception of the ID card specified in **Section 2.12.5.1.15** below, shall also be provided annually thereafter:

2.12.5.1.1. An Enrollee Handbook document, or a distinct and separate Notice on how to access the Enrollee Handbook online and how to request a hard copy, that is consistent with the requirements at 42 C.F.R. § 438.10, includes information about all Covered Services, as outlined below, and that uses the model document developed by EOHHS.

2.12.5.1.2. Enrollee rights (see **Appendix N**);

2.12.5.1.3. An explanation of how Enrollee records are stored and shared with key caregivers;

2.12.5.1.4. How to obtain a copy of the Enrollee's record;

2.12.5.1.5. How to obtain access to specialty, behavioral health, pharmacy, oral health, and LTSS providers;

2.12.5.1.6. How to obtain services and prescription drugs for Emergency Medical Conditions and Urgent Care in and out of the Provider Network and in and out of the Service Area, including:

2.12.5.1.6.1. What constitutes emergency medical condition, Emergency Services, and Post-stabilization Services, with reference to the definitions is 42 C.F.R. § 438.114(a);

- 2.12.5.1.6.2. The fact that prior authorization is not required for Emergency Services;
- 2.12.5.1.6.3. The process and procedures for obtaining Emergency Services, including the use of 911 or other emergency service hotlines;
- 2.12.5.1.6.4. The locations of any emergency settings and other locations at which providers and hospitals furnish Emergency Services and Post-stabilization Services covered under the Contract; and
- 2.12.5.1.6.5. That the Enrollee has a right to use any hospital or other setting for emergency care.
- 2.12.5.1.7. How to access the Contractor's twenty-four (24) hour Clinical Advice and Support Line required under **Section 2.7.9.4**.
- 2.12.5.1.8. Information on how to report suspected fraud or abuse.
- 2.12.5.1.9. The Behavioral Health Help Line and Community Behavioral Health Centers and how to access them.
- 2.12.5.1.10. Information about Advance Directives (at a minimum those required in 42 C.F.R. § 489.102 and 42 C.F.R. § 422.128, and § 438.3(j)), which information shall be updated to reflect any changes in Massachusetts law as soon as possible, but no later than ninety (90) days after the effective date of changes, including:
 - 2.12.5.1.10.1. Enrollee rights under the laws of the Commonwealth;
 - 2.12.5.1.10.2. The Contractor's policies respecting the implementation of those rights, including a statement of any limitation regarding the implementation of Advance Directives as a matter of conscience;
 - 2.12.5.1.10.3. The Grievances concerning noncompliance with the Advance Directive requirements may be filed with EOHHS;
 - 2.12.5.1.10.4. Designating a health care proxy; and
 - 2.12.5.1.10.5. Other mechanisms for ensuring that future medical decisions are made according to the desire of the Enrollee.
- 2.12.5.1.11. How to obtain assistance from ESRs.

- 2.12.5.1.12. How to file Grievances and Internal and External Appeals, including:
 - 2.12.5.1.12.1. Grievance, Appeal, and fair hearing procedures and timeframes;
 - 2.12.5.1.12.2. Toll free numbers that the Enrollee can use to file a Grievance or an Appeal by phone;
 - 2.12.5.1.12.3. How to access assistance in the filing process;
 - 2.12.5.1.12.4. The right to file a grievance directly with EOHHS, how to do so, and EOHHS contact information; and
 - 2.12.5.1.12.5. A statement that if the Enrollee files an Appeal or request for State Fair Hearing within the timeframes specified for filing and when requested by the Enrollee, benefits will continue at the plan level for all benefits;
 - 2.12.5.1.12.6. How the Enrollee can identify who the Enrollee wants to receive written notices of denials, terminations, and reductions;
 - 2.12.5.1.12.7. How to obtain assistance with the Appeals processes through the ESR and other assistance mechanisms as EOHHS may identify, including an Ombudsman;
 - 2.12.5.1.12.8. The extent to which, and how Enrollees may obtain benefits, including family planning services, from non-network providers;
 - 2.12.5.1.12.9. How and where to access any benefits that are available under the State plan but are not covered under the Contract, including any cost-sharing in accordance with 42 C.F.R. § 447.50 through 42 C.F.R. § 447.60, and how transportation is provided;
 - 2.12.5.1.12.10. How to change providers; and
 - 2.12.5.1.12.11. How to disenroll voluntarily.
- 2.12.5.1.13. A Summary of Benefits that contains a concise description of the important aspects of enrolling in the One Care Plan, as well as the benefits offered under the Contractor's plan, including no cost-sharing, applicable conditions and limitations, and any other conditions associated with receipt or use of benefits, and uses the model document developed by the Commonwealth. The Summary of Benefits shall

provide sufficient detail to ensure that Enrollees understand the benefits to which they are entitled;

- 2.12.5.1.14. A combined provider and pharmacy directory that is consistent with the requirements in **Section 2.12.6**, or a distinct and separate notice on how to access this information online and how to request a hard copy, as specified in the Medicare Managed Care Manual and the Medicare/Medicaid marketing guidance;
 - 2.12.5.1.15. A single identification (ID) card for accessing all Covered Services under the plan;
 - 2.12.5.1.16. A comprehensive, integrated formulary that includes prescription drugs and over-the-counter products required to be covered by Medicare Part D and the Commonwealth's outpatient prescription drug benefit and that uses the model document developed by the Commonwealth, or a distinct and separate notice on how to access this information online and how to request a hard copy, as specified in the Medicare Communications and Marketing Guidelines and any additional EOHHS- marketing guidance; and
 - 2.12.5.1.17. The procedures for an Enrollee to change One Care Plans.
- 2.12.5.2. The Contractor shall provide an Annual Notice of Change that summarizes all major changes to the Contractor's covered benefits from one contract year to the next.
 - 2.12.5.3. The Contractor shall provide all Medicare Part D required notices, with the exception of the LIS Rider, the creditable coverage notices required under Chapter 4 of the Prescription Drug Benefit Manual, and the late enrollment penalty notices required under Chapter 13 of the Prescription Drug Benefit Manual.
 - 2.12.5.4. The Contractor shall provide Enrollees with at least thirty (30) days advance notice regarding certain changes to the comprehensive, integrated formulary.
 - 2.12.5.5. The Contractor shall ensure that all information provided to Enrollees and eligible MassHealth Members (and families when appropriate) is provided in a manner and format that is easily understood and that is:
 - 2.12.5.5.1. Made available in large print (at least 18-point font) to Enrollees as an Alternative Format, upon request;

- 2.12.5.5.2. For vital materials, available in Prevalent Languages, as provided for in the Medicare/Medicaid marketing guidance;
- 2.12.5.5.3. Written with cultural sensitivity and at a sixth--grade reading level or below; and
- 2.12.5.5.4. Available in Alternative Formats, according to the needs of Enrollees and Eligible Beneficiaries, including Braille, oral interpretation services in non-English languages, as specified in **Section 2.10.5** and **Section 2.12.2** of this Contract, audiotape, American Sign Language video clips, and other alternative media, as requested, and the availability of auxiliary aids and services.

2.12.6. Provider/Pharmacy Network Directory

2.12.6.1. Maintenance and Distribution

2.12.6.1.1. The Contractor shall:

- 2.12.6.1.1.1. Maintain and update a combined Provider/Pharmacy Network directory that uses the model document developed by EOHHS.
- 2.12.6.1.1.2. Provide either a copy or a separate notice on how to access the information online in a machine-readable file and format and how to request a hard copy, as specified in the Medicare Communication and Marketing Guidelines and the Medicare/Medicaid marketing guidance, to all new Enrollees at the time of enrollment and annually thereafter, The Contractor shall update such information no later than thirty (30) calendar days after being made aware of any change in information.
- 2.12.6.1.1.3. When there is a significant change to the network, send a provider notice to impacted Enrollees.
- 2.12.6.1.1.4. Ensure an up--to--date copy is available on the Contractor's website, consistent with the requirements at 42 C.F.R. § 438.10(h).
- 2.12.6.1.1.5. Consistent with **Section 2.9** of this Contract, make a good faith effort to provide written notice of termination of a contracted provider or pharmacy at least thirty (30) calendar days before the termination effective date, irrespective of whether the termination was for cause or without cause, to all Enrollees who regularly use the provider or pharmacy's services. If a contract termination

involves a PCP, the Contractor shall notify all Enrollees who are patients of that PCP.

2.12.6.1.1.6. Include written and oral offers of such Provider/Pharmacy Network directory in its outreach and orientation sessions for new Enrollees.

2.12.6.1.1.7. Provide a notice to all Enrollees impacted by a termination or non-renewal of a hospital, community health center or community mental health center contract, chain pharmacy, or other primary care Provider site.

2.12.6.2. Content of Provider/Pharmacy Network Directory

2.12.6.2.1. The Provider/Pharmacy Network directory shall include, at a minimum, the following information for all providers in the Contractor's Provider Network, including physicians, hospitals, pharmacies, Behavioral Health Providers, oral health, and LTSS providers:

2.12.6.2.1.1. The names, addresses, telephone numbers and website URL as appropriate and the total number of each type of provider, and any specialty and group affiliation as appropriate.

2.12.6.2.1.2. As applicable, Network Providers with training in and experience treating:

2.12.6.2.1.2.1. Persons with physical disabilities, chronic illness, HIV/AIDS, and/or persons with serious mental illness, and/or substance use disorder;

2.12.6.2.1.2.2. Homeless persons;

2.12.6.2.1.2.3. Persons who are Deaf or hard of hearing and blind or visually impaired;

2.12.6.2.1.2.4. Persons with co-occurring disorders; and

2.12.6.2.1.2.5. Other specialties.

2.12.6.2.1.3. For Network Providers that are health care professionals or non-facility based and, as applicable, for facilities and facility based Network Providers, office hours, including the names of any Network Provider sites open after 5:00 p.m. (Eastern Time) weekdays and on weekends;

- 2.12.6.2.1.4. Cultural capabilities, including, as applicable, whether the health care professional or non-facility-based Network Provider has completed cultural competence training;
- 2.12.6.2.1.5. Whether the Network Provider has specific accommodations for people with physical disabilities, such as wide entry, wheelchair access, accessible exam rooms and tables, lifts, scales, bathrooms and stalls, grab bars, or other accessible equipment;
- 2.12.6.2.1.6. Whether the Network Provider is accepting new patients as of the date of publication of the directory;
- 2.12.6.2.1.7. Whether the Network Provider is on a public transportation route;
- 2.12.6.2.1.8. Any languages other than English, including ASL, spoken by Network Providers or offered by skilled medical interpreters at the provider's site;
- 2.12.6.2.1.9. As applicable, whether the Network Provider has access to language line interpreters; and
- 2.12.6.2.1.10. The directory shall include a description of the roles of the PCP and ICT and the process by which Enrollees select and change PCPs.
 - 2.12.6.2.1.10.1. The directory shall include, at a minimum, the following information for all pharmacies in the Contractor's Pharmacy Network:
 - 2.12.6.2.1.10.1.1. The names, addresses, telephone numbers of all current pharmacies; and
 - 2.12.6.2.1.10.1.2. Instructions for the Enrollee to contact the Contractor's toll--free Enrollee Services telephone line (as described in **Section 2.11**) for assistance in finding a convenient pharmacy, including one that is linguistically accessible.

2.13. Grievances and Appeals

2.13.1. General Requirements

2.13.1.1. The Contractor shall:

- 2.13.1.1.1. Maintain written policies and procedures for the receipt and timely resolution of Grievances and Internal Appeals. Such policies and procedures shall be approved by EOHHS; and
- 2.13.1.1.2. Review the Grievance and Internal Appeals policies and procedures, at least annually, to amend and improve those policies and procedures. The Contractor shall provide copies of any such amendments to EOHHS, for review and approval, 30 calendar days prior to the date of the amendment, unless otherwise specified by EOHHS.
- 2.13.1.2. The Contractor shall put in place a standardized process that includes:
 - 2.13.1.2.1. A means for assessing and categorizing the nature and seriousness of a Grievance or Internal Appeal;
 - 2.13.1.2.2. A means for tracking how long the Contractor takes to dispose of or resolve Grievances and Internal Appeals and to provide notice of such disposition or resolution, as specified in **Sections 2.13.2 and Section 2.13.3** below; and
 - 2.13.1.2.3. A means for expedited resolution of Internal Appeals, as further specified in **Section 2.13.4.2**, when the Contractor determines (for a request from the Enrollee) or a Provider indicates (in making the request on the Enrollee's behalf or supporting the Enrollee's request) that taking the time for a standard resolution, in accordance with **Section 2.13.4.2**, could seriously jeopardize the Enrollee's life or health or ability to attain, maintain, or regain maximum function.
- 2.13.1.3. The Contractor shall put in a place a mechanism to:
 - 2.13.1.3.1. Accept Grievances filed either orally or in writing; and
 - 2.13.1.3.2. Accept Internal Appeals filed either orally or in writing within 60 calendar days from the notice of Adverse Action specified in **Section 2.13.4.3** provided that if an Internal Appeal is filed orally, the Contractor shall not require the Enrollee to submit a written, signed Internal Appeal form subsequent to the Enrollee's oral request for an appeal. Internal Appeals filed later than 60 days from the notice of Adverse Action may be rejected as untimely.
- 2.13.1.4. The Contractor shall send a written acknowledgement of the receipt of any Grievance or Internal Appeal to Enrollees and, if an Appeals Representative filed the Grievance or Internal Appeal, to the

Appeals Representative and the Enrollee within 1 business day of receipt by the Contractor.

- 2.13.1.5. The Contractor shall track whether an Internal Appeal was filed orally or in writing within 60 calendar days from the notice of Adverse Action specified in **Section 2.13.4.3**.
- 2.13.1.6. The Contractor shall create and maintain records of Grievances, Internal Appeals, BOH Appeals, Hospital Discharge Appeals, appeals to the CMS Independent Review Entity, and all subsequent levels of External Appeals via both Medicare and Medicaid routes, using the health information system(s) specified in **Section 2.15.6** to document:
 - 2.13.1.6.1. The type and nature of each Grievance, Internal Appeal, BOH Appeal, and review by the CMS Independent Review Entity;
 - 2.13.1.6.2. How the Contractor disposed of or resolved each Grievance, Internal Appeal, BOH Appeal, Hospital Discharge Appeal, or review by the CMS Independent Review Entity; and
 - 2.13.1.6.3. What, if any, corrective action the Contractor took.
- 2.13.1.7. The Contractor shall report to EOHHS on Grievances, Internal Appeals, BOH Appeals, Hospital Discharge Appeals, and reviews by the CMS Independent Review Entity as described in **Appendix A** in a form and format specified by EOHHS, including but not limited to a summary, the number of appeals per 1,000 Enrollees, and the number of Grievances per 1,000 Enrollees.
- 2.13.1.8. The Contractor shall assure that individuals with authority, such as senior and executive level staff, participate in any corrective action that the Contractor determines is necessary following the resolution of any Grievance, Internal Appeal, BOH Appeal, Hospital Discharge Appeal, or review by the CMS Independent Review Entity.
- 2.13.1.9. The Contractor shall provide Enrollees with information about Grievance, Internal Appeal, and BOH Appeal procedures and timeframes in an accessible manner, as specified in **Section 2.13**.
- 2.13.1.10. The Contractor shall provide information about the Contractor's Grievance and Internal Appeal system to all Providers and Material Subcontractors at the time they enter into a contract with the Contractor, including, at a minimum, information on the Grievance, Internal Appeal, and fair hearing procedures and timeframes. Such information shall include:

- 2.13.1.10.1. The right to file a Grievance or Internal Appeal;
 - 2.13.1.10.2. The requirements and timeframes for filing a Grievance or Internal Appeal; and
 - 2.13.1.10.3. The availability of assistance in the filing process.
- 2.13.1.11. The Contractor shall accept Grievances or internal Appeals and requests for determination or service authorization from the following individual or entities, who shall be considered parties to the case:
- 2.13.1.11.1. The Enrollee or their representative;
 - 2.13.1.11.2. An assignee of the Enrollee (that is, a physician or other provider who has furnished or intends to furnish a service to the Enrollee and formally agrees to waive any right to payment from the Enrollee for that service), or any other provider or entity (other than the Contractor) who has an appealable interest in the proceeding;
 - 2.13.1.11.3. The legal representative of a deceased Enrollee's estate; or
 - 2.13.1.11.4. Any provider that furnishes, or intends to furnish, services to the Enrollee. If the provider requests that the benefits continue while the appeal is pending, pursuant to 42 CFR § 422.632 and consistent with State law, the provider shall obtain the written consent of the Enrollee to request the Appeal on behalf of the Enrollee.
- 2.13.1.12. The timeframes and notice requirements set forth in this **Section** shall be the same for all Covered Services. Timeframe and notice requirements for Part B drugs are governed by and shall comply with 42 CFR 422.568(b)(2), 422.570(d)(2), 422.572(a)(2), 422.584(d)(1), 422.590(c), and 422.590(e)(2).
- 2.13.1.13. The Contractor's failure to adhere to the notice and timing requirements regarding service authorizations, determinations, and internal Appeals shall constitute an Adverse Action for the Enrollee such that:
- 2.13.1.13.1. For service authorizations and determinations, the Enrollee shall be entitled to file an internal Appeal; and
 - 2.13.1.13.2. For Internal Appeals, the Enrollee shall be entitled to file a BOH Appeal or receive CMS Independent Review Entity pursuant to **Section 2.13.5.1**.

2.13.1.14. In the event that an Enrollee pursues an external Appeal in multiple forums and receives conflicting decisions, the Contractor is bound by and shall act in accordance with decisions most favorable to the Enrollee.

2.13.2. Grievances

2.13.2.1. The Contractor shall maintain written policies and procedures for the filing by Enrollees or Appeals Representatives and the receipt, timely resolution, and documentation by the Contractor of all Grievances which shall include, at a minimum, the following, in accordance with 42 CFR §§ 422.629 – 422.634, 438.210, and CFR Part 438, Subpart F. This includes:

2.13.2.1.1. Grievances and internal Appeals systems that meet the standards described in §422.629;

2.13.2.1.2. An integrated Grievance process that complies with §422.630; and

2.13.2.1.3. A process for effectuation of decisions consistent with §422.634.

2.13.2.2. General Requirements

2.13.2.2.1. The Contractor shall put in place a standardized process that includes:

2.13.2.2.1.1. A means for assessing and categorizing the nature and seriousness of a Grievance; and

2.13.2.2.1.2. A means for tracking how long the Contractor takes to dispose of or resolve Grievances and to provide notice of such disposition or resolution, as specified in **Section 2.13.2.**

2.13.2.2.1.2.1. The Contractor shall put in a place a mechanism to accept Grievances at any time filed either orally or in writing; and

2.13.2.2.1.2.2. The Contractor shall send a written acknowledgement of the receipt of any Grievance to Enrollees and, if an Appeals Representative filed the Grievance, to the Appeals Representative and the Enrollee within 1 business day of receipt by the Contractor.

2.13.2.3. Handling of Grievances

2.13.2.3.1. In handling Grievances, the Contractor shall:

2.13.2.3.1.1. Inform Enrollees of the Grievance procedures, as specified in **Section 2.5.3.2.1**.

2.13.2.3.1.2. Give reasonable assistance to Enrollees in completing forms and following procedures applicable to Grievances, including, but not limited to, providing interpreter services and toll-free numbers with TTY/TDD and interpreter capability;

2.13.2.3.1.3. Accept Grievances filed in accordance with **Section 2.13.1.2**;

2.13.2.3.1.4. Send written acknowledgement of the receipt of each Grievance to the Enrollee and Appeal Representative within one business day of receipt by the Contractor;

2.13.2.3.1.5. Provide meaningful procedures for timely hearing and resolving Grievances between Enrollees and the Contractor or any other entity or individual through which the Contractor provides covered items and services; and

2.13.2.3.1.6. Ensure that the individuals who make decisions on Grievances:

2.13.2.3.1.6.1. Are individuals who were not involved in any previous level of review or decision-making, and are not the subordinates of any such individuals; and

2.13.2.3.1.6.2. Take into account all comments, documents, records, and other information submitted by the Enrollee or the Appeal Representative.

2.13.2.3.1.7. Ensure that the following types of Grievances are decided by health care professionals who have the appropriate clinical expertise in treating the Enrollee's medical condition, performing the procedure, or providing the treatment that is the subject of the Grievance:

2.13.2.3.1.7.1. Grievances regarding the denial of an Enrollee's request that an Internal Appeal be expedited, as specified in **Section 2.13.4.4.1.8**; and

2.13.2.3.1.7.2. Grievances regarding clinical issues.

2.13.2.4. Resolution and Notification of Grievances and Internal Appeals

2.13.2.4.1. The Contractor shall:

2.13.2.4.1.1. Dispose of each Grievance and provide notice of each Grievance disposition as expeditiously as the Enrollee's health condition requires. For the standard resolution of Grievances and notice to affected parties, no more than 30 calendar days from the date the Contractor received the Grievance, either orally or in writing, from a valid party, e.g., the Enrollee or the Enrollee's Authorized Appeal Representative, unless this timeframe is extended in accordance with **Section 2.13.2.2**;

2.13.2.4.1.2. Extend the timeframes in **Section 2.13.2.2** by up to 14 calendar days if:

2.13.2.4.1.2.1. The Enrollee or Appeal Representative requests the extension, or

2.13.2.4.1.2.2. The Contractor can justify (to EOHHS upon request) that:

2.13.2.4.1.2.2.1. The extension is in the Enrollee's interest; and

2.13.2.4.1.2.2.2. There is a need for additional information where:

2.13.2.4.1.2.2.2.1. There is a reasonable likelihood that receipt of such information would lead to approval of the request, if received, and

2.13.2.4.1.2.2.2.2. Such outstanding information is reasonably expected to be received within 14 calendar days.

2.13.2.4.1.2.3. For any extension not requested by the Enrollee, the Contractor shall:

2.13.2.4.1.2.3.1. Make reasonable efforts to give the Enrollee and Appeal Representative prompt oral notice of the delay.

2.13.2.4.1.2.3.2. Provide the Enrollee and Appeal Representative written notice of the reason for the delay within 2 calendar days. Such notice shall include the reason for the extension of the timeframe.

2.13.2.4.1.2.3.3. Provide notice in accordance with **Section 2.13** regarding the disposition of a Grievance as follows:

2.13.2.4.1.2.3.3.1. All such notices shall be in writing in a form approved by EOHHS and satisfy the language and format standards set forth in 42 CFR 438.10.

2.13.2.5. External Grievances

2.13.2.5.1. The Contractor shall inform Enrollees that they may file an external Grievance through 1-800 Medicare. The Contractor shall display a link to the electronic Grievance form on the Medicare.gov Internet Web site on the Contractor's main Web page as required by 42 C.F.R. § 422.504(b)(15)(ii). The Contractor shall inform Enrollees of the email address, postal address, or toll-free telephone number where an Enrollee Grievance may be filed. Authorized representatives may file Grievances on behalf of Enrollees to the extent allowed under applicable federal or State law.

2.13.2.5.2. External Grievances filed with EOHHS shall be entered by the EOHHS contract manager into the CMS Grievances tracking module, which will be accessible to the Contractor.

2.13.3. Enrollee Appeals

2.13.3.1. Initial Appeals (first level internal Appeal) shall be filed with the Contractor.

2.13.3.2. Subsequent Appeals for Medicare A and B services (e.g., Medicare is the primary payer) shall be automatically forwarded to the Medicare Independent Review Entity (IRE) by the Contractor.

2.13.3.3. Subsequent Appeals for services covered by MassHealth only (e.g., Personal Assistance Services, Behavioral Health Diversionary Services, dental services, LTSS, and MassHealth-covered drugs excluded from Medicare Part D) may be Appealed to the MassHealth Board of Hearings (Board of Hearings) after the initial plan-level Appeal has been completed.

2.13.3.4. Appeals for services for which Medicare and Medicaid overlap (including, but not limited to, Home Health, Durable Medical Equipment and skilled therapies, but excluding Part D) shall be auto-forwarded to the IRE by the Contractor, and an Enrollee may also file a request for a hearing with the Board of Hearings. If an Appeal is filed with both the IRE and the Board of Hearings, any

determination in favor of the Enrollee shall bind the Contractor and shall require payment by the Contractor for the service or item in question granted in the Enrollee's favor which is closest to the Enrollee's relief requested on appeal.

- 2.13.3.5. The Contractors shall utilize and all Enrollees may access the existing Medicare Part D Appeals Process. Consistent with existing rules, Part D Appeals will be automatically forwarded to the IRE if the Contractor misses the applicable adjudication timeframe. The Contractor shall maintain written records of all Appeal activities and notify CMS and MassHealth of all internal Appeals.

2.13.4. Internal Appeals

- 2.13.4.1. The Contractor shall maintain written policies and procedures for the filing by Enrollees or Appeals Representatives and the receipt, timely resolution, and documentation by the Contractor of any and all Internal Appeals which shall include, at a minimum, the following, in accordance with 42 CFR 42 §§ 422.629 – 422.634, 438.210, and CFR Part 438, Subpart F. This includes:

- 2.13.4.1.1. A process for making integrated organization determinations (referred to here as “determinations” or “service authorizations”) consistent with §422.631;
- 2.13.4.1.2. Continuation of benefits (“Continuing Services”) while an internal Appeal is pending consistent with §422.632;
- 2.13.4.1.3. A process for making integrated reconsiderations consistent with §422.633 (referred to here as “internal Appeals”); and
- 2.13.4.1.4. A process for effectuation of decisions consistent with §422.634.

2.13.4.2. General Requirements

- 2.13.4.2.1. The Contractor shall put in place a standardized process that includes:
 - 2.13.4.2.1.1. A means for assessing and categorizing the nature and seriousness of an Internal Appeal;
 - 2.13.4.2.1.2. A means for tracking how long the Contractor takes to dispose of or resolve Internal Appeals and to provide notice of such disposition or resolution, as specified in **Section 2.13.4.3 and Section 2.13.4.4** below; and

- 2.13.4.2.1.3. A means for expedited resolution of Internal Appeals, as further specified in **Section 2.13.4.4.1.7**, when the Contractor determines (for a request from the Enrollee) or a Provider indicates (in making the request on the Enrollee's behalf or supporting the Enrollee's request) that taking the time for a standard resolution, in accordance with **Section 2.13.4.4**, could seriously jeopardize the Enrollee's life or health or ability to attain, maintain, or regain maximum function.
- 2.13.4.2.2. The Contractor shall put in a place a mechanism to accept Internal Appeals filed either orally or in writing within 60 calendar days from the notice of Adverse Action specified in **Section 2.13.4.3**, provided that if an Internal Appeal is filed orally, the Contractor shall not require the Enrollee to submit a written, signed Internal Appeal form subsequent to the Enrollee's oral request for an appeal and shall send the Enrollee or Appeal Representative an acknowledgement letter to confirm the facts and basis of the Internal Appeal. Internal Appeals filed later than 60 days from the notice of Adverse Action may be rejected as untimely unless the Enrollee shows good cause why the untimely Internal Appeal should be accepted.
- 2.13.4.2.3. The Contractor shall send a written acknowledgement of the receipt of any Internal Appeal to Enrollees and, if an Appeals Representative filed the Internal Appeal, to the Appeals Representative and the Enrollee within 1 business day of receipt by the Contractor.
- 2.13.4.2.4. The Contractor shall track whether an Internal Appeal was filed orally or in writing within 60 calendar days from the notice of Adverse Action specified in **Section 2.13.4.3**.
- 2.13.4.2.5. The Contractor shall track and report to EOHHS in the form and format specified by EOHHS the status, dates of various actions, and timeliness of all Appeals from receipt of the Internal Appeal through to the most advanced stage of the Appeal, including External Appeals stages when applicable, as well as the decisions at all levels of the Appeal process, notifications for Appeals at all levels, the status of Continuing Services requests and implementation, and the resolution of the Appeal, including implementation of the Appeal decision for the Enrollee.
- 2.13.4.2.6. When making internal Appeal decisions, the Contractor shall apply the definition of Medical Necessity in this Contract and

shall apply the cumulative Medicare and MassHealth requirements for Covered Services for services that overlap between payers, including any resulting expanded amount, duration, and scope, as well as frequency and type criteria.

- 2.13.4.2.7. The Contractor shall provide Continuing Services for all prior approved non-Part D benefits that are terminated or modified pending internal Contractor Appeals, per timeframes in 42 C.F.R. § 438.420. This means that such benefits shall continue to be provided by providers to Enrollees and that the Contractors shall continue to pay providers for providing such services or benefits pending an internal Appeal. The Contractor may not recover the cost of services furnished to Enrollees under this **Section** without prior EOHHS approval of such a policy and provision of advance notice to Enrollees.

2.13.4.3. Notice of Adverse Action/Coverage Decision Letter

- 2.13.4.3.1. In accordance with 42 CFR §438.210, the Contractor shall provide a Coverage Decision Letter to the requesting provider and the Member for any decision by the Contractor to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested.
- 2.13.4.3.2. As a FIDE SNP, the Contractor shall complete and issue a Coverage Decision Letter to Enrollees, when, as a result of an integrated organization determination under 42 CFR §422.631, it reduces, stops, suspends, or denies, in whole, or in part, a request for a service or item (including a Medicare Part B drug) or a request for a payment of a service or item (including a Medicare Part B drug) the Enrollee has already received.
- 2.13.4.3.3. The Contractor shall use the Coverage Decision Letter in place of the Adverse Action or the Notice of Denial of Medical Coverage (or Payment) (NDMCP) form (CMS-10003). The Contractor shall use the template approved by EOHHS for this purpose.
- 2.13.4.3.4. The Contractor shall not send this letter when the request for a service or item is fully covered by the Contractor's One Care Plan, either under the Medicare or Medicaid benefit.
- 2.13.4.3.5. This letter shall not be used for Medicare Part D denials. The provisions of this **Section 2.13.4.3** do not apply to Medicare

Part D denials. For Part D denials, the Contractor shall use form CMS-10146, Notice of Denial of Medicare Prescription Drug Coverage.

- 2.13.4.3.6. The Coverage Decision Letter shall meet the language and format requirements specified in **Section 2.10.9.7**.
- 2.13.4.3.7. At a minimum, and in accordance with 42 CFR §422.631(d)(1), the Coverage Decision Letter shall explain the following Enrollee rights:
 - 2.13.4.3.7.1. The right of the Enrollee to be provided, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the Adverse Action, such as medical necessity criteria and processes, strategies, and standards related to the Adverse Action;
 - 2.13.4.3.7.2. The Enrollee's right to file an Internal Appeal (also referred to as an "integrated reconsideration") or to designate an Appeal Representative to file an Internal Appeal on behalf of the Enrollee, including exhausting the appeal process and right to file an appeal with the Board of Hearings;
 - 2.13.4.3.7.3. That the Contractor shall provide the Enrollee Continuing Services, if applicable, pending resolution of the review of an Internal Appeal if the Enrollee submits the request for the review within 10 days of the Adverse Action; and
 - 2.13.4.3.7.4. That the Contractor shall provide the Enrollee Continuing Services, if applicable, pending resolution of a BOH Appeal if the Enrollee submits the request for the BOH Appeal within 10 days of receipt of notice of the Final Internal Appeal Decision, unless the Enrollee specifically indicates that they do not want to receive Continuing Services.
- 2.13.4.3.8. At a minimum, and in accordance with 42 CFR §422.631(d)(1), the Coverage Decision Letter include the following:
 - 2.13.4.3.8.1. Key contact information, including the health plan name, the plan customer service phone number, the Ombudsman phone number, and any other applicable program phone number;
 - 2.13.4.3.8.2. The applicable integrated plan's determination;

- 2.13.4.3.8.3. The date the determination was made;
- 2.13.4.3.8.4. The date the determination will take effect;
- 2.13.4.3.8.5. The reasons for the determination;
- 2.13.4.3.8.6. The enrollee's right to file an integrated reconsideration and the ability for someone else to file an appeal on the enrollee's behalf;
- 2.13.4.3.8.7. Procedures for exercising enrollee's rights to an integrated reconsideration;
- 2.13.4.3.8.8. Circumstances under which expedited resolution is available and how to request it; and
- 2.13.4.3.8.9. If applicable, the enrollee's rights to have benefits continue pending the resolution of the integrated appeal process.

2.13.4.4. Timing of Notice

- 2.13.4.4.1. In accordance with 42 CFR § 422.631(2), the Contractor shall mail the coverage decision letter within the following timeframes:
 - 2.13.4.4.1.1. In cases where a previously approved service is being reduced, suspended, or terminated, at least fifteen (15) calendar days prior to the date of action, including:
 - 2.13.4.4.1.1.1. Ten (10) calendar days before the date of action (that is, before the date on which a termination, suspension, or reduction becomes effective); and
 - 2.13.4.4.1.1.2. An additional five (5) calendar days for mailing.
 - 2.13.4.4.1.2. In circumstances where an exception is permitted under 42 CFR §§ 431.213 and 431.214, and in accordance with 42 CFR 431.214, the period of advance notice may be shortened to 5 calendar days before the Date of Action if the Contractor has facts indicating that action shall be taken because of probable fraud by the Enrollee and the facts have been verified, if possible, through secondary sources.
 - 2.13.4.4.1.3. For standard service authorization decisions that deny or provide limited authorization for requested services, as specified in **Section 2.10.9**, as expeditiously as the

Enrollee's health condition requires but no later than 14 calendar days following receipt of the service request, unless the timeframe is extended up to 14 additional calendar days.

2.13.4.4.1.4. The Contractor may extend the timeframe for a standard or expedited integrated organization determination by up to fourteen (14) calendar days only if:

2.13.4.4.1.4.1. The Provider, Enrollee, or Appeal Representative requests the extension; or

2.13.4.4.1.4.2. The Contractor can justify (to EOHHS, upon request) that:

2.13.4.4.1.4.2.1. The extension is in the Enrollee's interest; and

2.13.4.4.1.4.2.2. There is a need for additional information where:

2.13.4.4.1.4.2.3. There is a reasonable likelihood that receipt of such information would lead to approval of the request, if received; and

2.13.4.4.1.4.2.4. Such outstanding information is reasonably expected to be received within 14 calendar days.

2.13.4.4.1.5. If the Contractor extends the timeframe, it shall:

2.13.4.4.1.5.1. Give the Enrollee written notice of the reason for the extension as expeditiously as the Enrollee's health condition requires but no later than within 2 calendar days of making the decision to extend the timeframe, and inform the Enrollee of the right to file a Grievance if the Enrollee disagrees with that decision; and

2.13.4.4.1.5.2. Issue and carry out its determination as expeditiously as the Enrollee's health condition requires and no later than the date the extension expires.

2.13.4.4.1.6. For denial of payment where coverage of the requested service is at issue, on the day of the payment denial, except that no notice is necessary for procedural denials of payment where coverage of the requested service is

not at issue, which include, but are not limited to, denials for the following reasons:

- 2.13.4.4.1.6.1. Failure to follow prior authorization procedures;
- 2.13.4.4.1.6.2. Failure to follow referral rules; and
- 2.13.4.4.1.6.3. Failure to file a timely claim.
- 2.13.4.4.1.7. For expedited service authorization decisions that deny or provide limited authorization for requested services, as specified in **Section 2.10.9**, and for expedited requests for determinations, as expeditiously as the Enrollee's health requires but no later than 72 hours after the receipt of the expedited request for service.
- 2.13.4.4.1.8. If the Contractor denies the request for expedited authorization or determination, the Contractor shall:
 - 2.13.4.4.1.8.1. Automatically transfer the request to the standard timeframe and make the determination within the 14-day timeframe set forth in **Section 2.13.4.4.1.3**. The 14-day period begins with the day the Contractor receives the request for expedited determination.
 - 2.13.4.4.1.8.2. Give the Enrollee prompt oral notice of the denial and transfer and subsequently deliver, within 3 calendar days, a written notice that:
 - 2.13.4.4.1.8.2.1. Explains that the contractor shall process the request using the 14-day timeframe for standard determinations,
 - 2.13.4.4.1.8.2.2. Informs the Enrollee of the right to file an expedited Grievance if the Enrollee disagrees with the decision not to expedite,
 - 2.13.4.4.1.8.2.3. Informs the Enrollee for the right to resubmit a request for an expedited determination with any physician's support, and
 - 2.13.4.4.1.8.2.4. Provides instructions about the Grievance process and its timeframes.
- 2.13.4.4.1.9. If the Contractor must receive medical information from non-contracted providers, the Contractor shall request the necessary information from the non-contracted

provider within twenty-four (24) hours of the initial request for an expedited determination. Non-contracted providers must make reasonable and diligent efforts to expeditiously gather and forward all necessary information to assist the Contractor in meeting the required timeframe. Regardless of whether the Contractor must request information from non-contracted providers, the Contractor is responsible for meeting the timeframe and notice requirements of this **Section**.

2.13.4.4.1.10. The Contractor may extend the timeframe for an expedited Service Authorization Request up to 14 additional calendar days. Such extension shall be implemented as follows:

2.13.4.4.1.10.1. The extension shall only be allowed if:

2.13.4.4.1.10.1.1. The Provider, Enrollee or Appeal Representative requests the extension; or

2.13.4.4.1.10.1.2. The Contractor can justify (to EOHHS, upon request);

2.13.4.4.1.10.1.2.1. The extension is in the Enrollee's interest; and

2.13.4.4.1.10.1.2.2. There is a need for additional information where:

2.13.4.4.1.10.1.2.2.1 There is a reasonable likelihood that receipt of such information would lead to approval of the request, if received; and

2.13.4.4.1.10.1.2.2.1 Such outstanding information is reasonably expected to be received within 14 calendar days.

2.13.4.4.1.10.2. If the Contractor extends the timeframe, it shall do the following:

2.13.4.4.1.10.2.1. Give the Enrollee written notice of the reason for the extension as expeditiously as the Enrollee's health condition requires, but no later than the expiration of the extension, and inform the Enrollee of the right to file a

Grievance if the Enrollee disagrees with that decision, and

2.13.4.4.1.10.2.2. Issue and carry out its determination as expeditiously as the Enrollee's health condition requires and no later than the date the extension expires.

2.13.4.4.2. For standard or expedited service authorization decisions not reached within the timeframes specified in **Section 2.10.9** on the day that such timeframes expire.

2.13.4.4.3. When the Contractor fails to provide services in a timely manner in accordance with the access standards in **Section 2.10.9**, within one business day upon notification by the Enrollee or Provider that one of the access standards in **Section 2.10.9** was not met.

2.13.5. External Appeals

2.13.5.1. CMS Independent Review Entity

2.13.5.1.1. If on internal Appeal the Contractor does not decide fully in the Enrollee's favor and the Appeal is regarding a Medicare covered service, within the relevant time frame, the Contractor shall, in accordance with CMS guidelines, prepare a written explanation and forward the case file to the CMS Independent Review Entity, contracted by CMS, for a new and impartial review within the following timeframes:

2.13.5.1.1.1. For standard internal Appeals, as expeditiously as the Enrollee's health condition requires, but no later than 30 calendar days from the date it received the internal Appeal (or the end of an extension pursuant to **Section 2.13.4**, and

2.13.5.1.1.2. For expedited internal Appeals, as expeditiously as the Enrollee's health condition requires, but no later than twenty-four (24) hours of its affirmation (or the end of an extension) pursuant to **Section 2.13.4**.

2.13.5.1.2. The Contractor shall make reasonable and diligent efforts to assist in gathering and forwarding information to the CMS Independent Review Entity.

2.13.5.1.3. For standard external Appeals, the CMS Independent Review Entity will send the Enrollee and the Contractor a letter with its decision within 30 calendar days after it

receives the case from the Contractor, or at the end of up to a 14 calendar day extension.

- 2.13.5.1.4. If the CMS Independent Review Entity decides in the Enrollee's favor and reverses the Contractor's decision, the Contractor shall authorize the service under dispute within 72 hours from the date the Contractor receives the review entity's notice reversing the Contractor's decision or provide the service under dispute as expeditiously as the Enrollee's health condition requires, but no later than 14 calendar days from the date of the notice.
- 2.13.5.1.5. For expedited external Appeals, the CMS Independent Review Entity will send the Enrollee and the Contractor a letter with its decision within 72 hours after it receives the case from the Contractor, or at the end of up to a 14 calendar day extension.
- 2.13.5.1.6. If the CMS Independent Review Entity decides in the Enrollee's favor, the Contractor shall authorize or provide the service under dispute as expeditiously as the Enrollee's health condition requires but no later than 72 hours from the date the Contractor receives the notice reversing the decision. If the CMS Independent Review Entity reverses an Action to deny, limit, or delay services, and the Enrollee received such services while the appeal was pending, the Contractor shall pay for such services.
- 2.13.5.1.7. If the Contractor or the Enrollee disagrees with the CMS Independent Review Entity's decision, further levels of Appeal are available, including a hearing before an Administrative Law Judge, a review by the Departmental Appeals Board, and judicial review. The Contractor shall comply with any requests for information or participation from such further Appeal entities.

2.13.5.2. Board of Hearings

- 2.13.5.2.1. If, on internal appeal, the Contractor does not decide fully in the Enrollee's favor, and the Appeal concerns a Medicaid covered service, The Contractor shall:
 - 2.13.5.2.1.1. Require Enrollees and their Appeal Representatives to exhaust the Contractor's Internal Appeals process before filing an appeal with the Board of Hearings (BOH). The exhaustion requirement is satisfied if either of the following conditions is met:

- 2.13.5.2.1.1.1. The Contractor has issued a decision following its review of the Adverse Action; or
- 2.13.5.2.1.1.2. The Contractor fails to act within the timeframes for reviewing Internal Appeals or fail to satisfy applicable notice requirements.
- 2.13.5.2.1.2. Include with any notice following the resolution of a standard Internal Appeal or an expedited Internal Appeal, as specified in **Section 2.13.4**, any and all instructive materials and forms provided to the Contractor by EOHHS that are required for the Enrollee to request a BOH Appeal; and
- 2.13.5.2.1.3. Notify Enrollees that:
 - 2.13.5.2.1.3.1. Any Continuing Services being provided by the Contractor that are the subject of a BOH Appeal will continue, unless the Enrollee specifically indicates that they do not want to receive Continuing Services; and
 - 2.13.5.2.1.3.2. It is the Enrollee's or the Appeal Representative's responsibility to submit any request for a BOH Appeal to the BOH and to ensure that the BOH receives the request within the time limits, as specified in 130 CMR 610.015(B)(7), specifically:
 - 2.13.5.2.1.3.2.1. 120 days after the Enrollee's receipt of the Contractor's Final Internal Appeal Decision where the Contractor has reached a decision wholly or partially adverse to the Enrollee, provided, however, that if the Contractor did not resolve the Enrollee's Internal Appeal within the time frames specified in this Contract and described by 130 CMR 508.010(A), 120 days after the date on which the time frame for resolving that Internal Appeal has expired; and
 - 2.13.5.2.1.3.2.2. For all BOH Appeals in which the Enrollee wants Continuing Services that are the subject of the BOH Appeal, such request must be submitted within 10 calendar days after the notice following the Internal Appeal, as specified in **Section 2.13.4.2.3**.

- 2.13.5.2.1.4. Be a party to the BOH Appeal, along with the Enrollee and their representative or the representative of a deceased Enrollee's estate.

2.13.6. Additional Requirements

- 2.13.6.1. If the Contractor or the Enrollee disagrees with the BOH decision, further levels of appeal are available, including judicial review of the decision under M.G.L. c. 30A. At the direction of EOHHS, the Contractor shall be a party to the Board of Hearings Appeal and any subsequent actions and further levels on the Appeal, along with the Enrollee and their representative or the representative of a deceased Enrollee's estate. The Contractor shall comply with any final decision upon judicial review.
- 2.13.6.2. The Contractor shall designate an Appeal coordinator to act as a liaison between the Contractor and Board of Hearings.
- 2.13.6.3. If an Appeal is filed with both the IRE and the Board of Hearings, any determination in favor of the Enrollee will bind the Contractor and will require payment by the Contractor for the service or item in question granted in the Enrollee's favor which is closest to the Enrollee's relief requested on Appeal.
- 2.13.6.4. The Contractor shall:
 - 2.13.6.4.1. For all Final Internal Appeal Decisions upholding an Adverse Action, in whole or in part, the Contractor shall provide EOHHS upon request, within one business day of issuing the decision, with a copy of the decision sent to the Enrollee and Appeal Representative, as well as all other materials associated with such Appeal, to assist in EOHHS's review of the Contractor's determination. This requirement shall also apply to situations when the Contractor fails to act within the timeframes for reviewing Internal Appeals. EOHHS may consult with other state agencies in its review of the Contractor's decision;
 - 2.13.6.4.2. Upon learning of a hearing scheduled on a BOH Appeal concerning such a Final Internal Appeal Decision, notify EOHHS immediately and include the names of the Contractor's clinical and other staff who will be attending the BOH hearing,;
 - 2.13.6.4.3. Comply with any EOHHS directive to reevaluate the basis for its decision in a manner that is consistent with EOHHS's interpretation of any statute, regulation, and contractual provisions that relates to the decision;

- 2.13.6.4.4. Submit all applicable documentation to the BOH, EOHHS, the Enrollee and the designated Appeal Representative, if any, within 5 business days prior to the date of the hearing, or if the BOH Appeal is expedited, within 1 business day of being notified by the BOH of the date of the hearing. Applicable documentation shall include, but not be limited to, a copy of the notice of Adverse Action, any documents relied upon by the Contractor in rendering the decision resolving the Internal Appeal, and any and all documents that will be relied upon at hearing;
- 2.13.6.4.5. Make best efforts to ensure that a Provider, acting as an Appeal Representative, submits all applicable documentation to the BOH, the Enrollee and the Contractor within 5 business days prior to the date of the hearing, or if the BOH Appeal is expedited, within 1 business day of being notified by the BOH of the date of the hearing. Applicable documentation shall include, but not be limited to, any and all documents that will be relied upon at the hearing,
- 2.13.6.4.6. Comply with and implement the decisions of the BOH;
- 2.13.6.4.7. In the event that the Enrollee appeals a decision of the BOH, comply with and implement the decisions of any court of competent jurisdiction; and
- 2.13.6.4.8. Designate an Appeals Coordinator to act as a liaison between EOHHS and the BOH to:
 - 2.13.6.4.8.1. Determine whether each Enrollee who requests a BOH Appeal has exhausted the Contractor's Internal Appeals process, in accordance with **Section 2.13.4**;
 - 2.13.6.4.8.2. If requested by the Enrollee, assist the Enrollee with completing a request for a BOH Appeal;
 - 2.13.6.4.8.3. Receive notice from the BOH that an Enrollee has requested a BOH Appeal, immediately notify EOHHS, and track the status of all pending BOH Appeals;
 - 2.13.6.4.8.4. Ensure that Continuing Services are provided when informed by the BOH that a request for a BOH Appeal was timely received, unless the Enrollee specifically indicates that they do not want to receive Continuing Service;
 - 2.13.6.4.8.5. Instruct Enrollees for whom an Adjustment has been made about the process of informing the BOH in writing

of all Adjustments and, upon request, assist the Enrollee with this requirement, as needed;

- 2.13.6.4.8.6. Ensure that the case folder and/or pertinent data screens are physically present at each hearing;
 - 2.13.6.4.8.7. Ensure that appropriate Contractor staff attend BOH hearings;
 - 2.13.6.4.8.8. Coordinate with BOH requests to reschedule hearings and ensure that the Contractor only requests that hearings be rescheduled for good cause;
 - 2.13.6.4.8.9. Upon notification by BOH of a decision, notify EOHHS immediately;
 - 2.13.6.4.8.10. Ensure that the Contractor implements BOH decisions upon receipt;
 - 2.13.6.4.8.11. Report to EOHHS within 30 calendar days of receipt of the BOH decision that such decision was implemented;
 - 2.13.6.4.8.12. Coordinate with the BOH, as directed by EOHHS; and
 - 2.13.6.4.8.13. Ensure that appropriate Contractor staff attend BOH Appeals training sessions organized by EOHHS.
- 2.13.6.4.9. Provide information about the Contractor's grievances and appeals policies to all Providers and Material Subcontractors at the time the Contractor and these entities enter into a contract; and
- 2.13.6.4.10. Maintain records of Grievances and Appeals in a manner accessible to EOHHS, available to CMS upon request, and that contain, at a minimum, the following information:
- 2.13.6.4.10.1. A general description of the reason for the Appeal or Grievance;
 - 2.13.6.4.10.2. The date received, the date of each review, and, if applicable, the date of each review meeting;
 - 2.13.6.4.10.3. Resolution of the Appeal or Grievance, and date of resolution; and
 - 2.13.6.4.10.4. Name of the Enrollee for whom the Appeal or Grievance was filed.

2.13.7. Continuing Services

2.13.7.1. The Contractor shall:

- 2.13.7.1.1. Comply with the provisions of 42 CFR 422.632 and 42 CFR 438.420 and, in addition, provide Continuing Services while an Internal Appeal is pending and while a BOH Appeal is pending, unless the Enrollee specifically indicates that they do not want to receive Continuing Services, when the appeal involves the reduction, suspension, or termination of a previously authorized service.
- 2.13.7.1.2. Provide Continuing Services until one of the following occurs:
 - 2.13.7.1.2.1. The Enrollee withdraws the Internal Appeal or BOH Appeal; or
 - 2.13.7.1.2.2. The BOH issues a decision adverse to the Enrollee.
 - 2.13.7.1.2.3. For Appeals involving Medicaid benefits:
 - 2.13.7.1.2.3.1. The Enrollee does not request a BOH Appeal in a timely fashion;
 - 2.13.7.1.2.3.2. The Enrollee withdraws the BOH Appeal; or
 - 2.13.7.1.2.3.3. The BOH issues a decision adverse to the Enrollee.
- 2.13.7.1.3. If the Contractor or BOH reverses an Adverse Action to deny, limit, or delay services that were not furnished while the Internal Appeal or BOH Appeal were pending, the Contractor shall authorize or provide the disputed services promptly, and as expeditiously as the Enrollee's health condition requires but no later than 72 hours from the date it receives notice reversing the determination.
- 2.13.7.1.4. If the Contractor or BOH reverses an Adverse Action to deny, limit, or delay services and the Enrollee received Continuing Services while the Internal Appeal or BOH Appeal were pending, the Contractor shall pay for such services.
- 2.13.7.1.5. If the Contractor or BOH upholds an Adverse Action to deny, limit, or delay services:

2.13.7.1.5.1. The Contractor may not pursue recovery for costs of services furnished by the Contractor pending the internal Appeal, to the extent that the services were furnished solely under the requirements of this **Section**.

2.13.7.1.5.2. If, after the internal Appeal decision is final, an Enrollee requests that Medicaid services continue through a BOH Appeal, state rules on recovery of costs, in accordance with the requirements of § 438.420(d) of this chapter, apply for costs incurred for services furnished pending appeal subsequent to the date of the integrated reconsideration decision. The Contractor may not recover the cost of services furnished to Enrollees during an external Appeal without prior EOHHS approval of such a policy and provision of advance notice to Enrollees.

2.13.8. Discharge Appeals

2.13.8.1. Hospital Discharge Appeals

2.13.8.1.1. When a Dual Eligible Enrollee is being discharged from the hospital, the Contractor shall assure that the Enrollee receives a written notice of explanation required by 42 CFR §§ 422.620-622.

2.13.8.1.2. The Enrollee has the right to request a review of any hospital discharge notice by a Quality Improvement Organization (QIO). The notice includes information on filing the QIO Appeal. Such a request shall be made by noon of the first workday after the receipt of the notice.

2.13.8.1.3. If the Enrollee asks for immediate review by the QIO, the Enrollee will be entitled to this process instead of the standard Appeals process described above. Note: An Enrollee may file an oral or written request for an expedited 72-hour Contractor Appeal if the Enrollee has missed the deadline for requesting the QIO review.

2.13.8.1.4. The QIO will make its decision within one full working day after it receives the Enrollee's request, medical records, and any other information it needs to make its decision.

2.13.8.1.5. If the QIO agrees with the Contractor's decision, the Contractor is not responsible for paying the cost of the hospital stay beginning at noon of the calendar following the day the QIO notifies the Enrollee of its decision.

- 2.13.8.1.6. If the QIO overturns the Contractor's decision, the Contractor shall pay for the remainder of the hospital stay.

2.13.8.2. Other Discharge Appeals

- 2.13.8.2.1. The Contractor shall comply with the termination of services Appeal requirements for individuals receiving services from a comprehensive outpatient rehabilitation facility, skilled nursing facilities, or home health agency at 42 C.F.R. §§ 422.624 and 422.626.

2.14. Quality Management

2.14.1. Quality Improvement (QI) Program

- 2.14.1.1. Deliver quality care that enables Enrollees to stay healthy, get better, manage chronic illnesses and/or disabilities, maintain their independence in the community, and maintain/improve their quality of life. Quality care refers to:
 - 2.14.1.1.1. Clinical quality of physical health care, including primary and specialty care;
 - 2.14.1.1.2. Clinical quality of mental health care focused on recovery, resiliency, and rehabilitation;
 - 2.14.1.1.3. Clinical quality of substance use disorder treatment focused on intervention, treatment, recovery, resiliency and rehabilitation;
 - 2.14.1.1.4. Quality of LTSS;
 - 2.14.1.1.5. Quality of oral health care;
 - 2.14.1.1.6. Adequate access and availability to primary, mental health care, substance use disorder treatment, specialty health care, oral health care, pharmacy, and LTSS providers and services;
 - 2.14.1.1.7. Continuity and coordination of care across all care and service settings, and for transitions in care; and
 - 2.14.1.1.8. Enrollee experience with respect to clinical quality, access, and availability of high quality, coordinated, culturally and linguistically competent health care and services, inclusive of LTSS across the care continuum, as well as continuity and coordination of care.

- 2.14.1.2. Apply the principles of continuous quality improvement (CQI) to all aspects of the Contractor's service delivery system through ongoing analysis, evaluation and systematic enhancements based on:
 - 2.14.1.2.1. Quantitative and qualitative data collection and data--driven decision--making;
 - 2.14.1.2.2. Up-to-date evidence--based practice guidelines and explicit criteria developed by recognized sources or appropriately certified professionals or, where evidence--based practice guidelines do not exist, consensus of professionals in the field;
 - 2.14.1.2.3. Feedback provided by Enrollees and Network Providers in the design, planning, and implementation of its Continuous Quality Improvement activities; and
 - 2.14.1.2.4. Issues identified by the Contractor and/or EOHHS.
- 2.14.1.3. Ensure that the QI requirements of this Contract are applied to the delivery of primary and specialty health care services, Behavioral Health Services, community--based services, and LTSS.
- 2.14.2. QI Program Structure
 - 2.14.2.1. The Contractor shall maintain a well-defined QI organizational and program structure that supports the application of the principles of CQI to all aspects of the Contractor's service delivery system. The 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 QI organizational and program structure shall comply with all applicable provisions of 42 C.F.R. § 438, including Subpart E, Quality Measurement and Improvement, and shall meet the quality management and improvement criteria described in the most current NCQA Health Plan Accreditation Requirements.
 - 2.14.2.2. The Contractor shall:
 - 2.14.2.2.1. Establish a clearly defined set of QI functions and responsibilities that are proportionate to, and adequate for, the planned number and types of QI initiatives and for the completion on Quality Improvement initiatives in a competent and timely manner;
 - 2.14.2.2.2. Ensure that such 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, Continuous Quality Improvement to all clinical and non-clinical aspects of the Contractor's service delivery system; and

- 2.14.2.2.3. Establish internal processes to ensure that the QM activities for Physical Health Services, Behavioral Health Services, Specialty, community--based services, and LTSS reflect utilization across the Network and include all of the activities in this **Section 2.14** of this Contract and, in addition, the following elements:
 - 2.14.2.2.3.1. A process to utilize Healthcare Plan Effectiveness Data and Information Set (HEDIS) and non-HEDIS quality measure results, including Member experience data, in designing QI activities.
 - 2.14.2.2.3.2. 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 HEDIS and non-HEDIS quality measure results to identify disparities and address Health Equity.
 - 2.14.2.2.3.3. A process to utilize HEDIS and non-HEDIS quality measure performance data, including as stratified for the identification of health inequities and to inform design of QM/QI activities to address Health Equity.
 - 2.14.2.2.3.4. A medical record review process for monitoring Provider Network compliance with policies and procedures, specifications, and appropriateness of care. Such process shall include the sampling method used, which shall be proportionate to utilization by service type. The Contractor shall submit its process for medical record reviews and the results of its medical record reviews to EOHHS upon request;
 - 2.14.2.2.3.5. A process to measure Network Providers and Enrollees, at least annually, regarding their satisfaction with the Contractor's Plan. The Contractor shall submit the survey plan to EOHHS for approval and shall submit the results of the survey to EOHHS;

- 2.14.2.2.3.6. A process to measure clinical reviewer consistency in applying Clinical Criteria to Utilization Management activities, using inter-rater reliability measures;
 - 2.14.2.2.3.7. A process for including Enrollees and their families in Quality Management activities, as evidenced by participation in the Consumer Advisory Board; and
 - 2.14.2.2.3.8. In collaboration with and as further directed by EOHHS, develop a customized medical record review process to monitor the assessment for and provision of LTSS, including the assessment of care between settings and a comparison of services and supports received with those in the Enrollee's Individualized Care Plan.
- 2.14.2.2.4. Have in place, and submit to EOHHS annually, a written description of the QI Program that delineates the structure, goals, and objectives of the Contractor's QI initiatives. Changes from a prior year shall be clear in the annual submission. Such description shall:
- 2.14.2.2.4.1. Address all aspects of health care quality improvement including but not limited to specific reference to mental health care, substance use disorder treatment, oral health and to LTSS, with respect to monitoring and improvement efforts, and integration with physical health care;
 - 2.14.2.2.4.2. Address Health Related Social Needs and Health Equity;
 - 2.14.2.2.4.3. Identify the resources dedicated to the QI program, including staff, or data sources, and analytic programs or IT systems;
 - 2.14.2.2.4.4. Address the roles of designated physician(s), behavioral health clinician(s), community--based service providers, and LTSS providers with respect to the QI program; and
 - 2.14.2.2.4.5. Include organization -wide policies and procedures that document processes through which the Contractor ensures clinical quality, access and availability of health care and services, and continuity and coordination of care. Such processes shall include, but not be limited to, Appeals and Grievances and Utilization Management.
- 2.14.2.2.5. Submit to EOHHS an annual QI Work Plan that broadly describes the Contractor's annual QI activities under its QI program, in accordance with **Appendix B**, and that includes

the following components or other components as directed by EOHHS:

- 2.14.2.2.5.1. Planned clinical and non-clinical initiatives;
 - 2.14.2.2.5.2. The objectives for planned clinical and non-clinical initiatives;
 - 2.14.2.2.5.3. The short- and long--term time frames within which each clinical and non-clinical initiative's objectives are to be achieved;
 - 2.14.2.2.5.4. The individual(s) responsible for each clinical and non-clinical initiative;
 - 2.14.2.2.5.5. Any issues identified by the Contractor, EOHHS, Enrollees, and providers, and how those issues will be tracked and resolved over time;
 - 2.14.2.2.5.6. The evaluations of clinical and non-clinical initiatives, including Provider profiling activities as described in **Section 2.9.9** and the results of Network Provider satisfaction surveys as described in **Section 2.14.2.2.3.5**; and
 - 2.14.2.2.5.7. Process for correcting deficiencies.
- 2.14.2.2.6. Evaluate the results of QI initiatives at least annually and submit the results of the evaluation to the EOHHS QM manager. The evaluation of the QI program initiatives shall include, but not be limited to, the results of activities that demonstrate the Contractor's assessment of the quality of physical and behavioral health care rendered, the effectiveness of LTSS services, initiatives related to health-related social need or health equity, as well as accomplishments and compliance and/or deficiencies in meeting the previous year's QI Strategic Work Plan; and
 - 2.14.2.2.7. Maintain sufficient and qualified staff employed by the Contractor to manage the QI activities required under the Contract, and establish minimum employment standards and requirements (e.g., education, training, and experience) for employees who will be responsible for QM. QI staff shall include:
 - 2.14.2.2.7.1. At least one designated physician, who shall be a medical director or associate medical director, at least one designated behavioral health clinician, and a

professional with expertise in the assessment and delivery of long-term services and supports with substantial involvement in the QI program;

2.14.2.2.7.2. A qualified individual to serve as the QI Director who will be directly accountable to the Contractor's contract manager or equivalent position and has direct access to the Plan's executive leadership team. This individual shall be responsible for:

2.14.2.2.7.2.1. Overseeing all QI activities related to Enrollees, ensuring compliance with all such activities, and maintaining accountability for the execution of, and performance in, all such activities;

2.14.2.2.7.2.2. Maintaining an active role in the Contractor's overall QI structure;

2.14.2.2.7.2.3. Ensuring the availability of staff with appropriate expertise in all areas, as necessary for the execution of QI activities including, but not limited to, the following:

2.14.2.2.7.2.3.1. Physical and behavioral health care;

2.14.2.2.7.2.3.2. Pharmacy management;

2.14.2.2.7.2.3.3. Care management;

2.14.2.2.7.2.3.4. LTSS;

2.14.2.2.7.2.3.5. Financial;

2.14.2.2.7.2.3.6. Statistical/analytical;

2.14.2.2.7.2.3.7. Information systems;

2.14.2.2.7.2.3.8. Marketing, publications;

2.14.2.2.7.2.3.9. Enrollment; and

2.14.2.2.7.2.3.10. Operations management.

2.14.2.2.7.2.4. Actively participating in, or assigning staff to actively participate in, QI workgroups and other meetings, including any quality management workgroups or activities that may be facilitated by EOHHS, or an EOHHS Contractor, that may be

attended by representatives of EOHHS, an EOHHS Contractor, MassHealth--contracted One Care Plans, and other entities, as appropriate; and

- 2.14.2.2.7.2.5. Serving as liaison to, and maintain regular communication with, EOHHS QI representatives. Responsibilities shall include, but are not limited to, promptly responding to requests for information and/or data relevant to all QI activities.

2.14.3. QI Activities

2.14.3.1. Performance Measurement and Improvement Projects

- 2.14.3.1.1. The Contractor shall engage in performance measurement and performance improvement projects, designed to achieve, through ongoing measurement and intervention, significant improvements, sustained over time, in clinical care and non-clinical care processes, outcomes and Enrollee experience. The Contractor's QI program shall include a health information system to collect, analyze, and report quality performance data as described in 42 CFR 438.242(a) and (b).
- 2.14.3.1.2. As further specified by EOHHS, the Contractor shall report the results of, or submit to EOHHS data which enables EOHHS to calculate, 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). At the direction of EOHHS, the Contractor shall support health Equity initiatives through the stratification of select performance measure or the submission of data elements, which may include, but shall not be limited to, factors such as race, ethnicity, language, disability, status, age, sexual orientation, gender identity, and Health Related Social Needs.
- 2.14.3.1.3. EOHHS may, at its discretion and at any time, identify certain thresholds for Performance Measures or stratified measures which the Contractor shall meet, and the Contractor shall work with EOHHS on such thresholds upon EOHHS' request. If EOHHS requests further information about the Contractor's performance on such measures, the Contractor shall discuss such performance, and upon request, provide EOHHS with an analysis explaining the Contractor's performance.

- 2.14.3.1.4. Upon request, the Contractor shall submit an improvement plan to EOHHS. The Contractor shall implement, as approved by EOHHS, a concrete plan for improving its performance. The Contractor shall demonstrate how the contractor shall utilize Performance Measure results or stratified measures in designing ongoing QM/QI initiatives to measure, monitor, and improve quality and Health Equity.

2.14.3.2. Member Experience Surveys (MES)

- 2.14.3.2.1. The Contractor shall contribute to and participate in all EOHHS Member experience survey activities, as directed by EOHHS.
- 2.14.3.2.2. In accordance with 42 CFR 438.330 (c), Contractor shall collect (or assist EOHHS in the collecting) and submit to EOHHS, or EOHHS' designee, in a timely manner, Member experience survey results. The Contractor shall administer and submit annually to EOHHS the results from the Medicare Advantage Prescription Drug Consumer Assessment of Healthcare Providers and Systems (MA PD CAHPS) conducted by an approved CAHPS vendor, including the results of any Supplemental Questions as required by EOHHS, as specified in **Appendix A**.
- 2.14.3.2.3. As directed by EOHHS, the Contractor shall conduct the HCBS Experience survey for Enrollees utilizing LTSS during the prior calendar year. This shall require that individuals conducting such survey are appropriately and comprehensively trained, culturally competent, and knowledgeable of the population being surveyed.
- 2.14.3.2.4. As directed by EOHHS, the Contractor shall conduct a quality-of-life survey adapted for general populations. This survey may be self-administered or administered by a trained interviewer.
- 2.14.3.2.5. As directed by EOHHS, the Contractor shall contribute to data quality assurance processes, including responding, in a timely manner, to data quality inadequacies identified by EOHHS and rectifying those inadequacies, as directed by EOHHS.
- 2.14.3.2.6. Contractor shall contribute, as directed by EOHHS, to processes culminating in the development of an annual report by EOHHS regarding the individual and aggregate

MES performance of MassHealth-contracted One Care Plans.

2.14.3.2.7. The Contractor shall demonstrate best efforts to utilize Member experience survey results in designing QI initiatives.

2.14.3.2.8. All measurement activities and reporting shall be conducted such that the resulting data and information is specific and exclusive to the population served under this Contract.

2.14.3.3. Quality Improvement Project Requirements

2.14.3.3.1. The Contractor shall implement and adhere to all processes relating to the Quality Improvement Project requirements, as directed by EOHHS and as specified in **Appendix L**, as follows:

2.14.3.3.1.1. In accordance with 42 C.F.R. §438.330 (d), collect information and data in accordance with Quality Improvement project requirements for its Enrollees.

2.14.3.3.1.2. Implement well-designed, innovative, targeted, and measurable quality improvement interventions, in a culturally and linguistically competent manner, to achieve objectives as specified in **Appendix L**;

2.14.3.3.1.3. Evaluate the effectiveness of quality improvement interventions incorporating specified targets and measures for performance;

2.14.3.3.1.4. Plan and initiate processes to sustain achievements and continue improvements;

2.14.3.3.1.5. Submit to EOHHS comprehensive written reports, using the format, submission guidelines, and frequency specified by EOHHS, and in accordance with **Appendix A** and **Appendix L**. Such reports shall include information regarding progress on Quality Improvement goals, barriers encountered, and new knowledge gained. As directed by EOHHS, the Contractor shall present this information to EOHHS at the end of the quality improvement project cycle as determined; and

2.14.3.3.1.6. Participate in efforts by the State to prevent, detect, and remediate critical incidents (consistent with assuring beneficiary health and welfare pursuant to 42 C.F.R §§ 441.302 and 441.730(a)) that are based, at a minimum,

on the requirements on the State for HCBS waiver programs under 42 C.F.R. § 441.302(h).

2.14.4. External Quality Review (EQR) Activities

2.14.4.1. 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 C.F.R. Part 438.358. EQR Activities shall include, but are not limited to:

2.14.4.1.1. Annual validation of performance measures reported to EOHHS, as directed by EOHHS, or calculated by EOHHS;

2.14.4.1.2. Annual validation of performance improvement projects required by EOHHS;

2.14.4.1.3. At least once every three years, review of compliance with standards mandated by 42 C.F.R. Part 438, Subpart D, and at the direction of EOHHS, regarding access, structure and operations, and quality of care and services furnished to Enrollees; and

2.14.4.1.4. Annual validation of network adequacy during the preceding 12 months.

2.14.4.2. The Contractor shall take all steps necessary to support the EQRO in conducting EQR Activities including, but not limited to:

2.14.4.2.1. Designating a qualified individual to serve as Project Director for each EQR Activity who shall, at a minimum:

2.14.4.2.1.1. Oversee and be accountable for compliance with all aspects of the EQR activity;

2.14.4.2.1.2. 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;

2.14.4.2.1.3. Serve as the liaison to the EQRO, EOHHS and answer questions or coordinate responses to questions from the EQRO and EOHHS in a timely manner; and

2.14.4.2.1.4. 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.

- 2.14.4.2.2. Maintaining data and other documentation necessary for completion of EQR Activities specified above for a minimum of seven years;
- 2.14.4.2.3. 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;
- 2.14.4.2.4. Participating in--meetings relating to the EQR process, EQR findings, and/or EQR trainings with the EQRO and EOHHS;
- 2.14.4.2.5. 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
- 2.14.4.2.6. Participating in any other activities deemed necessary by the EQRO and approved by EOHHS.

2.14.5. QI for Utilization Management Activities

- 2.14.5.1. The Contractor shall utilize QI to ensure that it maintains a well-structured utilization management (UM) program that supports the application of fair, impartial and consistent UM determinations and shall address findings regarding underutilization and overutilization of services. The QI activities for the UM Program shall include:
 - 2.14.5.1.1. Assurance that such UM mechanisms do not provide incentives for those responsible for conducting UM activities to deny, limit, or discontinue Medically Necessary Services;
 - 2.14.5.1.2. At least one designated senior physician, who may be a medical director, associate medical director, or other practitioner assigned to this task, at least one designated Behavioral Health practitioner, who may be a medical director, associate medical director, or other practitioner assigned to this task, and a professional with expertise in the assessment and delivery of Long-term Services and Supports representative of the Contractor or Material Subcontractor, with substantial involvement in the UM program; and
 - 2.14.5.1.3. A written document that delineates the structure, goals, and objectives of the UM program and that describes how the Contractor utilizes QI processes to support its UM program. Such document may be included in the QI description, or in

a separate document, and shall address how the UM program fits within the QI structure, including how the Contractor collects UM information and uses it for QI activities.

2.14.6. Clinical Practice Guidelines

2.14.6.1. The Contractor shall:

2.14.6.1.1. Adopt, disseminate, and monitor the use of clinical practice guidelines relevant to Enrollees that:

2.14.6.1.1.1. Are based on valid and reliable clinical evidence or a consensus of health care professionals in the relevant field, or professionals with expertise in the assessment and delivery of long--term services and supports in the relevant field, community--based support services or the Contractor's approved behavioral health performance specifications and Clinical Criteria;

2.14.6.1.1.2. Consider the needs of Enrollees;

2.14.6.1.1.3. Stem from recognized organizations that develop or promulgate evidence--based clinical practice guidelines, or are developed with involvement of board--certified providers from appropriate specialties or professionals with expertise in the assessment and delivery of long--term services and supports;

2.14.6.1.1.4. Do not contradict existing Massachusetts-promulgated guidelines as published by the Department of Public Health, the Department of Mental Health, or other State agencies;

2.14.6.1.1.5. Prior to adoption, have been reviewed by the Contractor's Medical Director, as well as other One Care Plan practitioners and Network Providers, as appropriate; and

2.14.6.1.1.6. Are reviewed and updated, as appropriate, or at least every two (2) years.

2.14.6.1.2. Guidelines shall be reviewed and revised, as appropriate based on changes in national guidelines, or changes in valid and reliable clinical evidence, or consensus of health care and LTSS professionals and providers;

- 2.14.6.1.3. For guidelines that have been in effect two years or longer, the Contractor shall document that the guidelines were reviewed with appropriate practitioner involvement, and were updated accordingly;
- 2.14.6.1.4. Disseminate, in a timely manner, the clinical guidelines to all new Network Providers, to all affected providers, upon adoption and revision, and, upon request, to Enrollees and Eligible Beneficiaries. The Contractor shall make the clinical and practice guidelines available via the Contractor's Web site. The Contractor shall notify providers of the availability and location of the guidelines, and shall notify providers whenever changes are made;
- 2.14.6.1.5. Establish explicit processes for monitoring the consistent application of clinical and practice guidelines across Utilization Management decisions and Enrollee education; and
- 2.14.6.1.6. Submit to EOHHS a listing and description of clinical guidelines adopted, endorsed, disseminated, and utilized by the Contractor, upon request.

2.14.7. QI Workgroups

- 2.14.7.1. As directed by EOHHS, the Contractor shall actively participate in QI workgroups that are led by EOHHS, including any Quality Management workgroups or activities, attended by representatives of EOHHS, One Care Plans, and other entities, as appropriate, and that are designed to support QI activities and to provide a forum for discussing relevant issues. Participation may involve contributing to QI initiatives identified and/or developed collaboratively by the workgroup.

2.14.7.2. Healthcare Plan Effectiveness Data and Information Set (HEDIS)

- 2.14.7.2.1. The Contractor shall collect annual HEDIS data and contribute to all HEDIS related processes, as directed by EOHHS, and as follows:
 - 2.14.7.2.1.1. Provide EOHHS with an analysis as to why the Contractor's performance is at the level it reports;
 - 2.14.7.2.1.2. Collect and submit to EOHHS, annually, full Interactive Data Submission System (IDSS) for HEDIS measures as reported to NCQA for monitoring purposes that may be publicly reported as determined by EOHHS;

- 2.14.7.2.1.3. Upon request, submit to EOHHS Contractor-stratified rates for selected HEDIS measures specified by EOHHS, Stratification of measures may include age, race, ethnicity, language, disability status, sexual orientation, gender identity, health related social needs, or other demographic elements as available;
- 2.14.7.2.1.4. Contribute to EOHHS' data quality assurance processes, which shall include but not limited to, responding, in a timely manner, to data quality inadequacies identified by EOHHS and rectifying those inadequacies, as directed by EOHHS;
- 2.14.7.2.1.5. If directed by EOHHS, contribute to EOHHS processes regarding the individual and aggregate performance of MassHealth contract plans with respect to selected HEDIS measures; and
- 2.14.7.2.1.6. Contribute to EOHHS processes culminating in the publication of any technical or other reports by EOHHS related to selected HEDIS measures.

2.14.7.3. EOHHS -Directed Performance Incentive Program

- 2.14.7.3.1. The Contractor shall meet specific performance requirements in order to receive payment of withheld amounts over the course of the Contract. These withhold measures are detailed in **Section 4.7.2**. In order to receive any withhold payments, the Contractor shall comply with all EOHHS withhold measure requirements while maintaining satisfactory performance on all other Contract requirements.

2.14.7.4. Enrollee Incentives.

- 2.14.7.4.1. 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:
 - 2.14.7.4.1.1. Take measures to monitor the effectiveness of such Enrollee incentives, and to revise incentives as appropriate, with consideration of Enrollee feedback;
 - 2.14.7.4.1.2. Ensure that the nominal value of Enrollee incentives do not exceed one hundred dollars (\$100); and
 - 2.14.7.4.1.3. 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 -State and federal laws.

2.14.8. Behavioral Health Services Outcomes

2.14.8.1. The Contractor shall require Behavioral Health Providers to measure and collect clinical outcomes data, to incorporate that data in treatment planning and within the medical record, and to make clinical outcomes data available to the Contractor, upon request.

2.14.8.2. The Contractor's Behavioral Health Provider contracts shall require the provider to make available Behavioral Health Clinical Assessment and outcomes data for quality management and Network Management purposes.

2.14.8.3. The Contractor shall use outcome measures based on behavioral health care best practices. As directed by EOHHS, the Contractor shall collaborate with Behavioral Health Providers to develop outcome measures that are specific to each Behavioral Health Service type. Such outcome measures may include:

2.14.8.3.1. Recidivism;

2.14.8.3.2. Adverse occurrences;

2.14.8.3.3. Treatment drop- out;

2.14.8.3.4. Length of time between admissions; and

2.14.8.3.5. Treatment goals achieved.

2.14.9. LTSS Measurement Development

2.14.9.1. The Contractor shall participate with EOHHS in the ongoing development and adoption of quality measures related to delivery of Long-term Services and Supports.

2.14.10. External Research Projects

2.14.10.1. The Contractor may participate in external research projects that are pre-approved by EOHHS, at the discretion of the Contractor, through which the Contractor supplies Enrollee data to an external individual or entity. The Contractor shall:

2.14.10.1.1. As a covered entity (CE), follow HIPAA privacy and security rules with respect to Protected Health Information (PHI), in accordance with 45 CFR 164.501 and **Section 5.2** of this contract;

- 2.14.10.1.2. Submit to EOHHS, at the direction of and in a form and format specified by EOHHS, an application to participate in an external study and application for release of MassHealth data, as appropriate, for prior review and approval; and
- 2.14.10.1.3. Submit to EOHHS, the results of any external research projects for which the Contractor has received EOHHS approval to share MassHealth data.

2.14.11. External Audit/Accreditation Results

- 2.14.11.1. The Contractor shall inform EOHHS if it is nationally accredited or if it has sought and been denied such accreditation and authorize the accrediting entity to submit to EOHHS, at the direction of EOHHS, a copy of its most recent accreditation review including the expiration date, the recommended action or improvements, corrective action plans, and summaries of findings if any, in addition to the results of other quality related external audits, if any.

2.14.12. Health Information System

- 2.14.12.1. The Contractor shall maintain a health information system or systems consistent with the requirements established in the Contract, the objectives of 42 C.F.R. § 438.242, and that supports all aspects of the QI Program.

2.14.13. Health Equity Strategic Plan and Reporting

- 2.14.13.1. The Contractor shall create, monitor, and update a Five-year Health Equity Strategic Plan, which shall be submitted to EOHHS for review and approval as follows:
 - 2.14.13.1.1. In accordance with **Appendix A**, the Five-year Health Equity Strategic Plan shall be submitted to EOHHS for approval one (1) year after the Contract Operational Start Date.
 - 2.14.13.1.2. Following the submission of the Five-year Health Equity Strategic Plan, the Contractor shall submit modifications annually for EOHHS approval. In addition, the Contractor shall submit evaluations annually, demonstrating how the plan goals, objectives, and activities are progressing, as described in **Section 2.14.13.2**.
 - 2.14.13.1.3. All submissions of the Five-year Health Equity Strategic Plan shall be limited to a maximum of ten (10) pages.

2.14.13.2. The Contractor shall include in the plan an executive summary, in a form and format that is clear and concise, and includes an overview of all the key sections of the plan, including but not limited to:

2.14.13.2.1. The Identification of Goals, Objectives, and Activities:

2.14.13.2.1.1. The Contractor shall develop goals, objectives, and activities that are specific to advancing Health Equity-related initiatives and reducing health-related disparities for each year of the Contract for the entire five-year Contract; and

2.14.13.2.1.2. Goals shall be broad and overarching statements that describe what the Five-year Health Equity Plan is trying to achieve. Goals are not necessarily measurable. Rather, each goal will have specific objectives that are measurable. An example of a goal may be, "To deliver high-quality care that continuously reduces inequities in One Care plans."

2.14.13.2.1.3. Objectives are specific measures for achieving a goal. Objectives shall be specific, measurable, achievable, realistic, and time-bound (SMART). The objectives shall show what the plan hopes to improve (in terms of outcomes). An example of an objective may be "To increase the percentage of pregnant individuals aged 21-35 years old in One Care plans who use prenatal care services to 80% by 2027."

2.14.13.2.1.4. Activities shall be specific actions or interventions that are required to achieve objectives. An example of an activity may be "To train all Providers in the Contractor's Provider Network in how to establish a culture of equity by the end of year two of the Five-year Health Equity Strategic Plan."

2.14.13.2.2. Evidence-based Interventions: The Contractor's planned approaches to developing and implementing evidence-based interventions, including how it will:

2.14.13.2.2.1. Inform the development of interventions through quality performance data collection and subsequent analysis. Quality performance data should be stratified by social risk factors, which may include but are not limited to race, ethnicity, language, disability, sexual orientation, and gender identity. The Contractor shall describe how the data is used to monitor progress toward health equity

goals and objectives. In addition, the Contractor shall include:

- 2.14.13.2.2.1.1. Data submissions that specifically support the executive summary, including additional data requested by EOHHS;
 - 2.14.13.2.2.1.2. Baseline values or an explanation of why a baseline value is not available;
 - 2.14.13.2.2.1.3. A description of which interventions support the progress toward plan goals and objectives and how they will support such progress;
 - 2.14.13.2.2.1.4. As applicable, a description of what contributed to the achievement of the interventions;
 - 2.14.13.2.2.1.5. A description of how plans are ensuring equitable access to healthcare; and
 - 2.14.13.2.2.1.6. A description of how plans deliver high-quality care that continuously reduces inequities.
- 2.14.13.2.3. Stakeholder Collaboration: How the Contractor sought and incorporated input from stakeholders, including the One Care Implementation Council, the Consumer Advisory Board (CAB), and Providers representing the composition of the Contractor's Provider Network such as community hospitals, other community-based providers, ASAPs, Enrollees, and Enrollees' families.
- 2.14.13.2.4. Health Equity Trainings: The Contractor's approaches to establishing a culture of equity that recognizes and prioritizes the elimination of inequities through respect, cultural competency, and advocacy, including through the provision of trainings for health equity, implicit bias, anti-racism, and related trainings. Trainings shall be 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)).
- 2.14.13.2.5. Policy and Procedures: The Contractor's approach to reviewing policy and procedures for impact on health inequities and how they will update such policy and procedures to mitigate such inequities. In addition, the Contractor shall describe how policy and procedures 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) grievances and appeals, 6) utilization management, and 7) flexible benefits,.

2.14.13.3. The Contractor shall identify gaps in the achievement of targeted goals and objectives, observed barriers to achieving goals and objectives, and specific plans for the upcoming year to overcome such gaps.

2.14.13.4. At EOHHS's request, the Contractor shall meet with EOHHS to discuss its reporting on items in this **Section**.

2.14.13.5. The Contractor shall publicly post the executive summaries of its Health Equity Strategic Plan, update them annually, and make these documents available to EOHHS for posting on EOHHS' website.

2.14.14. Optional Community Needs Assessment

2.14.14.1. The Contractor may implement a Population and Community Needs Assessment to inform the Five-year Health Equity Strategic Plan. The content of the Community Needs Assessment may include:

2.14.14.1.1. A brief description of the population of Enrollees the Contractor serves and the communities in which they live,

2.14.14.1.2. A description of the characteristics of such population and communities, including at a minimum:

2.14.14.1.2.1. The approximate number of Enrollees in the population;

2.14.14.1.2.2. The population's demographic characteristics, including but not limited to age, race, ethnicity, languages spoken, disability status, sexual orientation, gender identity; and

2.14.14.1.2.3. 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.

2.14.14.1.3. A description of the health, functional, and other care needs of such population and communities, including but not limited to:

- 2.14.14.1.3.1. A list and description of prevalent conditions in the population, including chronic diseases;
- 2.14.14.1.3.2. A description of the population's behavioral health needs;
- 2.14.14.1.3.3. A description of the population's LTSS needs,
- 2.14.14.1.3.4. A description of the population's health-related social needs; and
- 2.14.14.1.3.5. A description of the community resources that currently exist in such communities.

2.14.15. NCQA Health Equity Accreditation

2.14.15.1. The Contractor may pursue accreditation by the National Committee on Quality Assurance (NCQA) for its Health Equity Accreditation program. If the Contractor is pursuing or is already NCQA Health Equity Accredited, the Contractor shall:

- 2.14.15.1.1. Annually, inform EOHHS if it is nationally accredited through NCQA or if it has sought and been denied such accreditation;
- 2.14.15.1.2. As directed by EOHHS, submit a summary of its accreditation status and the results, if any, in addition to the results of other quality-related external audits, if any to EOHHS; and
- 2.14.15.1.3. Authorize NCQA to provide EOHHS a copy of the Contractor's most recent accreditation review, including but not limited to, as applicable, accreditation status, survey type, level, accreditation results, recommended actions, recommended improvements, corrective action plans, summaries of findings, and the expiration date of accreditation.

2.15. Data Management, Information Systems Requirements, and Reporting Requirements

2.15.1. General Requirements

2.15.1.1. The Contractor shall:

- 2.15.1.1.1. 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;

- 2.15.1.1.2. 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;
- 2.15.1.1.3. 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. If directed by EOHHS, establish appropriate links on the Contractor's website that direct users back to the EOHHS website;
- 2.15.1.1.4. Fully cooperate with EOHHS in its efforts to verify the accuracy of all Contractor data submissions to EOHHS; and
- 2.15.1.1.5. 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.

2.15.2. Encounter Data

2.15.2.1. The Contractor shall collect, manage, and report Encounter Data as described in this Section and as further specified by EOHHS, including specifications documented in **Appendix H**, which EOHHS may update at any time. The Contractor shall:

- 2.15.2.1.1. Collect and maintain one hundred percent (100%) Encounter Data for all One Care Covered Services provided to Enrollees, including services provided through any Material Subcontractor, including from any sub-capitated sources. Such data must be able to be linked to MassHealth eligibility data, specifically:
 - 2.15.2.1.1.1. All Medicare services provided to Enrollees, including Medicare Parts A, B, and D services and Medicare Supplemental Benefits;
 - 2.15.2.1.1.2. All MassHealth services described in **Appendix C**; and
 - 2.15.2.1.1.3. Flexible Benefits.

- 2.15.2.1.2. Participate in site visits and other reviews and assessments by EOHHS, or its designee, for the purpose of evaluating the Contractor's collection and maintenance of Encounter Data.
- 2.15.2.1.3. Participate in data management reviews to identify and remediate Encounter Data gaps in advance of key business process deadlines upon request of EOHHS.
- 2.15.2.1.4. Upon request by EOHHS, or its designee, assist with validation assessments by providing Enrollees' medical records and a report from specified administrative databases of the Encounters related to those Enrollees.
- 2.15.2.1.5. Produce, maintain, and validate Encounter Data according to the specifications, format, and mode of transfer established by EOHHS, or its designee, in consultation with the Contractor. Such Encounter Data shall include data elements described in **Appendix H**, specified information about the delivering provider, and elements and level of detail determined necessary by EOHHS. Required data elements may be updated at the discretion of EOHHS. As directed by EOHHS, such Encounter Data shall also include:
 - 2.15.2.1.5.1. The most current version of Encounters;
 - 2.15.2.1.5.2. The National Provider Identifier (NPI) of the Servicing/Rendering, Referring, Prescribing, and Primary Care Provider, and any National Drug Code (NDC) information on drug claims;
 - 2.15.2.1.5.3. Information related to denied claims and 340B Drug Rebate indicators;
 - 2.15.2.1.5.4. All initial Behavioral Health Clinical Assessments that are performed; and
 - 2.15.2.1.5.5. All One Care Covered Services provided to Enrollees as described in **Section 2.7** above.
- 2.15.2.1.6. Provide Encounter Data to EOHHS on a monthly basis or within time frames specified by EOHHS in consultation with the Contractor, including at a frequency determined necessary by EOHHS to comply with any and all applicable statutes, rules, regulations and guidance. The Contractor shall submit Encounter Data by the last calendar day of the month following the month of the claim payment. Such submission shall be consistent with all Encounter Data specifications set forth in **Appendix H**.

- 2.15.2.1.7. Submit Encounter Data that is at a minimum ninety-nine (99%) percent complete and ninety-five (95%) percent accurate. To meet the completeness standard, all critical fields in the data must contain valid values. To meet the accuracy standard, the Contractor shall have systems in place to monitor and audit claims. The Contractor shall also correct and resubmit denied encounters as necessary. The data shall be considered complete and accurate if the error rate in the initial submission is no more than three (3%) percent and the number of encounters that need to be manually overridden is no more than one (1%) percent. The Contractor shall meet data quality requirements regarding completeness, accuracy, timeliness, and consistency to ensure Encounter Data is correct, provable, and trusted.
- 2.15.2.1.8. Correct and resubmit rejected Encounter Data as necessary. See **Appendix H**. The Contractor shall submit any correction and manual override files within 10 business days from the date EOHHS places the error report on the Contractor's server. Such submission shall be consistent with all Encounter Data specifications set forth in **Appendix H**.
- 2.15.2.1.9. Report as a voided claim in the monthly Encounter Data submission any claims that the Contractor pays, and then later determines should not have paid. At EOHHS' request, the Contractor shall submit denied claims as part of its Encounter Data submission, as further specified by EOHHS.
- 2.15.2.1.10. As further described in **Appendix H**, submit on a monthly basis a crosswalk between the Contractor's internal provider identification numbers and MassHealth PID/SLs in coordination with MassHealth.
- 2.15.2.1.11. Comply with any modifications EOHHS makes to the specifications required for submission of Encounter Data, including but not limited to requiring the Contractor to submit additional data fields to support the identification of Enrollees' affiliation with their Primary Care Provider.
- 2.15.2.1.12. At a time specified by EOHHS, comply with all Encounter Data submission requirements related to HIPAA and the ASCX12N 837 format. This may include submitting Encounter Data to include professional, institutional, and dental claims, and submitting pharmacy claims using NCPDP standards. This submission may require the Contractor to re-submit Encounter Data previously submitted to EOHHS in a different format. This may also require the

Contractor to assess testing milestones, provide a stabilization plan, and monitor timeliness of post-production issue resolution.

- 2.15.2.1.13. Participate in, and be responsive to requests for information during, EOHHS' quarterly assessment of the Contractor's Encounter Data submissions. Such assessment shall include, but may not be limited to, determining the Contractor's compliance with the following:

- 2.15.2.1.13.1. Meeting the specifications in **Appendix H**;

- 2.15.2.1.13.2. Being responsive to Encounter Data related inquiries by EOHHS, including but not limited to investigations of data observations and implementation of data fixes;

- 2.15.2.1.13.3. Avoiding critical failures or disruptions to EOHHS' data submission, processing, and downstream analytics; and

- 2.15.2.1.13.4. Meeting the completeness, accuracy, timeliness, quality, form, format, and other standards in this **Section 2.15.2** and as further specified by EOHHS.

- 2.15.2.2. If EOHHS, or the Contractor, determines at any time, including during any of the quarterly assessments described in **Section 2.15.2.1.13**, that the Contractor's Encounter Data is not compliant with the specifications described in **Section 2.15.2.1.13**, the Contractor shall:

- 2.15.2.2.1. Notify EOHHS, prior to Encounter Data submission, that the data is not complete or accurate.

- 2.15.2.2.2. Submit for EOHHS approval, within a time frame established by EOHHS which shall not exceed 30 days from the day the Contractor identifies or is notified that it is not in compliance with the Encounter Data requirements, a data remediation action plan and timeline for resolution to bring the accuracy and completeness to an acceptable level.

- 2.15.2.2.2.1. Such action plan shall be reviewed and approved by EOHHS. The Contractor shall modify its proposed action plan as requested by EOHHS.

- 2.15.2.2.2.2. The Contractor may request an extension at least three business days prior to the due date of the data remediation action plan described in this **Section 2.15.2** including with its request the reason for the needed

extension and an action plan and timeline for when the Contractor is able to submit its proposed action plan.

- 2.15.2.2.3. Implement the EOHHS-approved data remediation plan within a time frame approved by EOHHS, which shall not exceed 30 days from the date that the Contractor submits the data remediation plan to EOHHS for approval.
- 2.15.2.2.4. Participate in a validation study to be performed by EOHHS following the end of a twelve-month period after the implementation of the data remediation action plan to assess whether the Contractor's Encounter Data is compliant with the standards described in **Appendix H**.

- 2.15.2.3. If the Contractor fails to satisfy the data remediation plan requirements as set forth in **Section 2.15.2.2**, EOHHS may apply a capitation payment deduction as specified in **Section 5.3.14**.
- 2.15.2.4. The Contractor shall meet any diagnosis and/or encounter reporting requirements that are in place for Medicare Advantage plans and Medicaid managed care organizations including the EOHHS Encounter Data Set Request, as may be updated from time to time. Furthermore, the Contractor's Systems shall generate and transmit Encounter Data files according to additional specifications as may be provided by EOHHS and updated from time to time. The Contractor shall maintain processes to ensure the validity, accuracy, and completeness of the Encounter Data in accordance with the standards specified in this **Section**. EOHHS will provide technical assistance to the Contractor for developing the capacity to meet encounter reporting requirements.

2.15.3. Medicaid Drug Rebate

- 2.15.3.1. The Contractor shall collect, manage, and report Drug Rebate Data as described in this **Section** and as further specified by EOHHS. The Contractor shall:
- 2.15.3.2. Collect and retain 100% of the Drug Rebate Data in accordance with **Appendix Q**. In addition, the Contractor shall:
 - 2.15.3.2.1. Ensure Drug Rebate Data is consistent with MassHealth eligibility data;
 - 2.15.3.2.2. Create and maintain the file record layouts/schemas in accordance with EOHHS requirements for the purposes of capturing and submitting all drug claims to EOHHS and its designee. The Contractor shall satisfy any EOHHS-required

timely updates to the file record layouts/schema in response to changing requirements;

- 2.15.3.2.3. As directed by EOHHS, include as part of its Drug Rebate Data information related to denied claims and 340B Drug Rebate indicators;
- 2.15.3.2.4. In the event EOHHS or its designee is unable to accept certain Drug Rebate Data records due to validation errors, retrieve and promptly correct those claim records and resubmit them in accordance with current EOHHS schema and schedules;
- 2.15.3.2.5. Participate in workgroups, discussions, and meetings with EOHHS and its designees to support MassHealth rebate invoicing to drug manufacturers;
- 2.15.3.2.6. Validate that all National Drug Codes (NDCs) submitted on physician-administered drugs for rebate match the Healthcare Common Procedure System (HCPCS) being billed for, and include accurate NDC information (unit of measure and quantity);
- 2.15.3.2.7. Instruct Providers to use the following indicators to identify 340B claims:
 - 2.15.3.2.7.1. For Physician-administered Drugs add the identifier of “UD” to the HCPCS; and
 - 2.15.3.2.7.2. For Pharmacy-dispensed drugs attach Submission Clarification Code 20.
- 2.15.3.2.8. Perform all system and program activities determined necessary to:
 - 2.15.3.2.8.1. Properly identify drugs purchased through the Federal 340B Drug Pricing Program;
 - 2.15.3.2.8.2. Collect all of the following information on claims for physician-administered drugs and deny any claim for such drugs that does not include all such information;
 - 2.15.3.2.8.3. All information set forth in 42 CFR 447.511 that EOHHS specifies the Contractor needs to provide, including but not limited to National Drug Code (NDC);
 - 2.15.3.2.8.4. Metric Quantity; and

2.15.3.2.8.5. Unit of Measure.

- 2.15.3.2.9. Participate in site visits and other reviews and assessments by EOHHS, or its designee, for the purpose of evaluating the Contractor's collection and maintenance of Drug Rebate Data.
- 2.15.3.2.10. Produce Drug Rebate Data according to the specifications, format, and mode of transfer reasonably developed by EOHHS or its designee.
- 2.15.3.2.11. Provide Drug Rebate Data to EOHHS monthly or within time frames specified by EOHHS, including at a frequency determined necessary by EOHHS to comply with any and all applicable statutes, rules, regulations, and guidance.
- 2.15.3.2.12. Submit Drug Rebate Data that is 100% on time and 99% complete. To meet the completeness standard, all critical fields in the data must contain valid values. The Contractor shall correct and resubmit errored claims as necessary.
- 2.15.3.2.13. Report as voided or reversed any claims in the Drug Rebate Data submission that the Contractor includes in a file and then later determines should not have been included.
- 2.15.3.2.14. Ensure that the Drug Rebate contractual requirements are transferred completely and without interruption to the published MassHealth Drug Rebate file upload schedule whenever there is a change in the Drug Rebate operations or technical support staff.
- 2.15.3.2.15. If EOHHS or the Contractor determines at any time that the Contractor's Drug Rebate Data will not be or is not 100% on time and 99% complete:
 - 2.15.3.2.15.1. Notify EOHHS, five days prior to the Drug Rebate Data scheduled submission date, that the Drug Rebate Data will not be delivered on time or is not complete and provide an action plan and timeline for resolution;
 - 2.15.3.2.15.2. Submit a corrective action plan to EOHHS, for approval, within a timeframe not to exceed 30 days, from the day the Contractor identifies or is notified that it is not in compliance with the Drug Rebate Data requirements, to implement improvements or enhancements to bring the timeliness and completeness to an acceptable level;

2.15.3.2.15.3. Implement the EOHHS-approved corrective action plan within a time frame approved by EOHHS which shall in no event exceed 30 days from the date that the Contractor submits the corrective action plan to EOHHS for approval; and

2.15.3.2.15.4. Participate in a validation study to be performed by EOHHS, or its designee, following the end of a twelve-month period after the implementation of the corrective action plan to assess whether the Drug Rebate Data is 100% on time and 99% complete. The Contractor may be financially liable for such validation study.

2.15.3.2.16. Operate and maintain a state-of-the-art National Council for Prescription Drug Programs (NCPDP)-compliant, on-line pharmacy claims processing system. Such system shall allow for having a separate BIN, PCN, and group number combination for MassHealth claims to differentiate them from other claims. The Contractor shall notify EOHHS of BIN, PCN, and group number combination changes as set forth in **Appendix Q**.

2.15.4. Outpatient Drugs

2.15.4.1. Pursuant to 42 U.S.C. § 1396b(m)(2)(A)(xiii), covered outpatient drugs dispensed to Enrollees shall be subject to the same rebate required by the agreement entered into under 42 U.S.C. § 1396r-8 as the State is subject to and the State shall collect such rebates from manufacturers. The Contractor shall report to the State, on a timely and periodic basis specified by the Secretary, information on the total number of units of each dosage form and strength and package size by National Drug Code of each covered outpatient drug dispensed to Enrollees for which the Contractor is responsible for coverage (other than outpatient drugs) and other data as the Secretary determines necessary.

2.15.4.2. The Contractor shall provide outpatient drugs pursuant to this **Section** in accordance with Section 1927 of the Social Security Act and 42 CFR 438.3(s), including, but not limited, to complying with all applicable requirements related to coverage, drug utilization data, drug utilization review program activities and prior authorization policies.

2.15.5. Medical Records

2.15.5.1. Documentation Standards

2.15.5.1.1. The Contractor shall use and require commonly accepted standards for medical record documentation, as follows:

2.15.5.1.1.1. Each page in the record contains the patient's name or ID number;

2.15.5.1.1.2. All entries in the medical record contain the author's identification. Author identification may be a handwritten signature, unique electronic identifier, or initials;

2.15.5.1.1.3. All entries are dated;

2.15.5.1.1.4. The record is legible to someone other than the writer;

2.15.5.1.1.5. Significant illnesses and medical conditions are indicated on the problem list;

2.15.5.1.1.6. Encounter forms or notes have a notation, regarding follow-up care, calls or visits, when indicated. The specific time of return is noted in weeks, months, or as needed;

2.15.5.1.1.7. Unresolved problems from previous office visits are addressed in subsequent visits;

2.15.5.1.1.8. There is appropriate notation for under- or over-utilization of specialty services or pharmaceuticals;

2.15.5.1.1.9. If a consultation is requested, there is a note from the specialist in the record;

2.15.5.1.1.10. There is no evidence that the patient is placed at inappropriate risk by a diagnostic or therapeutic procedure; and

2.15.5.1.1.11. There is evidence that preventive screening and services are offered in accordance with the Provider's own practice guidelines, including the administration of behavioral health screenings.

2.15.5.2. Provide Records to EOHHS

2.15.5.2.1. The Contractor shall:

2.15.5.2.1.1. Provide a copy of the Centralized Enrollee Record and other medical records pertaining to Enrollees, at EOHHS's request, for the purpose of monitoring the quality of care provided by the Contractor in accordance

with federal law (e.g., 42 USC 1396a(a)(30)), or for the purpose of conducting performance evaluation activities of the Contractor under this contract. Medical record audits conducted by the Contractor at the request of EOHHS may be subject to validation performed directly by EOHHS or its designee.

2.15.5.2.1.2. Provide any such medical or audit record(s) within 10 days of EOHHS's request, provided however, that EOHHS may grant the Contractor up to 30 days from the date of EOHHS's initial request to produce such record(s) if the Contractor specifically requests such an extension and where EOHHS reasonably determines that the need for such record(s) is not urgent and the Contractor is making best efforts to produce such record(s) in a timely fashion.

2.15.5.2.1.3. In the event of termination or expiration of the Contract, or in the event of Enrollee disenrollment, transfer all medical records and other relevant information in the Contractor's possession, in a format to be specified by EOHHS, to EOHHS, another Contractor, or other party as determined by EOHHS.

2.15.5.3. Data through Health Information Systems (HIS)

2.15.5.3.1. The Contractor shall ensure its HIS collects, analyzes, integrates, and reports data, including, but not limited to information regarding:

2.15.5.3.1.1. Utilization (including Medicare and Medicaid Covered Services, Medicare Supplemental Benefits, and Flexible Benefits) and claims;

2.15.5.3.1.2. Inquiries, Grievances, Appeals, including Internal and External Appeals, External Appeals includes Appeals escalated to both Medicare and Medicaid Appeal processes;

2.15.5.3.1.3. Voluntary Disenrollments as described in **Section 2.4.13.3**;

2.15.5.3.1.4. Provider information in order to comply with **Section 2.11.1.1.5**;

2.15.5.3.1.5. Services furnished to Enrollees through an Encounter Data system, as specified in **Section 2.15.2**;

- 2.15.5.3.1.6. Enrollee characteristics, including but not limited to, accommodation requests, disability type, homelessness, race, ethnicity, primary language, hearing loss and use of ASL Interpreter or CART services by deaf, hard-of-hearing and deaf blind persons, blindness and wheelchair use, sexual orientation and gender identity, and characteristics gathered through such Plan contact with Enrollees, e.g., intake and other screenings during Onboarding, Assessment processes, Care Management, or other reliable means; and
- 2.15.5.3.1.7. Care Coordination activities, status, responsibilities, and other information, including the mode of Care Coordination provided, such as documenting in-person engagement and in-home visits, video vs. audio only virtual engagement.

2.15.5.4. Data Integrity Standards

2.15.5.4.1. The Contractor shall:

2.15.5.4.1.1. Ensure that data received from Providers is 99% complete and 95% accurate by:

- 2.15.5.4.1.1.1. Verifying the accuracy and timeliness of reported data, including data from Network Providers the Contractor is compensating on the basis of capitation payments;
- 2.15.5.4.1.1.2. Screening the data for completeness, logic and consistency; and
- 2.15.5.4.1.1.3. Collecting data from providers, including service information, in standardized formats to the extent feasible and appropriate or as directed by EOHHS, including secure information exchanges and technologies utilized for State Medicaid quality improvement and care coordination efforts, pursuant to 42 CFR 438.242(b)(3)(iii).

2.15.5.4.1.2. Make all collected data available to EOHHS and, upon request, to CMS, as required by 42 CFR 438.242(b)(4),

2.15.5.5. Design Requirements

2.15.5.5.1. The Contractor shall:

- 2.15.5.5.1.1. Comply with EOHHS requirements, policies, and standards in the design and maintenance of its Systems in order to successfully meet the requirements of this Contract.
- 2.15.5.5.1.2. Ensure the Contractor's Systems interface with EOHHS's Legacy MMIS system, EOHHS's MMIS system, the EOHHS Virtual Gateway, Data Warehouse, and other EOHHS IT architecture as further specified by EOHHS.
- 2.15.5.5.1.3. Have adequate resources to support the MMIS interfaces. The Contractor shall demonstrate the capability to successfully send and receive interface files. Such Interface files are specified in **Appendix J** of this Contract.
- 2.15.5.5.1.4. Conform to HIPAA compliant standards for data management and information exchange.
- 2.15.5.5.1.5. Demonstrate controls to maintain information integrity.
- 2.15.5.5.1.6. Maintain appropriate internal processes to determine the validity and completeness of data submitted to EOHHS, consistent with **Section 2.15.5.4**.
- 2.15.5.5.1.7. As set forth in 42 CFR 438.242(b)(1), comply with Section 6504(a) of the Affordable Care Act.

2.15.5.6. Centralized Enrollee Record

- 2.15.5.6.1. To coordinate care, the Contractor shall maintain a single, centralized, comprehensive electronic record that documents the Enrollee's medical, prescription, functional, and social status. The Contractor shall ensure that the PCP and all Members of the ICT, including the LTS Coordinator, as well as any other appropriate providers, including Contractors, and Related Entities, make appropriate and timely entries describing the care provided, clinical assessments, diagnoses determined, medications prescribed, treatment plans, treatment services provided, treatment goals and outcomes, and pharmacy records.
- 2.15.5.6.2. The Centralized Enrollee Record shall contain the following:
 - 2.15.5.6.2.1. Enrollee identifying information and demographic information (including race, ethnicity, disability type, primary language and homelessness), and family and caregiver contact information;

- 2.15.5.6.2.2. Personal biographical data include the address, home telephone, mobile telephone, and work telephone numbers, name of employer, marital status, primary language spoken;
- 2.15.5.6.2.3. Documentation of each service provided, including the date of service, the name of both the authorizing provider and the servicing provider (if different), and how they may be contacted, and for prescribed medications, including dosages and any known drug contraindications;
- 2.15.5.6.2.4. Documentation of physical access and programmatic access needs of the Enrollee, as well as needs for accessible medical equipment;
- 2.15.5.6.2.5. Documentation of the Enrollee's communication preferences (e.g., text, email, phone, etc.) and communication access needs, including live interpreting services, access to telephone devices and advanced technologies that are hearing aid compatible, and video relay service or point-to-point video, for Enrollees who are Deaf or hard of hearing;
- 2.15.5.6.2.6. Documentation of Comprehensive Assessments, including diagnoses, prognoses, plans of care, and treatment and progress notes, signed and dated by the appropriate provider;
- 2.15.5.6.2.7. Ensure that documentation of behavioral health treatment in the Centralized Enrollee Record includes only documentation of behavioral health assessment, diagnosis, treatment plan, therapeutic outcome or disposition, and any medications prescribed (psychotherapeutic session notes shall not be recorded in the Centralized Enrollee Record);
- 2.15.5.6.2.8. Laboratory and radiology reports;
- 2.15.5.6.2.9. Updates on the Enrollee's involvement and participation with community agencies that are not part of the Provider Network, including any services provided;
- 2.15.5.6.2.10. Physician orders;
- 2.15.5.6.2.11. Enrollee's individual Advance Directives and health care proxy, recorded and maintained in a prominent place;

- 2.15.5.6.2.12. Plan for Emergency Medical Conditions and Urgent Care, including identifying information about any emergency contact persons;
- 2.15.5.6.2.13. Emergency psychiatric crisis plans;
- 2.15.5.6.2.14. Allergies and special dietary needs, and
- 2.15.5.6.2.15. Information that is consistent with the utilization control requirement of 42 C.F.R. 456 et. seq.
- 2.15.5.6.3. Coordination of Centralized Enrollee Record Information: systems shall be implemented to ensure that the Centralized Enrollee Record is:
 - 2.15.5.6.3.1. Maintained in a manner that is current, detailed, and organized and that permits effective patient care, utilization review and quality review by each applicable provider of care;
 - 2.15.5.6.3.2. Available and accessible twenty-four (24) hours per day, seven (7) days per week, either in its entirety or in a current summary of key clinical information, to triage and acute care providers for Emergency Medical Conditions and Urgent Care, and
 - 2.15.5.6.3.3. Available and accessible to specialty, LTSS, mental health and SUD providers, and to LTS Coordinators.
- 2.15.6. Health Information Technology and Health Information Systems
 - 2.15.6.1. General
 - 2.15.6.1.1. The Contractor shall, as further specified by EOHHS, establish and implement policies and procedures to:
 - 2.15.6.1.1.1. Enhance interoperability of its health information technology through health information exchange technologies.
 - 2.15.6.1.1.2. Increase utilization of health information exchange services operated or promoted by the Mass Hlway, including but not limited to direct messaging, Statewide event notification service (ENS) Framework, and Query and Retrieve functionality.
 - 2.15.6.1.1.3. Upon notification by EOHHS that additional Mass Hlway services are developed, operated, or promoted, establish

and implement policies and procedures to increase connectivity to such services and work with its Network PCPs to increase their connectivity.

2.15.6.1.1.4. Ensure effective linkages of clinical and care management information systems to facilitate timely information sharing, including through the Enrollee's electronic medical record, among all Providers, including clinical subcontractors and LTS Coordinators, in accordance with national technical standards where applicable.

2.15.6.1.1.5. Leverage information sharing and communication that facilitates and improves coordination of care, including among the ICT Members and the Enrollee's Care Coordinator, including for care provided outside of the primary care site, for referrals, and for discharge planning and other care transitions.

2.15.6.1.2. The Contractor shall provide EOHHS with such policies and procedures described above upon EOHHS request.

2.15.6.2. Quality Data Collection

2.15.6.2.1. 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.

2.15.6.2.2. For the purposes of quality management and Rating Category determination, the Contractor shall accept, process, and report to EOHHS uniform person-level Enrollee data, based upon a Comprehensive Assessment process that includes ICD-10 diagnosis codes, the Minimum Data Set (MDS-HC or MDS 2.0 or 3.0), and any other data elements deemed necessary by EOHHS.

2.15.6.3. Communication Technology Resources for Network Providers

2.15.6.3.1. The Contractor shall ensure that its Network 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 Network PCPs to

integrate such event notifications into appropriate Care Management or population health management workflows.

- 2.15.6.3.2. The Contractor shall ensure that its Network PCPs enable and utilize Query and Retrieve functionality that is natively available in the Network PCPs' EHRs, as further specified by EOHHS.
- 2.15.6.3.3. 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. Upon request of EOHHS, Contractors shall report on the per cent of providers who meet the above standard.

2.15.6.4. Health Information Systems (HIS)

- 2.15.6.4.1. The Contractor shall maintain a health information system (HIS) or Information Systems (together, the Contractor's Systems).
- 2.15.6.4.2. The Contractor's Systems shall support current EOHHS requirements, and 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:
 - 2.15.6.4.2.1. The EOHHS Unified Process Methodology User Guide;
 - 2.15.6.4.2.2. The User Experience and Style Guide Version 2.0;
 - 2.15.6.4.2.3. Information Technology Architecture Version 2.0; and
 - 2.15.6.4.2.4. Enterprise Web Accessibility Standards 2.0.
- 2.15.6.4.3. Upon EOHHS request, the Contractor shall provide to EOHHS data elements from the automated data system necessary for program integrity, program oversight, and administration to cooperate with EOHHS data processing and retrieval systems requirements.

2.15.7. Claims Processing Requirements

- 2.15.7.1. The Contractor shall operate and maintain an industry standard HIPAA-compliant, online Claims processing system that includes but is not limited to the following characteristics:

- 2.15.7.1.1. Supports HIPAA standard Inbound and Outbound Transactions, as defined by EOHHS:
 - 2.15.7.1.1.1. Health Care Claim Status Request and Response (276/277);
 - 2.15.7.1.1.2. Health Care Services Review – Request and Response (278);
 - 2.15.7.1.1.3. Health Care Claim Payment/Advice (835);
 - 2.15.7.1.1.4. Health Care Claim/Professional (837P);
 - 2.15.7.1.1.5. Health Care Claim/Institutional (837I);
 - 2.15.7.1.1.6. Health Care Eligibility Benefit Inquiry and Response (270/271);
 - 2.15.7.1.1.7. Functional Acknowledgement for Health Care Insurance (997);
 - 2.15.7.1.1.8. Implementation Acknowledgement for Health Care Insurance (999);
- 2.15.7.1.2. Complies with all future updates to the HIPAA transactions and standards within the required timeframes;
- 2.15.7.1.3. Has flexibility to receive Provider claims submitted in various HIPAA compliant formats. The Contractor shall collaborate with Providers to allow Providers to submit Claims utilizing various industry standard procedures; and
- 2.15.7.1.4. Adjudicates Claims submitted in accordance with the timeframes specified in **Section 2.8.5**.

2.15.7.2. Additional Requirements

- 2.15.7.2.1. In addition, the Contractor shall:
 - 2.15.7.2.1.1. Implement timely filing initiatives to ensure that Claims are submitted within the allotted time restrictions set by the Contractor;
 - 2.15.7.2.1.2. Implement waiver parameters for Providers that do not meet allotted time restrictions including but not limited to a waiver at the request of EOHHS; and
 - 2.15.7.2.1.3. Implement and maintain policies and procedures related to the financial, eligibility, and clinical editing of Claims.

These policies and procedures shall include an edit and audit system that allows for editing for reasons such as, ineligibility of Enrollees, providers and services, duplicate services, and rules or limitations of services. As further specified by EOHHS, the Contractor shall report these edits to EOHHS.

2.15.7.3. Claims Review

2.15.7.3.1. The Contractor shall:

- 2.15.7.3.1.1. Maintain written, EOHHS-approved Claims resolution protocols. The Contractor shall submit any proposed changes to such protocols to EOHHS for prior review and approval and implement such changes upon the date specified by EOHHS;
- 2.15.7.3.1.2. Review Claims resolutions protocols no less frequently than annually and, as appropriate, recommend modifications to the protocols to EOHHS to increase the efficiency or quality for the Claims resolution process;
- 2.15.7.3.1.3. Review suspended Claims for reasons why Claims were suspended, including reasons specified by EOHHS;
- 2.15.7.3.1.4. Review all Claims that suspend for being untimely in accordance with EOHHS-approved protocols. The Contractor shall waive the timeliness deadline for those Claims meeting the EOHHS-approved criteria as described in **Section 2.15.1** and as further described by EOHHS; and
- 2.15.7.3.1.5. Implement appropriate quality control processes to ensure that Claim review requirements are met within EOHHS-defined parameters including but not limited to maintaining an electronic record or log of the quality review process.

2.15.7.4. Recoveries and Erroneous Payments

- 2.15.7.4.1. The Contractor shall notify EOHHS of recoveries and erroneous payments as described in **Section 2.3.6**.
- 2.15.7.4.2. The Contractor shall at a minimum have systems in place to monitor and audit claims.

2.15.8. Reporting Requirements

2.15.8.1. General

- 2.15.8.1.1. The Contractor shall provide and require its Material Subcontractors to provide, in accordance with the timelines, definitions, formats, and instructions contained herein or as further specified by EOHHS:
 - 2.15.8.1.1.1. All information EOHHS requires under this Contract, including the requirements of this Section, in **Appendix A**, and other information related to the Contractor's performance of its responsibilities hereunder or under subcontracts, including non-medical information for the purposes of research and evaluation;
 - 2.15.8.1.1.2. Any information EOHHS requires to comply with all applicable federal or State laws and regulations;
 - 2.15.8.1.1.3. Any information EOHHS requires for external rapid cycle evaluation including program expenditures, service utilization rates, rebalancing from institutional to community settings, Enrollee satisfaction, Enrollee Grievances and Appeals and enrollment/disenrollment rates;
 - 2.15.8.1.1.4. Provide any information in its or its subcontractors' possession to permit EOHHS to comply with 42 C.F.R. § 438;
 - 2.15.8.1.1.5. Any data from their clinical systems, authorization systems, claims systems, medical record reviews, Network Management visits, and Enrollee and family input;
 - 2.15.8.1.1.6. Time sensitive data to EOHHS in accordance with EOHHS timelines; and
 - 2.15.8.1.1.7. High quality, accurate data in the format and in the manner of delivery specified by EOHHS.
- 2.15.8.1.2. Where practicable, EOHHS shall consult with the Contractor to establish time frames and formats and detailed specifications reasonably acceptable to both parties.
- 2.15.8.1.3. Upon request, the Contractor shall participate in work groups led by EOHHS to develop and comply with reporting specifications and to adopt the reporting models formulated by these work groups and approved by EOHHS, pursuant to the timeline established by EOHHS.

- 2.15.8.1.4. Upon request, provide EOHHS with the original data sets, stratified by EOHHS standards, used by the Contractor in the development of any required reporting or ad-hoc reporting in accordance with the time frames and formats established by EOHHS.

2.15.8.2. Contract-related Reports

- 2.15.8.2.1. The Contractor shall meet all Contract-related report and data submission requirements, which include, but are not limited to, reports related to Contract performance, management, and strategy as set forth in **Appendix A**.

- 2.15.8.2.1.1. The Contractor shall submit **Appendix A** reports in accordance with the timeframes and other requirements specified in **Appendix A**, and consistent with any form and format requirements specified by EOHHS.

- 2.15.8.2.1.2. For any report that indicates the Contractor is not meeting a target 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.

- 2.15.8.2.1.3. Failure to meet the reporting requirements in **Appendix A** shall be considered a breach of Contract.

- 2.15.8.2.2. Furthermore, the Contractor shall submit to EOHHS all applicable MassHealth reporting requirements in compliance with 42 C.F.R. § 438.602—606, as detailed in **Appendix A**,

2.15.8.3. Personal Care Management (PCM) Agency Reporting

- 2.15.8.3.1. The Contractor shall collect from its PCM Agencies, and provide to EOHHS upon request, reports as directed by EOHHS. Such reports may include, but are not limited to, the following information:

- 2.15.8.3.1.1. The number of overtime approval requests received; and

- 2.15.8.3.1.2. The number of overtime approval requests submitted to MassHealth.

2.15.8.4. Internal Management Reports

- 2.15.8.4.1. Upon request, any internal reports that the Contractor uses for internal management shall be provided to EOHHS. Such reports shall include, but not be limited to, internal reports that analyze the medical loss ratio, financial stability, or other compliance reports,

2.15.8.5. Additional Reports

- 2.15.8.5.1. In addition to the reports specifically required in **Appendix A**, the Contractor shall participate with EOHHS in the development of additional reports based on specific topics identified jointly by EOHHS and the Contractor as a result of ongoing analysis and review of data, and/or administrative and clinical processes. The Contractor shall participate in meetings led by EOHHS to develop analytical approaches and specifications for such reports. The Contractor shall produce data and written analyses of each topic in a time frame established by EOHHS but, at minimum, by the end of each Contract Year.
- 2.15.8.5.2. The Contractor shall provide EOHHS, in a form and format approved by EOHHS and in accordance with the timeframes established by EOHHS, all reports, data or other information EOHHS determines are necessary for compliance with federal rules, including, but not limited to, the Affordable Care Act of 2010, Subtitle F, Medicaid Prescription Drug Coverage, and applicable implementing regulations and interpretive guidance and 42 CFR 438.66(e). Further, the Contractor shall correct any errors in such reports in accordance with EOHHS guidelines.
- 2.15.8.5.3. The Contractor shall provide to EOHHS, in accordance with the timeframes and other requirements specified by EOHHS all reports, data or other information EOHHS determines necessary for compliance with program report requirements set forth in 42 CFR 438.66(e).
- 2.15.8.5.4. The Contractor shall report to EOHHS in a form and frequency specified by EOHHS, payment discrepancies and enrollment discrepancies.
- 2.15.8.5.5. The Contractor shall provide and require its Material Subcontractors to provide any information required for the implementation and operation of Electronic Visit Verification (EVV) to ensure that the Contractor's EVV systems comply

with the requirements outlined in Section 12006 of the 21st Century Cures Act (codified as 42 USC 1396b(l)) and as directed by EOHHS.

2.15.8.6. Other Ad Hoc Reports

- 2.15.8.6.1. The Contractor shall provide EOHHS with additional ad hoc or periodic reports related to this Contract at EOHHS's request in the time frame and format specified by EOHHS.

2.15.8.7. Quality Survey Data

- 2.15.8.7.1. The Contractor shall submit to EOHHS all quality, survey, Member experience, process, and other data required by CMS and submitted to CMS or its designee in accordance with the Contractor's Medicare D-SNP Contract for its One Care plan.
- 2.15.8.7.2. The Contractor shall report to EOHHS annually all collected HEDIS, HOS, and CAHPS data, as well as measures related to LTSS. HEDIS, HOS, and CAHPS measures will be reported consistent with Medicare requirements, plus additional Medicaid measures required by EOHHS.
- 2.15.8.7.3. In accordance with **Section 2.14.2.2.3**, and as further specified by EOHHS, the Contractor shall submit HEDIS data annually, six months after the end of the HEDIS reporting period in accordance with the format, method and time frames specified by EOHHS.

2.15.8.8. Grievances and Appeals

- 2.15.8.8.1. In a form, format, and frequency specified by EOHHS, and as described in **Appendix A**, the Contractor shall report:
 - 2.15.8.8.1.1. The number and types of Grievances filed by Enrollees and received by the Contractor, specifying how and in what time frames they were resolved (see **Section 2.13**). The Contractor shall cooperate with EOHHS to implement improvements based on the findings of these reports.
 - 2.15.8.8.1.2. The number, types, status, resolutions, and associated timeframes of Appeals filed (see **Section 2.13**), as well as information on Continuing Services requested or provided, for External Appeals, the Contractor shall report Appeals that go through the CMS Medicare Appeals process (e.g., beginning with the CMS

Independent Review Entity), the Medicaid Appeals process (e.g., beginning with the MassHealth Board of Hearings), or both.

2.15.9. Related Systems

2.15.9.1. System Access Management and Information Accessibility Requirements

- 2.15.9.1.1. The Contractor shall make all Systems and system information available to authorized EOHHS and other agency staff as determined by EOHHS to evaluate the quality and effectiveness of the Contractor's data and Systems.
- 2.15.9.1.2. The Contractor is prohibited from sharing or publishing EOHHS data and information without prior written consent from EOHHS.

2.15.9.2. System Availability and Performance Requirements

- 2.15.9.2.1. The Contractor shall ensure that its Enrollee and Provider web portal functions and phone-based functions are available to Enrollees and Providers twenty-four (24) hours a day, seven (7) days a week.
- 2.15.9.2.2. The Contractor shall draft an alternative plan that describes access to Enrollee and Provider information in the event of system failure. Such plan shall be contained in the Contractor's Continuity of Operations Plan (COOP) and shall be updated annually and submitted to EOHHS upon request. In the event of System failure or unavailability, the Contractor shall notify EOHHS upon discovery and implement the COOP immediately.
- 2.15.9.2.3. The Contractor shall preserve the integrity of Enrollee-sensitive data that resides in both a live and archived environment.

2.15.9.3. Virtual Gateway

- 2.15.9.3.1. If EOHHS directs the Contractor during the term of this Contract to access certain services through the Virtual Gateway, or its successor information system, the Contractor shall:
 - 2.15.9.3.1.1. Submit all specified information including, but not limited to, MDS-HC (or successor) assessment data, invoices,

Contract or other information to EOHHS through these web-based applications;

- 2.15.9.3.1.2. Comply with all applicable EOHHS policies and procedures related to such services;
- 2.15.9.3.1.3. Use all business services through the Virtual Gateway as required by EOHHS;
- 2.15.9.3.1.4. Take necessary steps to ensure that it, and its subcontractors or affiliates, has access to and utilize all required web-based services; and
- 2.15.9.3.1.5. Execute and submit all required agreements, including subcontracts, Memoranda of Agreements, confidentiality and/or end user agreements in connection with obtaining necessary end user accounts for any Virtual Gateway business service.

2.15.9.4. Notification of Hospital Utilization

- 2.15.9.4.1. The Contractor shall indicate, as set forth in **Appendix A**, at a frequency specified by EOHHS, that it has notified each Massachusetts acute hospital of the number of inpatient days of service provided by each hospital to Enrollees who receive inpatient hospital services under this Contract pursuant to M.G.L. c. 118E, § 13F.

2.15.9.5. Certification Requirements

- 2.15.9.5.1. 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 provided in **Appendix A**, certifying that the information, data, and documentation being submitted by the Contractor is true, accurate, and complete to the best of their knowledge, information and belief, after reasonable inquiry, under the penalty of perjury:
 - 2.15.9.5.1.1. Data on which payments to the Contractor are based;
 - 2.15.9.5.1.2. All enrollment information, Encounter Data, and measurement data;
 - 2.15.9.5.1.3. Data related to medical loss ratio requirements in aggregate for the Contractor's Enrollee population;

- 2.15.9.5.1.4. Data or information related to protection against the risk of insolvency;
- 2.15.9.5.1.5. Documentation related to requirements around Availability and Accessibility of services, including adequacy of the Contractor's Provider Network;
- 2.15.9.5.1.6. Information on ownership and control, such as that pursuant to **Section 5.1.6.2.1**;
- 2.15.9.5.1.7. Reports related to overpayments; and
- 2.15.9.5.1.8. Data and other information required by EOHHS, including but not limited to, reports and data described in this Contract.

2.15.9.6. My Services Web Portal

- 2.15.9.6.1. The Contractor's responsibilities related to updating Enrollee information in the My Account Page application may be updated by EOHHS, including for implementation of the "My Services" web portal or similar successor applications.

2.16. Financial Stability Requirements

2.16.1. General

- 2.16.1.1. The Contractor shall remain fiscally sound as demonstrated by meeting the criteria in this **Section**.

2.16.2. DOI Licensure

- 2.16.2.1. The Contractor shall be licensed as a Health Maintenance Organization by the Massachusetts Division of Insurance (DOI), pursuant to 211 CMR 43.

2.16.3. Cash Flow

- 2.16.3.1. 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, and other financial documents, to demonstrate compliance with this requirement for a period specified by EOHHS.

2.16.4. Net Worth

- 2.16.4.1. The Contractor shall comply with the adjusted initial net worth requirements set forth in M.G.L. c 176G § 25(a) and 211 CMR 43:06(1).

2.16.5. Cash Reserves

- 2.16.5.1. Throughout the term of this Contract, the Contractor shall maintain a minimum cash reserve of \$1,000,000 to be held in a restricted reserve entitled "Reserve for MassHealth Managed Care Obligations." Funds from this restricted cash reserve may be dispersed only with prior written approval from EOHHS during the term of this Contract.

2.16.6. Working Capital Requirements

- 2.16.6.1. The Contractor shall demonstrate and maintain working capital as specified below. For the purposes of this Contract, working capital is defined as current assets minus current liabilities. Throughout the term of this Contract, the Contractor shall maintain a positive working capital balance, subject to the following conditions:

- 2.16.6.1.1. If, at any time, the Contractor's working capital decreases to less than 75% of the amount reported on the prior year's audited financial statements, the Contractor shall notify EOHHS within two business days and submit, for approval by EOHHS, a written plan to reestablish a positive working capital balance at least equal to the amount reported on the prior year's audited financial statements.

- 2.16.6.1.2. EOHHS may take any action it deems appropriate, including termination of the Contract, if the Contractor:

- 2.16.6.1.2.1. Does not maintain a positive working-capital balance, or

- 2.16.6.1.2.2. Violates a corrective plan approved by EOHHS.

- 2.16.6.1.2.3. Does not propose a plan to reestablish a positive working capital balance within a reasonable period of time as determined by EOHHS,

- 2.16.6.1.2.4. EOHHS determines that negative working capital cannot be corrected within a reasonable amount of time as determined by EOHHS.

2.16.7. Insolvency Protection

- 2.16.7.1. Throughout the term of this Contract, the Contractor shall remain financially stable and maintain adequate protection against

insolvency, as determined by EOHHS. To meet this general requirement, the Contractor, at a minimum, shall comply with, and demonstrate such compliance to the satisfaction of EOHHS, the solvency standards imposed on HMOs by the Massachusetts Division of Insurance (DOI). A DOI-licensed Contractor shall submit copies of its DOI financial reports to EOHHS on a quarterly basis. The Contractor shall also submit reports set forth in **Appendix A**.

- 2.16.7.2. The Contractor shall immediately notify EOHHS when the Contractor has reason to consider insolvency or otherwise has reason to believe it or any Material Subcontractor is other than financially sound and stable, or when financial difficulties are significant enough for the chief executive officer or chief financial officer to notify the Contractor's board of the potential for insolvency.

2.16.8. Auditing and Other Financial Requirements

2.16.8.1. The Contractor shall:

- 2.16.8.1.1. Ensure that an independent financial audit of the Contractor, and any parent or subsidiary, is performed annually. These audits shall comply with the following requirements and shall be accurate, prepared using an accrual basis of accounting, verifiable by qualified auditors, and conducted in accordance with generally accepted accounting principles (GAAP) and generally accepted auditing standards:

- 2.16.8.1.1.1. No later than 120 days after the Contractor's fiscal year end, the Contractor shall submit to EOHHS the most recent year-end audited financial statements (balance sheet, statement of revenues and expenses, source and use of funds statement, and statement of cash flows that include appropriate footnotes):

- 2.16.8.1.1.1.1. If directed by EOHHS, the Contractor shall produce financial statements for specific lines of business, other Medicaid products, and other Medicare products.

- 2.16.8.1.1.2. The Contractor shall demonstrate to its independent auditors that its internal controls are effective and operational as part of its annual audit engagement. The Contractor shall provide to EOHHS a Service Organization Controls report (SOC1 report) from its independent auditor on the effectiveness of the internal controls over operations of the Contractor, specific to this

Contract in accordance with statements and standards for attestation engagements as promulgated by the American Institute of Certified Public Accountants. The Contractor shall provide such report annually and within 30 days of when the independent auditor issues such report.

- 2.16.8.1.1.3. The Contractor shall submit, on an annual basis after each annual audit, the final audit report specific to this Contract, together with all supporting documentation, a representation letter signed by the Contractor's chief financial officer and its independent auditor certifying that its organization is in sound financial condition and that all issues have been fully disclosed;
- 2.16.8.1.2. Utilize a methodology to estimate incurred but not reported (IBNR) claims adjustments for each Rating Category and annually provide to EOHHS a written description of the methodology utilized in the preparation of the Contractor's audited financial statements to estimate IBNR claims adjustments for each Rating Category. The Contractor shall provide EOHHS with the lag triangles and completion factors used in the development of the quarterly financial reports in accordance with reporting timelines in **Appendix A**. The Contractor shall submit its proposed IBNR methodology to EOHHS for review and approval and, as directed by EOHHS, shall modify its IBNR methodology in whole or in part;
- 2.16.8.1.3. Immediately notify EOHHS of any material negative change in the Contractor's financial status that could render the Contractor unable to comply with any requirement of this Contract, or that is significant enough for the chief executive officer or chief financial officer to notify the Contractor's Governing Board of the potential for insolvency;
- 2.16.8.1.4. Notify EOHHS in writing of any default of its obligations under this Contract, or any default by a parent corporation on any financial obligation to a third party that could in any way affect the Contractor's ability to satisfy its payment or performance obligations under this Contract;
- 2.16.8.1.5. Advise EOHHS no later than 30 calendar days prior to execution of any significant organizational changes, new Material Subcontracts, or business ventures being contemplated by the Contractor that may negatively impact the Contractor's ability to perform under this Contract; and

- 2.16.8.1.6. Not invest funds in, or loan funds to, any organization in which a director or principal officer of the Contractor has a financial interest.

2.16.9. Provider Risk Arrangements

- 2.16.9.1. To the extent permitted by law, the Contractor may enter into arrangements with Providers that place Providers at risk subject to the following limitations:

- 2.16.9.1.1. No incentive arrangement may include specific payments as an inducement to withhold, limit, or reduce services to Enrollees.

- 2.16.9.1.2. The Contractor shall remain responsible for assuring that it complies with all of its obligations under the Contract including, but not limited to, access standards, providing all Medically Necessary One Care Covered Services, including Medicare services and Supplemental Benefits, services described in **Appendix C**, Flexible Benefits pursuant to the Enrollee's Care Plan, including consideration of value and outcomes as described in **Section 2.10.11**, quality, and health equity. The Contractor shall monitor Providers who are at risk to assure that all such requirements are met and shall terminate or modify such arrangements if necessary.

- 2.16.9.1.3. The Contractor shall disclose these arrangements including all contracts, appendices and other documents describing these arrangements, to EOHHS as follows:

- 2.16.9.1.3.1. As a part of Readiness Review;

- 2.16.9.1.3.2. As requested by EOHHS; or

- 2.16.9.1.3.3. If there are any changes in its risk arrangements with any Members of its Provider Network, including, but not limited to, primary care, specialists, hospitals, nursing facilities, other long-term care providers, behavioral health providers, and ancillary services.

2.16.10. Right to Audit and Inspect Books

- 2.16.10.1. The Contractor shall provide EOHHS, the Secretary of the U.S. Department of Health and Human Services, and their designees its books and records for audit and inspection of:

- 2.16.10.1.1. The Contractor's capacity to bear the risk of potential financial losses;

- 2.16.10.1.2. Services performed or the determination of amounts payable under the Contract;
- 2.16.10.1.3. Rates and payments made to Providers for each service provided to Enrollees; and
- 2.16.10.1.4. Financial data and Encounter Data, and related information, including but not limited to such data and information needed for EOHHS to conduct audits for any Contract Year in accordance with 42 CFR 438.602(e).

2.16.11. Other Information

- 2.16.11.1. The Contractor shall provide EOHHS with any other information that EOHHS deems necessary to adequately monitor and evaluate the financial strength of the Contractor or that must be provided to EOHHS by law. Such information shall include, but not be limited to, the revenue, expenses and utilization reports set forth in **Appendix A**, and the outstanding litigation report set forth in **Appendix A**.

2.16.12. Reporting

- 2.16.12.1. The Contractor shall submit to EOHHS all required financial reports, as described in this **Section 2.16** and **Appendix A**, in accordance with specified timetables, definitions, formats, assumptions, and certifications, as well as any ad hoc financial reports required by EOHHS.
- 2.16.12.2. In the event that the Contractor is a non-federally qualified managed care organization (as defined in Section 1310(d) of the Public Health Service Act, it shall report a description of certain transactions with parties of interest, as identified in Section 1903(m)(4)(A) of the Social Security Act.

2.17. Benefit Coordination

2.17.1. General Requirements

2.17.1.1. Coordination of Benefits

- 2.17.1.1.1. EOHHS shall, via the HIPAA 834 Outbound Enrollment file, provide the Contractor with all third party health insurance information on Enrollees where it has verified that third party health insurance exists.
- 2.17.1.1.2. EOHHS shall refer to the Contractor the Enrollee's name and pertinent information where EOHHS knows an Enrollee

has been in an accident or had a traumatic event where a liable third party may exist.

2.17.1.2. The Contractor shall:

- 2.17.1.2.1. Designate a third-party liability (TPL) Benefit Coordinator who shall serve as a contact person for Benefit Coordination issues related to this Contract.
- 2.17.1.2.2. Designate one or more recoveries specialist(s), whose function shall be to investigate and process all transactions related to the identification of TPL.
- 2.17.1.2.3. Perform Benefit Coordination in accordance with this **Section 2.17.1**. The Contractor shall work with EOHHS via interface transactions with the MMIS system to assist with TPL investigations and recoveries.

2.17.1.3. Third Party Health Insurance Information:

- 2.17.1.3.1. The Contractor shall implement procedures to (1) determine if an Enrollee has other health insurance except Medicare Part A and B and MassHealth Standard or CommonHealth, and (2) identify other health insurance that may be obtained by an Enrollee using, at a minimum, the following sources:
 - 2.17.1.3.1.1. The HIPAA 834 Outbound Enrollment File (for more information on this interface with MMIS and all interfaces, in **Appendix J**;
 - 2.17.1.3.1.2. Claims Activity;
 - 2.17.1.3.1.3. Point of Service Investigation (Customer Service, Member Services and Utilization Management); and
 - 2.17.1.3.1.4. Any TPL information self-reported by an Enrollee.

2.17.1.4. At a minimum, such procedures shall include:

- 2.17.1.4.1. If the Contractor also offers commercial policies or a Qualified Health Plan offered through the Exchange, the Contractor shall perform a match within their own commercial plan or Qualified Health Plan offered through the Exchange. If an Enrollee is found to also be enrolled in the Contractor's commercial plan or a Qualified Health Plan offered through the Exchange, the Enrollee's information shall be sent to EOHHS or a designee assigned by EOHHS. EOHHS shall verify the Enrollee's enrollment and eligibility

status and if EOHHS confirms that the Contractor was correct, disenroll the Enrollee retroactive to the effective date of other insurance.

- 2.17.1.4.2. Reviewing claims for indications that other insurance may be active (e.g., explanation of benefit attachments or third party payment).

2.17.2. Third Party Health Insurance Cost Avoidance, Pay and Recover Later and Recovery

- 2.17.2.1. Once an Enrollee is identified as having other health insurance, the Contractor shall cost avoid claims for which another insurer may be liable, except in the case of prenatal services per 42 U.S.C. 1396(a)(25)(E) and 42 C.F.R. § 433.139.

- 2.17.2.2. The Contractor shall perform the following activities to cost avoid, pay and recover later, or recover claims when other health insurance coverage is available:

2.17.3. Cost Avoidance

- 2.17.3.1. The Contractor shall:

- 2.17.3.1.1. On the Daily Inbound Demographic Change File provide all third party liability information on the Contractor's Enrollees;
- 2.17.3.1.2. Pend claims that are being investigated for possible third party health insurance coverage in accordance with EOHHS's guidelines;
- 2.17.3.1.3. Deny claims submitted by a provider when the claim indicates the presence of other health insurance;
- 2.17.3.1.4. Instruct providers to use the TPL Indicator Form to notify EOHHS of the potential existence of other health insurance coverage and to include a copy of the Enrollee's health insurance card with the TPL Indicator Form if possible; and
- 2.17.3.1.5. Distribute TPL Indicator Forms at the Contractor's provider orientations.

2.17.4. Pay and Recover Later

- 2.17.4.1. The Contractor shall take all actions necessary to comply with the requirements of 42 U.S.C. § 1396a(a)(25)(E) and 42 C.F.R. § 433.139.

2.17.5. Recovery

2.17.5.1. The Contractor shall:

- 2.17.5.1.1. Identify claims it has paid inappropriately when primary health insurance coverage is identified. Identification will be achieved through data matching processes and claims analyses;
- 2.17.5.1.2. Implement policies and procedures and pursue recovery of payments made where another payer is primarily liable; and
- 2.17.5.1.3. Develop procedures and train staff to ensure that Enrollees who have comprehensive third-party health insurance are identified and reported to EOHHS.

2.17.6. Reporting

2.17.6.1. Semiannually, the Contractor shall report to EOHHS the following, in accordance with the requirements set forth in **Appendix A**:

- 2.17.6.1.1. Other Insurance – the number of referrals sent by the Contractor on the Inbound Demographic Change File, and the number of Enrollees identified as having TPL on the monthly HIPAA 834 Inbound Enrollment file;
- 2.17.6.1.2. Pay and Recover Later – the number and dollar amount of claims that were paid and recovered later consistent with the requirements of 42 U.S.C. § 1396a(a)(25)(E) and 42 C.F.R. § 433.139;
- 2.17.6.1.3. Cost avoidance – the number and dollar amount of claims that were denied by the Contractor due to the existence of other health insurance coverage on a semiannual basis, and the dollar amount per Enrollee that was cost avoided on the denied claim; and
- 2.17.6.1.4. Recovery Claims that were initially paid but then later recovered by the Contractor as a result of identifying coverage under another health insurance plan, on a semiannual basis, and the dollar amount recovered per Enrollee from the other liable insurance carrier or provider.

2.17.7. Accident and Trauma Identification and Recovery Identification

2.17.7.1. Cost Avoidance and Recovery

- 2.17.7.2. The Contractor shall recover or cost avoid claims where an Enrollee has been involved in an accident or lawsuit in accordance with **Appendix A**.

2.17.8. Claims Editing and Reporting

- 2.17.8.1. The Contractor shall utilize the following claims editing and reporting procedures to identify potential accident and/or other third party liability cases:

- 2.17.8.1.1. Claims Reporting – Specific diagnosis ranges that may indicate potential accident and casualty cases;
- 2.17.8.1.2. Provider Notification – Claims where providers have noted accident involvement;
- 2.17.8.1.3. Patient Questionnaires – Questionnaires will be sent to Enrollees who are suspected of having suffered an injury as a result of an accident; and
- 2.17.8.1.4. Questionnaires will be based on a predetermined diagnosis code range.

2.17.9. Medical Management

- 2.17.9.1. The Contractor shall identify any requested medical services related to motor vehicle accidents, or work-related injuries, and refer these claims to the recoveries specialist for further investigation.

2.17.10. Reporting

- 2.17.10.1. On a semiannual basis, the contractor shall provide EOHHS with cost avoidance and recovery information on accidents and trauma cases as specified in **Appendix A**.

2.17.11. No Third-Party Enforcement

- 2.17.11.1. No person not executing this Contract shall be entitled to enforce this Contract against a party hereto regarding such party's obligations under this Contract.

3 EOHHS Responsibilities

3.1. Contract Management

3.1.1. Administration of FIDE SNP

3.1.1.1. EOHHS shall:

- 3.1.1.1.1.** Designate a contract manager from EOHHS that is authorized and empowered to represent EOHHS about all aspects of the Contract. EOHHS' contract manager shall act as a liaison between the Contractor and EOHHS during the Contract Term, and
- 3.1.1.1.2.** Coordinate a Contract Management Team (CMT) that shall, at EOHHS' discretion and to facilitate joint State/CMS Oversight pursuant to 42 CFR 422.107(e), include at least one (1) representative from CMS.
- 3.1.1.2.** Joint State/CMS Oversight shall include, but not be limited to, EOHHS and CMS sharing with each other relevant plan information, coordinating on program audits, and consulting on network exception requests.
- 3.1.1.3.** At EOHHS direction and discretion, contract management, administration, monitoring, and oversight activities shall be conducted through direct electronic submission of materials to EOHHS, coordinated with CMS reviews, and when specified, shall be via submissions in CMS' Health Plan Management System (HPMS) (or its successor), as indicated in 42 CFR 422.107(e)(3).

3.1.2. Oversight

3.1.2.1. EOHHS shall, through both its contract manager and the CMT:

- 3.1.2.1.1.** Monitor compliance with the terms of the Contract;
- 3.1.2.1.2.** Receive and respond to all inquiries and requests made by the Contractor under this Contract;
- 3.1.2.1.3.** Meet with the Contractor's representative and leadership on a periodic or ad hoc basis for regular monitoring, performance, and contract management;
- 3.1.2.1.4.** Coordinate with the Contractor, as appropriate, on Contractor requests for technical assistance or coordination on Contractor responsibilities;

- 3.1.2.1.5. Make best efforts to resolve any issues applicable to the Contract identified by the Contractor, EOHHS, or in consultation with CMS;
- 3.1.2.1.6. At its discretion, conduct annual validity studies to determine the completeness and accuracy of Encounter Data;
- 3.1.2.1.7. Inform the Contractor of any discretionary action by EOHHS under the provisions of the Contract;
- 3.1.2.1.8. Review, approve (including providing feedback or direction on issues needing resolution prior to approval), otherwise monitor, and coordinate with CMS as needed regarding the Contractor's:
 - 3.1.2.1.8.1. Marketing, Outreach, education, and orientation materials and procedures, and all Member other Member facing communications and materials;
 - 3.1.2.1.8.2. Grievance and Appeals data and procedures; and
 - 3.1.2.1.8.3. Denials, including Prior Authorization and Utilization Management processes, criteria, and related policies;
- 3.1.2.1.9. Receive and respond to incidents and or grievances;
- 3.1.2.1.10. Monitor compliance with all applicable rules and requirements, and issue compliance notices and other compliance actions, as appropriate; and
- 3.1.2.1.11. Sanction, under **Section 5.3.14**, if it determines that the Contractor is in violation of any of the terms of the Contract.
- 3.1.2.2. At its discretion, EOHHS shall conduct periodic audits and surveys of the Contractor, as described under **Section 5.4**, including through on-site and/or virtual visits as determined necessary by EOHHS to verify the accuracy of reported data.
 - 3.1.2.2.1. At the time of such visits, the Contractor shall assist EOHHS in activities pertaining to an assessment of all facets of the One Care Plan's operations including, but not limited to, financial, administrative, clinical, utilization and Network Management, pharmacy and claims processing functions and the verification of the accuracy of all data submissions to EOHHS as described herein.
- 3.1.2.3. If it determines that the Contractor is out of compliance with **Section 5.1** of the Contract, EOHHS shall notify the Secretary of

such non-compliance and determine the impact on the term of the Contract in accordance with **Section 5.5** of the Contract.

- 3.1.2.4. EOHHS shall notify the Contractor, as promptly as is practicable, of any Providers suspended or terminated from participation in MassHealth so that the Contractor may take action as necessary, in accordance with **Section 2.9**.

3.1.3. Performance Evaluation

- 3.1.3.1. EOHHS shall, at its discretion, including in coordination with CMS:

- 3.1.3.1.1. Annually review the impact and effectiveness of the Quality Management/Quality Improvement program by reviewing the results of performance improvement projects, performance on standard measures, and all other quality initiatives specified in **Section 2.14**.
- 3.1.3.1.2. Evaluate, through inspection or other means, the Contractor's compliance with the terms of this Contract, including but not limited to the reporting requirements in **Sections 2.15 and 2.16**, and the performance measurement and performance improvement projects set forth in **Section 2.14** and **Appendix B** and shall at its discretion, monitor and evaluate any or all of the Contractor's operational processes and metrics that indicate the Contractor's organizational health. EOHHS will provide the Contractor with the written results of these evaluations, including in coordination with CMS if applicable, including, at its discretion, feedback on how the Contractor has performed relative to its own historical performance and relative to other managed care plans, Massachusetts FIDE SNP plans, the other One Care plans, or other appropriate benchmarks.
- 3.1.3.1.3. Conduct periodic audits of the Contractor, as further described in **Section 5.4**, including, but not limited to, annual External Quality Review Activities, as specified in **Section 2.14.4** and an annual operational review site visit or virtual visit pursuant to **Section 3.1.2.2**.
- 3.1.3.1.4. Conduct annual Enrollee surveys and provide the Contractor with written results of such surveys.
- 3.1.3.1.5. Evaluate, in conjunction with the U.S. Department of Health and Human Services, through inspection or other means, the quality, appropriateness, and timeliness of services performed by the Contractor and all Network Providers.

- 3.1.3.1.6. Meet with the Contractor at least semi-annually to assess the Contractor's performance.

3.2. Enrollment and Disenrollment Systems

3.2.1. EOHHS will provide to the Contractor:

- 3.2.1.1. Enrollment and disenrollment responses and transactions, including to the Contractor as applicable;
- 3.2.1.2. Rating category determinations and Medicare risk adjustment scores, including to the Contractor, as applicable; and
- 3.2.1.3. Continuous verification of eligibility status.

3.3. Outreach, Marketing, and Education Monitoring

- 3.3.1. The Contractor shall use required Outreach, Marketing, and Education materials that integrate Medicare and Medicaid content as specified, reviewed, and approved by EOHHS pursuant to 42 CFR 422.107(e)(1)(ii), **Section 2.12**, and as further described below.
- 3.3.2. EOHHS shall monitor the Contractor's Outreach, Marketing, and Education activities and distribution of related materials on an ongoing basis, including through:
 - 3.3.2.1. Review and approval of all such materials, which shall be required prior to use, unless otherwise authorized by EOHHS;
 - 3.3.2.2. Random on-site review of Outreach, Marketing, and Education forums, products, and activities;
 - 3.3.2.3. Random review of actual Outreach, Marketing, and Education pieces as they are used in or by the media; and
 - 3.3.2.4. For-cause review of Outreach, Marketing, and Education materials and activities when grievances are made by any source.
- 3.3.3. If EOHHS finds that the Contractor is violating these requirements, EOHHS may issue and sanction and shall monitor the development and implementation of a corrective action plan.
- 3.3.4. EOHHS shall coordinate such monitoring activities with CMS as applicable, and, as described in **Section 2.12**.

4 Payment and Financial Provisions

4.1. One Care Rating Categories and Assignment

4.1.1. Assignment

- 4.1.1.1. EOHHS will assign each Enrollee to a Rating Category according to the individual Enrollee's clinical, functional, and demographic status and setting of care, using the criteria described in **Section 4.1.2**.
- 4.1.1.2. Notwithstanding the provision below requiring submission of an MDS-HC, EOHHS may make temporary Rating Category assignments using other available data sources pending the Contractor's timely submission of a completed MDS-HC.
- 4.1.1.3. EOHHS may propose modifications, additions, or deletions to the Rating Categories over the course of the Contract. EOHHS shall inform the Contractor of such changes to the Rating Categories in writing, and the Contractor shall accept such changes.

4.1.2. Rating Categories

4.1.2.1. Facility-based Care (F1)

- 4.1.2.1.1. Enrollees will be classified as Facility-based Care if they have been identified by MassHealth as having a stay exceeding ninety (90) days in a skilled nursing facility or nursing facility or a chronic hospital, rehabilitation hospital, or a psychiatric hospital.

4.1.2.2. Community Tier 4 – Transitional Living Need (C4):

- 4.1.2.2.1. Enrollees will be classified as Transitional Living Need if they do not meet F1 criteria and they meet all three (3) of the following criteria:
 - 4.1.2.2.1.1. Their most recent MDS-HC assessment submitted to EOHHS indicates the Enrollee has a daily skilled need, or daily chronic and stable routine need for which the Enrollee requires assistance, along with two (2) or more ADL impairments requiring limited assistance to total dependence. The ADL count shall be conducted per **Section 4.1.2.2.1.2** below;
 - 4.1.2.2.1.2. Their most recent MDS-HC assessment submitted to EOHHS indicates one (1) or more of the ICD-10 diagnoses listed below, reflecting traumatic brain injury:

- 4.1.2.2.1.2.1. S06.1 (Traumatic cerebral edema);
- 4.1.2.2.1.2.2. S06.2 (Diffuse traumatic brain injury);
- 4.1.2.2.1.2.3. S06.3 (Focal traumatic brain injury);
- 4.1.2.2.1.2.4. S06.4 (Epidural hemorrhage);
- 4.1.2.2.1.2.5. S06.5 (Traumatic subdural hemorrhage);
- 4.1.2.2.1.2.6. S06.6 (Traumatic subarachnoid hemorrhage);
- 4.1.2.2.1.2.7. S06.8 (Other specified intracranial injuries); and
- 4.1.2.2.1.2.8. Type of residence is equal to a board and care assisted living/group home.

4.1.2.3. Community Tier 3 – High Community Need (C3)

- 4.1.2.3.1. Enrollees will be classified as High Community Needs as follows:

- 4.1.2.3.1.1. Enrollees will be classified as High Community Needs if they do not meet F1 or C4 criteria and their most recent MDS-HC assessment indicates they:

- 4.1.2.3.1.1.1. Have a daily skilled need, or daily chronic and stable routine need, for any qualifying treatments or programs, for which the Enrollee requires assistance;
- 4.1.2.3.1.1.2. Have a skilled need, or a chronic and stable routine need, for which the Enrollee requires assistance, at least three (3) days per week for any qualifying treatment or program along with two (2) or more ADL impairments requiring more than supervision;
- 4.1.2.3.1.1.3. Have four (4) or more ADL impairments requiring more than supervision;
- 4.1.2.3.1.1.4. Have four (4) or more ADL impairments (including those requiring only supervision), and have moderately to severely impaired cognitive decision-making skills; or
- 4.1.2.3.1.1.5. Have four (4) or more ADL impairments (including those requiring only supervision) and have one (1)

or more of the behavioral health diagnoses listed in **Section 4.1.2.4** (i.e., SUD, schizophrenia, or psychosis) below, confirmed in medical records, that are chronic and ongoing.

- 4.1.2.3.1.1.6. All activities will contribute to the ADL impairment count, but limitations dressing upper body and limitations dressing lower body together will be treated as a single ADL. Supervision needs will contribute to the ADL impairment count only if there is a corresponding cognitive deficit or select behavioral health diagnosis also present, and if there are four (4) or more ADL impairments.

- 4.1.2.3.2. Enrollees meeting the above criteria for this rating tier will be further stratified based on the indication of specific diagnoses as follows:

- 4.1.2.3.2.1. Community Tier 3 – Very High Community Need (C3B)

- 4.1.2.3.2.1.1. Enrollee meets the criteria for C3 in **Section 4.1.2.3**, and their most recent MDS-HC assessment indicates one (1) or more of the diagnoses listed below reflecting ALS, Muscular Dystrophy, quadriplegia, or respirator dependence:

- 4.1.2.3.2.1.1.1. G12.21 (ALS);
- 4.1.2.3.2.1.1.2. G71.0 (Muscular Dystrophy);
- 4.1.2.3.2.1.1.3. G71.2 (Muscular Dystrophy);
- 4.1.2.3.2.1.1.4. G80.0 (quadriplegia);
- 4.1.2.3.2.1.1.5. G82.50 (quadriplegia);
- 4.1.2.3.2.1.1.6. G82.51 (quadriplegia);
- 4.1.2.3.2.1.1.7. G82.52 (quadriplegia);
- 4.1.2.3.2.1.1.8. G82.53 (quadriplegia);
- 4.1.2.3.2.1.1.9. G82.54 (quadriplegia);
- 4.1.2.3.2.1.1.10. Z99.11 (respirator dependence); or
- 4.1.2.3.2.1.1.11. Z99.12 (respirator dependence).

4.1.2.3.2.2. Community Tier 3 – High Community Need (C3A)

- 4.1.2.3.2.2.1. Enrollee meets the criteria for C3 in **Section 4.1.2.3** but does not have one of the diagnoses for C3B specified in **Section 4.1.2.3.2.1**.

4.1.2.4. Community Tier 2 – Community High Behavioral Health (C2)

- 4.1.2.4.1. Enrollees will be classified as Community High Behavioral Health if they do not meet F1, C4, or C3 criteria, and their most recent MDS-HC assessment indicates one (1) or more of the behavioral health diagnoses listed below (using ICD-10), reflecting an ongoing condition such as schizophrenia or episodic mood disorder, psychosis, or alcohol or drug dependence not in remission. Diagnoses shall be confirmed in medical records and be chronic and ongoing.

4.1.2.4.1.1. F10.2-F10.29, excluding F10.21 (SUD)

4.1.2.4.1.2. F11.2-F11.29, excluding F11.21 (SUD)

4.1.2.4.1.3. F12.2-F12.29, excluding F12.21 (SUD)

4.1.2.4.1.4. F13.2-F13.29, excluding F13.21 (SUD)

4.1.2.4.1.5. F14.2-F14.29, excluding F14.21 (SUD)

4.1.2.4.1.6. F15.2-F15.29, excluding F15.21 (SUD)

4.1.2.4.1.7. F16.2-F16.29, excluding F16.21 (SUD)

4.1.2.4.1.8. F18.2-F18.29, excluding F18.21 (SUD)

4.1.2.4.1.9. F19.2-F19.29, excluding F19.21 (SUD)

4.1.2.4.1.10. F20-F20.9, F25-F25.9 (schizophrenia)

4.1.2.4.1.11. F28, F29 (other psychosis)

4.1.2.4.1.12. F30-F30.9 (bipolar)

4.1.2.4.1.13. F31-F31.9 (bipolar)

4.1.2.4.1.14. F32-F32.9 (major depression)

4.1.2.4.1.15. F33-F33.9 (major depression)

4.1.2.4.1.16. F34.8, F34.9, F39 (mood disorders)

4.1.2.4.2. Enrollees meeting the above criteria for this rating tier will be further stratified based on criteria developed by EOHHS, which are indicative of higher than average costs for this rating tier. The Rating Category assignment will be as follows:

4.1.2.4.2.1. Community Tier 2 – Community Very High Behavioral Health (C2B).

4.1.2.4.2.1.1. Enrollee meets the criteria of C2 in **Section 4.1.2.4**, and their most recent MDS-HC assessment and/or other information sources reflect one (1) or more specific diagnoses or other characteristics indicative of higher than average costs for this rating tier.

4.1.2.4.2.2. Community Tier 2 – Community High Behavioral Health (C2A)

4.1.2.4.2.2.1. Enrollee meets the criteria of C2 in **Section 4.1.2.4** but does not have one of the diagnoses or characteristics for C2B specified in **Section 4.1.2.4.2.1**.

4.1.2.5. Community Tier 1 – Community Other (C1)

4.1.2.5.1. Enrollees will be classified as Community Other if they do not meet F1, C2, C3, or C4 criteria.

4.2. Payment Methodology and Terms

4.2.1. Payment for FIDE SNP with Exclusively Aligned Enrollment

4.2.1.1. The contractor shall receive monthly capitation payments from EOHHS and from Medicare for each Enrollee.

4.2.1.2. To obtain payment from Medicare, the Contractor shall comply with Medicare Advantage and Medicare Part D requirements, including as required pursuant to its Medicare Advantage D-SNP Contract with CMS.

4.2.2. Medicaid Payment for Enrollees

4.2.2.1. EOHHS will make monthly Medicaid payments to the Contractor for each Enrollee for the Covered Services and activities described in this Contract, in accordance with the Rating Categories described in **Section 4.1.2**, the payment provisions set forth in this **Section 4**, the Base Capitation Rates and payment provisions contained in

Appendix D, and subject to all applicable Federal and State laws, regulations, rules, billing instructions, and bulletins, as amended.

- 4.2.2.2. EOHHS may further apply Risk Adjustment using the blended risk score to the Base Capitation Rates in calculating monthly capitation payments.
 - 4.2.2.3. EOHHS may further apply additional adjustments to the Base Capitation Rates (e.g., Quality Withholds, Alternative Payment Methodologies, or other adjustments described in this **Section 4**), in calculating monthly capitation payments.
 - 4.2.2.4. The Contractor shall accept as payment in full such Risk Adjusted Capitation Rates.
 - 4.2.2.5. EOHHS will make monthly, prospective capitation payments to the Contractor. EOHHS will categorize Enrollees by Rating Category according to the process outlined in **Section 4.1.2**. The Medicaid monthly capitation payment for each Rating Category and Region will be the product of the number of Eligible Enrollees in each Rating Category in each Region, multiplied by the payment rate for that Rating Category and Region, and further multiplied by the Blended Risk Score for that Rating Category and Region, as applicable. Enrollee Contribution to Care amounts will be deducted from the total Medicaid monthly capitation payment amount, in accordance with **Section 4.2.3**.
- 4.2.3. Base Capitation Rates
- 4.2.3.1. In accordance with 42 CFR 438.4, beginning on the Contract Operational Start Date, Base Capitation Rates for each Rating Category and Region in the Contractor's Service Area shall be Actuarially Sound Capitation Rates.
 - 4.2.3.2. These Base Capitation Rates shall be set for each Massachusetts County in which One Care is offered. EOHHS may roll up Counties to Regions for rate setting purposes.
 - 4.2.3.3. Base Capitation Rates shall be incorporated into the Contract in **Appendix D**.
 - 4.2.3.4. The Base Capitation Rate shall reflect the applicable cost of Administrative Services, underwriting gain, care management, all Medicaid services (including services for which Medicaid covers Medicare cost-sharing and Medicaid-only services), and any non-medical costs not otherwise paid for under the Contract, including but not limited to activities related to advancing Health Equity.

- 4.2.3.5. EOHHS intends that the Base Capitation Rates shall be consistent for all One Care Plans.
- 4.2.4. Risk Adjusted Capitation Rates
 - 4.2.4.1. EOHHS may apply risk adjustment to the Base Capitation Rates. Such risk adjustment shall be based on an aggregation of the individual risk profiles of One Care Enrollees, using a risk adjustment methodology to be developed.
 - 4.2.4.2. EOHHS reserves the right to implement such risk adjustment as early as the Contract Operational Start Date.
- 4.2.5. Modifications to Capitation Rates
 - 4.2.5.1. Base Capitation Rates will be updated for January 1st of each calendar year, and as otherwise indicated by EOHHS. EOHHS shall meet with the Contractor annually, upon request, to announce and explain the Base Capitation Rates for the upcoming calendar year.
 - 4.2.5.2. EOHHS will notify the Contractor in advance and in writing of any proposed changes to the Capitation Rates, and the Contractor shall accept such changes as payment in full as described in **Section 4.6**.
 - 4.2.5.3. Prior to the beginning of the Contract Year, EOHHS shall incorporate, by amendment, the Base Capitation Rates by Rating Category and Region into the Contract at **Appendix D**.
 - 4.2.5.4. Prior to the beginning of the Contract Year, the Contractor shall accept the Base Capitation Rates for the new Contract Year as follows:
 - 4.2.5.4.1. In writing, in a form and format specified by EOHHS, by a deadline specified by EOHHS that allows sufficient time for EOHHS to load such Base Capitation Rates into EOHHS's payment system,
 - 4.2.5.4.2. Prior to the beginning of the Contract Year, by executing an amendment to the Contract incorporating the new Base Capitation Rates, as described above.
 - 4.2.5.5. EOHHS may amend the Base Capitation Rates 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 One Care participation requirements, One

Care Covered Services, or primary payer assignment between Medicare and Medicaid.

4.2.6. Timing of Capitation Payments

- 4.2.6.1. EOHHS shall make monthly per Member per month capitation payments to the Contractor. The PMPM capitation payment for a particular month will reflect payment for the Enrollees with effective enrollment into the Contractor's One Care Plan as of the first day of that month, as described in **Section 2.4**.
- 4.2.6.2. The final per Member per month capitation payment made by EOHHS to the Contractor for each Enrollee shall be for the month in which the disenrollment was submitted in accordance with **Section 2.4**, the Enrollee loses eligibility (i.e., the month in which the Enrollee's last day of eligibility occurs), or the Enrollee dies.

4.2.7. Enrollee Contribution to Care Amounts

- 4.2.7.1. If, in the financial eligibility process conducted by EOHHS, an Enrollee residing in a nursing facility is determined to owe a monthly Enrollee-paid amount, such amounts are the Enrollee's contribution to care. At the time of enrollment, and as adjusted thereafter, EOHHS will advise the Contractor of the amount of the Enrollee's contribution to care. When an Enrollee contribution to care is established, EOHHS will subtract that amount from the monthly capitation payment for that Enrollee. The Contractor is responsible for collecting this amount from the Enrollee subject to the Enrollee rights provisions of the Contractor's Evidence of Coverage (see **Appendix N**).

4.2.8. Indian Enrollees and Indian Health Care Providers

- 4.2.8.1. All payments to the Contractor are conditioned on compliance with the provisions below and all other applicable provisions of the American Recovery and Reinvestment Act of 2009. See also 42 C.F.R. § 438.14;
- 4.2.8.2. The Contractor shall offer Indian Enrollees the option to choose an Indian health care provider as a PCP if the Contractor has an Indian PCP in its network that has capacity to provide such services. The Contractor shall permit Indian Enrollees to obtain Covered Services from non-network Indian Health Care Providers from whom the Enrollee is otherwise eligible to receive such services. The Contractor shall also permit a non-network Indian Health Care Provider to refer an Indian Enrollee to a Network Provider;

- 4.2.8.3. The Contractor shall demonstrate that it has sufficient access to Indian Health Care Providers to ensure access to Covered Services for Indian Enrollees;
- 4.2.8.4. The Contractor shall pay both network and non-network Indian Health Care Providers or I/T/U who provide Covered Services to Indian Enrollees a negotiated rate which shall be no lower than the MassHealth fee-for-service rate for the same service or the applicable encounter rate published annually in the Federal Register by the Indian Health Service, whichever is greater, in the absence of a negotiated rate, an amount not less than the amount that the Contractor would pay for the Covered Service provided by a non-Indian Health Care Provider or I/T/U or the MassHealth fee for service rate for the same service, whichever is greater;
- 4.2.8.5. The Contractor shall make prompt payment to Indian Health Care Providers.
- 4.2.8.6. The Contractor shall pay non-network Indian Health Care Providers that are FQHCs for the provision of services to an Indian Enrollee at a rate equal to the rate that the Contractor would pay to a network FQHC that is not an Indian Health Care Provider, including any supplemental payment described in 42 C.F.R. § 438.14(c)(1); and
- 4.2.8.7. The Contractor shall not impose enrollment fees, premiums, or similar charges on Indians served by an Indian Health Care Provider, Indian Health Service, an I/T/U or through referral under contract health services. The Contractor shall exempt from all cost-sharing any Indian Enrollee who is currently receiving or has ever received an item or service furnished by an Indian Health Care Provider or through referral under contract health services.
- 4.2.9. One-time 72 Hour Medication Supply
 - 4.2.9.1. In accordance with 130 CMR 406.414(c), if a pharmacist cannot bill Contractor at the time an Enrollee presents the pharmacist with a prescription for a MassHealth covered medication and MassHealth pays for a one-time seventy-two (72) hour supply of the prescribed medications, the Contractor shall reimburse MassHealth for such sum, as set forth in **Section 2.10.7.9**.
- 4.2.10. Delivery of Medications
 - 4.2.10.1. The Contractor shall reimburse pharmacy providers for delivery of medications to a personal residence (including homeless shelters) at a rate no less, and in a manner no more restrictive, than EOHHS uses in its fee-for-service program.

4.2.11. Federally Qualified Health Centers (FQHC)

- 4.2.11.1. The Contractor shall ensure that its payments to Federally Qualified Health Centers (FQHCs) and Rural Health Centers (RHCs) for services to Enrollees are greater than or equal to the payment amounts described in 42 USC § 1396a(bb). In order to comply with this requirement, the Contractor shall pay FQHCs and RHCs at least the amount EOHHS would pay for such services on a fee-for-service basis as specified in 101 CMR 304.04, et seq., excluding any supplemental rate paid by MassHealth to FQHCs or RHCs.

4.2.12. Loss of Program Authority

- 4.2.12.1. 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 shall do no work on that part after the effective date of the loss of program authority. EOHHS shall adjust capitation rates 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 shall not be paid for that work. If EOHHS or CMS 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 EOHHS or CMS, respectively. However, if the Contractor worked on a program or activity prior to the date legal authority ended for that program or activity, and EOHHS or CMS 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.

4.3. Transitions Between Rating Categories

4.3.1. Rating Category Changes

- 4.3.1.1. The Enrollee's Rating Category Assignment will be updated following a change in an Enrollee's status, based on facility status and the Minimum Data Set-Home Care (the MDS-HC), or any subsequent documentation required by the Commonwealth as follows.
- 4.3.1.2. On a monthly basis, as part of capitation payment processing, the Rating Category of each Enrollee will be determined based on the Enrollee's facility status and the most recent MDS-HC information

as of the 1st of the month. With the exception of F1, Rating Categories will be determined based on assessment information provided to the MassHealth MDS-HC system by the Contractor's nurse reviewers. MDS-HC information will be updated within ninety (90) days of enrollment as described in **Section 2.5.2.3.** and at least annually, including when substantial change in the Enrollee's status occurs.

4.4. Reconciliation

4.4.1. EOHHS shall implement a process to reconcile enrollment and capitation payments for the Contractor that will take into consideration the following circumstances: transitions between Rating Categories, retroactive changes in eligibility, Rating Categories, or Enrollee contribution amounts, and changes through new enrollment, disenrollment, or death. The reconciliation may identify underpayments or overpayments to the Contractor.

4.4.1.1. Reconciliation for transition between Rating Categories includes retroactive reconciliation of up to three (3) calendar months for timely assessments of new Enrollees as described in **Section 2.5.2.3.1.**

4.4.2. EOHHS shall:

4.4.2.1. Perform a quarterly reconciliation of the monthly capitation payments as described below:

4.4.2.1.1. Calculate the correct EOHHS payment of the Capitation Rate for each month per Enrollee by determining the Enrollee's appropriate RC and the appropriate Enrollee contribution, as well as enrollment and eligibility status; and

4.4.2.1.2. Reconcile the monthly EOHHS Capitation Rate paid per Enrollee for each month of the quarter with the correct Capitation Rate.

4.4.2.2. Remit to the Contractor the full amount of any underpayment it identifies. The Contractor shall remit to EOHHS within sixty (60) calendar days the full amount of any overpayments or other payments in excess of amounts specified in the Contract identified by EOHHS pursuant to **Section 4.4.** Such payment shall be made either through a check or, at the discretion of EOHHS, through adjustment or recoupment of future capitation and/or reconciliation payments.

4.4.2.3. Reconciliation for the EOHHS payment may also occur based on a longer and/or older prior period as appropriate and necessary.

4.4.3. Audits/Monitoring

- 4.4.3.1. EOHHS will conduct periodic audits to validate RC assignments or other coding. Audits may be conducted by a peer review organization or other entity assigned this responsibility by EOHHS.

4.4.4. Family Planning Services Reconciliation Process

- 4.4.4.1. EOHHS shall perform an annual family planning services reconciliation as follows. EOHHS shall:
 - 4.4.4.1.1. Calculate all FFS claims paid by EOHHS for family planning services, including family planning pharmacy services, provided to Enrollees each CY; and
 - 4.4.4.1.2. Deduct the amount of such claims paid from a future capitation payment to the Contractor after written notification to the Contractor of the amount and timing of such deduction.

4.4.5. Continuing Services Reconciliation

- 4.4.5.1. For each Contract Year, EOHHS shall perform a Continuing Services reconciliation as follows:
 - 4.4.5.1.1. The Contractor shall process and pay its providers' claims for all Continuing Services at the Contractor's contracted rate with its providers;
 - 4.4.5.1.2. EOHHS shall perform a reconciliation by June 30th, following the end of the CY to determine those Continuing Service claims paid by the Contractor for which the Contractor's Adverse Action was upheld by the BOH and which were provided following the conclusion of the final internal Appeal ("approved Continuing Service claims"); provided, that the Contractor submits to EOHHS by March 31st, following the end of the CY, all data regarding such services as required in **Section 4.4.5.2**; and
 - 4.4.5.1.3. EOHHS shall pay the Contractor no later than twelve (12) months following the end of the CY being reconciled, the total value of the approved Continuing Service claims referenced in **Section 4.4.5.2** that were provided within the applicable CY, provided the Contractor timely submitted all data required by EOHHS pursuant to **Section 4.4.5.2**.
- 4.4.5.2. Approved Continuing Service claims shall include, at a minimum, the following information:

- 4.4.5.2.1. Enrollee information by MassHealth identification number, including Medicare identification number, date of birth, sex, dates of enrollment, the date on which the Continuing Services were provided, and current enrollment status,
- 4.4.5.2.2. Costs incurred, by MassHealth identification number, and Medicare identification number, including date of service,
- 4.4.5.2.3. Such other information as may be required pursuant to any EOHHS request for information,
- 4.4.5.2.4. The reconciliation payment procedures may include an audit, to be performed by EOHHS or its authorized agent, to verify all claims for the Enrollee by the Contractor, and
- 4.4.5.2.5. The findings of such audit shall determine the amount, if any, that the Contractor shall be reimbursed by EOHHS. If an audit is not conducted, EOHHS shall reimburse the Contractor as otherwise provided in this **Section 4.4**.

4.5. Risk Corridors

- 4.5.1. Risk corridors shall be established for Contract Years 1 through 5

4.5.2. General Provisions

4.5.2.1. Calculation of Gains and Losses

- 4.5.2.1.1. The risk-sharing arrangement described in this **Section** of the Contract may result in payment by EOHHS to the Contractor or by the Contractor to EOHHS.
- 4.5.2.1.2. All payments to be made by EOHHS to the Contractor or by the Contractor to EOHHS will be calculated and determined by EOHHS.
- 4.5.2.1.3. All calculations, determined by EOHHS, will be based on the Contractor's reporting of Actual and Adjusted Service and Non-Service Expenditures, as required in **Section 4.5.4** below. All financial reporting will be subject to review and/or audit at EOHHS' discretion.
- 4.5.2.1.4. EOHHS will perform settlements of the payments made by the Contractor to EOHHS, or by EOHHS to the Contractor, as described in **Section 4.5.4** below.

4.5.2.2. Allowable Expenditures

- 4.5.2.2.1. EOHHS shall determine the Adjusted Service Expenditures and the Adjusted Non--Service Expenditures, based on Encounter Data, cost data, and financial reporting data submitted by the Contractor (as required by **Section 4.5.4** below, and **Section 2.15-2.17** of this Contract). EOHHS reserves the right to audit Actual and Adjusted Service and Non--Service Expenditure data.
- 4.5.2.2.2. EOHHS and the Contractor agree that to the extent there are differences in expenditure data reported across various sources, including the encounter, cost, financial reporting, or other data submitted by the Contractor, EOHHS and the contractor shall confer and make a good faith effort to reconcile those differences before the calculation of the settlement.
 - 4.5.2.2.2.1. The review procedures may include a review of the Contractor's Encounter Data and/or audit, to be performed by EOHHS, or EOHHS' authorized agents, to verify that all paid claims for Enrollees by the Contractor are for Covered Services and/or that provider reimbursement is not excessive.
- 4.5.2.2.3. EOHHS reserves the right to adjust expenditures for services that are reimbursed at more than five (5%) percent above the average reimbursement rate of all One Care Plans. Notwithstanding any contractual provision or legal right to the contrary, the Contractor agrees that there shall be no redress against EOHHS for a determination to adjust or a failure to adjust expenditures for services of any One Care Plan.

4.5.3. Risk Sharing Arrangement for the Contract Year

- 4.5.3.1. For all Rating Categories, the Contractor and EOHHS shall share risk on Actual and Adjusted Service and Non-Service Expenditures, by calculating the difference between the Risk Adjusted Capitation Rate Payments and Actual and Adjusted Service and Non-Service Expenditures (Total Adjusted Expenditures) in accordance with the following provisions.
- 4.5.3.2. Risk sharing shall be calculated using a tiered Contractor-level symmetrical risk corridor to include all Medicaid-eligible Adjusted Service and Non-Service Expenditures relative to the Risk Adjusted Capitation payments, and as if all Contractors had received the full quality withhold payment.

- 4.5.3.3. EOHHS shall determine the Contractor's Total Adjusted Expenditures in aggregate across all Rating Categories related to the provision of One Care Covered Services in **Appendix C** and Flexible Benefits for the applicable Contract Year based on the data submitted by the Contractor, as described in **Section 4.5.4** below, and may verify such data in a manner it determines appropriate.
 - 4.5.3.4. For the reports specified in **Section 4.5.4** below, the Contractor shall include 6 months of claims run-out.
 - 4.5.3.5. If the Contractor's Total Adjusted Expenditures (as defined in **Section 1**, and as determined by EOHHS in accordance with the above provisions across all Rating Categories) is greater than or less than the Risk Adjusted Capitation Rate payment, EOHHS and the Contractor shall share the resulting loss or gain, respectively, in accordance with the risk sharing corridors set forth in **Appendix E**.
 - 4.5.3.6. EOHHS shall exclude from all calculations related to this risk sharing arrangement the Contractor's reinsurance premiums paid and recovery revenues received if the Contractor chooses to purchase reinsurance.
- 4.5.4. Risk Sharing Settlement:
- 4.5.4.1. EOHHS shall determine settlement of payments made by the Contractor to EOHHS or by EOHHS to the Contractor under this **Section**. Final settlement amounts shall be calculated for each Contract Year. The settlement shall be based on fifteen (15) months of claims runout and an Incurred But Not Reported (IBNR) estimate.
 - 4.5.4.1.1. For the purpose of the final settlement, the contractor shall provide to EOHHS the following within four hundred-eighty (480) calendar days following the end of each Contract Year:
 - 4.5.4.1.1.1. A complete and accurate report of Actual Non-service Expenditures for Enrollees in the Contract Year;
 - 4.5.4.1.1.2. A complete and accurate report of Actual Service Expenditures, based on category of services, for Enrollees based on claims incurred for the Contract Year, including fifteen (15) months of claims runout;
 - 4.5.4.1.1.3. The Contractor's best estimate of any claims incurred but not reported for claims run-out beyond fifteen (15) months and any IBNR completion factors by category of service;

- 4.5.4.1.1.4. A complete and accurate report of Part D revenue and expenditure, as required under 42 C.F.R. § 423.514(a)(1);
- 4.5.4.1.1.5. A complete and accurate report reflecting any recoveries from other payors outside of claims adjudication that are not reflected in the reported Actual Service Expenditures, including those pursuant to coordination of benefits, third-party liability, rebates, supplemental payments, adjustments in claims paid, adjustments from providers including adjustments to claims paid, and Enrollee contributions to care (as described in **Section 4.2.7**);
- 4.5.4.1.1.6. A complete and accurate report of net reinsurance costs that are included in the reported Actual Non--Service Expenditures;
- 4.5.4.1.1.7. Financial Reports;
- 4.5.4.1.1.8. Encounter Data, as required under **Section 2.15.2** of this Contract, unless otherwise permitted by EOHHS; and
- 4.5.4.1.1.9. The Contractor shall provide any additional information upon request from EOHHS necessary to calculate Total Adjusted Expenditures.
- 4.5.4.1.2. EOHHS shall provide the Contractor with a final risk corridor reconciliation under the risk corridor arrangement by within five hundred and ten (510) calendar days following the end of each Contract Year. Any balance due between the Contractor and EOHHS shall be paid within sixty (60) days of the Contractor receiving the final risk corridor reconciliation from EOHHS.
- 4.5.4.1.3. The Contractor may request an earlier, interim settlement. EOHHS, at its sole discretion, may choose to make the settlement. If such an interim settlement is made:
 - 4.5.4.1.3.1. The balance due for the final settlement shall be net of any payments made for the interim settlement, and shall be paid within sixty (60) days of the Contractor receiving such interim reconciliation from EOHHS; and
 - 4.5.4.1.3.2. For the final settlement, the parties shall comply with the requirements in this **Section 4.5.4**.
- 4.5.5. Medical Loss Ratio (MLR) Requirements

4.5.5.1. Medicaid-only MLR

- 4.5.5.1.1. Annually, and upon any retroactive change to the Capitation Rates by EOHHS, the Contractor shall calculate a Medical Loss Ratio for those Covered Services for which Medicaid is the payor (Medicaid-only MLR) in accordance with 42 CFR 438.8.
- 4.5.5.1.2. The Contractor shall perform such Medicaid-only MLR calculation in the aggregate for the Contractor's Enrollee population and individually for each Rating Category. By July 31 of each year, the Contractor shall report such Medicaid-only MLR calculations for the prior calendar year to EOHHS in a form and format specified by EOHHS and as set forth in **Appendix A**. Pursuant to 42 CFR 438.604(a)(3), such report shall include all of the data on the basis of which EOHHS will determine the Contractor's compliance with the MLR requirement set forth in 42 CFR 438.8, including, but not limited to, the following:
 - 4.5.5.1.2.1. The Contractor shall calculate and report its Medicaid-only MLR as required in **Section 4.5.5.3** below, and in accordance with 42 CFR 438.8, as follows:
 - 4.5.5.1.2.1.1. The numerator of the Contractor's Medicaid-only MLR for each year is the sum of the Contractor's incurred Medicaid claims, expenses for activities that improve health care quality, including medical sub-capitation arrangements, and fraud reduction activities, all of which shall be calculated in accordance with 42 CFR 438.8.
 - 4.5.5.1.2.1.2. The denominator of the Contractor's Medicaid-only MLR for each year is the difference between the total Medicaid capitation payment received by the Contractor and the Contractor's federal, state, and local taxes and licensing and regulatory fees, all of which shall be calculated in accordance with 42 CFR 438.8.
 - 4.5.5.1.2.2. As further directed by EOHHS, the Contractor shall maintain a minimum Medicaid-only MLR of eighty-five (85) percent in the aggregate for the Contractor's Enrollee population. If the Contractor does not maintain such minimum, the Contractor shall, pursuant to 42 CFR 438.8(j), remit an amount equal to the difference between the Contractor's actual Medicaid-only MLR numerator

and the Medicaid-only MLR numerator that would have resulted in a MLR of 85%.

- 4.5.5.1.2.3. Calculation of the Contractor's Medicaid-only MLR for the purposes of determining whether the Contractor has maintained such minimum shall occur before any reconciliation under the risk-sharing arrangement set forth in **Section 4.5.3**.

4.5.5.2. Blended Medicare--Medicaid MLR:

- 4.5.5.2.1. Annually, and upon any retroactive change to the Capitation Rates by EOHHS, the Contractor shall calculate a MLR in the aggregate for all Covered Services (regardless of whether Medicare or Medicaid is the payor) for the Contractor's Enrollee population and individually for each Rating Category, in accordance with 42 CFR 438.8, and any additional guidance provided by EOHHS.
- 4.5.5.2.2. The Contractor shall report such MLR calculations for the prior calendar year in a form and format specified by EOHHS. The Contractor shall report such initial MLR calculations to EOHHS no later than July 31 of each year, or as otherwise directed by EOHHS, and shall report such final MLR calculations, which shall be refreshed to include subsequent reconciliations, to EOHHS by early December of each year, consistent with the due date for Medicare Advantage plans more generally, or as otherwise directed by EOHHS.
- 4.5.5.2.3. The Contractor shall calculate and report its Blended Medicare-Medicaid MLR as required in **Section 4.5.5.2** below, and in accordance with 42 CFR 438.8, as follows:
 - 4.5.5.2.3.1. The numerator of the Contractor's Blended MLR for each year is the sum of the Contractor's incurred Medicaid claims, expenses for activities that improve health care quality, including medical sub-capitation arrangements, and fraud reduction activities, all of which shall be calculated in accordance with 42 CFR 438.8.
 - 4.5.5.2.3.2. The denominator of the Contractor's Blended MLR for each year is the difference between the total capitation payment received by the Contractor and the Contractor's federal, state, and local taxes and licensing and regulatory fees, all of which shall be calculated in accordance with 42 CFR 438.8.

- 4.5.5.2.4. As further directed by EOHHS, the Contractor shall maintain a minimum Blended MLR of eighty-five (85) percent in the aggregate for the Contractor's Enrollee population.
- 4.5.5.2.5. Calculation of the Contractor's Blended MLR for the purposes of determining whether the Contractor has maintained such minimum shall occur before any reconciliation under the risk-sharing arrangement set forth in **Section 4.5.3.**
- 4.5.5.3. Pursuant to 42 C.F.R. § 438.604(a)(3), and any additional EOHHS guidance, such report shall include all of the data on the basis of which EOHHS will determine the Contractor's compliance with the Medicaid MLR requirement set forth in 42 C.F.R. § 438.8. EOHHS will also use this report to inform the combined Medicare and Medicaid program level financial performance. Such MLR calculations described in **Sections 4.5.5.1. and 4.5.5.2.** above shall include at least the following, pursuant to 42 CFR 438.8(k):
 - 4.5.5.3.1. Total incurred claims;
 - 4.5.5.3.2. Expenditures on quality improvement activities;
 - 4.5.5.3.3. Expenditures related to activities compliant with 42 C.F.R. § 438.608(a)(1)-(5),(7),(8), and (b);
 - 4.5.5.3.4. Non-claims costs;
 - 4.5.5.3.5. Premium Revenue;
 - 4.5.5.3.5.1. For the Medicaid-only MLR under **Section 4.5.5.1.** above, the Premium Revenue shall reflect Medicaid revenue. The Contractor shall include the amounts paid back to the Contractor under all quality withhold and quality incentive payments as part of the MLR denominator;
 - 4.5.5.3.5.2. For the Blended Medicare-Medicaid MLR under **Section 4.5.5.2.** above, the Premium Revenue shall be the sum of Medicaid revenue as described in **Section 4.5.5.3.6.** above, and Medicare revenue;
 - 4.5.5.3.6. Taxes, licensing, and regulatory fees;
 - 4.5.5.3.7. Methodology(ies) for allocation of expenses;
 - 4.5.5.3.8. Any credibility adjustment applied, consistent with EOHHS guidance;

- 4.5.5.3.9. Any remittance owed to EOHHS and/or CMS, if applicable;
 - 4.5.5.3.10. The calculated MLR, which shall be the ratio of the numerator (as set forth in **Section 4.5.5.1.2.1.1**) to the denominator (as set forth in **Section 4.5.5.1.2.1.2**);
 - 4.5.5.3.11. A comparison of the information reported in this **Section** with the audited financial report required under **Section 2.16**;
 - 4.5.5.3.12. A description of the aggregation method used in calculating MLR;
 - 4.5.5.3.13. The number of Member months;
 - 4.5.5.3.14. An attestation that the calculation of the MLR is accurate and in accordance with 42 C.F.R. § 438.8 and relevant EOHHS guidance; and
 - 4.5.5.3.15. Any other information required by EOHHS.
- 4.5.5.4. At its discretion, EOHHS may use the Contractor's submitted encounter data to verify the Contractor's reported Medicaid-only MLR and Blended MLR and may impose intermediate sanctions as described in **Section 5.3.14**. in circumstances in which encounter data does not support the Contractor's reported Medicaid-only MLR and/or Blended MLR.

4.6. Payment in Full

- 4.6.1. The Contractor shall accept, as payment in full for all obligations under this Contract, the MassHealth Capitation Rates and the terms and conditions of payment set forth herein.

4.7. Performance Incentive Arrangements and Withholds

4.7.1. General

- 4.7.1.1. Each month EOHHS may withhold a percentage of the Contractor's Estimated Capitation Payment for Performance Incentives.
- 4.7.1.2. All Performance Incentive withholds shall meet the following requirements:
 - 4.7.1.2.1. Performance Incentive withholds shall be for a fixed period of time, which shall be described in the specific Performance Incentive;

- 4.7.1.2.2. No Performance Incentive withhold shall be renewed automatically;
- 4.7.1.2.3. All Performance Incentive withholds shall be made available to both public and private Contractors under the same terms of performance;
- 4.7.1.2.4. No Performance Incentive withhold shall be conditioned on intergovernmental transfer agreements;
- 4.7.1.2.5. All Performance Incentives withholds shall be necessary for the specified activities, targets, and performance measures or quality-based outcomes that support program initiatives as specified by the state's quality strategy under 42 CFR 438.340; and
- 4.7.1.2.6. The Contractor's performance under any Performance Incentive withhold shall be measured during the Contract Year in which the Performance Incentive withhold is effective.

4.7.2. Quality Withhold Policy

- 4.7.2.1. EOHHS will withhold a percentage of the Capitation Rate. The withheld amounts will be repaid subject to the Contractor's performance consistent with established quality thresholds.
- 4.7.2.2. EOHHS will evaluate the Contractor's performance according to the specified metrics required in order to earn back the quality withhold for a given year.
- 4.7.2.3. Whether or not the Contractor has met the quality withhold requirements in a given year will be made public.
- 4.7.2.4. Additional details regarding the quality withholds, including the more detailed specifications, required thresholds and other information regarding the methodology are available in **Appendix L**.
- 4.7.2.5. Withhold Measures in Contract Years 1 through 5
 - 4.7.2.5.1. The quality withhold will be 3.25% in Contract Year 1. . EOHHS may increase the quality withhold in Years 2, 3, 4, and 5, by no more than a 0.25% increase in each subsequent Year.
 - 4.7.2.5.2. Payment will be based on performance on the quality withhold measures listed in Figure 4.2, below. The

Contractor shall report these measures according to the prevailing technical specifications for the applicable measurement year.

- 4.7.2.5.3. If the Contractor is unable to report at least three of the quality withhold measures listed in Figure 4.2 for a given year due to low enrollment or inability to meet other reporting criteria, alternative measures will be used in the quality withhold analysis.

Figure 4.2: Quality Withhold Measures for Contract Years 1 Through 5

Measure	Measure Steward/ Data Source	NQF #	State-Specified Withhold Measure
Controlling High Blood Pressure	NCQA	0018	X
Colon Cancer Screening	NCQA	0034	X
Antidepressant Medication Management*	NCQA	0105	X
Follow-up After Hospitalization for Mental Illness*	NCQA	0576	X
Medication Reconciliation Post-Discharge (Transitions of Care)*	NCQA	0097	X
Member Experience (MA PDP CAHPS)	CMS	N/A	X
Documentation of Care Goals	CMS	N/A	X
Long-term Services and Supports Minimizing Facility Length of Stay	CMS	3457	X
Initiation and Engagement of SUD treatment (IET) – Initiation Total and Engagement Total*	NCQA	0004	X
Diabetes Care: Blood Sugar Controlled	NCQA	0575	X
Breast Cancer Screening	NCQA	2372	X
Plan All-Cause Readmissions	NCQA	1768	X

4.7.3. Finder's Fee Performance Incentive

- 4.7.3.1. If, as further described in **Section 2.3.6** EOHHS determines the Contractor meets the requirements to receive a finder's fee performance incentive, the amount of the incentive payment shall be equal to 50% of the Contractor's pro rata amount of the net state share of the total settlement or verdict amount, based on the Contractor's percentage of the single damages from covered conduct over the relevant time period as determined by EOHHS. The net state share is the gross amount of the verdict or settlement minus any amounts owed as a repayment of federal financial participation to the federal government or other restitution called for in the verdict or settlement.

5 Additional Terms and Conditions

5.1. Administration

5.1.1. Notification of Administrative Changes

- 5.1.1.1. The Contractor shall notify EOHHS and CMS in writing of all changes affecting the delivery of care, the administration of its program, or its performance of Contract requirements. The Contractor shall notify EOHHS in writing no later than 60 days prior to any material change to the way services are rendered to Enrollees, including but not limited to re-procurement or termination of a Material Subcontractor to implementation of new systems or large-scale system updates. The Contractor shall notify EOHHS and CMS in writing, of all other changes no later than five business days prior to the effective date of such change. The Contractor shall notify EOHHS in writing no later than 90 days prior to the effective date of any material administrative and operational change with respect to the Contractor, including but not limited to a change to the Contractor's corporate structure, ownership, or tax identification number.

5.1.2. Assignment or Transfer

- 5.1.2.1. The Contractor shall not assign or transfer any right or interest in this Contract to any successor entity or other entity, including any entity that results from a merger of the Contractor and another entity, without the prior written consent of EOHHS. The Contractor shall include in such request for approval a detailed plan for EOHHS to review. The purpose of the plan review is to ensure uninterrupted services to Enrollees, evaluate the new entity's ability to support the Provider Network, ensure that services to Enrollees are not diminished and that major components of the organization and EOHHS programs are not adversely affected by the assignment or transfer of this Contract.

5.1.3. Independent Contractors

- 5.1.3.1. The Contractor, its employees, Material Subcontractors, 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 the federal government, EOHHS or the Commonwealth of Massachusetts, or CMS.

5.1.4. Subrogation

- 5.1.4.1. Subject to EOHHS and CMS lien and third-party recovery rights, the Contractor shall:
 - 5.1.4.1.1. Be subrogated and succeed to any right of recovery of an Enrollee against any person or organization, for any services, supplies, or both provided under this Contract up to the amount of the benefits provided hereunder; and
 - 5.1.4.1.2. Require that the Enrollee pay to the Contractor all such amounts recovered by suit, settlement, or otherwise from any third person or their insurer to the extent of the benefits provided hereunder.

5.1.5. Prohibited Affiliations and Exclusion of Entities

- 5.1.5.1. In accordance with 42 USC § 1396u-2(d)(1) and 42 CFR 438.610, the Contractor shall not knowingly have an employment, consulting, provider, Material 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.
- 5.1.5.2. The Contractor shall be excluded from participating in MassHealth if it meets any of the conditions set forth in 42 CFR 438.808(b).

5.1.6. Disclosure Requirements

- 5.1.6.1. 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.

5.1.6.2. 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.

5.1.6.2.1. Ownership and Control

5.1.6.2.1.1. 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.

5.1.6.2.2. Business Transactions

5.1.6.2.2.1. 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.

5.1.6.2.3. Criminal convictions

5.1.6.2.3.1. 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.

5.1.6.2.4. Other disclosures

5.1.6.2.4.1. 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.

5.1.6.2.4.2. 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.

- 5.1.6.2.4.3. Unless otherwise instructed by EOHHS, for the purposes of making the disclosures to EOHHS set forth in **Section 5.1.6.2.** above, the Contractor shall fully and accurately complete the EOHHS forms developed for such purpose as specified by EOHHS, 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.
- 5.1.6.2.4.4. EOHHS may immediately terminate this Contract in whole or in part if the Contractor fails to comply with **Section 5.1.** or in response to the information contained in the Contractor's disclosures under **Section 5.1.** 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.

5.1.7. Physician Incentive Plans

The Contractor:

- 5.1.7.1. May, in its discretion, operate a physician incentive plan only if:
 - 5.1.7.1.1. No single physician is put at financial risk for the costs of treating an Enrollee that are outside the physician's direct control.
 - 5.1.7.1.2. No specific payment is made directly or indirectly under the plan to a physician or physician group as an inducement to reduce or limit medically necessary services furnished to an individual Enrollee.
 - 5.1.7.1.3. The applicable stop-loss protection, Enrollee survey, and disclosure requirements of 42 CFR Part 417 are met.
- 5.1.7.2. Shall comply, and assure its Material Subcontractors comply, with all applicable requirements governing physician incentive plans, including but not limited to such requirements appearing at 42 CFR Parts 417, 434 and 1003 and 42 CFR 438.3(i), 422.208 and 422.210. The Contractor shall submit all information required to be disclosed to EOHHS in the manner and format specified by EOHHS.

- 5.1.7.3. Shall be liable for any and all loss of federal financial participation (FFP) incurred by the Commonwealth that results from the Contractor's or its Material Subcontractors' failure to comply with the requirements governing physician incentive plans at 42 CFR Parts 417, 434 and 1003 and 42 CFR 438.3(i), 422.208 and 422.210, provided, however, that the Contractor shall not be liable for any loss of FFP under this provision that exceeds the total FFP reduction attributable to Enrollees in the Contractor's plan, provided, further, that the Contractor shall not be liable if it can demonstrate, to the satisfaction of EOHHS, that it has made a good faith effort to comply with the cited requirements.

5.1.8. National Provider Identifier

- 5.1.8.1. The Contractor shall require each Provider providing Covered Services to Enrollees under this Contract to have a unique identifier in accordance with the system established under 42 U.S.C. 1320d-2(b). The Contractor shall provide such unique identifier to EOHHS for each of its PCPs in the format and time frame established by EOHHS.

5.1.9. Provider-Enrollee Communications

- 5.1.9.1. In accordance with 42 USC 1396u-2(b)(3) and 42 CFR 438.102, the Contractor may not prohibit, or otherwise restrict, a health care professional acting within the lawful scope of practice, from advising or advocating on behalf of an Enrollee who is their patient, for the following:
- 5.1.9.1.1. The Enrollee's health status, medical care, or treatment options, including any alternative treatment that may be self-administered;
 - 5.1.9.1.2. Any information the Enrollee needs to decide among all relevant treatment options;
 - 5.1.9.1.3. The risks, benefits, and consequences of treatment or non-treatment; and
 - 5.1.9.1.4. The Enrollee's right to participate in decisions regarding their health care, including the right to refuse treatment, and to express preferences about future treatment decisions.
- 5.1.9.2. Notwithstanding the provisions of **Section 5.1.9** above, and subject to the requirements set forth below, the Contractor is not required to provide, reimburse for, or provide coverage of, a counseling or referral service if the Contractor objects to the service on moral or religious grounds. The Contractor shall furnish information about

any service the Contractor does not cover due to moral or religious grounds as follows.

5.1.9.2.1. To EOHHS:

5.1.9.2.1.1. With its application for a Medicaid contract; and

5.1.9.2.1.2. At least 60 days prior to adopting the policy during the term of the Contract.

5.1.9.2.2. To potential Enrollees, via enrollment/Marketing materials, at least 30 days prior to adopting the policy during the term of the contract.

5.1.9.2.3. To Enrollees, at least 30 days prior to adopting the policy during the term of the Contract and in the Enrollee handbook. The Contractor shall also describe in the Enrollee handbook that the Enrollee may access such services by contacting MassHealth directly and provide contact information.

5.1.9.3. The Contractor shall accept a reduction in the Capitation Rate for any service it does not provide, reimburse for, or provide coverage of due to moral or religious grounds.

5.1.10. No Enrollee Liability for Payment

5.1.10.1. The Contractor shall:

5.1.10.1.1. Ensure, in accordance with 42 USC §1396 u-2(b)(6) and 42 CFR 438.106, that an Enrollee will not be held liable:

5.1.10.1.1.1. For debts of the Contractor, in the event of the Contractor's insolvency;

5.1.10.1.1.2. For services provided under this Contract, except as otherwise provided in **Section 2.7.4**, to the Enrollee in the event that:

5.1.10.1.1.2.1. The Contractor fails to receive payment from EOHHS or CMS for such services; or

5.1.10.1.1.2.2. A Provider fails to receive payment from EOHHS, CMS, or the Contractor for such services.

- 5.1.10.1.2. Not deny any service provided under this Contract to an Enrollee who, prior to becoming MassHealth eligible, incurred a debt that has not been paid.
- 5.1.10.1.3. Not deny any service provided under this Contract to an Enrollee for failure or inability to pay any charge permitted under **Section 5.1.10.2**.
- 5.1.10.1.4. Return to the Enrollee the amount of any liability inappropriately imposed on and paid by the Enrollee.

5.1.10.2. Copayments and Cost-sharing

- 5.1.10.2.1. As described in **Section 2.7.3**, the Contractor's One Care Plan shall not apply cost-sharing to One Care Enrollees.
- 5.1.10.2.2. The Contractor shall not charge an Enrollee for cost-sharing, coinsurance, deductibles, financial penalties, or any other amount in full or part, for any service provided under this Contract, except as specifically authorized by EOHHS in writing.
- 5.1.10.2.3. The Contractor shall ensure Provider compliance with all Enrollee cost-sharing and payment restrictions.
- 5.1.10.2.4. Contractor shall implement cost-sharing compliance processes as directed by EOHHS. The Contractor shall submit such process to EOHHS for EOHHS approval, modify any part of the process upon receiving feedback from EOHHS, and resubmit such updated proposed process for EOHHS approval. The Contractor shall implement the final, EOHHS-approved process and report on overages as specified in **Appendix A**.
 - 5.1.10.2.4.1. Such processes shall minimally address situations in which an Enrollee is erroneously charged cost-sharing by a Provider and shall not require an Enrollee taking initial action (also referred to as Member overage).
- 5.1.10.2.5. Consistent with the requirements of 42 CFR 422.100, the Contractor shall track the Medicare cost-sharing amounts paid by Enrollees toward the Medicare Maximum Out of Pocket (MOOP) limit and shall apply the data obtained through tracking amounts paid by Enrollees toward the MOOP limit to claims processing and encounter data for purposes of identifying actual Medicaid costs for dual eligible individuals.

5.1.11. Medicaid Drug Rebate

- 5.1.11.1. Non Part D covered outpatient drugs dispensed to Enrollees shall be subject to the same rebate requirements as the State is subject under Section 1927 of the Social Security Act and that the State shall collect such rebates from pharmaceutical manufacturers.
- 5.1.11.2. The Contractor shall submit to EOHHS, on a timely and periodic basis no less than forty-five (45) calendar days after the end of each quarterly rebate period, information on the total number of units of each dosage form and strength and package size by the National Drug Code of each non Part D covered outpatient drug dispensed to Enrollees and other data as EOHHS determines necessary.
- 5.1.11.3. The Contractor shall provide outpatient drugs pursuant to this **Section** in accordance with Section 1927 of the Social Security Act and 42 CFR 438.3(s), including, but not limited, to complying with all applicable requirements related to coverage, drug utilization data, drug utilization review program activities and prior authorization policies.

5.1.12. Covered Entities

- 5.1.12.1. EOHHS and the Contractor acknowledge that they are covered entities, as defined at 45 CFR 160.103.

5.1.13. Contractor's Compliance with HIPAA

- 5.1.13.1. The Contractor represents and warrants that:
 - 5.1.13.1.1. It shall conform to the requirements of all applicable Health Insurance Portability and Accountability Act (HIPAA) requirements and regulations;
 - 5.1.13.1.2. It shall work cooperatively with EOHHS on all activities related to ongoing compliance with HIPAA requirements, as directed by EOHHS; and
 - 5.1.13.1.3. It shall execute, at EOHHS's direction, a Trading Partner Agreement, and any other agreements EOHHS determines are necessary to comply with HIPAA requirements.

5.1.14. Title and Intellectual Property Rights

- 5.1.14.1. Definitions

- 5.1.14.1.1. 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.
- 5.1.14.1.2. 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.

5.1.14.2. Contractor Property and License

- 5.1.14.2.1. The contractor shall 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.
- 5.1.14.2.2. 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.

5.1.14.2.3. 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 Material 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 shall provide to EOHHS the most current copies of any Contractor Property to which EOHHS has rights pursuant to the foregoing, including any related Documentation.

5.1.14.2.4. 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.

5.1.14.3. Commonwealth Property

5.1.14.3.1. In conformance with the Commonwealth Terms and Conditions, all Deliverables created under this Contract whether made by the Contractor, Material 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 Material 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.

- 5.1.14.3.2. All material contained within a Deliverable and created under this Contract are works made for hire.
- 5.1.14.3.3. 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 5.1** 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.
- 5.1.14.3.4. 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.
- 5.1.14.3.5. 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 COMMONWEALTH 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."

5.1.15. Termination Authority

5.1.15.1. The termination provisions contained in this Contract are pursuant to state authority, unless otherwise specifically provided.

5.1.16. Additional Modifications to the Contract Scope

5.1.16.1. In its sole discretion, EOHHS may, upon written notice to the Contractor:

- 5.1.16.1.1. Modify Covered Services,
- 5.1.16.1.2. Require the Contractor to enhance its policies and procedures for promoting information sharing, certified electronic health record (EHR) systems, and Mass Hlway connections,
- 5.1.16.1.3. Modify access and availability requirements and standards,
- 5.1.16.1.4. Implement standardized provider credentialing policies and procedures,
- 5.1.16.1.5. Implement new Encounter Data reporting formats, including, but not limited to, HIPAA 837 standards or X12 837 Post-Adjudicated Claims Data Reporting (PACDR) standards for submission of professional, institution, and dental Encounters and NCPDP format for submission of pharmacy Encounters as well as 277CA for reporting errors, not including Provider or Enrollee supplemental files,
- 5.1.16.1.6. Modify the Withhold provisions, and
- 5.1.16.1.7. Modify the scope of this Contract to implement other initiatives in its discretion.

5.2. Confidentiality

5.2.1. Statutory Requirements

- 5.2.1.1. The Contractor understands and agrees that EOHHS may require specific written assurances and further agreements regarding the security and Privacy of protected health information that are deemed necessary to implement and comply with standards under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) as implemented in 45 C.F.R., parts 160 and 164. The Contractor further represents and agrees that, in the performance of the services under this Contract, it will comply with all legal obligations as a holder of personal data under M.G.L. c. 66A. The Contractor represents that it currently has in place policies and procedures that will adequately safeguard any confidential personal data obtained or created in the course of fulfilling its obligations under this Contract in accordance with applicable State and Federal laws. The Contractor is required to design, develop, or operate a system of records on individuals, to accomplish an agency function subject to the Privacy Act of 1974, Public Law 93 579, December 31, 1974 (5 U.S.C.552a) and applicable agency regulations. Violation of the Act may involve the imposition of criminal penalties.

5.2.2. Personal Data

- 5.2.2.1. The Contractor shall inform each of its employees having any involvement with personal data or other confidential information of the laws and regulations relating to confidentiality.

5.2.3. Data Security

- 5.2.3.1. The Contractor shall take reasonable steps to ensure the security of personal data or other protected information under its control to ensure it is not compromised. The Contractor shall put all appropriate administrative, technical, and physical safeguards in place before the start date to protect the Privacy and security of protected health information in accordance with 45 C.F.R. §164.530(c). The Awardee shall meet the security standards, requirements, and implementation specifications as set forth in 45 C.F.R. part 164, subpart C, the HIPAA Security Rule.

5.2.4. Return of Personal Data

- 5.2.4.1. The Contractor shall return all personal data, with the exception of medical records, furnished pursuant to this Contract promptly at the request of EOHHS in whatever form it is maintained by the Contractor. Upon the termination or completion of this Contract, the

Contractor shall not use any such data, or any material derived from the data for any purpose, and, where so instructed by EOHHS shall destroy such data or material.

5.2.5. Destruction of Personal Data

- 5.2.5.1. For any PHI received regarding an Eligible Beneficiary referred to Contractor by EOHHS who does not enroll in Contractor's plan, the Contractor shall destroy the PHI in accordance with standards set forth in National Institute of Science and Technology (NIST) Special Publication 800 88, Guidelines for Media Sanitizations, and all applicable State and federal Privacy and security laws including HIPAA and its related implementing regulations, at 45 C.F.R. Parts 160, 162, and 164, as may be amended from time to time.

5.2.6. Research Data

- 5.2.6.1. The Contractor shall seek and obtain prior written authorization from EOHHS 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.

5.3. General Terms and Conditions

5.3.1. Applicable Law

5.3.1.1. Compliance with Laws

- 5.3.1.1.1. The Contractor shall comply with all applicable statutes, orders, and regulations promulgated by any federal, state, municipal, or other governmental authority relating to the performance of this Contract as they become effective. Without limiting the generality of the foregoing, the Contractor shall comply with Title VI of the Civil Rights Act of 1964, as implemented by regulations at 45 CFR Part 80, Title IX of the Education Amendments of 1972, the Age Discrimination Act of 1975, as implemented by regulations at 45 CFR Part 91, the Rehabilitation Act of 1973, the Americans with Disabilities Act, the Assisted Suicide Funding Restriction Act of 1997, Titles XIX and XXI of the Social Security Act and waivers thereof, Chapter 141 of the Acts of 2000 and applicable regulations, Chapter 58 of the Acts of 2006 and applicable regulations, 42 CFR Part 438, The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (commonly referred to as the Mental Health Parity Law) and applicable regulations, and relevant provisions of the Patient Protection and Affordable Care Act and Health Care and Education

Reconciliation Act of 2010, including but not limited to Section 1557 of such Act, to the extent such provisions apply and other laws regarding privacy and confidentiality, and as applicable, the Clean Air Act, Federal Water Pollution Control Act, and the Byrd Anti-Lobbying Amendment and, as applicable, the CMS Interoperability and Patient Access Final Rule (CMS 9115-F).

5.3.1.1.2. In accordance with 130 CMR 450.123(B), the Contractor shall review its administrative and other practices, including the administrative and other practices of any contracted Behavioral Health organization, for the prior calendar year for compliance with the relevant provisions of the federal Mental Health Parity Law, regulations and guidance and submit a certification to EOHHS in accordance with 130 CMR 450.123(B)(1)-(3) and any additional instructions provided by EOHHS.

5.3.1.1.3. The Contractor shall be liable for all loss of Federal Financial Participation (FFP) incurred by the Commonwealth that results from the Contractor's failure to comply with any requirement of federal law or regulation.

5.3.2. Sovereign Immunity

5.3.2.1. Nothing in this Contract will be construed to be a waiver by the Commonwealth of Massachusetts of its rights under the doctrine of sovereign immunity and the Eleventh Amendment to the United States Constitution.

5.3.3. Advance Directives

5.3.3.1. The Contractor shall comply with (1) the requirements of 42 CFR Part 489, Subpart I and 42 CFR 422.128, relating to the maintenance of written policies and procedures regarding advance directives, and (2) the requirements of 130 CMR 450.112 and 42 CFR 438.3(j). The Contractor shall provide adult Enrollees with written information on advance directives policies, including a description of applicable state law. The information shall reflect changes in State law as soon as possible, but no later than 90 days after the effective date of the change. Nothing in this Contract shall be interpreted to require an Enrollee to execute an Advance Directive or agree to orders regarding the provision of life sustaining treatment as a condition of receipt of services under the Medicare or Medicaid program.

5.3.4. Loss of Licensure

- 5.3.4.1. If, at any time during the term of this Contract, the Contractor or any of its Providers or Material Subcontractors incurs loss of clinical licensure, accreditation or necessary state or federal approvals, the Contractor shall report such loss to CMS and EOHHS. Such loss may be grounds for termination of this Contract under the provisions of **Section 5.5**.

5.3.5. Indemnification

- 5.3.5.1. The Contractor shall indemnify and hold harmless EOHHS and the Commonwealth from and against any and all liability, loss, damage, costs, or expenses which EOHHS or the Commonwealth may sustain, incur, or be required to pay, arising out of or in connection with any negligent action or inaction or willful misconduct of the Contractor, or any person employed by the Contractor, or any of its Material Subcontractors provided that:

- 5.3.5.1.1. The Contractor is notified of any claims within a reasonable time from when EOHHS becomes aware of the claim, and,

- 5.3.5.1.2. The Contractor is afforded an opportunity to participate in the defense of such claims.

5.3.6. Prohibition against Discrimination

- 5.3.6.1. In accordance with 42 USC § 1396u-2(b)(7) and 42 CFR 438.12, the Contractor shall not discriminate with respect to participation, reimbursement, or indemnification as to any Provider who is acting within the scope of the Provider's license or certification under applicable state law, solely on the basis of such license or certification. If the Contractor declines to include individual or groups of Providers in its network, it shall give the affected providers written notice of the reasons for its decision. This **Section** shall not be construed to prohibit the Contractor from including Providers only to the extent necessary to meet the needs of the Contractor's Enrollees, or from using different reimbursement for different Providers, or from establishing any measure designed to maintain quality and control costs consistent with the responsibilities of the Contractor.

- 5.3.6.2. If a grievance or claim against the Contractor is presented to the Massachusetts Commission Against Discrimination (MCAD), the Contractor shall cooperate with MCAD in the investigation and disposition of such grievance or claim.

- 5.3.6.3. In accordance with 42 U.S.C. § 1396u-2 and 42 CFR 438.3(d), M.G.L. c. 151B, § 4(10), and all other applicable state or federal laws and regulations, the Contractor shall not discriminate and will

not use any policy or practice that has the effect of discriminating against a Member eligible to enroll in the Contractor's MassHealth Plan on the basis of health status, need for health care services, race, color, national origin, sex, sexual orientation, gender identity, or disability.

5.3.7. Anti-Boycott Covenant

- 5.3.7.1. During the time this Contract is in effect, neither the Contractor nor any affiliated company, as hereafter defined, shall participate in or cooperate with an international boycott, as defined in Section 999(b)(3) and (4) of the Internal Revenue Code of 1954, as amended, or engage in conduct declared to be unlawful by M.G.L. c. 151E, §2. Without limiting such other rights as it may have, EOHHS will be entitled to rescind this Contract in the event of noncompliance with this **Section 5.3.7**. As used herein, an affiliated company is any business entity directly or indirectly owning at least 51% of the ownership interests of the Contractor.

5.3.8. Information Sharing

- 5.3.8.1. During the course of an Enrollee's enrollment or upon transfer or termination of enrollment, whether voluntary or involuntary, and subject to all applicable federal and state laws, the Contractor shall arrange for the transfer, at no cost to EOHHS or the Enrollee, of medical information regarding such Enrollee to any subsequent provider of medical services to such Enrollee, as may be requested by the Enrollee or such provider or be directed by EOHHS, the Enrollee, regulatory agencies of the Commonwealth, or the United States Government. With respect to Enrollees who are children in the care or custody of the Commonwealth, the Contractor shall provide, upon reasonable request of the state agency with custody of the Enrollee, a copy of said Enrollee's medical records and any Care Management documentation in a timely manner.

5.3.9. Other Contracts

- 5.3.9.1. Nothing contained in this Contract shall be construed to prevent the Contractor from operating other comprehensive health care plans or providing health care services to persons other than those covered hereunder, provided, however, that the Contractor shall provide EOHHS with a complete list of such plans and services, upon request. EOHHS shall exercise discretion in disclosing information which the Contractor may consider proprietary, except as required by law. Nothing in this Contract shall be construed to prevent EOHHS from contracting with other comprehensive health care plans, or any other provider, in the same Service Area.

5.3.10. Counterparts

- 5.3.10.1. 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.

5.3.11. Entire Contract

- 5.3.11.1. 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 except as otherwise provided in **Section 5.3**. The terms of this Contract shall prevail notwithstanding any variances with the terms and conditions of any verbal communication subsequently occurring, except as otherwise provided herein. This Contract, including the Commonwealth of Massachusetts Standard Contract Form and Commonwealth Terms and Conditions, shall supersede any conflicting verbal or written agreements, forms, or other documents relating to the performance of this Contract.

5.3.12. No Third Party Rights or Enforcement

- 5.3.12.1. No person not executing this Contract is entitled to enforce this Contract against a party hereto regarding such party's obligations under this Contract.

5.3.13. Corrective Action Plan

- 5.3.13.1. If, at any time, EOHHS reasonably determines that the Contractor is deficient in the performance of its obligations under the Contract, EOHHS may require the Contractor to develop and submit a corrective action plan that is designed to correct such deficiency. EOHHS may accept, reject, or require modifications to the corrective action plan based on its reasonable judgment as to whether the corrective action plan will correct the deficiency. The Contractor shall incorporate all modifications and shall promptly and diligently implement the corrective action plan and demonstrate to EOHHS that the implementation of the plan was successful in correcting the problem. Failure to implement the corrective action plan promptly and diligently may subject the Contractor to termination of the Contract by EOHHS or other intermediate sanctions as described in **Section 5.3.14**.
- 5.3.13.2. EOHHS may also initiate a corrective action plan for the Contractor to implement. The Contractor shall promptly and diligently implement any EOHHS-initiated corrective action plan. Failure to

implement the corrective action plan promptly and diligently may subject the Contractor to termination of the Contract by EOHHS or other Intermediate Sanctions as described in this **Section 5.3.14**.

5.3.14. Intermediate Sanctions and Civil Monetary Penalties

5.3.14.1. In addition to termination under **Section 5.5**, EOHHS may impose any or all of the sanctions in **Section 5.3.14** upon any of the events below, provided, however, that EOHHS will only impose those sanctions it determines to be reasonable and appropriate for the specific violations identified. Sanctions may be imposed if the Contractor:

- 5.3.14.1.1. Fails substantially to provide Covered Services required to be provided under this Contract to Enrollees;
- 5.3.14.1.2. Imposes charges on Enrollees in excess of any permitted under this Contract;
- 5.3.14.1.3. Discriminates among Enrollees or individuals eligible to enroll on the basis of health status or need for health care services, race, color or national origin, and will not use any policy or practice that has the effect of discriminating on the basis of race, color, or national origin;
- 5.3.14.1.4. Misrepresents or falsifies information provided to CMS, Enrollees, contractors, or Network Providers;
- 5.3.14.1.5. Fails to comply with requirements regarding physician incentive plans (see **Section 5.1.7**);
- 5.3.14.1.6. Fails to comply with federal or State statutory, regulatory, bulletins or other sub-regulatory requirements related to this Contract;
- 5.3.14.1.7. Violates restrictions or other requirements regarding marketing;
- 5.3.14.1.8. Fails to comply with quality management requirements consistent with **Section 2.14**;
- 5.3.14.1.9. Fails to comply with any corrective action plan required by EOHHS;
- 5.3.14.1.10. Fails to comply with financial solvency requirements;
- 5.3.14.1.11. Fails to meet one or more of the standards for Encounter Data described in this Contract, including accuracy;

completeness, timeliness, and other standards for Encounter Data described in **Section 2.15.2**;

5.3.14.1.12. Fails to comply with reporting requirements, or

5.3.14.1.13. Fails to comply with any other requirements of this Contract.

5.3.14.2. Such sanctions may include:

5.3.14.2.1. Financial measures EOHHS determines are appropriate to address the violation;

5.3.14.2.2. Intermediate sanctions consistent with 42 C.F.R. § 438 Subpart I;

5.3.14.2.3. The appointment of temporary management to oversee the operation of the Contractor in those circumstances set forth in 42 U.S.C. §1396 u 2(e)(2)(B) and 42 C.F.R. § 438.706;

5.3.14.2.4. Notifying the affected Enrollees of their right to disenroll;

5.3.14.2.5. Suspension of enrollment;

5.3.14.2.6. 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,

5.3.14.2.7. Disenrollment of Enrollees;

5.3.14.2.8. Suspension of marketing;

5.3.14.2.9. Limitation of the Contractor's coverage area;

5.3.14.2.10. Additional sanctions allowed under federal law or state statute or regulation that address areas of noncompliance; and

5.3.14.2.11. Such other measures as EOHHS determines appropriate to address the violation.

5.3.14.3. If EOHHS has identified a deficiency in the performance of a Material Subcontractor and the Contractor has not successfully implemented a corrective action plan in accordance with **Section 5.3.13**, EOHHS may:

5.3.14.3.1. Require the Contractor to subcontract with a different Material Subcontractor deemed satisfactory by EOHHS; or

- 5.3.14.3.2. Require the Contractor to change the manner or method in which the Contractor ensures the performance of such contractual responsibility.
 - 5.3.14.4. Before imposing any intermediate sanctions, EOHHS shall give the entity timely written notice that explains the basis and nature of the sanction.
 - 5.3.14.5. For each month where the Contractor has not met data submission standards for Encounter Data as described in **Section 2.15.2, Appendix A**, and elsewhere in this Contract, EOHHS may apply Capitation Payment deduction as follows:
 - 5.3.14.5.1. EOHHS may deduct two (2%) percent from the Contractor's Capitation Payment for each month.
 - 5.3.14.5.2. Once the Contractor has corrected the data submission and EHS is able to validate its accuracy EOHHS shall pay the Contractor the amount of the deduction applied.
 - 5.3.14.5.3. Nothing in this **Section** shall prohibit EHS from imposing additional sanctions for the failure to accurately report Encounter Data.
- 5.3.15. Additional Administrative Procedures
 - 5.3.15.1. EOHHS may, from time to time, issue program memoranda clarifying, elaborating upon, explaining, or otherwise relating to Contract administration and other management matters. The Contractor shall comply with all such program memoranda as may be issued from time to time.
- 5.3.16. Effect of Invalidity of Clauses
 - 5.3.16.1. If any clause or provision of this Contract is in conflict with any federal or State law or regulation, that clause or provision will be null and void and any such invalidity will not affect the validity of the remainder of this Contract. Moreover, the Contractor shall comply with any such applicable state or federal law or regulation.
- 5.3.17. Insurance for Contractor's Employees
 - 5.3.17.1. The Contractor shall agree to maintain at the Contractor's expense all insurance required by law for its employees, including worker's compensation and unemployment compensation, and shall provide EOHHS with certification of same upon request. The Contractor, and its professional personnel providing services to Enrollees, shall obtain and maintain appropriate professional liability insurance

coverage. The Contractor shall, at EOHHS's request, provide certification of professional liability insurance coverage.

5.3.17.2. The Contractor shall offer health insurance to its employees.

5.3.18. Waiver

5.3.18.1. EOHHS's 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, 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.

5.3.19. Section Headings

5.3.19.1. The headings of the Sections of this Contract are for convenience only and will not affect the construction hereof.

5.4. Record Retention, Inspection, and Audit

5.4.1. The Contractor shall cause the administrative and medical records maintained by the Contractor, its Material Subcontractors, and Network Providers, as required by EOHHS and other regulatory agencies, to be made available to EOHHS and its agents, designees or contractors, any other authorized representatives of the Commonwealth of Massachusetts or the United States Government, or their designees or contractors, at such times, places, and in such manner as such entities may reasonably request for the purposes of financial and/or medical audits, programmatic review, inspections, and examinations, provided that such activities shall be conducted during the normal business hours of the Contractor. Such records shall be maintained and available to EOHHS for seven (7) years. Such administrative and medical records shall include but not be limited to Care Management documentation, financial statements, Provider Contracts, contracts with Material Subcontractors, including financial provisions of such Provider Contracts and Material Subcontractor contracts. The Contractor further agrees that the Secretary of the U.S. Department of Health and Human Services or his designee, the Governor or his designee, and the State Auditor or his designee may inspect and audit any financial records of the Contractor or its Material Subcontractors.

5.4.2. Notwithstanding the generality of the foregoing, 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 Material

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.

- 5.4.3. In cases where such an audit or review results in EOHHS believing an overpayment has been made, EOHHS may seek to pursue recovery of overpayments. EOHHS will notify the Contractor in writing of the facts upon which it bases its belief, identifying the amount believed to have been overpaid and the reasons for concluding that such amount constitutes an overpayment. When the overpayment amount is based on a determination by a federal or state agency (other than EOHHS), EOHHS will so inform the Contractor and, in such cases, the Contractor may contest only the factual assertion that the federal or state agency made such a determination. The Contractor may not contest in any proceeding before or against EOHHS the amount or basis for such determination.

5.5. Termination of Contract

5.5.1. Termination without Prior Notice

- 5.5.1.1. In the event the Contractor materially fails to meet its obligations under this Contract or has otherwise violated the laws, regulations, or rules that govern the Medicare or MassHealth programs, EOHHS may take any or all action under this Contract, law, or equity, including but not limited to immediate termination of this Contract. EOHHS may terminate the Contract in accordance with regulations that are current at the time of the termination.
- 5.5.1.2. Without limiting the above, if EOHHS determines that participation of the Contractor in the Medicare or MassHealth program, may threaten or endanger the health, safety, or welfare of Enrollees or compromise the integrity of the MassHealth program, EOHHS, without prior notice, may immediately terminate this Contract, suspend the Contractor from participation, withhold any future payments to the Contractor, or take any or all other actions under this Contract, law, or equity. Such action may precede beneficiary enrollment into any Contractor and shall be taken upon a finding by EOHHS that the Contractor has not achieved and demonstrated a state of readiness that will allow for the safe and efficient provision of covered services to eligible Beneficiaries.

- 5.5.1.3. United States law will apply to resolve any claim of breach of this Contract.

5.5.2. Termination with Prior Notice

- 5.5.2.1. EOHHS may terminate this Contract without cause upon no less than ninety (90) days prior written notice to the Contractor specifying the termination date unless applicable law requires otherwise. If the termination is pursuant to EOHHS's authority under 42 CFR 438.708, such notice shall include the reason for termination and the time and place of the pre-termination hearing pursuant to 42 CFR 438.710(b)(1).
- 5.5.2.2. The Contractor may terminate this Contract without cause upon no less than 180 days prior written notice to EOHHS specifying the termination date unless applicable law requires otherwise.
- 5.5.2.3. In the event that this Contract is terminated with prior notice per this **Section 5.5.2.**, the Contractor shall report Encounter Data and performance measurement results through the effective termination date of the Contract, including but not limited to HEDIS, HOS, and CAHPS, as outlined in **Section 2.15** unless otherwise permitted by EOHHS.

5.5.3. Termination for Cause

- 5.5.3.1. Either party may terminate this Agreement upon ninety (90) days' prior written notice due to a material breach of a provision of this Contract unless EOHHS determines that a delay in termination would pose an imminent and serious risk to the health of the individuals enrolled with the Contractor or the Contractor experiences financial difficulties so severe that its ability make necessary health services available is impaired to the point of posing an imminent and serious risk to the health of its Enrollees, whereby EOHHS may expedite the termination.
- 5.5.3.2. Pretermination Procedures. Before terminating a contract under 42 CFR §438.708, such written notice provided by EOHHS shall include the reason for termination and the time and place of the pre-termination hearing pursuant to 42 CFR 438.710(b)(1). Such written notice shall notify the Contractor of its Appeal rights as provided in 42 CFR §438.710.

5.5.4. Termination due to a Change in Law

- 5.5.4.1. In addition, EOHHS may terminate this agreement upon thirty (30) days' notice due to a material change in law, or with less or no notice if required by law.

5.5.5. Continued Obligations of the Parties

5.5.5.1. In the event of termination, expiration, or non-renewal of this Contract, or if the Contractor otherwise withdraws from the Medicare or MassHealth programs, the Contractor shall continue to have the obligations imposed by this Contract or applicable law. These include, without limitation, the obligations to continue to provide Covered Services to each Enrollee at the time of such termination or withdrawal until the Enrollee has been disenrolled from the Contractor's Plan, provided, however, that EOHHS will exercise best efforts to complete all disenrollment activities within six months from the date of termination or withdrawal.

5.5.5.2. In the event that this Contract is terminated, expires, or is not renewed for any reason:

5.5.5.2.1. If EOHHS elects to terminate the Contract, EOHHS will 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 care.

5.5.5.2.2. If the Contractor elects to terminate or not renew the Contract, the Contractor shall be responsible for notifying all Enrollees and the general public, in accordance with federal and State requirements:

5.5.5.2.2.1. The Contractor shall promptly return to EOHHS all payments advanced to the Contractor for Enrollees after the effective date of their disenrollment;

5.5.5.2.2.2. The Contractor shall supply to EOHHS all information necessary for the payment of any outstanding claims determined by EOHHS to be due to the Contractor, and any such claims shall be paid to the Contractor accordingly;

5.5.5.2.3. If the Contractor has Continued Obligations as described in this **Section**, the Contractor shall accept the Risk-Adjusted Capitation Rate 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, as payment in full for Covered Services and all other services required under this Contract until all Enrollees have been disenrolled from the Contractor's Plan;

5.5.5.2.4. EOHHS shall calculate Gain and Loss as described in **Appendix E**, 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; and

- 5.5.5.2.5. The Contractor shall, to facilitate the transition of Enrollees to another MassHealth One Care Plan, share information with EOHHS relating to its Enrollees, including but not limited to PCP assignment, Enrollees with active prior authorizations, and Enrollees' active drug prescriptions.

5.6. Order of Precedence

- 5.6.1. The following documents are incorporated into and made a part of this Contract, including all appendices:

- 5.6.1.1. This Contract, including any Appendices and amendments hereto;

- 5.6.1.2. The Procurement for One Care Plans and Senior Care Options (SCO) Plans RFR #23EHKAONECARESCOPROCURE;

- 5.6.1.3. The Contractor's response to the Procurement for One Care Plans and Senior Care Options (SCO) Plans RFR #23EHKAONECARESCOPROCURE; and

- 5.6.1.4. Any special conditions that indicate they are to be incorporated into this Contract and which are signed by the parties.

- 5.6.2. In the event of any conflict among the documents that are a part of this Contract, including all appendices, the order of priority to interpret the Contract shall be as follows:

- 5.6.2.1. This Contract, including all appendices;

- 5.6.2.2. The Procurement for One Care Plans and Senior Care Options (SCO) Plans RFR #23EHKAONECARESCOPROCURE;

- 5.6.2.3. The Contractor's response to The Procurement for One Care Plans and Senior Care Options (SCO) Plans RFR #23EHKAONECARESCOPROCURE; and

- 5.6.2.4. Any special conditions that indicate they are to be incorporated into this Contract and that are signed by the parties.

5.7. Contract Term

- 5.7.1. This Contract shall be in effect as of the Contract Effective Date and end on December 31, 2031, subject to (1) the Contractor's acceptance of Capitation Rates as determined by EOHHS under this Contract, (2) the Contractor's satisfactory performance, as determined by EOHHS, of all duties and obligations under this Contract, and (3) the provisions of **Section 5.3**, provided, however that EOHHS may extend the Contract in any increments up to December 31, 2036, at the sole discretion of EOHHS, upon terms agreed upon 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 mutual agreement on terms by both parties, further legislative appropriations, continued legislative authorization, and EOHHS' determination of satisfactory performance.

5.8. Amendments

- 5.8.1. The parties agree to negotiate in good faith to cure any omissions, ambiguities, or manifest errors herein. By mutual agreement, the parties may amend this Contract where such amendment does not violate state or federal statutory, regulatory, or waiver provisions, provided that such amendment is in writing, signed by authorized representatives of both parties, and attached hereto. Further, the Contractor agrees to take such action as is necessary to amend this Contract in order for EOHHS to comply with all applicable state and federal laws, including, but not limited to, the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the Balanced Budget Amendments of 1997 (BBA) and any regulations promulgated thereunder, the Deficit Reduction Act, and Health Care Reform, as well as any regulations, policy guidance, and policies and procedures related to any such applicable state and federal laws. EOHHS additionally reserves the right, at its sole discretion, to amend the Contract to implement judicial orders, settlement agreements, or any state or federal initiatives or changes affecting EOHHS or the Contract. EOHHS may terminate this Contract immediately upon written notice in the event the Contractor fails to agree to any such amendment.
- 5.8.2. EOHHS and 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.

5.9. Written Notices

5.9.1. Notices to the parties as to any matter hereunder will be sufficient if given in writing and sent by certified mail, postage prepaid, or delivered in hand to:

5.9.1.1. To EOHHS:

Assistant Secretary for MassHealth
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

Chief, Long Term Services and Supports
Executive Office of Health and Human Services
One Ashburton Place, 11th Floor
Boston, MA 02108

Director, MassHealth Integrated Care Program
Executive Office of Health and Human Services
One Ashburton Place, 11th Floor Boston, MA 02108

5.9.1.2. To the Contractor:

5.9.1.2.1. Notice to the contractor shall be provided to the individual identified in **Appendix O**.